Programming for Men Who Purchase Sex

Why focus on men who purchase sex (MWPS)?

In 2019, key populations and their sexual partners—including clients of sex workers—accounted for 62% of all new HIV infections globally.[1] Sex workers' clients are mostly men and are considered a bridge for HIV transmission between higher burden and lower burden risk networks. Since the early days of the HIV epidemic, sex in exchange for money has been associated with a high risk of HIV transmission to both the person offering the sexual service and the client. While most HIV programs have focused primarily on improving services for people who sell sex, particularly women, very few have introduced specific approaches for reaching men who purchase sex (MWPS) with HIV testing, care, and treatment services.[2]

MWPS are not a homogenous group and some MWPS overlap with other key population groups, including men who have sex with men (MSM), people who inject drugs (PWID), and sex workers themselves. MWPS tend to have multiple sexual partners (including, for some, with other men), may use substances (drugs/alcohol) to reduce inhibitions or increase sexual pleasure, report inconsistent condom use, and have high rates of sexually transmitted infections (STIs). While HIV prevalence and risk vary across countries and across regions, data from 21 countries suggest a high burden of HIV among MWPS, with a pooled HIV prevalence of 5% (2%–11% in Africa, 3%–7% in Asia, and 1%–8% in Latin America).[3] When compared to men in the general population in the same country, the relative risk of HIV infection among MWPS was consistently higher.

MWPS need better access to HIV prevention and treatment services. Not all MWPS perceive purchasing sex as risky and not all MWPS are at a higher risk of HIV infection or onward transmission. However, overall, as with men in general, they have traditionally been hesitant to engage in health services and may, as a subgroup of men, face substantial barriers to accessing HIV services. As we strive to reach more men in general, specific efforts and client-centered strategies are required to ensure that MWPS are not left behind. Programs must be designed to meet them in a variety of locations that are not only convenient to them, but also less stigmatizing (such as workplaces instead of hot spots) while bearing in mind the heterogeneity of the population. These efforts can easily leverage existing service delivery platforms created and used by key population programs across the world.

EpiC is a global cooperative agreement dedicated to achieving and maintaining HIV epidemic control. It is led by FHI 360 with core partners Right to Care, Palladium International, Population Services International (PSI), and Gobee Group. For more information about EpiC, including the areas in which we offer technical assistance, click here.

Key considerations to improve programming for MWPS

UNDERSTAND THE POPULATION

MWPS are a diverse population whose demographic characteristics, motivations for purchasing sex, and risk profiles vary in terms of age, economic status, and profession. Some may purchase sex regularly, whereas others have one-time or intermittent experiences. Some may purchase sex repeatedly from the same sex workers, whereas others may engage with a different sex worker each time they purchase sex. In countries where sex work is criminalized, the HIV-related risks for MWPS may be exacerbated.[4] To support MWPS with comprehensive and tailored HIV interventions, it is critical to understand who they are, the legal and sociocultural contexts in which they purchase sex, their risk profiles and behavioral motivations, places where they can be reached, the population size estimate at national and local levels (e.g., for setting targets), and the types of services they require. Programs intending to work with MWPS should conduct programmatic mapping and use available data to define the population and tailor services. While categorizing MWPS into specific typologies based on demographics, risk profiles, and where they purchase sex may be important in providing programmatic entry points, further analysis is important to understand their perceived barriers to safer sex practices and uptake of HIV services, including testing, prevention, and treatment services.

CONDUCT COMMUNITY ENGAGEMENT AND MOBILIZATION IN THE DESIGN AND IMPLEMENTATION OF HIV PROGRAMS

In the spirit of “nothing for us without us,” engaging MWPS and sex workers in the design and implementation of HIV interventions for MWPS is a key element for success. It is particularly important to engage MWPS, sex workers, and key-population-led and trusted organizations, especially those serving sex workers, in each setting before beginning population size estimation and mapping, and to conduct these activities with their participation. Their knowledge and perspective will make these activities—and the program designs that follow—more effective. Engaging with these communities will encourage ownership of HIV programs; ensure that they are client-centered and grounded in human rights principles; and enable programs to tailor services to the differentiated needs and preferences of the community members. Some of the ways in which MWPS may be engaged in HIV program design and delivery include:

- Identify, hire, and train MWPS to help establish and run drop-in centers and safe spaces for these men.
- Train and mentor MWPS peer educators and peer navigators to serve as critical connections between the community and clinics, linking newly diagnosed peers and bringing those whose treatment has been interrupted back into treatment.

- Provide capacity development and organizational strengthening to organizations that work with MWPS.
- Train and sensitize health care workers and other service providers on the provision of stigma-free services at selected facilities within the districts where programs for MWPS are being implemented.
- Consult regularly with the community of MWPS who receive services and involve them in community-led monitoring efforts to ensure that services are continuously improved to meet the needs of the MWPS community.

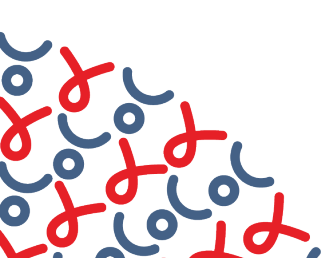
USE DIFFERENTIATED SERVICE DELIVERY MODELS TO PROVIDE SERVICES ACROSS THE CASCADE

HIV services for MWPS across the cascade should be adapted to reflect the preferences of their various typologies as well as individual preferences. This can be achieved through a differentiated service delivery (DSD) approach, which improves efficiency and allows programs to deliver client-centered care and address bottlenecks in health systems while ensuring expanded access to HIV services. For many years, DSD models have focused on HIV treatment, primarily on providing convenient and less frequent scheduling for stable HIV patients. However, DSD models are now being expanded to include populations, such as MWPS, who face additional challenges to HIV prevention, diagnosis, retention, adherence, and viral load suppression. Successful programming for MWPS will require full integration and implementation of DSD models that include:

- Differentiated models of HIV testing, such as HIV self-testing, testing by peer and lay counselors, and social network testing approaches
- MWPS-friendly service delivery points, including at public facilities, community-run sites, and private facilities
- Community-based antiretroviral therapy provision, (including multimonth dispensing), and decentralized drug distribution through pharmacies, lockers, and other preferred pick-up points
- Follow-up visits that are delivered at the community level, or calls from case managers and peer outreach workers
- Models for expanding access to viral load testing at the community level
- Use of online platforms to reach MWPS, support them to conduct self-assessments of their risk, promote risk reduction, and connect them to services

PAY ATTENTION TO GENDER CONSIDERATIONS

Working with MWPS presents several opportunities to complement and bolster activities implemented with sex workers. Working in tandem can support sex workers in their own HIV

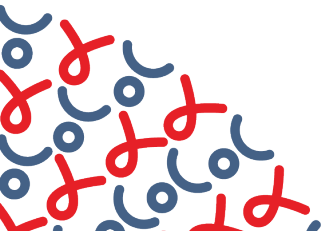


risk reduction, including by preventing violence against them.[5] Topics that can be addressed in programming with MWPS to benefit both groups include:

- The importance of condom use, which can limit risks to MWPS and also lower their resistance to sex workers' requests for condom use.
- Pre-exposure prophylaxis (PrEP) and messaging about undetectable = untransmittable, which can reduce stigma related to knowing one's status—a barrier to HIV testing by MWPS.[6] Addressing these topics will also help MWPS understand that sex workers who are actively using antiretrovirals are actually limiting both their own and their clients' risks of HIV infection, and could reduce the chances that MWPS would seek to interfere with sex workers' HIV service-seeking behaviors.
- Sex workers' rights under the law (including the right to live free of emotional, sexual, physical, and economic violence) and the systems in place to support sex workers who are abused. This knowledge can serve as a deterrent to abuse by MWPS by making clear that violence of any kind will not happen with impunity.
- Substance abuse by MWPS, a known driver of abuse against sex workers.[7]
- How to become an ally in addressing violence against sex workers, which allows clients to consider the potential of playing a positive role in sex workers' lives.
- Gender norms that discourage service-seeking by men and encourage violence against women—which includes violence against sex workers as well as intimate partner violence. Men who hold inequitable gender beliefs are more likely to be living with HIV and to commit violence against women.[8]

Outreach to MWPS via carefully vetted peers creates opportunities for both discussion and the modeling of desired behaviors. This makes the selection and training of MWPS especially important—for example, male peers should be screened by sex workers to ensure that they do not engage in negative behaviors that may harm sex workers; asked about their attitudes and behaviors related to violence and condom use; and selected based on the respect that other MWPS may have for them.

There is limited evidence on interventions that have focused on engaging male clients in reducing violence against sex workers. This makes community leadership—through engagement of both sex workers and MWPS—even more critical, because the lack of a clear blueprint for action makes avoiding the potential for harm all the more important. Continuous monitoring of sex workers' experiences with the MWPS who have been engaged by HIV programs will also provide important information on what is working and should be scaled up.



DEVELOP A STRONG MONITORING AND EVALUATION SYSTEM

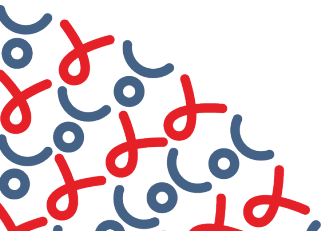
Robust monitoring and evaluation is needed to guide the design of programs targeting MWPS and to continuously monitor program achievements. First, monitoring systems are required to understand the characteristics, size, distribution, dynamics, and needs of this population. Second, continuous measurements are needed to understand whether the interventions are reaching the intended beneficiaries and having the intended effects. Third, project teams must continuously analyze and use the data from the monitoring and evaluation systems to adjust their interventions as needed.

Projects may employ data from different sources to understand the population of MWPS in their settings. Programmatic mapping[9] should be used to identify the sites where these men can be reached, recognizing that these sites will often overlap with hot spots or venues where sex workers congregate. Programmatic mapping can involve conducting interviews or focus group discussions (FGDs) with both sex workers and MWPS and identifying and visiting various hot spots and places where MWPS can be found. Other important sources of data for defining this population may include surveys among the general population, such as demographic and health surveys, and other specific populations of men, and neighboring STI clinics or other sites that treat STIs. Together, data from these sources will help programs categorize MWPS into specific typologies—based on demographics, risk profiles, access to services, and where they purchase sex—in order to tailor interventions for them.

Target setting for this population could be based on local data about the number of sex workers and the number of unique clients they engage in a typical week (or year, which can be calculated from surveillance data). In the initial stages, projects may aim to reach at least 50% of this reported number of unique clients.

For continuous measurements that are needed during program implementation to understand whether the interventions are reaching the intended beneficiaries and having the intended effects, a clear definition of the target population is required. While the basic element of exchanging sex for money or other gifts will be constant, it is likely that the population group to be included in the definition may vary in different settings. In addition, peer educators will need a screening tool that can be used to identify MWPS, and existing frontline tools will need to be adapted to include MWPS as a target group to facilitate data collection and analysis. Measuring the interventions on some outcomes, such as violence, may require collecting data from the MWPS, the sex workers with whom they engage, and other stakeholders.

Finally, monitoring efforts should continually seek to identify unintended consequences, especially for sex workers. As knowledge of the need to address gender norms with men has grown, HIV programs in particular have rolled out one-off interventions that are not theoretically sound and do not have an impact.[10] Especially when the goal is gender norm transformation, sufficient training of implementers and time for implementation must be included in the



approach. In addition, while many sex workers have requested the engagement of male clients to support risk-reduction behaviors, such as condom use, sex workers also articulate concerns that clients may use knowledge of HIV prevention to pressure sex workers to use specific technologies, such as PrEP, so that the clients do not need to use condoms. Collecting routine feedback from sex workers about their experiences with the MWPS who have been engaged by HIV programs is a critical component of monitoring and evaluating programming with MWPS.

Case studies

UNDERSTANDING AND TAILORING SERVICES TO MWPS IN MALAWI

In Malawi, the USAID- and PEPFAR-supported LINKAGES project conducted FGDs with MWPS to better understand their needs and preferences for HIV services. Through this process, the project found that MWPS in Malawi held various occupations including fishermen, bicycle taxi operators, call boys for minibuses, street and flea market vendors, drivers of heavy goods vehicles, construction men, and policemen. MWPS who participated in the FGDs expressed that they preferred HIV services to be provided by men, and they also had varying preferences for timings of services. For example, fishermen preferred receiving services in the mid-morning and construction men preferred after hours. Various new modalities of service delivery were introduced to adjust to these preferences, including providing services at rented huts at the beach and via boats or canoes for the fishermen. Construction men preferred for services to be delivered away from the construction premises, so covert cars were sent to locations of their choice and used by HTS counsellors to conduct HIV testing. Other service modalities, such as drop-in centers, outreaches, hybrid clinics, and safe spaces continued to be used. After the FGDs, willing participants were asked to join the program as peer educators to reach peers through outreach and at hot spots. The MWPS peer educators were trained on peer mobilization skills using the LINKAGES microplanning tools. The project also reached MWPS through index testing and secondary distribution of HIV self-testing via female sex workers (FSWs). These approaches, initiated under LINKAGES and continued under EpiC, led to an increase in case finding among MWPS in Malawi, from 6.4% in FY19 Q4 to 12.6% in FY20 Q2.

REACHING AND TESTING MWPS THROUGH DSD IN THE DEMOCRATIC REPUBLIC OF THE CONGO

In the DRC, the LINKAGES project implemented multiple strategies to reach, test, and retain MWPS on care and treatment, including index testing of FSWs, with an emphasis on MWPS; service delivery points tailored specifically for MWPS; targeted mobile testing in well-known locations with a high volume of FSW clients including mining sites, truck and car parks, and other hot spots; and the enhanced peer outreach approach (EPOA).[11] For EPOA, the project mobilized FSW peer educators and navigators to distribute coupons for HIV services to both FSWs and MWPS, and then asked those individuals to distribute the coupons further to more MWPS peers. Through this combination of strategies, in one quarter, the program reached 2,235 MWPS, who comprised 27% of the total number of people tested in FY20 Q4 through the project. Among the MWPS tested in Q4, 196 (9%) were newly diagnosed, contributing to 24% of the total case finding that quarter.

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USAID Missions should contact Judy Chen (juchen@usaid.gov) for more information about EpiC.

For all other enquiries, please contact Hally Mahler, EpiC Project Director: hmahler@fhi360.org.

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