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Sexually transmitted diseases and condom interventions among prostitutes and their clients in Cross River State

Eka Esu-Williams

AIDSCAP Field Office, Calabar

The Cross River State commercial sex worker project started in 1989 as a pilot program to test HIV/AIDS and sexually transmitted disease interventions among full-time and part-time sex workers, their partners and their clients. Three main locations were targeted: Calabar and Ikom in the Cross River State in the first phase of the program and Port Harcourt where outreach started in 1992 to test the replicability of the project outside the Cross River State. The project activities were co-ordinated from Calabar which is 200 kilometres from Ikom and 180 kilometres from Port Harcourt. Approximately 800 prostitutes and 2,000 clients in Cross River State have been reached through 17 sites (12 in Calabar and 5 in Ikom) for full-time sex workers and ten sites (6 in Calabar and 4 in Ikom) for part-time sex workers. In Ikom, a large population of paramilitary men, such as customs officials deployed at border posts between Cross River State and the Republic of Cameroon have been targeted. In contrast, of the 25 sites estimated for full-time and 15 sites for part-time prostitutes in Port Harcourt, only twelve were reached because they were more widely dispersed and prostitute groups were more diverse when gauged by social and economic indicators. The Port Harcourt project aimed to reach approximately 1500 sex workers and 3000 clients within an eight-month period, January to August, 1992.

Preliminary contact with prostitutes and their clients was made in 1987 in Calabar by members of the Cross River State AIDS committee. At the time, AIDS was hardly a topical issue for the generality of Nigerians. Primarily it was regarded as a subject of concern for prostitutes, foreigners, and Africans in East and Central African countries. It was not possible to initiate a formal project before 1989 because of financial constraints, resulting in a prolonged period of unstructured interaction with the target group. Nonetheless, this provided the opportunity to build understanding and trust and to sustain dialogue on issues of common interest with the target group. Also during this period, key members of the population such as 'chairladies' (leading prostitutes); their assistants; 'policing agents' responsible for maintenance of law and order and welfare of prostitutes; hotel proprietors and managers and others such as security agents with substantial influence or authority over the target population were identified, and their support secured. It became apparent through this interaction that the effectiveness of any HIV/AIDS and STD prevention and control program aimed at sex workers and their partners would depend on the active participation in project design and implementation of members of the target population.

The main objectives were to develop and implement an intervention program to reduce the transmission of HIV/AIDS and STDs among prostitutes, as well as their partners and clients, through providing STD services, condom promotion and health education.

Target population

This includes women in full-time prostitution, resident in hotels and compounds; part-time, non-resident prostitutes; clients and partners of prostitutes; and hotel owners and managers. Often, hotel owners and managers establish sexual liaisons with prostitutes in exchange for a wide range of favours.

Full-time prostitutes live alone or with their children and operate in easily identifiable sites with well defined community structures. These structures provide the basis for program implementation and sustainability. Low charges, approximately 50 cents per sex act, make it imperative for full-time prostitutes to entertain a large number of clients a day, ranging from two to twenty.

Part-time prostitutes who usually are low-income earners and students canvass for clients outside big hotels and night clubs. They lack a visible social structure and working norm, and often operate in small loosely organized groups. On the average, they receive one client per day and charge over six times more than full-time prostitutes for a sex act.

Description of intervention

A major problem at the onset of the intervention was the prevalence of misconception and apathy about HIV/AIDS and STDs, ignorance about condoms, and poor access to them, which were compounded by the poor state of available health information and services on these issues. To identify the specific knowledge gaps, and to determine the appropriate strategies for HIV/AIDS and STD intervention, the collection of baseline KAP data, focus group discussions and HIV seroprevalence survey were accomplished between 1988 and 1989. At the time approximately 1 per cent of prostitutes and 1.5 per cent of their clients were HIV-infected. No baseline data were available on the prevalence of other STDs. A project which focused on HIV/AIDS and STD prevention and control was overwhelmingly endorsed by the sex workers, and enthusiasm to participate was expressed by key members of the target group. These discussions buttressed earlier presumptions that health promotion activities would best be served in this population if tied with actions which responded to the perceived needs of prostitutes. These prompted the inclusion of additional activities including advocacy of reducing official harassment and extortion; welfare activities for children; improving the hygienic conditions of the hotels and compounds where the women live; and later skills training.

A project with three main components was subsequently designed and implemented with the following strategies.

(1) Health Education: on-site educational sessions held in the hotels and compounds for prostitutes and clients; group discussions with key members of the target group; film shows and distribution of materials, including condoms, in hotels and night clubs for part-time prostitutes; outreach to all project sites by male and female peer educators; HIV/AIDS and STD educational workshops for all members of the target population.

(2) Condom promotion and use were based on an initial distribution of free condoms through peer educators to all project sites and at the STD clinic. This was later replaced by a cost recovery arrangement which allowed condom vendors ('chairladies' and managers) to earn a small profit from sales. Stressing the benefits of regular condom use and the savings made from avoiding the practice of habitual self-medication with expensive antibiotics (normally used prophylactically for STDs) enhanced the acceptability of use of condoms.

(3) STD services dispensed through a project clinic encouraged early diagnosis and treatment of STDs and also provided a range of other clinical and preventive services including counselling. The 'Special Clinic' was set up with the support of the State Ministry of Health, which provided staff and equipment. The Clinic name and hours of operation were

determined by the target community, and in the first year it only admitted prostitutes and their clients. By the second year the Clinic was open to the public following decisions reached by the community members. Clinic attendance by prostitutes and clients was stimulated by adopting a number of approaches. These included the referral of clients through prostitutes.

Sexual behaviour

Women's practices

At the baseline survey, many prostitutes (40%) reported having more than five different customers per day, and 37 per cent reported between four and five customers. At the follow-up survey, 52 per cent reported having 0-5 customers in the last two days. Forty-nine per cent reported more than five customers in the last two days. The most common sexual practice for prostitutes was vaginal intercourse (97%). Very few reported other sexual practices.

Nearly half (47%) of the prostitutes at follow-up reported having worked in commercial sex for 1-2 years, and 38 per cent had worked for less than one year.

Clients' practices

It was evident from client reports at the baseline survey that frequent contact with prostitutes over a period of years was quite common for the population surveyed. Thirty-seven per cent of the men had visited prostitutes for 1-5 years, 31 per cent 6-10 years, 32 per cent for eleven or more years. Clients most frequently reported having between six and ten contacts (35%) per month. Twenty-nine per cent of men reported having 11 and 15 contacts per month, and 26 per cent reported between one and five contacts per month. At follow-up, men reported on the number of sexual encounters with all partners (including spouses and girl-friends) in the past week: 37 per cent of the men reported 0-1 sexual encounters, 36 per cent reported 2-3, and 27 per cent reported four or more. Because questions on the level of sexual activity were asked differently at baseline and follow-up, it was difficult to determine whether there was a change in the number of partners, although it appeared that the number of partners per week did decrease somewhat.

Men reported on the type of sexual encounters at the base-line survey. All of the clients reported practising vaginal intercourse, half reported oral-penile intercourse, and only two per cent reported practising oral-vaginal or anal intercourse.

Male-female comparison

Prostitutes had more sexual partners per day than the men, which was expected given the nature of their occupation. Both groups reported the most common sexual practice was vaginal intercourse. However, many more men than women reported oral-penile intercourse as practice.

STD knowledge, history and treatment

STD knowledge was measured at the baseline survey for both sex workers and clients. When they were asked to list which sexually transmitted diseases they knew, gonorrhoea was the disease most frequently mentioned (97% of women and 96% of men), followed by AIDS (17% of women; 34% of men). Knowledge of other STDs was quite limited. Only 14 per cent of prostitutes and 29 per cent of their customers listed syphilis, five per cent of prostitutes and 17 per cent of customers listed chancroid, and none spontaneously listed herpes or chlamydia.

High recognition by sex workers of gonorrhoea as a sexually transmitted disease may be related to prevention behaviour, as 96 per cent of them stated that they examined their customers for gonorrhoea or discharge.

At baseline, few prostitutes (14%) reported having had an STD in the past two years; 81 per cent of clients reported ever having had an STD.

When an STD clinic was established in Calabar for prostitutes and their clients in December, 1989, there was a demand for one in Ikom and this was established in 1993. There was no charge for examination and tests, but women and clients did pay for medicine and treatment. While 76 per cent of clients and 93 per cent of prostitutes were aware at the follow-up of the existence of the clinic, only one per cent of the men stated that they had attended the STD clinic established as part of the intervention. However, clinic records indicate that men are in fact attending the clinic. Eighty-seven per cent of prostitutes stated that they had attended the clinic.

AIDS knowledge

Transmission

Knowledge of modes of transmission of HIV was measured for both groups at baseline and follow-up. While knowledge at baseline was low for both sex workers and clients, the men demonstrated greater knowledge than the women of sexual transmission (65% and 29%), transmission through dirty needles (15% and 3%), and vertical transmission from mother to child (4% and 2%). This discrepancy between prostitutes and clients remained at follow-up for knowledge of dirty needles as a mode of transmission (51% of clients, 8% of prostitutes) and mother-to-child transmission (25% and 4%), but a greater number of prostitutes than clients identified sexual intercourse as a mode of transmission at follow-up (90% and 61%). This was probably due to the intervention's intensive focus on sex as a mode of transmission.

Increases in knowledge of sexual and needle transmission were significant between baseline and follow-up for both men and women. Prostitutes' knowledge of sexual transmission increased from 29 to 90 per cent while the percentage of clients who identified this mode of transmission increased from 65 to 81.

A high percentage of prostitutes and clients at follow-up recognized that healthy people can transmit the AIDS virus (96% and 83%), compared to only 45 per cent of prostitutes at the baseline survey, when this question was not asked of clients.

Means of protection

Means of prevention were also identified at follow-up. Eighty-eight per cent of sex workers and 59 per cent of clients mentioned condom use as a method to prevent AIDS. Abstinence was identified as a preventive measure by 42 per cent of clients at follow-up; however, only one per cent of prostitutes mentioned abstinence as a method of avoiding AIDS. It seems logical that women in the sex industry would be unlikely to readily identify abstinence as an important prevention activity, as commercial sex is their primary or sole source of income.

Risk perception

Prostitutes and clients were questioned at baseline and follow-up whether they were worried about getting AIDS. A higher percentage of prostitutes reported concern about AIDS, both at baseline (84% of prostitutes and 68% of clients) and at follow-up (95% and 76%).

There was an association between ever-use of condoms and risk perception for clients. Seven per cent of clients at baseline who reported having used condoms were worried about AIDS, while only 31 per cent of those who had not used condoms were worried about AIDS. At follow-up 85 per cent of male condom users perceived themselves to be at risk, compared with 44 per cent of non-users.

This association was not apparent among prostitutes at baseline; 84 per cent who had ever used a condom perceived themselves to be at risk and 74 per cent of those who had never used a condom felt at risk. It is possible that prostitutes perceived themselves to be at risk because of their work, regardless of their specific sexual behaviour. Clients have been less likely to feel at risk.

Condom use

Sex workers

At baseline, 77 per cent of the women had ever used a condom, while at follow-up 97 per cent had used a condom at least once. The frequency of condom use also increased at follow-up. At baseline 11 per cent of sex workers always used condoms; at follow-up 23 per cent always used condoms. The number of prostitutes who sometimes used condoms increased sharply between baseline and follow-up, from 24 to 61 per cent. The percentage who did not often use, or never used, a condom decreased between baseline and follow-up, from 62 to 16 per cent.

Clients

There was also a slight increase in ever-use of condoms among the clients at follow-up, although the increase was not as large as among sex workers. Sixty-eight per cent of clients said that they had ever used a condom at baseline; 76 per cent reported ever-use at follow-up. The frequency of use actually decreased from baseline to follow-up although the decrease was not significant. At baseline eight per cent said that they always used condoms, and at follow-up four per cent reported consistent use. Similarly, 37 per cent reported that they sometimes use condoms at baseline, and 33 per cent reported this at follow-up. However, the number of clients who reported that they never used condoms decreased from 34 per cent at baseline to 29 per cent at follow-up.

Relation to AIDS knowledge

Condom use appeared related to the respondents' level of AIDS knowledge. While a higher percentage of prostitutes using condoms frequently than those using condoms infrequently were aware that AIDS could be transmitted sexually, there was a much greater relationship between level of condom use and AIDS knowledge with the client population. At baseline, only 49 per cent of clients using condoms infrequently knew that sexual intercourse was a primary mode of transmission, while 89 per cent of those using condoms frequently knew of this route of transmission.

Similarly, at follow-up 79 per cent of clients using condoms infrequently correctly recognized sexual intercourse as a mode of transmission, while 91 per cent of those using condoms frequently responded correctly. This suggests that if prostitutes and clients were aware of sexual intercourse as a primary mode of transmission, they may have been more likely to use condoms. Conversely, those men who use condoms frequently may have been more likely to learn about the possible role of sexual transmission.

Barriers and reasons for success

The major obstacles experienced occurred during the early part of the project. These included apathy to HIV/AIDS; lack of confidence and trust of project staff; lack of co-operation of hotel owners and managers; non-co-operation by clients or partners; irregular supply and poor quality of condoms; low self esteem of sex workers; self-medication; and reluctance to use condoms. While many of these have been satisfactorily addressed, adequate access to clients and partners, mobility of prostitutes, and an increasing influx of young girls into prostitution pose new challenges. The sale of condoms, though widely accepted, is hampered by the inability of prostitutes to purchase large numbers of condoms, making accounting and record-keeping tedious. The outreach program in Port Harcourt faced logistical problems, given the distance between areas with large pools of prostitutes.

The key reasons for the success of the program could be the following.

(1) The extensive period of interaction with the target population and its involvement in major decisions and activities of the program. Additionally, this interaction allowed the promotion of community cohesion and setting up of relevant bodies such as the 'chairladies' group and the hotel owners association with a mandate to discuss and decide on program issues.

(2) The ability of project staff to respond to delicate matters such as police arrest or detention, harassment and extortion, and their advocacy of appropriate rents and facilities for resident sex workers and higher charges for sexual services to reduce the number of clients per day.

(3) Official endorsement and support of project was an important factor in reducing stigma, marginalization and interference, and also helped to build confidence.

(4) The flexible approach adopted in the implementation of activities proved very useful, and allowed for greater participation in decision-making and reformulating aspects of the program which were not yielding satisfactory results.

(5) Through its response to the perceived needs of the community, the overall good intentions of the program became evident and attracted more co-operation. A narrow health focus among a population which had suffered a lot of marginalization and stigmatization was regarded as inappropriate to effectively mobilize the community for the program.

To conclude, the Cross River AIDS Committee intervention among prostitutes and their clients in Cross River State has provided a community-based model for intervention aimed at controlling the spread of HIV/AIDS and other sexually transmitted diseases. Condom promotion constitutes an important part of any strategy for prevention and the acceptability of condoms by prostitutes can be guaranteed when they are made affordable and available and the women themselves see a clear health and economic reason for using them regularly. Whereas prostitutes can be reached quite readily and are amenable to program interventions, the same cannot be said of their partners and clients. Specific strategies such as using motivated prostitutes, hotel managers, peers and outreach workers are useful ways of reaching this subpopulation.

It is also important to promote a program which includes the development of vocational skills to ensure that women in sex work do not depend exclusively on exchange of sex for money but are able to earn additional income through other options. A literacy component which includes literacy skills and reproductive health education has been introduced to build self esteem and allow women to understand in a holistic manner issues around reproductive health covering HIV/AIDS and STD; family planning, unsafe abortions, self medication and infertility. A community approach in our experience provides the best way to ensure that the program can be sustained long after donor grants become unavailable.