

RESEARCH BRIEF

April 2013

Background

Female sex workers (FSW), men who have sex with men (MSM), and transgender women (TW) are key populations that are disproportionately affected by HIV around the world. While key populations are frequently the target of HIV-related surveillance and primary prevention efforts, little is known about the prevention and care experiences of individuals from these groups who are living with HIV, particularly as they relate to the Positive Health, Dignity and Prevention (PHDP) framework. This study explored the prevention, treatment and care needs of FSW, MSM, and TW living with HIV in the Dominican Republic (DR) and Swaziland in order to better tailor PHDP programs and messages to meet their specific needs.

Swaziland and the DR differ on a number of important factors. Swaziland has a widespread generalized HIV epidemic, whereas the DR has a concentrated epidemic characterized by lower population-level HIV prevalence and a disproportionate burden among key populations. In Swaziland, both sex work and same-sex practices are explicitly illegal. While the legal environment is less repressive in the DR, ongoing stigma and discrimination experienced by these two population groups is still significant. Such differences allow the two countries to serve as comparative case studies of the HIV-related experiences of key populations across epidemic typologies and social contexts.

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EXPLORING THE POSITIVE HEALTH, DIGNITY AND PREVENTION NEEDS OF FEMALE SEX WORKERS, MEN WHO HAVE SEX WITH MEN, AND TRANSGENDER WOMEN IN THE DOMINICAN REPUBLIC AND SWAZILAND

KEY FINDINGS AND RECOMMENDATIONS

SOCIAL, STRUCTURAL, AND ECONOMIC CONTEXT OF KEY POPULATIONS

Female sex workers (FSW), men who have sex with men (MSM), and transgender women (TW) in both Swaziland and the Dominican Republic (DR) described a social context characterized by multiple layers of stigma and discrimination related to gender, sexual orientation, professional identity, poverty, and their positive HIV status.

In Swaziland, where both same-sex behavior and sex work are criminalized, police harassment and violence were commonly reported. All key populations in the DR frequently cited barriers to economic opportunity, including discriminatory hiring and firing practices by employers.

In both settings, participants described living in situations of social and economic disadvantage.

Many FSW experienced an ongoing cycle of economic need, sex work, and HIV-infection inhibiting their opportunities to find other work if desired or to practice protective behaviors to avoid further HIV transmission. MSM also reported socio-economic struggles related to their own multi-layered experiences of stigma.

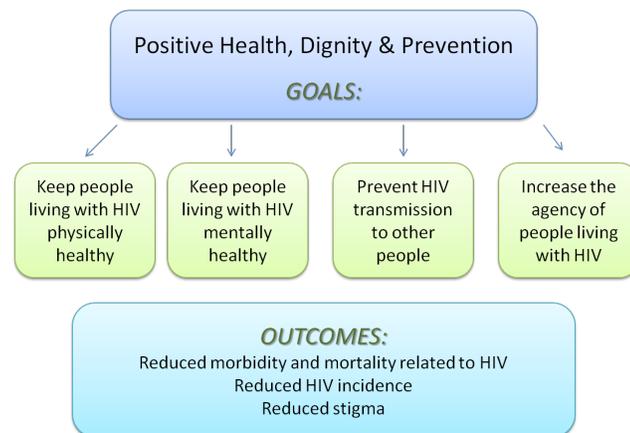
POSITIVE HEALTH, DIGNITY AND PREVENTION FOR KEY POPULATIONS

Examining these multiple layers of stigma in the context of the four goals of positive health, dignity and prevention (as illustrated in the figure below) generated a range of recommendations for interventions aiming to improve the health and well-being, of HIV-positive MSM, FSW, and TW.

1. PROTECTING PHYSICAL HEALTH

In both countries, participants reported perceived and experienced stigma, discrimination and embarrassment related to their sexual and professional identities in health care settings, contributing to low levels of care-seeking. Participants described long lines, high costs of clinic attendance, transportation costs, drug stock-outs, and little continuity of care—barriers that may particularly affect key populations

Abbreviated positive health, dignity and prevention conceptual framework¹



1. Adapted from: Kennedy, C., Medley, A.M., Sweat, M.D., & O'Reilly, K.R. (2010). Behavioral interventions for HIV positive prevention in developing countries: a systematic review and meta-analysis. Bulletin of the World Health Organization, 88, 615-623.



due to their socio-economic vulnerability. Participants did not all agree as to whether there should be special clinics or services for FSW, MSM and TW living with HIV, as some worried targeted services may reinforce stigma.

Recommendations: Train a cadre of peer navigators or “expert clients” to accompany individuals to appointments, identify social service programs, and provide social support. At the policy level in both countries, there is a need for greater advocacy to address the sustainability of access to treatment for key populations, to provide nutritional and economic support to facilitate optimal engagement with health services, and to train health care providers to be sensitive to the needs of key populations. Specialized clinics and services for key populations should be considered carefully based on the local context.

2. PROTECTING MENTAL WELL-BEING

While participants in both countries described very similar psychosocial support needs, the availability of services varied substantially. Key populations in the DR described greater use of formal mental health services than those in Swaziland. They did, however, note financial barriers to attending these services, as well as the fear of facing the additional burden of mental health stigma.

Recommendations: Existing HIV clinics should aim to integrate psychosocial counseling and support into their package of services. Developing discreet, safe support groups and socio-economic opportunities for key populations could help to address the gaps in psychosocial support and economic stability.

3. PREVENTING ONGOING HIV TRANSMISSION

Participants expressed a strong desire to prevent transmission of HIV to their partners, though participants in Swaziland emphasized an unmet need for HIV prevention services and limited distribution of condoms and lubricants. They also described assumptions of heterosexuality and monogamy by clinical providers, limiting opportunities for relevant conversations about safer sex in the context of sex work or same-sex practices. In both countries, participants emphasized that they tried to use condoms with every partner, although economic necessity hindered some FSW whose clients offered more money in exchange for sex without condoms. Another challenge was using condoms in more long-standing and intimate relationships.

Recommendations: Ensure access to basic prevention technologies including condoms and lubricants. Sensitize health care providers to specific safer sex needs of key populations living with HIV. Additionally, further outreach and education should be developed to target regular partners to safely address HIV protective behaviors, such as condom use, that require agreement from both members of the couple.

STUDY METHODS & DESIGN

Across both countries, a qualitative approach was used to address the study aims. Methods included (1) key informant interviews (n=47) with HIV program planners, policy makers, clinicians, and community leaders from the FSW, MSM and TW communities, (2) longitudinal in-depth interviews with FSW (n=41), MSM (n=36), and TW (n=5), all of whom were living with HIV, and (3) focus groups with FSW (3 groups per country, 43 total participants) and MSM (3 groups per country, 45 total participants). Interviews and focus group discussions were recorded, transcribed and analyzed using narrative and thematic coding procedures intended to preserve the holistic nature of participants’ stories while also identifying topical information related to study aims.

4. ENSURING AGENCY AND INVOLVEMENT IN PROGRAMS, ADVOCACY, AND POLICY-MAKING

Many participants in the DR were actively involved in education and support activities to prevent the further spread of HIV in their communities. They indicated that participation in these activities made them feel better, gave them a sense of purpose, and improved their own mental health. Participants in Swaziland, however, reported more challenges in becoming involved due to extremely heightened stigma and their hidden identities. For some individuals, this stigma means that they are not yet ready to participate openly in the HIV advocacy and prevention activities. However, ongoing activities in Swaziland and findings from this research suggest if approached in the right way, many MSM and FSW, including those living with HIV, are interested in participating in HIV prevention, care and treatment decisions for their communities.

Recommendations: Support for involvement of key populations in advocacy activities and policy-making must be designed with the specific legal structure and social consequences in each setting in mind.

CONCLUSION

This study highlights the need to develop integrated HIV prevention, treatment and care programs, supporting biomedical, behavioral, social and structural intervention elements for key populations. There are additional needs for community mobilization strengthening, safe work spaces, and health sector interventions/trainings to combat stigma and discrimination to more effectively meet the PHDP needs of FSW, MSM and TW. Areas for future research include further exploration of the multi-layered stigma faced by key populations, and the development and evaluation of tailored PHDP policies and programs for key populations in diverse socio-political and epidemiologic settings.