

RESEARCH BRIEF

March 2014



Background

The HIV epidemic in West and Central Africa (WCA) has distinct characteristics compared to other regions of sub-Saharan Africa. National prevalence data over time have shown moderate prevalence in the general population, with no country in the region currently presenting prevalence data over 5%.¹ Limited but emerging data among key populations (KP) at heightened risk of HIV in the WCA region indicate the burden of disease is disproportionately higher among female sex workers (FSW) and men who have sex with men (MSM). Although some data suggest a more concentrated nature of the HIV epidemic in countries where data are available, country-specific studies have either been limited or inconsistent to date for both FSW and MSM in the WCA region. In addition, emerging HIV research indicates that investing and targeting high-risk populations in the cascade or continuum of care for HIV is one long-term solution to address the needs of KP living with HIV as well as to promote population-level HIV prevention and control. However, little is known about the continuum of HIV care for KP in the region.

This study used the Modified Social Ecological Model (MSEM)² as a framework to examine the social-, individual- and policy-level factors contributing to heightened risk of HIV among KP and limited access to health services related to the continuum of HIV care among KP. This study was part of a larger, multi-country study conducted in the WCA region. Findings specific to Burkina Faso are presented in this research brief.

EXAMINING RISK FACTORS FOR HIV AND ACCESS TO SERVICES AMONG FEMALE SEX WORKERS AND MEN WHO HAVE SEX WITH MEN IN BURKINA FASO

KEY FINDINGS

POPULATION SIZE ESTIMATES AND CHARACTERISTICS

MSM

Using multiple population size estimation methods, this study estimated that 1.00% of the male population in Burkina Faso are MSM (95% Confidence Interval [CI]: 0.88-1.12). The population size estimate for MSM between the ages of 15 and 49 in urban areas in Burkina Faso is 8,806 (95% CI: 7,761-9,851), and the population size estimate for MSM between the ages of 15 and 49 at the national level is 34,060 (95% CI: 30,018-38,102).

In Ouagadougou 343 MSM and in Bobo-Dioulasso 330 MSM were surveyed. MSM participants in Burkina Faso were generally young, and the vast majority reported being single/never married. A majority of MSM surveyed had some secondary education, and approximately one-quarter reported having completed secondary school or higher. Just over half of MSM participants in Ouagadougou and Bobo-Dioulasso identified as gay or homosexual with another two-fifths identifying as bisexual.

FSW

Using multiple population size estimation methods, this study estimated that 1.17% of the female population in Burkina Faso are FSW (95% CI: 0.67-1.67). The population size estimate for FSW between the ages of 15 and 49 in urban areas in Burkina Faso is 10,876 (95% CI: 6,232-15,520), and the population

size estimate for FSW between the ages of 15 and 49 at the national level is 47,873 (95% CI: 27,431-68,314).

In Ouagadougou 349 FSW and in Bobo-Dioulasso 350 FSW were surveyed. FSW in Ouagadougou were generally younger and had higher levels of education than those in Bobo-Dioulasso. FSW in Ouagadougou were more likely to report secondary employment other than sex work and less likely to have ever been married compared to FSW in Bobo-Dioulasso. A slightly higher proportion of FSW in Bobo-Dioulasso than in Ouagadougou had disclosed their occupation to their family.

HIV PREVALENCE AND ASSOCIATED RISK FACTORS

MSM

HIV prevalence among MSM was found to be 4.7% in Ouagadougou and 4.9% in Bobo-Dioulasso. Among individuals living with HIV, 41.8% in Ouagadougou compared to 20.0% in Bobo-Dioulasso had previously been diagnosed with HIV. Though less than one-fifth of MSM reported having ever been forced to have sex, a higher proportion of MSM living with HIV reported ever being forced to have sex (43.8% in Ouagadougou and 20.0% in Bobo-Dioulasso). About half of MSM reported they had both male and female sexual regular partners in the past year. A majority of MSM reported having



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two or more male sexual partners in the past year. Consistent condom use with main partners was reported less than with casual partners. About one-quarter of MSM had never been tested for HIV.

FSW

HIV prevalence was higher among FSW surveyed in Bobo-Dioulasso compared to those in Ouagadougou (32.9% vs. 8.9%, respectively). Condom use with regular and new clients was high in both cities, however condom use during the last vaginal or anal sex with non-paying partners was reported by only about one-third of FSW in the two sites. FSW in Burkina Faso reported substantial experiences with sexual violence, with 42.0% in Ouagadougou and 39.7% in Bobo-Dioulasso reporting they were forced to have sex at least once. A majority of FSW reported having one or more biological children.

STRUCTURAL BARRIERS TO HEALTH SERVICES

MSM

Barriers to health service use reported by MSM in Burkina Faso included confidentiality concerns, discrimination by health providers, inadequate number of medical staff, and geographical distance to services. Though few MSM surveyed reported having been denied healthcare, 36.0% in Ouagadougou and 20.1% in Bobo-Dioulasso reported avoiding the health system. Verbal harassment was frequently reported, and about one-quarter of MSM in Ouagadougou and two-fifths of MSM in Bobo-Dioulasso reported experiencing acts of physical aggression. Some MSM also reported experiencing sexual violence, including being forced to have sex. MSM expressed a need for more affordable, confidential and MSM-specific services, as well as more mental health services.

FSW

Though the majority of FSW did not experience being denied police protection, many FSW reported being harassed or intimidated by the police. Twenty-one percent and 14.9% of FSW reported fear of seeking health services in Ouagadougou and Bobo-Dioulasso, respectively. However, fewer FSW reported avoiding health services. FSW who reported disclosing their occupation to a health provider received a wide range of responses: some providers became more engaged and offered additional services in order to address risks specific to FSW, but many others became hostile after disclosure. Barriers to HIV testing reported by FSW were travel distance, transportation costs and a fear of the HIV test results. FSW expressed a need for increased access to medication, contraceptives, condoms, testing, gynecological exams, FSW-specific health services and employment or funds to augment FSW income.

STUDY METHODS & DESIGN

This study used both quantitative and qualitative research methods:

1. **Quantitative component:** Respondent-driven sampling was used to recruit FSW and MSM who were surveyed, tested for HIV, and counseled before and after the HIV test. The survey covered condom use, sexual practices, relationship patterns, access to care, stigma and discrimination, reproductive health, and community dynamics within the given KP group. HIV test results were used to estimate HIV prevalence in each KP.
2. **Qualitative component:** In-depth interviews were conducted with key informants, FSW and MSM. Focus groups were also held with FSW and MSM. The topics for in-depth interviews and focus groups included experiences and practices of the respective KP group, organization and networks of the respective KP group, knowledge and practices regarding HIV and sexually transmitted infection prevention, and experiences with stigma and discrimination.

CONCLUSION

The burden of HIV among FSW and MSM found in this study highlights the need to develop comprehensive and integrated HIV prevention, care and treatment programs in Burkina Faso. Heightened prevalence and associated risk factors among these KP implies integration into the continuum of HIV care and regular testing in order to obtain early diagnosis and enrollment into treatment programs are essential. High levels of sexual and physical violence in both populations must be addressed programmatically and politically.

HIV prevalence was less than 5% among MSM but was still higher than HIV prevalence among the general population in the country. MSM in Burkina Faso were also found to have high risk sexual practices, and it is possible that the population surveyed could be a high HIV incidence, low HIV prevalence population similar to what was observed in many other settings in earlier phases of their HIV epidemics among MSM. Alternatively, MSM in Burkina Faso could be a low HIV prevalence and low incidence population, and it is simply that based on the composition of sexual networks, people living with HIV are not part of these networks. This reality also implies that once introduced into a network, HIV can rapidly expand, similar to what was termed “explosive” HIV transmission among MSM in Russia and Southern India in prior decades. There has been no part of the world that has been spared from expanding HIV epidemics among MSM—and indeed, this represents an important opportunity to prevent further HIV acquisition among these men instead of focusing on preventing HIV transmission, which neglects the complex nature of HIV risk among this population.

FSW in Burkina Faso have a disproportionate burden of HIV compared to other women of reproductive age. The disparity of HIV prevalence among FSW in the different sites of the study warrants further investigation and adapted programmatic approaches based on the epidemiology of HIV among these populations.

BARRIERS TO HEALTH SERVICES AMONG MSM AND FSW

... You go the hospital and it is complicated because some people know certain conditions are ones that only MSM develop. So when you come in and you're in front of a doctor who is closed-minded and he sees that you have an MSM-related disease, he may treat you however he wants to.

- MSM, Ouagadougou

This study identified structural barriers to health services for KP in Burkina Faso, including stigma and discrimination, the inability to disclose sexual practices and health needs to health practitioners, and economic limitations to seeking services. Some of these barriers could be overcome through community-based organizations providing comprehensive services and creating safe spaces for these populations to discuss health issues; however, the best models for service delivery remain unknown. Developing tailored services for KP which are integrated into general population services may prevent community-level stigma and discrimination from deterring individuals from accessing services.

MSM in Burkina Faso: HIV prevalence and risk factors

	Ouagadougou	Bobo-Dioulasso
HIV prevalence	8.9%	32.9%
Never tested for HIV	18.7%	10.9%
Tested once for HIV	21.0%	20.9%
Condom use at last sex* with regular client	87.0%	75.3%
Condom use at last sex* with new client	89.1%	88.2%
Condom use at last sex* with non-paying partner	36.5%	33.5%
Ever forced to have sex	42.0%	39.7%
Had an unwanted or unplanned pregnancy	50.4%	34.0%
Has biological child(ren)	72.6%	79.8%
* Vaginal or anal sex		

FSW in Burkina Faso: HIV prevalence and risk factors

	Ouagadougou	Bobo-Dioulasso
HIV prevalence	4.7%	4.9%
Never tested for HIV	24.8%	23.5%
Tested once for HIV	23.3%	21.4%
Male and female regular sexual partners	45.6%	46.3%
Two or more male sexual partners	68.9%	60.4%
Two or more female sexual partners	33.2%	20.6%
Consistent condom use with main male partners	51.3%	51.6%
Consistent condom use with casual male partners	70.1%	61.1%
Consistent condom use with main female partners	50.0%	63.8%
Consistent condom use with casual female partners	75.5%	73.5%
Ever forced to have sex	14.8%	15.6%

References

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