An E-tutorial

Clinical Components for Service Delivery for Most-at-Risk Populations (MARPs)

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India Learning Network- Bridge Project

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Clinical Components for Service Delivery for Most-at-Risk Populations (MARPs)

1. Background

The transmission of sexually transmitted infections (STI) is closely related to the sexual transmission of Human Immunodeficiency Virus (HIV). Individuals with STIs/RTIs have a significantly higher chance of acquiring and transmitting HIV. Moreover, STIs/RTIs are also known to cause infertility and reproductive morbidity. Controlling STIs/RTIs helps decrease the chances of HIV infection and provides a window of opportunity for counselling about HIV prevention and reproductive health.

Globally organizations are working to ‘reduce the transmission of HIV by reducing the STI incidence and prevalence among core populations/MARPs’. Access to health services is determined by three factors: (1) the health-seeking behaviour of the population, (2) the health care provider’s attitudes, and (3) the capacities of healthcare delivery systems. To be able to achieve the goal of reducing the transmission of HIV among the MARPs, it is essential that these marginalized populations have access to healthcare. In this effort, the clinic programmes form a critical component to the delivery of STI/RTI services to MARPs and while designing the clinic programs, the three factors that determine access to health services are placed at the core of the planning process.

2. An overview of Clinical Services for MARPs:

Clinical services include STI/RTI/HIV related testing, treatment and care designed and delivered for MARPs through the project/program at site and through referrals and linkages with the appropriate government and private service providers, promotion and distribution of free condoms and other commodities like lubricants for MSM, and needles/syringes for IDU.

Access to quality health services are provided to FSW, MSM and TG through a well-established, community-friendly ‘Clinic Program and Referral’ cycle, with the involvement of peer educators, project outreach staff, counsellors, doctors and community self-help groups. The strong linkages between the clinic and outreach activities are established to ensure that most at risk individuals and their clients are reached. It is the coordination
between the clinic team and the peer outreach team that helps to mobilize sex workers and MSM to visit clinics more regularly.

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All the case studies for each component of clinical services for MARPs will be based on Project Sankalp

**3. Clinical component number 1: STI/RTI Clinics for screening, treatment and care for MARPs**

Provision of STI/RTI treatment and care services is an important strategy to prevent HIV transmission and to promote sexual and reproductive health under the National AIDS Control Programme (NACP III) and Reproductive and Child Health (RCH II) of the National Rural Health Mission (NRHM) in India.

Every new registration and all registered members in the project service area/intervention are motivated to make a first visit to a Project Linked or Preferred Provider Clinic, where they are registered, and receive counselling, consultation and examination from a trained doctor. The Preferred Provider Clinic is a doctor/clinic in the site who/which is chosen by MARPs on their own will for consultation on common ailments. These Preferred Providers are subsequently trained by the project on Syndromic Case Management of STI

**2.1 Project Sankalp**

‘Sankalp’ was a project implemented by Karnataka Health Promotion Trust (KHPT) under ‘Avahan’, the India initiative of Bill and Melinda Gates Foundation from 2003 in 16 high HIV prevalence districts in the state of Karnataka in India with the goal to reduce the transmission of HIV and STIs in the state through result-based investments. The project was implemented in partnership with NGOs and CBOs in these districts.
and the clinical protocols for management of STI among sex workers to enable them to offer these services.

If the doctor prescribes treatment with STI drugs, the community member receives the prescribed drug kit, counselling services and condoms, free of cost through the intervention. Follow-up on treatment, ICTC, ART or PPTCT (pregnant women) referral and partner notification is also advised. The other services under the clinic program include counselling, syphilis screening, ICTC referrals for early HIV detection, CD4 testing and treatment linkages with ART centres and hospitals.

3.1 Establishing client-friendly STI/RTI Clinics: It is important to set up client friendly STI &RTI clinics for MARPs that offer a stigma-free environment for FSWs, MSMs, TGs and IDUs and ensures that the community accepts and utilizes the services. Stigma and discrimination towards MARPs from health care professionals and the general community was reported to be high. Some steps to reducing stigma and discrimination include listening to the voice of the community, addressing non-health issues of the community, engaging the community in designing the services, involving them in the implementation and building their capacity to monitor the program.

3.2 Different clinic settings in India:

STI/RTI services for MARPs in India are provided through targeted interventions (TIs) to high risk groups (HRGs) through three major specified clinic settings that include

- Targeted Intervention owned static STI/RTI clinics for locations with ≥ 1000 sex workers which are managed by NGOs and promote meaningful participation of sex workers/MARPs in the clinic operations and management. These are duly supported by NACO, SACS and DAPCU.
- Outreach clinics for smaller number of sex workers/MARPs are held on fixed days and fixed times. The Outreach Clinics are conducted by a team consisting of a doctor, counsellor, nurse, and outreach worker who visit fixed locations to conduct clinics within pockets of MARP populations who cannot access the project static clinics due to distance or other factors, but are willing to access services if these were provided at their doorsteps. A model of an outreach clinic is provided with this module.
- Referral linkages to government and private STI/RTI service providers in locations with ≤ 200 sex workers/MARPs. The government clinical service providers include the ICTC, ART, PPTCT services. Private service providers including those qualified in modern medicine, AYUSH and other health care providers which are involved by NACO, SACS and
DAPCU through a franchising-approach at the sub-district and district levels to provide STI/RTI services to MARPs (and general population).

AYUSH includes indigenous systems of medicine including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy.

### 3.3 Clinical Services Package:

The minimum package of services for treatment of STIs include:

- **Syndromic Case Management (SCM) of STIs**
- **Asymptomatic STI screening and treatment**
- **Enhanced scope of treatment**
- **Sexual and Reproductive Health**

The **Syndromic Case Management (SCM)** treats symptomatic STI by diagnosing a syndrome and providing drugs to treat all common causes of the syndrome. Drugs are pre-packaged in colour coded packs for the different syndromes. These drugs can be consumed under supervision since many of them are single dose combinations.
Screening for Asymptomatic STI includes speculum examination for all women who attend clinic in order to be able to detect ulcers, vaginitis and cervicitis. Additionally, syphilis screening using rapid or point of care tests is done for all women attending the clinic bi-annually using a finger-prick blood test and syphicheck kit.

Treatment of Asymptomatic STI includes prescription of a grey pack (containing Tab.Azithromycin1 gram and Tab. Cefixime 400mg) for treatment for cervicitis caused by gonorrhoea and Chlamydia when the sex worker attends the clinic for the first time; the dose is repeated if the sex worker has not attended the clinic/not had a check-up for the last six months or longer.

Enhancing the scope of treatment includes counselling and testing for HIV, verbal screening for TB symptoms, management of minor ailments and side-effects of STI treatment. FSW, MSM and TG living with HIV are registered at the ART centre, regularly screened for HIV-TB co-infection and treated in accordance with the national guidelines.

Sexual and Reproductive Health:

Sex workers have limited access to reproductive health due to stigma and discrimination and legal implications of reproductive health services (eg., safe abortion and family planning differ within the legal frameworks of each country). The clinical services can assess risk of and ensure protection against pregnancy among sex workers. It is found from a study conducted by UoM/KHPT that at least one in six sex workers had an unplanned pregnancy or induced abortion in their lifetime. Many of these abortions are performed in private clinics of unqualified doctors.

A referral system links FSW to RCH services including antenatal care, institutional delivery and postnatal care in government health facilities where maternal and child health services are a priority.

3.4 Project Sankalp and STI/RTI Testing and Treatment services for MARPs:

Under Project Sankalp clinical services were provided through a variety of outlets in addition to the project-linked clinics. The project trained private doctors, to whom it referred community members. Doctors under this project received drugs and equipment that they needed. STI treatment was standardized, simplified and significantly improved by supplying doctors with color-coded packaged combinations of drugs for SCM of symptomatic STI.
The Targeted Intervention clinics provide saturated coverage to MARPs by presumptive treatment, regular medical check-up and partner management. In most TIs there was one Project Linked Clinic (PLC) in each district and multiple Preferred Provider Clinics (PPP) for service delivery. The Preferred Provider Clinics are clinics located in the vicinity of sex work/cruising sites, with doctors who are liked/‘preferred’ by the community for accessing varied health needs. These PPP doctors receive training from the project on management of STIs.

The key populations are tracked on a monthly basis but are encouraged to visit the clinic once in 3 months. Regular medical check up of the key population strengthens STI diagnosis, treatment and follow-up.

4. Clinical component number 2: Counselling

4.1 Where?

MARPs receive counselling in the TI owned clinics (STI/RTI clinics, Outreach clinics), drop-in-centres, ICTCs, PPTCTs and ART centres and also in outreach services. Counselling is found associated with either testing/screening for STI/HIV/TB and treatment/care. Counselling is offered to all patients who undergo HIV testing or who receive treatment for STIs/HIV. The content of counselling includes the “four C’s” viz., Condom demonstration and promotion, ensuring compliance with treatment, counselling to know ones HIV status and contact treatment/partner management. When and where the “four C’s” are conducted will vary with different clinic sites but counselling should be carried out when the patient is at the clinic.

4.2 Why?

The goal of counselling is to create awareness, provide information and access to services with the larger mission to reduce HIV/STI risk behaviours and strengthen prevention of STI/HIV transmission.

Protocols for STI management in Clinic Program

- Symptomatic Treatment through Syndromic Case Management (SCM)
- Presumptive Treatment
- Regular Medical Check-up (RMC) once every quarter
- Bi-annual Syphilis Screening - Point of testing, treatment and care.
- Linkages with Public Health Services for specialized treatment
4.3 What?

When a new community member makes his/her first visit to a TI clinic or preferred provider clinic or a referred/linked government public health service centre, they are registered and receive counselling followed by examination by a trained doctor and consultation. If the doctor prescribes treatment with STI drugs, the community member receives the prescribed drug kit, free condoms and counselling services. Follow-up on treatment, referral to ICTC/PPTCT (for pregnant women) and partner notification is also advised further.

STI Counselling includes providing information on the nature of infection, its consequences, the importance of complying with treatment regimens, how to reduce risk through condom use, demonstration on the correct method to use a condom and condom negotiating skills, and contact treatment/partner management. In case of sex workers, partner referral and treatment refers to regular partners and boyfriends.

HIV counselling includes risk-reduction counselling- giving information that allows him/her to decide voluntarily for HIV testing, on both the benefits and the adverse psychological impact of knowing their HIV status. Confidentiality of HIV testing and counselling is ensured to patients. Each project STI/RTI clinic has a trained counsellor who can
provide post-test counselling if a patient prefers to have an on-going supportive counselling.

A counselling session includes not just health education and treatment information on STI and HIV; it also helps the patient cope with anxiety and stress caused by the diagnosis. It also ensures that patients are aware of safe healthcare practices and procedures pertaining to universal precautions that prevent transmission of HIV. For eg., demand use of clean needles, syringes and instruments for internal examination.

Information, Education and Communication (IEC) materials are sometimes given to the patients in the clinic at the time of counselling, if they are able to read and understand.

4.4 Who?

Counselling is conducted by a person who has been trained in counselling techniques, and who speaks and understands the dialect of the local community.

4.5 Impact?

Counselling has proven to have impact on increasing the number of MARPs who agree to have a HIV test on a regular basis. It was found from Project Sankalp experience in Karnataka State that good rapport with counsellors and doctors in ICTC and PPTCT centres resulted in larger numbers of FSWs and MSM volunteering for the STI/HIV test on a regular basis. Encouraging community members to visit the government ICTCs once every six months is an important component of the TI’s Clinic Program.
5. Clinical component number 3: Condom promotion and distribution

Information on condoms and access to condoms are found to be poor among the MARPs in most countries, and in India. Besides this, FSWs and MSMs also hesitate to carry condoms with them fearing police harassment and arrest. Female condoms are neither in the market nor supplied in programs until recently. Some of these issues were addressed through condom programming strategies.

The National AIDS Control Programme (NACP III) laid focus on ensuring condom

1) Availability

2) Accessibility

3) Correct and Consistent Usage of condoms by MARPs

5.1 Condom availability is made possible by free condom distribution by peers during outreach and at STI/RTI clinics and drop in centres. Designing condoms that fulfil special requirements of MARPs and ensuring its supply based on accurate condom requirement of a given site of intervention are important issues for consideration.

Condoms should always be available for free among MARPs. However, to increase accessibility condoms were made available using two strategies in India- the primary strategy involves supply of free condoms to FSWs through the Targeted Interventions by NGOs/CBOs while the secondary strategy involves social marketing (for creating demand for condoms) of condoms for clients of FSWs and MSM/TGs by NGOs/CBOs.

‘Free’ condom programming for FSWs/MSMs/TGs is based on the belief that ensuring availability and accessibility of condoms alone will increase its use by MARPs. However, mere distribution will not ensure condom use. The goal is increased correct and consistent usage of condoms by FSWs/MSMs/TGs.

In order to achieve this, free condoms are designed to meet the specific needs of FSWs, MSMs and TGs. For instance, FSWs/MSMs expressed the need for condoms with extra lubrication and length and MSMs for condoms with extra thickness. Additionally, lubricants are provided to MSM and TG to reduce the risk of abrasion and tear in the process of anal intercourse.

Condom requirement of any given site of intervention is calculated taking into account the number of sex workers operating in that area, the number of sex acts per day per sex
worker and the number of days the SW is ‘active’ in a month by the peer educators. Assessing condom requirement of a given site helps to forecast adequate supply of condoms.

**5.2 Condom accessibility** is made possible by assessing various aspects related to condom usage among the FSW/MSM/TG community at the site level before initiating condom programming there, and establishing key channels for ensuring condoms reach FSWs/MSMs/TGs.

Considerations followed before beginning a condom program at a site include a study of what the barriers to condom usage are (e.g., alcohol consumption, misconceptions and myths on condom usage, etc.,).

The key channels for ensuring condom distribution to FSWs/MSMs/TGs include the direct distribution by peer educators and outreach workers in the field, at the drop in centre and STI/RTI clinics; and indirect distribution through public toilets, petty shops, tea shops, lodges and brothel madams, brokers, auto drivers where condom vending machines are placed.

**5.3 Condom Use:** Condoms can be made available and accessible through free distribution by peer educators during outreach and through clinic based distribution. However, in order to ensure correct and consistent use of condoms, peer educators are trained to educate FSWs, MSM and Transgenders on how to put on a condom correctly, using a penis model. Studies have demonstrated that condom use rates were higher among FSW and MSM who visualised and practiced condom demonstration on a penis model. Additionally, FSW’s, MSM and Transgender are trained to recognise instances and situations wherein condom use can be compromised. In a one-on-one encounter, they are trained by experienced peer educators on how to negotiate condom use with their clients. Crisis response systems are put in place to reduce and address occurrence of violence. Community norms are set with regards to ‘no condom no sex’ and in relation to ‘no alcohol while at work’. Ensuring that they have the money first, that they choose the site and that they have access to ‘help’ if needed are key aspects to reducing the chance of being cheated into group sex and rape. Sex workers are also trained on their human and legal rights and the correct interpretation of the law.
6. Clinical component number 4: Referrals and linkages to public or private health services

Patients whose health problems cannot be addressed or are non-responsive to syndromic management are referred to a higher-level care/treatment facility such as a local hospital or a specialty care centre. Referral arrangements are in place for services which the clinic cannot provide but are needed by the community.

Referrals and linkages are also made to:

- Integrated Counselling and Testing Centre (ICTC) for HIV
- Anti Retroviral Therapy Centre (ART) for treatment of HIV/AIDS
- PLHIV care and support services (CSC)
- Other health services (TB, maternal and child health etc)

Clinics compile a list of relevant providers for referrals that includes names, addresses, telephone numbers and operating hours. A referral card is provided for every referral made so as to track completion of the referral.

6.1. Integrated Testing and Counselling Centre (ICTC)

Integrated Counselling and Testing Centres are centres where a person is counselled and tested for HIV, on his/her own free will or as advised by a medical provider. An ICTC can be located in a government, a private hospital or a government department like railways and industrial sites. Counselling is given before the voluntary testing for HIV and is called ‘pre-test counselling’ and after testing called ‘post-test counselling’. Persons found HIV-negative after the testing, are given information and (post-test) counselling to reduce risks and remain HIV-negative. People who are HIV-positive are given psychological support and linked to the Ante-Retroviral Therapy (ART) Centre for treatment and care.

The mandate of the ICTC is to include not just the individuals from general population in counselling and testing but also of most at risk populations like FSWs, MSM, TGs, IDUs, clients of SWs, truckers, migrant workers, and spouses and children of men who are prone to risky behaviours.
6.2 Anti Retroviral Therapy (ART) Centre

An ART centre provides treatment, care and support to people living with HIV (PLHIV). The services an ART offers include (i) registration; ii) laboratory services including baseline investigations and CD4 count to identify eligibility for initiating ART; (iii) free ARV drugs to eligible persons living with HIV/AIDS (recommended count of CD4 is <350, any count for a person co-infected with TB or a woman who is pregnant) (iii) Counselling before and during treatment to ensure adherence to treatment (iv) comprehensive education to PLHIV on nutritional requirements, hygiene and measures to be adopted to prevent transmission to others (v) provision of free condoms for those sexually active.
Clinical Services for MARPs

6.3 Care and Support Centres (CSC)

Care and Support Centres have been set up under the National AIDS Control Programme, where the PLHIV receive support for treatment adherence, psychological support and linkages to social entitlements and welfare schemes. Outreach workers from the CSC make follow-up home visits to ensure home care and treatment adherence; prepare family/spouse for acceptance of test status of PLHIV and to get themselves HIV tested, counselling for treatment adherence and assessment and linkage to social schemes.

7. Suggested Readings

NACO Operational guidelines for Strengthening STI/RTI Services

Targeted Interventions under NACP III Operational Guidelines for Core High Risk Groups
Link: http://www.naco.gov.in/upload/Publication/NGOs%20and%20targetted%20Intervations/NACP-III.pdf

Scaling Up Community Friendly STI/RTI Services for Most At Risk Populations, an Avahan Experience

We thank the authority of K.C General Hospital Bangalore and Karnataka State AIDS Prevention Society for their support in photo documenting the health infrastructure for service delivery for key populations.