Reaching men who purchase sex with differentiated service delivery in the Democratic Republic of Congo

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The western and central region of Africa has the third highest burden of people living with HIV (PLHIV) in the world. In 2021, key populations and their sexual partners–including clients of sex workers—accounted for 74 percent of HIV infections in the region. Five countries account for approximately two-thirds of all PLHIV in western and central Africa, one of which is the Democratic Republic of Congo (DRC), with 540,000 PLHIV at the end of 2021.[1]

The DRC is among the five poorest nations in the world. In sub-Saharan Africa, approximately one in six people living in extreme poverty resided in the DRC in 2021. Women in the DRC face significant barriers to economic opportunities,[2] leaving some to engage in sex work as a livelihood; in 2022, there were an estimated 526,000 sex workers in the country. The rate of condom use among sex workers was approximately 47 percent. HIV prevalence in this group was estimated at 7.5 percent in 2021, with 21,000 new infections annually. In contrast, the national HIV prevalence rate in the general population was approximately 0.7 percent.[3]

Historically, HIV programming targeting transactional sex has focused on reaching female sex workers (FSW). However, transactional sex is also associated with a high risk of HIV transmission to clients, who are typically men. These men can be a bridge for HIV transmission between higher- and lower-burden risk networks.[4]

The Meeting Targets and Maintaining Epidemic Control (EpiC) project in DRC, funded by the United States Agency for International Development (USAID) and led by FHI 360, supports HIV prevention and treatment services among FSWs and men who have sex with men (MSM), as well as their sexual partners and children. The project implements the full cascade of HIV services in Kinshasa, Lualaba, and Haut Katanga provinces. To address a gap in uptake of HIV services among MWPS, USAID increased the targets for reaching men who purchase sex (MWPS) for the period October 2020 through September 2021. In response, the EpiC DRC team began implementing multiple strategies to reach, test, and retain MWPS on HIV prevention, care, and treatment.

Identifying men who purchase sex

To reach MWPS, EpiC used known hot spots frequented by FSWs near mining company sites and trucking routes in Haut Katanga and Lualaba. These hot spots are identified and updated yearly through a project-wide mapping exercise. Project staff conducted index testing with FSWs in these areas, with an emphasis on identifying MWPS. Index testing is an HIV case-finding approach in which individuals who test positive for HIV are offered an opportunity to share a list of their sexual and drug-injecting partners, biological children, or risk network members who are at risk of HIV, do not know their status, or have not been tested recently and would therefore benefit from HIV testing.

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From May through July 2022, 42 counselors were trained on safe and ethical index testing and motivational counseling. While FSWs were initially wary about sharing MWPS contacts due to a fear of losing clients or retaliation, counselors were able to gain the trust of FSWs by using concepts they learned in the training. Counselors explained the benefits of sharing sexual contacts' information, taught them approaches to disclose their HIV status to partners, and provided them with resources to help them and their children to stay on treatment in the event of a reactive test result and initiation of antiretroviral therapy (ART). Some health care workers and peer navigators were sex workers themselves and worked closely with nurses during testing and HIV counseling to ensure clients felt safe and supported. Clients were also screened for gender-based violence and intimate partner violence and referred to services as appropriate.. The safety and confidentiality of both the client and partners were assured during index testing and counseling.

EpiC also used risk network referral (RNR) and the enhanced peer outreach approach (EPOA) to reach MWPS. Both approaches allow PLHIV or peer outreach workers to informally refer other members of their risk network to HIV testing services without requiring them to provide a contact's name. In RNR, clients can make confidential referrals by providing the phone numbers of individuals they would like to refer for HIV testing. This approach was suggested in the DRC intervention if clients declined index testing. At the service referral sites, EpiC then conducted a risk assessment in which clients were asked if they had ever purchased sex, to identify MWPS.

EpiC DRC's EPOA initially involved engaging FSW peer educators and navigators to distribute coupons for HIV services to both FSWs and MWPS. In early 2021, the project also began engaging MPWS to play a role in EPOA. MWPS were referred by FSW partners or by staff at one of EpiC DRC's eight drop-in-centers (DICs), and 15 individuals were selected to become mobilizers and trained on key HIV messaging. These MWPS mobilizers reached out to their social and sexual networks to encourage their peers to get tested for HIV and seek other related services. They distributed vouchers to their networks for testing services at the DIC, mobile community testing, or health facilities. The services and the DICs were free, but the vouchers helped staff see how well EPOA was working. For each voucher turned in at the DICs, mobilizers received a US$2 incentive for their efforts.

Reaching MWPS with differentiated service delivery

EpiC adapted HIV services across the cascade to reflect the preferences of MWPS and provide services in locations convenient to them through differentiated service delivery (DSD). DSD allows staff to deliver client-centered care and ensure expanded access to HIV services. Clients were able to access HIV services at community distribution stations for antiretrovirals—known as PODI for *"postes de distribution communautaire"*—which were attached to service delivery points (SDPs) and DICs. The schedules at these locations were made more flexible to accommodate the schedules of MWPS.

Clients were also able to access services through support groups, which provided an opportunity to discuss challenges they faced with HIV services, as well as adherence clubs, which are led by health care workers and focus on supporting clients to adhere to treatment. Fast-circuit programs were also available to "stable" clients— those on treatment for at least six months, virally suppressed, and without other common co-infections. This approach allowed clients to directly access health care facilities or pharmacies without a requirement to receive counseling first.

Self-testing was offered to partners of clients who tested positive. MWPS who tested positive for HIV through self-testing were referred to DICs or health facilities for treatment and viral load monitoring, while those who tested negative were referred for pre-exposure prophylaxis (PrEP), sexually transmitted infection (STI) screening, and other services. Some MPWS mobilizers continued to work with clients after testing and would conduct follow-up visits with MWPS on ART.

Compounding risk factors

To increase understanding of the risks MWPS faced, EpiC DRC collected data on other risk behaviors from 37,997 of the 46,828 MWPS who received HIV testing from FY21 through FY23. Community health workers used the Individual Risk Assessment tool to collect information from individuals at the clinic level before recording it in the DHIS2 eTracker.

Not all MWPS perceive purchasing sex as risky, and many participate in other behaviors with associated HIV risks. Some MWPS overlap with other key population groups, including MSM, people who use drugs including injection drugs, and sex workers. MWPS also tend to have multiple sexual partners, may use substances to reduce inhibitions or increase sexual pleasure, report inconsistent condom use, and have higher rates of STIs than the general population.[5] Among the MWPS, 17.6 percent reported never using a condom, 50.7 percent as sometimes using condoms, and 27.3 percent as often using condoms. Of these, MWPS who reported never using a condom had a 10.1 percent HIV positivity rate, those who sometimes used a condom had 7.7 percent positivity, and those who often used a condom had an HIV positivity rate of 6.6 percent, compared to 4.3 percent among those who reported always using condoms. Of those tested, 64.8 percent reported having an STI in the last three months. Alcohol and drug use were associated with higher rates of HIV (Table 1). These data were used to target hot spots frequented by MWPS with higher risk profiles, as well as to recruit mobilizers matching the demographics of those at higher risk to increase the impact of outreach.

Table 1. Compounding risk factors for HIV among MWPS, FY21–FY23

RISK FACTOR	POSITIVITY RATE
Condom use	
Never	10.1%
Sometimes	7.7%
Often	6.6%
Always	4.3%
No answer	7.4%
STI in last three months	
Yes	9.3%
No	6.9%
No answer	N/A
Alcohol use	
Never	5.5%
A few days	6.9%
Almost every day	7.1%
Every day	8.0%
No answer	8.0%

Outcomes

At the end of Q4 FY23, EpiC had reached 51,015 MWPS with prevention services and 46,828 individuals had been tested for HIV (92 percent). Of those who tested positive, 94 percent (n=3,679) were initiated on treatment, while 92 percent of those testing HIV negative were screened for PrEP services, of whom 17 percent were initiated on PrEP. Barriers to uptake of PrEP cited by MWPS included low perception of risk and the burden of taking a daily pill. Among MWPS, 162 individuals had a documented viral load test result in FY23, of whom 87 percent indicated being virally suppressed (n=141). At the end of Q4 FY23, 79 percent of MWPS who had tested positive during FY23 were offered index services, 52 percent of whom accepted. An average of 5.1 contacts were elicited per case, and 59 percent of contacts were found and tested for HIV. Case finding was notably high for index testing, likely due to peers' ongoing use of the risk assessment tool.

Next steps

In FY24, EpiC DRC plans to continue offering EPOA to reach previously unidentified MWPS for HIV prevention and testing—particularly those who are hard to reach and may be at high risk of HIV. This EPOA effort will be led by FSWs, who will engage MWPS in their own social and sexual networks to be tested for HIV. This is intended to reach MWPS who are not found at traditional hot spots, such as those using mobile phones or the internet to contact and meet sexual partners. EpiC will also continue to implement voluntary index testing strategies to reach more MWPS and their social and risk networks with additional services.

As this work continues, the project will analyze the reasons for low recruitment and performance at some traditional hot spots to optimize case finding. EpiC also plans to identify and roll out additional services that appeal to MWPS to ensure that these clients are retained.

In addition, the EpiC team has provided feedback to the Ministry of Health recommending that the national strategic information system be updated and expanded to include risk population categories, such as MWPS or FSW. Currently, the information system only allows for assigning individuals as female or male. The project will continue working to inform data tracking in FY24.

References

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