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Acceptability of three novel HIV prevention methods among Puerto Rican male and transgender female sex workers

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Abstract

Male and transgender female (TGF) sex workers need HIV-prevention methods they can control and incorporate easily in their work. We explored acceptability of the use of the HIV self test with clients, oral pre-exposure prophylaxis (PrEP), and rectal microbicide gel among 12 male and TGF sex workers in Puerto Rico. At baseline, we measured likelihood of use of each method. Five sex workers also completed a 12-week study of rectal microbicide placebo gel use prior to receptive anal intercourse with clients and explored in interviews how each method could be incorporated into their work. Most were interested in a rectal microbicide gel and able to use it covertly with clients. Challenges to using the HIV self test with clients included breach of confidentiality and violent situations. They expressed some interest in oral PrEP, but had concerns about side effects. Rectal microbicides may work well for this population.

Keywords

HIV prevention; sex workers; PrEP; rectal microbicide; HIV self test

Introduction

Sex workers are one of the groups most affected by human immunodeficiency virus (HIV), particularly male and transgender female (TGF) sex workers. A review of HIV prevalence among sex workers in 14 countries found that TGF sex workers have the highest prevalence of all sex workers (27.3%) with male sex workers in second place (15.1%) (1). In Latin

America, men's engagement in transactional sex was associated with a significant increase in HIV prevalence, with a higher odds ratio than any other region, based on a systematic review of men who have sex with men (MSM) in 17 countries (2). Previous research has focused on structural and behavioral risk factors for HIV such as having multiple partners, inconsistent condom use (often prompted by increased pay in exchange for sex without condoms or caused by lack of access to condoms), depression, substance use, injection drug use, homelessness, stigma, marginalization, criminalization of sex work and homosexuality, and poor access to health services (3–16). Most research to date has focused on potential structural and behavioral interventions for these populations including peer outreach programs to increase condom use, HIV testing rates, or use of oral pre-exposure prophylaxis (PrEP); community empowerment-based approaches to improving programs and services for sex workers; improving clinical care and community outreach; and increasing access to mental health services, substance abuse treatment, HIV/STI testing and other health services (17–24). A recent study found that interventions that include behavior change and biomedical interventions could be promising for reducing HIV incidence among TGF sex workers. (25)

Potential biomedical prevention techniques that are now, or may soon be, available include oral PrEP, rectal microbicide gels, and use of the rapid HIV self test, which uses oral fluid, to screen individuals and their partners. However, few studies have examined the acceptability of biomedical prevention methods in this population. One study of MSM and TGF in Peru found high acceptability of both oral PrEP and a rectal microbicide gel among 532 participants, 40% of whom had had transactional sex (26). Among sex workers in the study, oral PrEP appeared more popular than a rectal microbicide gel, with 57% of participants preferring a daily pill over a gel used during sex, only 25% preferring gel over pill, 11% indicating either was fine, and 7% stating they would use neither (Peinado, personal communication, Aug 11, 2015). Another study examined acceptability of oral PrEP among a similar population in Peru and found that out-of-pocket cost, efficacy, and potential side effects had the greatest impact on acceptability (27). A third study that took place in Vietnam with male sex workers showed that over 95% would be willing to use oral PrEP for HIV-prevention and less than a third preferred a lubricant gel over a pill (22); yet, research in this area is lacking and none have explored use of the HIV self test in the sex work context.

Our study sought to explore the potential use of three biomedical prevention methods (oral PrEP, rectal microbicide gels, and the HIV self test) in the sex work context by men and TGF. As part of an ongoing rectal microbicide study, we undertook a feasibility study to determine whether existing study sites in the US and Puerto Rico could recruit male and TGF sex workers. Sites were unable to recruit large samples; nevertheless, the study site in San Juan, Puerto Rico recruited twelve participants for a baseline evaluation, five of whom completed a second stage of the study in which they were instructed to use a rectal placebo gel before receptive anal intercourse (RAI) with clients. They then underwent an in-depth interview in which they were asked about acceptability of rectal gel use along with likelihood of use of oral PrEP and the HIV self test as prevention strategies. Despite the small sample size, participants provided important insights on the potential of biomedical prevention methods among a critical population. We describe their expectations, experiences

using the rectal gel before RAI with clients, and their reasons for wanting to try (or not try) oral PrEP and the HIV self test as prevention methods.

Methods

Sample

The data for this study came from a sub-study designed to establish the feasibility of recruitment and retention of male and transgender female sex workers in future Phase 1, 2, and 3 rectal microbicide trials and other HIV prevention trials. Participants were recruited in San Juan, Puerto Rico. Recruitment methods included posting advertisements in newspapers and on social media as well as recruiting from clinics, bars and clubs. The eligibility screening script explained that the purpose of the study was to learn about the sexual health of young men, and TGF, who have sex with men and to learn about their attitudes towards HIV prevention technologies. Eligibility criteria for initial screening included having had RAI at least once in the prior month and having had unprotected RAI at least once in the prior year, as well as having been involved in RAI as part of transactional sex work (defined as having received money or other goods or services in exchange for sex) at least twice in the previous two months. The study was reviewed and approved by the Institutional Review Boards at all participating institutions, and written informed consent was obtained from all individual participants included in the study.

Procedures

Twelve participants in San Juan, Puerto Rico were recruited between April and July of 2013 for the first stage of the study, which sought to identify prevalence of sexually transmitted infections (STIs) and anorectal pathology. Participants underwent a physical exam including a rectal exam and anoscopy and received STI/HIV testing, HIV counseling, and condoms. In addition, participants completed a Web-based computer assisted self-interview (CASI) that included questions on demographics, history of sex work, sexual behavior with clients, and likelihood of using rectal microbicide gels, rapid HIV self tests, and oral PrEP for HIV prevention in the future.

Participants returned to the clinic within 28 days for test results. Seven participants were given medical clearance (negative HIV and STI test results; no findings of active rectal infection requiring treatment; no allergies to drugs, parabens or latex; no history of inflammatory bowel disease or of alcoholism or drug abuse) and reported having unprotected RAI in the prior 3 months in their baseline questionnaire and thus were invited to enroll in the second stage of the study, which entailed a three-month trial. The other five participants were not eligible to continue due to clinical findings including diagnoses of HIV, syphilis, herpes simplex virus, and Chlamydia; these participants were offered treatment as needed for their conditions. The seven eligible participants underwent a new informed consent process, were given 20 rectal applicators filled with 4 mL of hydroxyethyl cellulose placebo gel, and were instructed to insert the entire contents of one applicator rectally within 90 minutes prior to each RAI episode with both clients and non-commercial partners. This was intended to mimic the way a future rectal microbicide gel may be used.

Six weeks later, participants returned for a follow-up visit in which they brought in used and unused applicators and received up to 20 new rectal applicators for use prior to RAI. After six more weeks, participants returned to the clinic for their final visit. Of the seven who enrolled in the second stage of the study, one participant was lost to follow-up; another suffered serious injuries in a motorcycle accident and was unable to return. Five participants completed the final follow-up visit in which they were interviewed via video teleconference and answered a final CASI assessment focused on microbicide gel acceptability and use with clients.

Measures

The web-based CASI administered at baseline included measures on demographics, sex work involvement, likelihood of using a rectal microbicide gel before RAI with clients if the gel were effective, likelihood to use rapid HIV self tests for testing self and clients, and likelihood to use oral PrEP.

The CASI administered at follow-up included measures on microbicide gel acceptability, use of gel before RAI with clients, and likelihood of gel use before RAI with clients in the future if it became available. CASI quantitative measures were developed by members of the research team based on items the team had used in previous sexual behavior research with MSM and TGF and in consultation with other research teams who had experience working with sex workers.

In addition, at the follow-up visit participants completed an in-depth interview via video teleconference (28) in which they discussed gel use (what it was like to use the gel, where it was applied, privacy in using the gel); problems with the gel; gel use during RAI with clients; and likelihood of using rectal microbicide gel, rapid HIV self test, and oral PrEP in the future.

Data Analysis

Due to the small sample size, quantitative analysis was limited to descriptive statistics.

For the qualitative analysis, two independent reviewers reviewed each in-depth interview transcript, and themes were summarized. The two reviewers then met to discuss the summaries. The first author selected quotes that contributed to understanding participants' motivations and experiences and, when necessary, translated them from Spanish into English.

Results

Demographics and Sex Work Experience

A description of the sample is shown in Table I. The 12 participants enrolled were young with relatively low education and income levels. Seven of the participants reported more than 10 clients in the past 3 months with a median of 28.5 clients. A majority of the sample identified as a woman/transsexual.

At baseline, participants were asked about their involvement in sex work. Half were recent entrants into commercial sex work and the rest had been involved in sex work for at least a year. Among the reasons for getting started in sex work (more than one choice was possible), the most common was to make money for oneself (n=6) or one's family (n=5), or to have a place to sleep (n=5). Other reasons included using the money from sex work to pay for education (n=4) or surgery (n=2), and a few indicated they got started in sex work for reasons such as pleasure (n=2), excitement (n=1), or to boost self-esteem (n=1). When asked why they continued to engage in sex work, the most common reason was to have a place to sleep (n=6), followed by to make money for one's family (n=4) or oneself (n=3) or to pay for education (n=3). No one reported getting started in or continuing with sex work due to coercion or to pay for drugs. For the majority (n=8), sex work was the only source of personal income.

We also asked where participants had met clients in the past three months (more than one choice was possible). Most met clients on the street (n=8), on the Internet (including Facebook, Grindr, Manhunt, Adam4Adam, and Badoo, n=6), or in a public place (n=5). Three had met clients through word of mouth, two at a hotel, and one through a pimp. Almost half (5 participants) had ever experienced verbal abuse while engaging in sex work, two had ever experienced physical abuse, and the following were selected by one participant: forced not to use a condom for anal sex, and forced alcohol use. No one reported ever having been forced to use drugs or to have anal sex.

Finally, we asked participants to rank the most important issues when they are about to have sex with a client, including "earning as much money as possible," "making sure we use condoms," "not getting a sexually transmitted disease other than HIV," "not passing a sexually transmitted disease," "not getting HIV," "that my client will like me and want to return," "taking as little time as possible," and "avoiding a violent interaction." The options most commonly selected as top priorities were "avoiding getting HIV" (n=6), followed by "making sure we use condoms" (n=3).

Likelihood of HIV Self Test Use

At baseline, participants were asked via CASI about their future likelihood of using various HIV prevention technologies, including rapid HIV self tests (Table II). Participants were very open to using rapid HIV self-testing kits, and all but one reported being likely to use such a test on themselves. Seven of the twelve participants (68%) reported being likely to use them to test clients.

Self-testing—During the in-depth interview at follow-up, participants elaborated about their likelihood of using the HIV self test to test themselves at home. One participant stated she did not trust the oral test and preferred a blood test. She explained that got tested every three months at the clinic, and even if the self test were available to her, she would continue to go to the clinic because she trusted the results more. The other four liked the idea and were interested in using the test themselves at home. One even stated that if they were priced affordably, he would buy a whole box of them.

HIV Self Test Use with Clients—Participants had mixed reactions to the idea of using the self test with clients. During the in-depth interview, one mentioned she could use it as a tradeoff for condomless sex:

If the client does not want us to use a condom, or this or that, OK. “But we have to do this” [use the self test]. It would be like an exchange...the idea would basically be brought up by him. Because if he does not want to use a condom, then obviously there I would tell him, “OK, but we are going to do this test.”

Another stated she would be more likely to use the test with younger clients because explaining the idea to them would be easier. She felt the hardest part of using the test would be explaining to clients what the test is for and how it works, stating that if a client reacted badly, then she would not have any sexual activity with them. Two others thought it would be easier to trick clients into testing. One stated that she would use it with all clients but would not tell them what she was doing. She would just ask them to first clean their mouths with the test swab before starting any sexual activity. Another said he would tell them that since he is a nursing student, he needs them to help him with a test for school:

Like they say here in Puerto Rico, “Come here papito, I’m going to give you a little test.” Oh! And since I study nursing, “I’m just practicing, they asked me to do this [laughs] project for school, and I have to do it for five people, and you’re the last one.”

One participant did not like the idea of using the self test with clients. She stated that even if the client’s test were negative, she would still use a condom during sex given that the client could have other STIs. In addition, she did not think clients would be open to it and discouraged discussion of health with clients:

No, well, with a client you don’t talk about that. With a client you never talk about your health. Do you understand? You go to suck, to fuck and that’s it, then you leave. Do you understand? You don’t have that talk with them...And they ask if you protect yourself, always. But they are the ones who ask. They are the curious ones.

HIV Self Test Use and Sex Work Business—We asked participants if they could test themselves in front of clients to show them they are HIV-negative, how this would affect their business as sex workers. Participants had mixed perspectives. One thought it could help clients to feel safer. Two said it would not affect business, either because they were on friendly terms with all of their clients or because they would use it without informing them. One thought it could scare clients away:

The client is going to have doubts; he is not going to want to be with me.

Another mentioned that clients would likely not believe the test results, so it would not help her business.

Positive HIV Self Test Results—Finally, we asked participants how they would handle positive test results with clients. All participants said that if a client had a positive test result, they would not have anal sex with that client. One said that she would still have oral sex with

a client using a condom. Another thought she would help out any clients with positive results:

I would help him get help, I would support him, nothing would change because I have a friend who had HIV, and he called me and he wanted to commit suicide and I met with him, I spoke with him, and he asked me if I would continue to be with him, and I don't have any kind of contact with him, but he is still my friend.

Another stated that she would put an end to the encounter:

How would I handle it? He has to leave. I would return his money and he leaves. Because it's not the same knowing it... once I know about it, it's different. Because you would not have sex knowing it.

When reflecting on the possibility of testing themselves in front of a client and receiving a positive result, most participants perceived the likelihood of a dangerous situation, whether at risk for physical or emotional harm:

I don't know what could happen to me at that moment. Many things could happen...it could be a life-threatening situation.

Another mentioned she would never test herself in front of a client:

No. No, I would not do it. I would not do it because it is, what if the result is positive, in front of him? You understand? That is my personal information. Clients who have sex with me are also clients of other co-workers of mine because they are not just my clients. They pay for sex with women, men, anyone who appears...I have some co-workers who are rivals of mine, who are – we are all rivals because we all each other's competition. If I get a positive result in front of a client, you know that he is going to tell someone else.

Only one participant, who mentioned being on friendly terms with all of his clients and who was the only male participant, said he did not fear emotional or physical harm and that he would let everyone know if he had a positive result.

In sum, most of the male and transgender sex workers in our study liked the idea of using the self test to test themselves and to screen clients for HIV but had different ideas of how to bring up testing with clients. They had mixed ideas of whether use of the self test would affect their business. All said they would not have sex with clients who had positive results, and most said that testing themselves in front of clients could be dangerous if they had a positive result.

Likelihood of Oral PrEP Use

Although none of the participants had heard of PEP or PrEP prior to study enrollment, after these treatment options were explained, most expressed an openness to use them in the future. Nine of the 12 responded with a rating of “10” indicating they would be very likely to use both PEP and PrEP if needed (Table II).

Interviewers first asked participants how likely they would be to take a pill everyday if it could prevent HIV. They were then told about possible side effects, including nausea,

vomiting, diarrhea, headaches, dizziness or a rash, and asked how they might deal with them.

Two of the five participants stated they would not take PrEP; one did not like the idea of taking pills and having side effects:

One way or another medications always affect some type of organ. So, I am not too convinced about the pill.

Another preferred to stick with condom use:

I would not take it because I trust condoms more. Up to now, I have been doing sex work for nine years with condoms. And thank the Lord, I don't have – all my results from all of my life, I have never had a scare, no problem, vomiting, diarrhea, nothing. No allergic reaction, nothing.

The other three participants stated they would take PrEP, but two mentioned that they would continue to use condoms regardless. In sum, a few participants preferred condoms to pills, and most stated that they would continue to use condoms whether or not they used PrEP.

Likelihood of Rectal Microbicide Gel Use

At baseline, participants were asked about their future intentions to use a rectal microbicide gel (Table II). All 12 participants reported that they would be very likely to use a microbicide gel every time they had receptive anal intercourse if it provided some protection against HIV (10 on a scale of 1–10). Likelihood of gel use with clients was also uniformly high. Although 1 participant was very unlikely to use a microbicide if it were in the form of a suppository or enema, likelihood of use for these alternative formulations was also high overall among these participants.

The five participants who completed the second stage of the 12-week study reported a median of 14 RAI occasions (range=4–50), a median of 2 RAI occasions without a condom (range=0–6) with clients, and a median of 13 RAI occasions with clients in which the gel was used (range=1–30). Reasons for not using the gel with a client included forgetting (n=2) or not having the gel on hand (n=1). All 5 participants reported using the gel with a client at least once.

Overall, reaction to the gel was favorable (Table III). Two participants gave the gel the highest possible rating and only one disliked the gel. Likelihood of use with clients varied: two would be very unlikely to use it while the other 3 would be very likely to use it. Ratings of likelihood of use on the 10-point scales typically were at the extremes (1 or 9/10) resulting in means that are overall lower than intentions reported at baseline.

During the in-depth interview, we explored participants' experiences using the gel with clients during the study, including overall reactions to gel use with sex, the gel application process and the applicator, privacy while using the gel and whether or not clients knew they were using the gel, and any other rectal practices or products used in addition to the gel.

Overall Reactions to Gel—Three of the five participants had positive first impressions of the gel, stating that it felt “fine”, “like using a regular lubricant”, or “nice, good.” The other two reported having problems. One explained that she found the gel bothersome at first, but then got used to it. Another mentioned having an allergic reaction after using the gel twice with itching inside the anus. She stopped using the gel and waited until she had a follow-up visit at the clinic one month later. A few mentioned a learning curve in which they found it easier to use the gel after the first few times.

Application Process and Applicator—Four out of five participants found the rectal applicator easy to use upon first application. Nevertheless, only one participant thought it was perfectly designed; the others had various suggestions for how to improve it. Two complained about having to assemble the applicator: one stated that the plunger fell on the floor the first time she used it. The other said if the applicator came ready to use, it would be a much faster application process. Another, who reported injuring herself by inserting the applicator too far the first time, suggested doing away with the applicator entirely:

I would change the gel to be in the form of a cream, like so that one could press it and it would come out and not have to be inserted with something, so that you don't have to insert those gels in there.

Finally, one mentioned that it should be smaller so that it could fit in one's pocket for easy portability.

Privacy and Covert Gel Use—Participants described using the gel in several different places, including at home, in the car, in a hotel, and in the bathroom. Several reported using the gel in private without discussing it with their clients. One described that while working in the streets, she got picked up by a client and inserted the gel in his car:

He saw me when I applied it, and I explained to him what it was for and he said it was fine...I told him that it was a lubricant, I did not tell him that it was a microbicide gel.

Another stated she always excused herself to the bathroom to apply the gel:

I never used it in front of the person. Always, since I was in the bedroom, I went to the bathroom, “Oh, I'll be right back.” You understand? Something that – well, since it was my client. I work in prostitution, you understand? I always went to the bathroom. Never – they never knew that I had the gel inside. You understand? Only I knew that... It was better for me to use it, I am the one in the study, but they did not know that I had it in.

One felt that she did not need to mention anything to her clients since she is HIV-negative and protecting herself:

Well I felt -- I felt good, because I don't have any reason to tell them. Since the one who is protecting herself is me, not them...So, I don't feel anything because since I don't have HIV or anything, I don't have – I mean, I don't have – I felt fine.

Another did not tell his clients about the gel because he was worried about a potential negative reaction:

Yes, because, um, when – at least it has happened to me, right? That I tried to do something new, so to speak, and they don't like it. I mean, it's just a lubricant, it doesn't do anything. That's why I decided no, not to tell them.

One stated that at times she did discuss gel use with clients she saw on a regular basis, but often did not explain it:

Obviously, there are times that you have, well, some clients who are more – that you see often and all that. And so, you talk with them, about this and that. And they, well, they were really surprised about what that was. They thought at first that it was like a lubricant that I was using. Then – and so, what they believed at times – at times they thought it was a lubricant, and so I left it at that and I didn't tell them anything. I told them that, yes, it was a lubricant.

While using the gel covertly, participants sometimes mentioned to clients that they were using a lubricant but did not report issues with clients noticing it or asking about it:

I was wet. They would say, “it's slippery,” you know? And I go, “Uh huh. Yep, you know.” I paid no attention.

In sum, most participants used the gel covertly or only mentioned that they were using a lubricant to clients, and none had any problems with clients noticing or questioning them about the gel.

Rectal Practices and Gel Use—Finally, we asked participants if they used any other rectal products in addition to the gel. All four of the transgender participants reported using a rectal douche before going to work and applying the gel after the douche:

I give myself a douche – first I bathe, I fix myself up, I put on my makeup. I get ready and leave, and when I come back, when I'm going to have sex with a client, then I applied the gel.

One reported not only douching before using the gel but also after receptive anal intercourse.

In sum, participants reported using the gel covertly with clients and being able to use it and apply it in a variety of work locations. Two had itching or irritation at first upon using it, but were later able to use it successfully. Also, many reported using a rectal douche before inserting the rectal microbicide and at times, afterwards as well.

Discussion

This study was the first to assess Puerto Rican male and TGF sex workers' likelihood to use an HIV self test or oral PrEP for HIV prevention and to evaluate acceptability of a placebo gel as rectal microbicide in the context of RAI with clients. Our findings indicate variable acceptability of these biomedical HIV prevention alternatives.

At baseline, a great majority indicated willingness to use a rapid HIV self test to test themselves for HIV. During the in-depth interview, most participants had not heard of the HIV self test but stated they would use the test on themselves. The main barrier identified was lack of trust in a test that uses oral fluid. Therefore, promotion of the over-the-counter

availability of the HIV self test among this population may be an effective way to increase HIV testing, and information would need to be made available about the comparable accuracy of oral fluid and blood-based tests. In contrast, use of the test with clients was more challenging. The scenarios they envisioned at times involved trying to test clients without informing them about the test. Likelihood of using the test with clients depended on several factors such as the client's willingness to use condoms, the client's age, and the sex worker's comfort with explaining the test to clients. All stated they would not have sex with clients who had positive results. Testing oneself in front of clients with the potential for an unexpected positive result was seen as challenging. Major barriers included the possibility for violence, breach of confidentiality with networks of clients and other sex workers, and a high likelihood of emotional harm. These possible challenges overshadowed any potential benefit to their business by being able to demonstrate to clients that they were HIV-negative.

Since the efficacy of oral PrEP for both MSM and TGF was demonstrated (29), much attention has been focused on rolling out oral PrEP for populations at high risk of HIV-infection. Our findings contribute to the little that is known about acceptability of oral PrEP to male and TGF sex workers. At baseline, the ratings for likelihood of oral PrEP use were quite high; however, during the interview some participants said they still preferred condoms to pills for HIV prevention, especially given that they protect from other STIs as well. Other barriers to oral PrEP use mentioned by participants included disliking the systemic effects of pills and potential side effects.

The final prevention option we explored was a rectal microbicide gel. At baseline, all participants reported being very likely to use a microbicide gel every time they have RAI with a client. Ratings for alternative formulations such as an enema or a suppository were not as high for everyone but still favorable overall. Among the sample that went on to use a rectal placebo gel before RAI with clients, most participants liked the gel and the application process, but overall they indicated being less likely to use the gel with clients than at baseline. A few had itching or irritation from using the gel at first, which may have dampened their enthusiasm. Similar to a larger sample of MSM (30), our sex worker sample had suggestions for improving the applicator, from making it smaller, all one piece, or in a squeezable bottle or cream formulation.

Notably, all participants were able to use the gel with clients, mostly covertly, by mentioning to clients that they were using a lubricant, if asked. This indicates great potential for incorporation of a gel formulation in the context of sex work. Finally, most participants stated that they used a rectal douche before going to work and sometimes afterwards. This points to the potential for a rectal microbicide enema formulation and for the need to study the possible effects of douching prior to and after microbicide gel use.

These data are based on a feasibility study to evaluate sites' ability to recruit sex workers for a microbicide trial. A very small number of participants were recruited, indicating this may be a very hard-to-reach population for future biomedical prevention trials. Due to the small sample, our results are not generalizable, particularly since four were TGF and one was male, and these two groups may have very different needs and work contexts. Nevertheless, given the dearth of knowledge on acceptability of HIV prevention technologies to male and

TGF sex workers, these limited findings suggest that rectal microbicides may be a feasible option in the sex work context.

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Table I

Sample description at baseline (N = 12)

	Median	Mean	SD	Range
Age	25.5	24.9	4.3	18–30
Years of education	12.0	9.8	3.6	2–13
Annual income	10,000	12,877	14,727	70–45,000
Number of clients, 3 months	28.5	55.9	73.6	2–252
Number of RAI ^a occasions with clients, 3 months	18.5	37.5	69.4	0–252
Number of condomless RAI occasions with clients, 3 months	1.5	23.2	72.2	0–252
Do you consider yourself...	N	%		
Man	4	33%		
Woman	2	17%		
Transgender	6	50%		

^a receptive anal intercourse

Table II

Intentions to use alternative HIV prevention methods (N = 12)

	Mean ^a	SD	Range
How likely use microbicide gel every time RAI ^b	10.0	0.0	10
How likely use microbicide gel every time RAI with a client	9.9	0.3	9–10
How likely use microbicide if suppository	9.1	2.6	1–10
How likely use microbicide if enema	8.3	2.8	2–10
How likely use PEP ^c if exposed to HIV	8.7	2.8	1–10
How likely use PrEP ^d	8.9	2.0	5–10
Would you use a rapid HIV ^e self test to test yourself?	N	%	
No way	1	8%	
Unlikely	0	0%	
Likely	5	42%	
Definitely	6	50%	
Would you use a rapid HIV self test to test clients?			
No way	3	25%	
Unlikely	2	17%	
Likely	5	42%	
Definitely	2	17%	

^aResponse scale: 1 = very unlikely to 10 = very likely^breceptive anal intercourse^cpost-exposure prophylaxis^dpre-exposure prophylaxis^ehuman immunodeficiency virus

Table III

Reactions to gel use (N = 5)

	Mean ^a	SD	Range
How much liked the gel	7.4	2.6	4–10
How much liked process of applying the gel	7.6	2.5	5–10
How likely use gel for receptive anal intercourse with clients	6.0	4.6	1–10
How likely use gel when don't use condoms	7.8	3.8	1–10
How likely use this applicator	6.2	4.8	1–10

^aResponse scale: 1 = disliked very much or very unlikely to 10 = liked very much or very likely