

Applying Innovative Approaches for Reaching Men Who Have Sex With Men and Female Sex Workers in the Democratic Republic of Congo

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Background: In the Democratic Republic of Congo (DRC), men who have sex with men (MSM) and female sex workers (FSW) have the highest HIV prevalence but have the least access to services due to their marginalization within Congolese society.

Methods: The Projet Intégré de VIH/SIDA au Congo (ProVIC) aims to reduce the risk and impact of HIV in the DRC through community- and facility-based prevention, counseling and testing, and treatment strategies aimed at high-risk populations, including MSM and FSW. To more effectively meet the needs of key populations, ProVIC tailored the existing interventions to better suit MSM and FSW by offering mobile counseling and rapid HIV testing services at night in MSM and FSW “hotspots,” targeting outreach to and mobilizing key populations through social networks of MSM and FSW peer educators and recruiters, and referring MSM and FSW who test HIV positive to “friendly” clinics.

Results: Through these approaches, ProVIC was able to reach 2,621 MSM and 12,746 FSW with targeted prevention messaging in 2013 and provide testing and counseling services to 4,366 MSM and 21,033 FSW from October 2012 to June 2014.

Conclusions: By applying innovative adaptations geared toward key populations, ProVIC has been able to better reach MSM and FSW in the DRC. ProVIC’s targeted interventions for MSM and FSW provide promising examples of programming that can be used to meet the HIV prevention and testing needs of key populations and

improve referrals for care and treatment, particularly in complex and unstable settings similar to the DRC.

Key Words: key populations, at-risk populations, men who have sex with men, sex workers, HIV, Democratic Republic of Congo

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INTRODUCTION

The Democratic Republic of Congo (DRC) is still struggling to emerge from 2 decades of armed conflict, which devastated the country’s economic and social welfare systems. Although political and economic progress has been achieved in recent years, the DRC is still one of the least developed countries, ranking 186 out of 187 on the Human Development Index in 2014, with an estimated 74% of its population living in poverty.^{1,2} The Congo Wars ravaged the DRC’s health care system, which the government is currently working to rebuild. However, the government faces several challenges that keep it from delivering high-quality health services to Congolese citizens, including inadequate transport and energy infrastructure and limited financial resources devoted to health.³

Preliminary results from the 2013–2014 Demographic and Health Survey indicate a national HIV prevalence of 1.2% among individuals aged 15–49 years.⁴ Although the general HIV prevalence rate is relatively low in the DRC when compared with its regional neighbors, HIV is more concentrated in certain geographic areas and populations. Key populations, particularly men who have sex with men (MSM) and female sex workers (FSW), are also disproportionately infected with HIV in the DRC, mirroring global trends. The 2013 Global AIDS Response Report for the DRC estimated the HIV prevalence rate among MSM at 17.9% and the rate among FSW at 6.9%.⁵ Research has shown that stigma, discrimination, and criminalization can impede access to care, inhibit service uptake, and reduce the disclosure of risks, thus increasing the vulnerability of MSM and FSW to HIV.⁶ MSM and FSW also have limited access to HIV prevention commodities, such as condoms and lubricants, as well as HIV education and counseling on sexual risk reduction. To date, HIV prevention efforts aimed at key populations in Africa have been insufficient to fully address the needs of these groups, leading to calls within the literature to identify approaches to better reach key populations.⁷

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This case study describes adaptations that the *Projet Intégré de VIH/SIDA au Congo (ProVIC)* made to its community-based prevention and HIV counseling and testing (HCT) approaches to better reach marginalized MSM and FSW populations with prevention messaging and treatment options. ProVIC is a 6-year project funded by the US President's Emergency Plan for AIDS Relief through the US Agency for International Development that began in 2009. It focuses on building the technical and organizational capacity of communities, health facilities, and nongovernmental organizations (NGOs) to provide HIV prevention, counseling, testing, care, support, and treatment services to reduce the incidence of HIV and mitigate its impact on people living with HIV, orphans and vulnerable children, and their families. ProVIC worked in 5 provinces in the DRC:

- Katanga, the heart of the DRC's mining sector and a major transit zone bordering Zambia and linked to southern Africa, with a large population of miners, trucker drivers, sex workers, and migrant workers.
- Kinshasa, the capital of the DRC, with a dense urban population of 10–12 million inhabitants.
- Sud Kivu and Orientale, conflict-prone areas that host significant populations of displaced people, Congolese military forces, and illegally armed militias.
- Bas-Congo, the site of the DRC's key seaports and a hub for truck drivers, traders, and sex workers.

ProVIC engaged with both communities and health facilities to provide a holistic package of HIV/AIDS services to individuals in the project's targeted areas in the DRC. ProVIC's primary strategy for mobilizing communities in HIV prevention and mitigation was through the *Champion Community (CC)* approach, a participatory process that empowered communities to identify needs and self-organize, plan, and self-evaluate tailored, community-level responses to the HIV epidemic. Guided by elected steering committees and annual action plans, CCs lead HIV prevention, care, and support activities, carried out by community health workers and caregivers, with linkages to local health facilities. An evaluation of the community's progress in achieving stated goals, led by ProVIC and the local health zone office, is held toward the end of the 12-month implementation cycle, and a community is awarded the status of "Champion Community" upon reaching their established targets and goals.⁸ ProVIC contracted with 14 local NGO partners to create and support 44 traditional CCs in the 5 provinces ProVIC worked in.

ProVIC also worked with local health facilities to provide follow-up testing, care, and treatment to HIV-positive individuals. In addition to daytime community-based mobile HCT activities, ProVIC offered HCT services at health facilities. Individuals who tested positive at community HCT sessions were referred to health facilities where they were able to access a comprehensive package of services, including HIV treatment, prevention of mother-to-child transmission services, palliative care, screening for tuberculosis, other sexually transmitted infections (STIs), and gender-based violence, and counseling on nutrition and family planning.

METHODS

ProVIC staff observed that project interventions, including the traditional CC model, were not very effective in reaching certain high-risk population groups that tend to be more mobile and not well-integrated into traditional community structures or processes. ProVIC noted that the least reached group among key populations targeted across all project interventions was MSM, numbering only 2.1% of individuals in at-risk groups reached with prevention messaging from 2010 to 2011. ProVIC tailored existing interventions to better reach MSM and FSW by

- adapting the traditional CC approach to create CCs around key population networks;
- offering prevention, counseling, and testing services at night in MSM and FSW "hotspots"; and
- referring HIV-positive MSM and FSW to "friendly" health clinics.

Champion Communities of Key Populations

In October 2012, ProVIC adapted the traditional model to create CCs of key population groups as a mechanism to associate MSM and FSW and provide them with HIV/AIDS knowledge, best practices, and information on safe and responsible behaviors. In contrast to the traditional CC model, which aims to engage all individuals living within a community, the key population CCs are created around networks of MSM and FSW who live within a larger urban area. ProVIC established 5 key population CCs in major urban hubs within the 5 provinces the project operated in, including Kinshasa, Matadi, Kisangani, Lubumbashi, and Bukavu. The key population CCs follow the same 12-month implementation cycle as a traditional CC, but also include an HIV vulnerability and beneficiary identification mapping exercise. This mapping exercise, carried out by community outreach workers, steering committee members, and peer educators from key population CCs, identifies the most vulnerable groups and high-risk behaviors within communities, as well as areas and venues frequented by key populations.

Providing HIV services through CCs of MSM and FSW has allowed ProVIC to tailor communication, messaging, and care services to the specific health needs of these groups. Information gathered through the mapping exercises is used to adapt messaging provided by peer educators during HIV prevention and sensitization sessions. ProVIC collaborated with the national AIDS program to revise peer educator training manuals to incorporate MSM- and FSW-specific prevention, care, and treatment information, including content on sexual violence, family planning, condom usage, and recognition and treatment of STIs. ProVIC also improved the package of services given to MSM at "moonlight" HCT sessions by including lubricants in prevention packets distributed to individuals at mobile HCT sessions and intensifying referrals to MSM- and FSW-friendly clinics for STI screening and treatment.

ProVIC recruits peer recruiters and educators on a voluntary basis by holding recruitment sessions at known MSM and FSW "hotspots," where information on the project's goals, the CC approach, and responsibilities of a peer recruiter and educator is provided. Peer recruiters and educators are

representative of the key population CC they work with, and selected volunteers are trained for 5 days on HIV, family planning, and sexual health issues specific to MSM and FSW. Peer recruiters have been critical to encouraging the uptake of HCT services among MSM and FSW communities by increasing awareness of upcoming HIV screening events within their urban centers. Awareness is increased by walking through communities distributing condoms, inviting individuals to get tested for HIV in mobile tents, and counseling those being tested. Peer recruiters also sent messages using coded language, known within MSM and FSW communities, through Facebook, e-mail, and SMS (short message service) to inform their social networks about upcoming testing events, encourage peers to get tested, and ease fears about testing. Peer educators have organized HIV sensitization activities within their networks, promoted the proper use of condoms and water-based lubricants, and raised awareness on proper care of STIs and available care and support services for MSM and FSW.

Mobile “Moonlight” HCT

The offering of mobile HCT at night was an adaptation made specifically to increase the number of MSM and FSW being tested for HIV, with the goal of identifying those who are HIV positive so they can be referred for treatment. ProVIC conducts mobile HCT services at night in known MSM and FSW “hotspots” around bars, nightclubs, and other commercial areas where MSM and FSW typically congregate, as identified through mapping exercises carried out by key population CCs.

Referrals to MSM- and FSW-Friendly Clinics

To better support individuals who test HIV positive move through the continuum of care, peer educators from key population CCs sought to identify MSM- and FSW-friendly health clinics where MSM and FSW can be linked to follow-up care and safely receive treatment without discrimination. St. Hilaire Health Center, well known in Kinshasa as an MSM- and FSW-friendly health facility, was identified as a “friendly” site for referrals, but the health clinic, like many others in the DRC, lacked the resources needed to address the needs of MSM and FSW. ProVIC provided St. Hilaire with tools to improve prevention and treatment services offered to MSM and FSW and funding to purchase specialized medical equipment, including a portable x-ray machine and proctoscopes. MSM who test positive at ProVIC HCT sessions are referred to St. Hilaire if they are in Kinshasa or to local health facilities regarded as the least discriminating if they are in other provinces. FSW who test positive at HCT sessions are referred either to a health facility within the health zone the HCT session was offered or to a “friendly” site, based on their preference.

Data Collection

ProVIC’s monitoring and evaluation system is aligned with President’s Emergency Plan for AIDS Relief indicators. ProVIC collects data on project indicators through data cards, completed by ProVIC-supported NGOs and health facilities

and submitted to ProVIC on a monthly basis. ProVIC’s monitoring and evaluation staff then uploads data received from partners into ProVIC’s online database to monitor the progress of project activities and analyze trends.

RESULTS

By incorporating these 3 adaptations into project interventions, ProVIC was able to achieve the following results:

- 2,621 MSM and 12,746 FSW were reached with targeted prevention messaging in 2013, in comparison to 757 MSM and 7,206 FSW reached in 2012, before the creation of key population CCs. The number of MSM and FSW visiting clinics for HIV testing services doubled, from 7,968 individuals in 2012 to 15,368 individuals in 2013.⁹
- 4,366 MSM and 21,033 FSW were provided with HIV testing and counseling services from October 2012 to June 2014. Of those tested, 1,406 FSW and 537 MSM were seropositive, a rate of 6.7% and 12.3%, respectively.
- 779 MSM visited St. Hilaire Health Center from October to December 2013, and 693 FSW also visited St. Hilaire during the same period.

MSM and FSW peer recruiters and educators have played an instrumental role in key population CCs, working through their social networks to increase awareness of sensitization and testing activities and mobilizing other MSM and FSW to be more actively involved in the activities of these CCs and advocacy efforts. A steering committee member of a FSW CC in Orientale province noted, “As I am the leader of the group, FSWs listen to me carefully and during sensitization campaigns ... many FSWs have agreed to be tested. They also suggested that we regularly organize sensitization in [poor neighborhoods].” Outreach to MSM and FSW by peers who live in these same communities also seems to help establish a foundation of trust, potentially decreasing the fear of stigmatization among MSM and FSW who attend sensitization and testing activities. According to an MSM peer educator in Kisangani, “Before ProVIC, it was not easy to express ourselves in society. Today, we not only have been trained among other members of the community to be involved in the fight against HIV and AIDS, but more importantly, we are more confident, empowered, and valued through the sensitization and awareness work that we do for the benefit of the whole community.”

ProVIC staff also observed that local authorities’ attitudes, especially towards homosexuality, seemed to be an important factor in the effectiveness of key population CCs. For example, in Kinshasa, where the MSM community has a stronger presence and more dynamic advocacy efforts, there was less discrimination against peer recruiters and educators from key population CCs than in more rural areas, such as Bukavu in Sud Kivu province, where MSM peer educators and human rights activists were repeatedly harassed and, in some instances, threatened and jailed.

DISCUSSION

Evidence shows that key populations, such as MSM and FSW, have not been effectively accessing HIV services

and they are at extremely high risk for new infection, but information on how to best reach these groups is limited, especially within postconflict settings with poor infrastructure and low resources. By innovatively adapting existing programs geared toward the general population, ProVIC has reached large numbers of MSM and FSW with HIV prevention, testing, and care services.

The results associated with key population CCs in the DRC suggests that creating CCs around specific beneficiary populations may better mobilize key populations and ultimately improve access to testing and clinical services. By offering “moonlight” rapid testing for MSM and FSW, ProVIC has increased access to HIV prevention and testing services by reaching people in locations and at times most convenient for them. The ease of access to HCT services and the ability to immediately receive test results suggest that the use of nighttime mobile testing may have increased satisfaction with and demand for testing services among MSM and FSW.

Peer educators have played a critical role in this intervention, generating demand by tapping into their social networks, which has increased awareness of HIV and the availability of “moonlight” HCT services.¹⁰ More research should be conducted on the most effective training methods for MSM and FSW peer educators, as well as on the effectiveness of using mobile health and technology as a tool for peer educators to reach and follow-up with key populations.⁷

Although mobile testing, and particularly “moonlight” mobile testing, has been successful at increasing testing among MSM and FSW, follow-up with individuals who test positive is a challenge due to the mobility of these key populations, as is providing follow-up services for those who test negative. Another challenge for “moonlight” testing conducted in “hotspots” involves security risks due to the nature of these neighborhoods and the late evenings during which the tests are conducted; ProVIC’s operations close relatively earlier than ideal (11 PM compared with activities that last until early morning) so that staff can return home safely.

Given the DRC’s weak health system, creating or finding MSM-friendly clinics remains challenging. Although ProVIC has seen promising results through the work with St. Hilaire, challenges exist in replicating this activity with additional clinics, largely due to low societal acceptance of homosexuality in the DRC.¹¹ Stigma still presents a strong barrier for MSM seeking services at health facilities, and St. Hilaire has proven to be an exception. Improved training of health care workers around issues related to MSM should be emphasized in the future.

This study has limitations. First, the approaches and results reported in this article were not associated with a research study but were activities implemented in support of ProVIC’s HIV service provision. As such, the data pool available for analysis was limited to project monitoring data. Causal inferences cannot be drawn with regard to the efficacy of the approaches described, and the results may have been influenced by other factors than those implemented.

In conclusion, ProVIC’s targeted interventions for MSM and FSW provide a promising example of the types of programming that can be used to meet the HIV prevention, testing, and care needs of key populations, especially in settings with challenges similar to those in the DRC. ProVIC’s technical shift toward the continuum of care through health facilities will likely contribute to increasing MSM’s and FSW’s access to facility-based care and treatment for HIV and coinfections. Although more evidence is needed to support ProVIC’s findings, HIV interventions geared toward the general population can be adapted to reach subpopulations with the highest burden of disease, even in complex and unstable settings such as the DRC.

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