

STD CONTROL IN FEMALE COMMERCIAL SEX WORKERS IN AFRICA

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Introduction

This paper will be divided into three sections. The first will describe briefly the STD/HIV/AIDS problem in Africa, the second strategies and intervention that have been tried and the third will suggest the way ahead into the next millennium.

Africa is still experiencing an explosive epidemic of sexually transmitted diseases (STD) including human immunodeficiency syndrome (HIV) which will continue well into the next millennium if drastic measures are not taken to slow down the transmission.

According to the World Health Organization estimation 1995, 333 million cases of curable sexually transmitted diseases (STDs) occurred in the world, 65 millions of which were from Sub-Sahara Africa alone. The vast majority were between 15-49 years of age.

Sexually transmitted disease	New cases (in millions)
Syphilis	3.5
Gonorrhoea	16
Chlamydia	15
Trichomoniasis	30
Total	64.5

Source: World Health Organisation, STD Estimated Cases, 1995 (1)

Given the sexual behaviour of the female commercial sex workers (FSWs) in Africa i.e. frequent partner change (2-10 per day with an average of 4) and lack of condom negotiation skills, poor power relations and low economic status the STD attack rates is higher in this population. The importance of holistic management of these diseases cannot be overemphasised as "the presence of STDs suggests a marked risk of concurrent HIV infection (2)".

In view of these rates of STD infections, high HIV prevalences have been reported in Africa. For example, more than 10 percent of women attending antenatal clinics in the 80's surveyed in urban areas of Kenya, Malawi, Rwanda, Tanzania, Zambia and Zimbabwe have been found infected with HIV. Similar patterns of HIV spread have expanded to Botswana, Lesotho, Swaziland and South Africa. The situation is even more explosive in FSWs where HIV sero prevalence ranges between 55% in Abidjan to 80% in Nairobi (3).

Targeted intervention is not easy as this latter population is hard to reach. However, although prostitution is illegal in these countries, sometimes, the Administration is tolerant to the practice as is the experience in Kenya (although intermittent harassment continues) which makes mobilization, education, counselling, condom provision and referral for STD treatment more manageable. The most difficult of these groups are street walkers and bar pick ups compared to home based and other institutionalised forms of commercial sex.

Once FSWs are organized, it becomes easier for them to make collective decision about consistent condom use and regulate their charges to avoid exploitation and safeguard their income (4).

Considering the importance of transforming FSWs into agents of change by, first becoming safer sex practitioners, secondly protecting their clients from STD/HIV, thirdly educating their peers and fourthly seeking prompt treatment when infected, this paper seeks to examine targeted interventions across the African region starting with Zimbabwe.

The Zimbabwe study was done to describe and evaluate an intervention to reduce STD transmission among FSWs and their clients. The design included formation of two committees, one of the professional staff and the other one of FSWs. The women were given cards after examination without which they could not enter premises to practice their trade. They were examined monthly for STDs. The result indicated that total case of STDs among males dropped from 452 cases in March 1988 to 117 in December, 1988 in a country where prostitution is illegal. The conclusion was that regular testing and treatment of STD of FSWs is effective in reducing transmission rates which in turn would lower the HIV transmission rates. The limitation of the study was that the women could use one another's card (5). The writers' view is that the card can also be used by authority to harass the women and the same can/does break confidentiality, thus forcing the women underground to hide their profession.

Another project in Nigeria was set to describe and evaluate an HIV prevention programme among FSWs. Full time prostitutes in 19 states including a sea port were recruited. A total number of 1150 FSWs and 1600 clients were thus reached and 4000-5000 condoms distributed monthly. The number of STD patients increased from 16135 in 10 months presumably due to this advocacy. Condom use increased from 12.2% at baseline to 24.2%.

The programme "faced obstacles including apathy, lack of trust etc. (6)" It is suggested that the itemised problems could be reduced by understanding the structures of the target population as part of the design.

An intervention to implement and evaluate an HIV prevention programme among 595 FSWs in Nairobi, Kenya was carried out between January and May 1985. A committee comprised of the researchers and the study population was set to oversee the implementation. The study population was divided into 3 groups namely, those who received intensive education and counselling (N=91), those who received less intensive education and counselling (N=67) and the control group (N=205). All groups received free condoms. Results indicated that condom use at baseline among three groups was 10%, 7% and 7% respectively. STD assessment was carried out and treatment given appropriately.

In November, 1986, condom use was found to have increased to 81%, 70%, 58%. This shows a dose response relation between increased exposure to health education and increased condom use. There is also a clear a dose response relationship between condom use and decreased risk of HIV seroconversion. The conclusion was that "the high efficacy of condoms in preventing HIV infection could in part, reflect a multiplier effect of condoms use. Reduced incidence of STDs was identified and this increased condom use resulted in a 3 fold reduction of HIV seroconversion. Therefore proper condom use with all sexual partners is vital with any population that has high frequency of partner change and high prevalence of STD. Of importance is that the FSWs must be part of the process of education and counselling. They have the same knowledge as their peers, and unique language, having lived through the experience themselves (7).

Interventions in Kenya and Zimbabwe were carried out to describe and evaluate two HIV prevention programmes. In Kenya the experience of successful intervention at Pumwani, Nairobi set the stage for replication in four other sites namely, Korogocho slum, Nairobi, Machakos, Nakuru and Thika. This was through informal contact and use of key informants at the entry point. Sexual

Educational Barazas or Open Meetings, were carried out and weekly peer education and social meetings were held. These were supervised monthly by the researchers. Condoms were made freely available at no cost and traditional and other appropriate media such as drama, songs, dance, posters, pamphlets and video were used. Counselling was provided for those with STD/HIV/AIDS allowing difficult issues such as condom negotiation, increase of charges uniformly for a single sex act to be discussed and resolved. These activities resulted in more cohesive group formation.

Of the women reporting any condom use (virtually all women) it was shown that a 3-fold reduction in incidence of HIV infection occurred. Reported condom use among FSWs rose from virtually nil in 1986 to about 80% of all reported sexual contacts by 1989, and has remained at that level since. Declines in STD rates; for example, the mean annual gonorrhoea incidence rate fell from 2.85 cases per woman in 1986 to 0.66 cases per women in 1989. It is estimated that over 10,000 new cases of HIV infection are prevented each year by the Pumwani programme which covers about 500 FSWs (8). A decline in STD has been observed in the number of men from Pumwani attending the main Nairobi STD clinic.

Evaluation carried out in the four new Kenyan sites (mentioned above), one year after implementation showed that the number of women who reported "always" using a condom increased from 4.6% at baseline to 36.5% (P=002).

An evaluation done in Bulawayo Zimbabwe in 1992 showed 4400 community meetings were held with 380,000 attendees. More than 2.4 million condoms were distributed to this population. However, the programme identified lack of funding, lack of political commitment (for sex worker), deficiencies in planning, lack of management and human resources (9).

A well planned and implemented intervention in Kinshasa, Democratic Republic of Congo (formerly Zaire), provided excellent information as well as encouragement for further interventions (10). It was a combined behavioural intervention (largely condom promotion) and monthly STD screening and free treatment. A cohort of 531 initially HIV-1 negative female CSW were followed from 1988 to 1991. Study participants were seen every month for interviews and STD laboratory diagnosis, and screening for HIV-1 antibodies every 3 months. Women received individual health education and free condoms monthly. In addition, every 3 months group sessions for condom promotion were held. HIV-1 incidence declined steadily from 11.7 per 100 PY during the first 6 months of follow-up to 4.4 per 100 PY over the last 6 months of follow-up, 3 years later ($p < 0.001$). There was a significant relationship between incidence rates and different levels of clinic use. The HIV-1 incidence rate increased from 2.7 per 100 PY among the most frequent clinic visitors to 7.1, 20.3, and 44.2 per 100 PY among regular, medium and irregular visitors, respectively. Condom use was also associated with regularity of clinic visits, but the declining trend of HIV-1 incidence with increasing regularity of clinic visit remained significant for both regular and irregular condom users. This is evidence that use of the clinic, with STD care, had an independent impact on the incidence of HIV-1, in addition to its impact on condom use. A recurrent theme in CSW interventions is that the main obstacle for reaching 100% condom use was male clients' refusal, highlighting the urgent need for additional chemical or physical barrier methods which are under the control of women.

A "saturation effect" can occur when the incidence of HIV infection declines due to the fact that the most susceptible individuals seroconvert first, whether or not there is a preventive intervention. The lower risk individuals in the cohort get infected at a lower rate because they are people who engage in less high risk behaviour, or because of other constitutional factors which remain to be fully elucidated. The Zairian CSWs who seroconverted did not report a significantly higher mean number of partners than those who did not seroconvert, suggesting that they were not a higher risk group. On the other hand, people who comply with requests to attend health facilities regularly are more likely

to be compliant with other facets of the intervention, in ways which are not fully measured. These factors which were not fully taken into consideration in the analysis but can influence the result, called residual confounding, are potentially present in every intervention. Examples of potential sources of residual confounding in CSW intervention research are client mix and elements of client choice, and this phenomenon can interfere with accurate interpretation of the results for the purposes of introduction of an appropriate intervention method mix.

The increasing difficulty in the African region, experienced by women to convince men to use condom for prevention of STD/HIV and the continued rapid spread of these infections have highlighted the urgent need for the scientists to discover a method of prevention that are under direct control of the woman be it a female sex worker or otherwise. It is with this in mind that a prospective, randomised placebo-controlled trial was initiated in Nairobi, Kenya's female sex workers. This was to determine the efficacy of N-9 contraceptive sponge in preventing sexual acquisition of HIV.

In this study, 138 HIV seronegative FSWs were enrolled of whom 74 were assigned to N-9 sponge use and 64 to placebo use, an oil based vaginal suppository as a placebo sponge was not possible to manufacture. The two groups did not significantly differ with respect to demographic characteristics, sexual practice, or prevalence of genital infections at enrolment, except for a lower number of sex partners per week and a higher initial prevalence of genital ulcers among women assigned to N-9 sponge use. Among the 116 women who returned for follow-up, the mean duration of follow-up were 14 and 17 months for the two groups, respectively.

The result indicated that N-9 sponge use was associated with an increased frequency of genital ulcers and vulvitis. Twenty seven (45%) of 60 women in the N-9 sponge group and 20 (36%) of 56 women in the placebo group developed HIV antibodies. The hazard ratio for the association between N-9 sponge use and HIV seroconversion was 1.7 (95%, CI, 0.9 to 3.0). Using multivariate analysis to control for the presence of genital ulcers at enrolment, the adjusted hazard ratio for the association between N-9 sponge use and seroconversion was 1.6 (95%, CI, 0.8 to 2.8).

Genital ulcers and vulvitis occurred with increased frequency in N-9 sponge users. We were unable to demonstrate that N-9 sponge use was effective in reducing the risk of HIV infection among highly exposed women¹¹. A large randomised controlled study in FSWs in Cameroon showed no beneficial effect of and use of N-9 film in prevention of HIV infection.

Considering the majority of FSWs in Africa are driven into it by poverty, a study was carried out in Kenya to identify and measure safer sex practices including condom use as well as reported status of gTDs as a result of improved social economic status. This method was used due to lack of laboratory support.

The 30 women were educated, counselled, and provided with condoms. They were also individually supported and trained to start alternative income generating activity of their choice. Finance to support their small businesses were provided ranging from US \$ 75 to US \$ 220 payable in 12 months.

Their income through alternative generating activity improved i.e. those earning US \$ 15 increased from 27% to 33% and US \$ 8 increased from 33% to 43%. Significant decrease is those earning US \$ 3 to US \$ 6 per month i.e. from 37% to 23%.

Sexual partners decreased from 2-10 per day to 0-5 per day. Two of the 30 women suspended having sex and are not sure how long this will go for. Negotiation for safer sex even with the "lover", "husband" which is most difficult to change increased to 93.3% within about one year.

It is noteworthy that 80% of the women had suffered an STD a year before the study compared to zero STD during the study period. Their self-esteem was noticeable in all of them. Drinking of alcohol decreased from 73.3% to 43.5% and smoking from 16.6% to 0%. All in all, the change in these women was remarkable. This is because for once, they were engaged in an income generating activity of their choice and not being forced into commercial sex due to lack of an alternative.

Suggestions for The Way Ahead Into the Next Millennium

There is just not sufficient coverage and targeted interventions for FSWs and their clients in African countries. Some have not even attempted to address the issue of STD/HIV/AIDS in relation to FSWs as a group that needs destigmatised holistic services. In our view, integrating FSWs interventions within the existing primary health and social/economic structures will yield greater and faster results. This should go hand in hand with youth and women STD/HIV prevention and control programmes. The rationale being advanced here is that FSWs clients are youth and men in the general population who also have other sexual partners including wives and girlfriends.

Proposed programme components:

- 1) Sensitise policy makers to enact laws which lead to tolerance of FSWs. This will be a cornerstone to destigmatisation and allow these women to enjoy a greater degree of human rights. It will also allow the government to set aside specific funding and to solicitate further input from the donor community.
- 2) Mobilization of FSWs for a systematic STD/HIV/AIDS prevention course that includes participatory education, prevention, and positive living when infected and peer counselling.
- 3) Proper use of condom always even with the "lover". This is crucial in the absence of a vaccine or cure. Storage and disposal methods should be covered in education. It is also important for FSWs to know where to get condoms from i.e. clinics, chemists and peer educators. The condoms should be free or at a price the FSWs can afford.
- 4) The FSWs should be trained and offered opportunities for alternative income generating activities. This is because according to the writer's experience, well over 90% of women in Africa are in commercial sex due to poverty and lack of an alternative. The low economic status also interferes with condom negotiation and therefore should be addressed.
- 5) Although condom is the prevention method of choice, it is not 100% efficient due to breakage or slipping, meaning that some FSWs will still get infected. Therefore prompt and proper management of STDs which includes counselling, condom use, contact tracing and compliance is vital for prevention of HIV transmission.

Treatment of STDs as a strategy for HIV prevention is well documented in Mwanza. In Tanzania early treatment in a rural population has been associated with a 42% decline in the rate of newly acquired HIV infections (12).

In view of the foregoing, it is suggested that well articulated STDs programmes be an integral part of Primary health care settings, and that STD clients be they FSWs or otherwise get the service advantage where they live and work. This service should also be affordable and should have sufficient as well as proper drugs for treatment.

The World Health Organization has suggested use of appropriate (well tested) flow charts for management of STDs where laboratory support is scarce or unavailable. Kenya and other African countries, have been using syndromic management of STDs for over 5 years. It has assisted in improving access to good STD care, and has proved popular with staff and clients alike.

Training of all operatives at various levels is imperative. Training of Trainers Course (TOT) should be taught by well prepared facilitators in community mobilization with focus to special groups such as FSWs and clients.

The TOTs in turn should be supported to train sufficient number of health care providers and related fields (i.e. social workers) to carry out the task in holistic manner and in a way that ensures maximum coverage of target population.

Female commercial sex workers peer educators is another strategy necessary to ensure that ownership and continuity are maintained. This also bridges the gap between the FSWs and the care providers in health and social sectors.

It is also important to include all the 5 components discussed in this paper in each country's pre-service training for health care providers, the clinicians e.g. Doctors, Nurses and Clinical Officers, getting the whole package and the non clinical cadre i.e. public health technicians, laboratory, pharmacy etc. getting the education package that has STD/HIV/AIDS education, counselling, community mobilization and condom promotion only.

Conclusion

In conclusion, the issue of FSWs in Africa can no longer be swept and left under the carpet, but should be part of inclusive (integrative) strategy for prevention of HIV transmission and reduction of its impact such as overcrowding in hospitals, deaths and orphans.

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