MAC AIDS Prevention of HIV Mother to Child Transmission Needs of Female Sex Workers

Research Brief

June 2015

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Background

South Africa has the largest number of people living with HIV (PLHIV) worldwide, with an overall adult HIV prevalence of 17.9%[1]. For women attending antenatal care, prevalence is estimated to be 29%[1]. Research consistently demonstrates that female sex workers (FSW) are disproportionately affected by HIV, even in the context of a generalized epidemic[2]. In 2012, the HIV prevalence among FSW in South Africa was estimated to be 59.6%, which, given an estimated population size of 153,000 FSW, suggests that there are over 90,000 FSW living with HIV throughout the country[3].The majority of FSW are mothers, and many may plan on having more children in the future. However, despite growing antiretroviral (ART) coverage among individuals living with HIV in South Africa and the recent national roll-out of Option B+ (lifelong ART for all HIV-infected pregnant women), access and uptake of PMTCT may not be evenly distributed across the population. This could be influenced by a number of factors, including the geographic distribution of facilities that provide ART, to stigmatization and discrimination of specific populations. Understanding the PMTCT gaps among FSW is critical in order to improve interventions.

The Eastern Cape has a population of 6.6 million and an HIV prevalence of 18.7%[1]. Among women attending ANC services, HIV prevalence has stabilized around 29% in the province over the past three years[1]. The Nelson Mandela Metropolitan Municipality (including Port Elizabeth) is located in the Eastern Cape Province and remains one of the metropolitan centers within South Africa where there has been limited investment into HIV prevention, treatment, and care programs and research among FSW. Still, there are 52 facilities in the Metro area currently providing ART. Due to the lack of reliable epidemiological data, projects and information campaigns targeting PMTCT needs of FSW in Port Elizabeth are rare. The study discussed in this brief fills this crucial gap by exploring the issue of HIV in the context of maternal health among FSW in Port Elizabeth and Uitenhage in the Nelson Mandela Metropolitan Municipality and identifying areas in need of further intervention.

Key Findings

Demographics

FSW who participated in the study ranged in age from 18 to 61, with 30% under the age of 25, 28% aged 25-29, 22% aged 30-34, and 20% aged 35 or older. The majority, 83%, were Africans. Of the remainder, 15% were coloured, 1% white, and 0.5% of Indian or Asian ancestry. Most reported that they were in a relationship at the time that they participated in the study (58%). The majority of women (88%) had never been married, while 3% were currently married, and 7% were divorced or separated. Only 15% had completed secondary school, and 95% were unemployed outside of sex work.

Stigma and Discrimination

As a result of performing sex work, 60% of participants reported verbal harassment, 22% reported having been blackmailed, and 33% reported having been harassed and/or intimidated by police officers. Physical abuse was reported by 62%, and 38% had been raped. Of the women surveyed, 15% were afraid to seek health services out of concern that someone would learn that they performed sex work, and 10% reported having avoided seeking health services for the same reason. Only 27% had ever disclosed to a healthcare worker that their engagement in sex work.

Reproductive Health

Most FSW (84%) reported that they had been pregnant at least once and 75% were mothers. Women who were mothers had a median of two children, although in our sample the number of children reported ranged between one and seven. Among women with a prior pregnancy, 92% had at least one live birth, 6% had at least one stillbirth, 24% had experienced a miscarriage, and 9% had voluntarily terminated a pregnancy. Among women who had given birth, 6% had lost a child. Of the total sample, 59% reported ever having had an unwanted or unplanned pregnancy. Overall, 53% were either using a hormonal form of birth control, had an IUD, or had undergone a bilateral tubal ligation. Seven percent of women were trying to become pregnant.

Among FSW who gave birth previously, 90% had attended a clinic for antenatal care during their most recent pregnancy. Overall 85% of women who had been pregnant or breastfeeding after testing positive for HIV had received PMTCT – demonstrating a gap of 15% in PMTCT coverage. Of the women who reported both that they were mothers and that they were living with HIV, 8% had at least one child who had also tested positive for HIV.

MAC AIDS FUND
HSRC Human Sciences Research Council
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HIV Risk Factors

Half of the women (55%) reported they always or almost always use a condom during vaginal sex. Almost all women reported that it was very easy for them to obtain condoms (96%), and the same percentage reported that the number of condoms that they were able to obtain in the past month were sufficient for their needs. Among women who had not consistently used condoms with clients in the past month, 90% reported having sex without a condom because the client did not want to use one or offered more money to have sex without one. Lubricant use during any type of sex was less common (36%). A very small minority (1%) reported ever injecting drugs, although a larger number (25%) reported having used non-injection drugs. Alcohol use was common among participants, with 26% of participants reporting that they drink alcohol two to three times a week, and 21% drinking alcohol four or more times a week. Among those who drank, 19% reported consuming 6 or more drinks at a time on a daily or almost daily basis.

Health Status and Engagement in HIV Care

Crude HIV and active syphilis prevalence in this sample were 64% and 20% respectively. After accounting for sampling methods, the RDS-adjusted estimate for HIV was 63.0% [95% CI 56.7-69.3] and 17.1% [95% CI 12.1-22.1] for syphilis. Among women living with HIV, 82% reported having tested positive for HIV previously. However despite awareness of HIV status, only 39% were on ART and nearly half of women not on treatment were ART-eligible based on national guidelines. Active syphilis infection was present in 20% of the sample. Approximately 5% of participants were pregnant. Among the ten pregnant women living with HIV with viral loads done, none were virally suppressed.

Study Methods & Design

This study was conducted by the Human Sciences Research Council (HSRC) in collaboration with the TB/HIV Care Association (THCA), and Johns Hopkins School of Public Health. The study included both quantitative and qualitative components. For the quantitative component, respondent driven sampling (RDS) was used to recruit 410 FSW aged 18 years and above for completion of a questionnaire and biological testing after consenting to participate. The questionnaire was administered by trained interviewers in the preferred language of the participant, covered demographics, access to healthcare services including antenatal care and PMTCT, reproductive health history, perceived and enacted stigma and discrimination, condom use, and sexual practices. HIV counseling and testing were performed by a trained nurse and along with diagnostic screening for pregnancy and syphilis. CD4 counts were performed for those who were living with HIV, and HIV viral load testing was performed among pregnant women living with HIV. The qualitative component consisted of in-depth interviews with FSW, health care workers, and key informants, and a focus group discussion with FSW in preferred language. The interviews focused on issues surrounding motherhood and its intersection with sex work, challenges in accessing healthcare services and HIV care, and past experiences seeking healthcare services.

The study was conducted in partnership with a strong implementation program including peer linked mobile HIV prevention programs and sex work community advisory groups (CAGs), which further enhanced the success of capturing this information. The THCA CAGs facilitated the involvement of the sex work community in the design of the study. This important community consultation mechanism helped to remove barriers to participation and to guide field staff, service implementers and researchers through any challenges. The CAGs have created safe spaces for FSW in Port Elizabeth, providing a range of health and human rights support services in a sex work community Drop in Centre. The research study helped enhance the FSW sense of ownership of the space together with the service implementers.

Barriers to health services

"Because of the way they dress you can tell that they are sex workers, so they're at the clinics they pass comments like 'why would a prostitute come waste time by testing when they should already know their status? You go around selling your body, you sleep with everyone, just leave and not waste our time here.'" – Postpartum FSW

"Lots of sex workers they're complaining [that] some of the nurses they shout at them: 'why did you take so long to come and take your treatment?' They are shouting for everyone to hear, which is unfair. Being a sex worker doesn't mean we aren't human beings. We are patients there; we are not at work there. They don't have to look at us and see us as sex workers." –Pregnant FSW

"Maybe you've got a discharge or something…which is suspicious that you [are] a sex worker and they start shouting at you about that and then you don't feel welcome anymore and you're not going to go there again because you didn't feel comfortable." –Pregnant FSW

"Well you see what makes people reluctant to go for testing is that… there is no caring. Even if you go for testing they make you sit there for long periods of time and sometimes you are told to come back the following day after having sat the entire day waiting." –Postpartum FSW

"I get my ARVs from the clinic. They know my treatment, they give it to me. Sometimes I must drink it there and not leave with [any ARV medication]. Maybe it's because they see that they are low on stock. [The following day] you go there again because maybe then they have enough to give you to take home."-Postpartum FSW

"I haven't been to the clinic because it's far from me. They said I must come at 6 o'clock…and [I have to] walk all the way there, [because] I don't have fare money." – Pregnant FSW

Conclusion

The high burden of HIV in this population underscores the need for comprehensive and integrated HIV prevention, care, and treatment programs for FSW in Port Elizabeth. Furthermore, the majority of women engaged in sex work have children and improved engagement of these mothers in ART care, including PMTCT and postpartum ART, is essential for the optimization of health outcomes for the mother and child.

This work has identified several key barriers to health services for FSW in Port Elizabeth. Stigmatization and discrimination were chief among these, with many participants reporting unwillingness to disclose their engagement in sex work to healthcare workers, and fear of being negatively judged by healthcare workers as well as by other patients. This could be overcome through sensitization of healthcare workers, and by creating safe spaces for FSW to access comprehensive care. Resource limitations—both at public healthcare facilities and among women—also represent a major barrier to health services. Participants reported long wait times at public clinics and medication stock-outs impacting their ability to access HIV treatment services. Awareness of HIV status was relatively high, however efforts are needed to improve engagement in ART care, including PMTCT and infant testing and re-testing after breastfeeding. Comprehensive care services provided by community-based organizations (CBOs) or non-governmental organizations (NGOs) and dedicated to providing PMTCT and ART care for FSW may help build trust between the FSW community and healthcare services. However, efficient mechanisms for government and CBO/NGO partnerships to deliver services are necessary in order to ensure sustainability.

References

1 National Department of Health. The 2012 National Antenatal Sentinel HIV and Herpes Simplex type-2 prevalence Survey. (2014). Pretoria, South Africa.

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3 South African National AIDS Council. National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers. (2013). Pretoria, South Africa.

Acknowledgements

This work was funded by the MAC AIDS Foundation, and conducted in collaboration by the Johns Hopkins Bloomberg School of Public Health, the Human Sciences Research Council and the TB/HIV Care Association. We are grateful to the women who shared their experiences with us and to the Community Advisory Group in Port Elizabeth for their guidance. The partners thank Johnson and Johnson for their donation of supplies to women participating in this study.

Table 1. HIV and Syphilis Seroprevalence and Reproductive Health History among FSW in Port Elizabeth

	Percentage	n/total
HIV and Syphilis Prevalence		
HIV prevalence	63.7%	261/410
RDS-adjusted HIV prevalence	63.0%	-
Syphilis prevalence	20.3%	81/400
RDS-adjusted syphilis prevalence	17.1%	-
Reproductive Health History and Current State		
Currently pregnant	4.7%	19/408
RDS-adjusted pregnancy	5.1%	NA
Ever tested for HIV	98.1%	402/410
Condom use at last sex with new client	93.6%	277/296
Condom use at last sex with regular client	86.2%	307/356
Condom use at last sex with casual non-paying partner	50.0%	31/62
Condom use at last sex with long term non-paying partner	30.1%	81/269
Ever forced to have sex	38.3%	157/410
Ever been pregnant	83.7%	343/410
Received antenatal care during most recent pregnancy	89.7%	305/340
Had an unwanted or unplanned pregnancy	59.3%	243/410
Has biological children	74.9%	307/410
Age of last born baby at return to sex work (months)	10.4 (mean)	143
Currently trying to become pregnant	6.5%	26/398
Wants to have one or more children in the future	40.5%	149/368