Aastha health services for MARPs: Benchmarks in Scale and Quality

आस्था
Aastha
Parivaar

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FOREWORD

The Avahan India AIDS initiative was launched in 2003 at a time when Phase II of the National AIDS Control Program (NACP-II) was operational in India. In addition to the HIV prevention interventions prevalent at that time, Avahan introduced monthly screening for sexually transmitted infections (STIs) using enhanced syndromic management, quarterly presumptive treatment of STIs (Gonorrhea and Chlamydia), and Syphilis screening as a part of its package of clinical services for sex workers. When the FHI 360 Aastha project began in mid-2004, it had to address the challenges of setting-up a service delivery system, incorporating demand creation, increasing access and uptake of the STI interventions, introducing quality assurance and quality improvement processes (ACQUA), micro-planning with community-based monitoring and individual tracking, and preparing the sex worker community to own and manage the services.

FOREWORD

Several innovations and best practices such as micro-planning with individual tracking were developed that successfully addressed these challenges. The Aastha project successfully scaled-up the uptake of STI screening services and met and sustained performance to create benchmarks. These innovations from Aastha were later incorporated within the other Avahan interventions as well as the National guidelines for targeted interventions developed as a part of NACP-III introduced in 2007-2008.

The second phase of Aastha that began in 2009 saw the Aastha project successfully develop, demonstrate and transition scaled-up HIV counseling and testing services for sex workers, design and introduce a community-owned continuum-of-care system to strengthen HIV care and treatment services for sex workers and create several new approaches such as segmented service delivery and dynamic micro-planning to take the Aastha project interventions to new benchmarks. These interventions were successfully transitioned to the Mumbai District AIDS Control Society (MDACS) and the Maharashtra State AIDS Control Society (MSACS) for continuing support and post transition support was provided to ensure that quality of services and performance was maintained and enhanced.

The following pages describe the Aastha best practices in the delivery and management of clinical services for sex workers.

Dr. Sanjeev Singh Gaikwad, MBBS, MD, MScCH; Director, Maharashtra; FHI 360

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ACQUA	Aastha Continuous Quality Approach
ART	Anti-Retroviral Treatment
BCC	Behaviour change communication
BMGF	Bill and Melinda Gates Foundation
CAC	Clinic advisory Committee
COC	Continuum of Care
CBO	Community Based Organization
CQMT	Clinic quality monitoring tool
CV	Community Volunteer
DAC	Department of AIDS Control
DIC	Drop in Center
ESP	Essential services package
EQAS	External quality assurance system
FSW	Female SW
FP	Family Planning
HIV	Human Immuno Deficiency Virus
ICTC	Integrated Counseling and Testing Center
IPC	Interpersonal communication
IUCD	Intrauterine contraceptive device
MDACS	Mumbai District AIDS Control Society
M & E	Monitoring and evaluation
MIS	Management Information System
MOU	Memorandum of Understanding
MSACS	Maharashtra State AIDS Control Society
MSW	Male sex worker
MTP	Medical termination of pregnancy
NACO	National AIDS Control Organization

NCUM	Non condom using men
NGO	Non-Governmental Organization
OCP	Oral contraceptive pills
OI	Opportunistic Infection
ORW	Outreach Worker
PE	Peer Educator
PO	Program officer
POC	Point of care
PLHIV	People Living with HIV
PP	Preferred providers
PPP	Public Private Partnership
PPTCT	Prevention of parent to child transmission
PT	Presumptive treatment
PTS	Post transition support
QA/QI	Quality assurance/Quality improvement
RPR	Rapid Plasma Reagin
SBC	Strategic Behavior Communication
SHG	Self Help Group
SOP	Standard Operating Procedure
SRL	State reference laboratory
STI	Sexually Transmitted Infection
TB	Tuberculosis
TI	Targeted Intervention
TO	Technical officer
TG	Transgender
TSU	Technical support unit
VCT	Voluntary Counseling and testing
WHO	World Health Organization

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We thank the following team members for their contribution to this document:

Development of strategies and innovations

- **Dr. Sanjeev Singh Gaikwad, Director** – Maharashtra Program, FHI 360

Technical support for the development of the manual

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The FHI 360 Aastha program and technical teams, Family Planning Association of India (FPAI) and Society for Services for Volunteers Association (SOSVA) successfully managed the implementation of the activities lead by Peer Educators and supported by Outreach workers.

TABLE OF CONTENTS

Intended audience: This document is intended for an extensive readership, including public health decision makers, program managers, program officers, health providers and health workers (governmental, nongovernmental and private) working with high-risk groups in the field of HIV prevention.

INTRODUCTION

A pioneering project, Aastha (2004–2014) has been working toward HIV/STI prevention among male, female and transgender sex workers (SWs) in two major districts (Mumbai and Thane) of the state of Maharashtra, India. The project has been funded by the Bill & Melinda Gates Foundation (BMGF) and implemented by FHI 360. The clinics established under Aastha NGOs provide a complete package of services to SWs, including STI prevention and management, condom distribution, syphilis screening, voluntary HIV counseling and testing, strategic behavior counseling and peer-led community mobilization.

Aastha's pioneering approach lies in the enhanced service delivery strategies it has developed to address the barriers generally faced by HIV/STI prevention programs for SWs. The transient and dispersed nature of SWs' life and work itself poses a major challenge to service uptake. Despite availability of project-run clinics, low self-risk perception, heterogeneity of SWs, their high mobility, physical distance from clinics, and harassment by regular partners and other stakeholders contribute to low uptake of clinical services. There are several other day-to-day challenges SWs meet in their struggle for survival.

In this scenario, health comes to assume a place of low or no-priority for them. Moreover, their lives are largely controlled by stakeholders like brothel managers, pimps, madams, bar managers and regular partners. Also, SWs themselves are extremely conscious of the perception of stigma and discrimination by service providers. The combined weight of the stigma associated with being HIV positive and being a woman/man/transgender into sex work prevents many SWs from accessing health services.

Aastha has sought to tackle these barriers and address the needs and risk levels of individual SWs by developing enhanced service delivery strategies, which are described in greater detail later in this document.

With the help of these improved service delivery strategies, Aastha created several international benchmarks till the full transition of its interventions to Government in 2012. Aastha's major benchmarks include the scaling-up of monthly STI screenings to 36 percent SWs (10,000 SWs/month), with quarterly STI screenings at 93 percent; decrease in STI incidence from 37 percent to 3 percent from 2004 to 2012; and increase in six monthly uptake of voluntary counseling and testing (VCT) from 3 percent to 50 percent from 2010-2012.

Strengthening community leadership was a crucial component of the project, which it sought to achieve through collectivization of SWs into site-level self-help groups (SHGs), government-recognized community-based organizations (CBOs); and the Aastha Parivaar, a federation of CBOs, so that voices of SWs are not only heard at all forums but they also develop ownership for every aspect of the project. Through its unique community involvement strategy, Aastha ensured that 99 percent of the crises faced by SWs were responded to within 24 minutes and police arrests were significantly reduced. Uptake of prevention messaging and condoms went up to nearly 100 percent. Aastha's buddy system led to a statistically significant increase in linkages of people living with HIV (PLHIV) SWs with care and treatment services in the public sector (65 percent vs. 53 percent, OR 1.62) from 2010-2012.While the number of identified PLHIV SWs went up by 60 percent, from 464 to 744, in the two-year period from 2009 to 2011, Aastha's continuum of care system ensured that pre-registration for antiretroviral therapy (ART) in government health facilities went up from 45 percent to 59 percent and membership in support groups increased from 23 percent to 50 percent. The Aastha Continuous Quality Approach (ACQUA) ensured a high level of service quality and regular innovations.

This present document, titled ***Aastha Health Services for Sex Workers: Benchmarks in Scale and Quality,*** aims to :

- Describe the enhanced service delivery strategies that are needed to achieve universal access to HIV prevention, treatment and care
- Guide the selection and prioritization of strategies for HIV prevention, treatment and care
- Direct toward references and links for each of the priority health interventions for further details and ease of replication

1. STI PREVENTION AND MANAGEMENT

1.1 Essential services package for sex workers

Effective STI control among vulnerable high-risk groups like SWs is an important strategy for reducing HIV transmission. Creation of an essential services package (ESP) for SWs is a pre-requisite for ensuring provision of effective and quality STI services.

Working in coordination with peer-based outreach and community-led structural interventions, the clinics supported by Aastha provided SWs an ESP designed to detect and treat curable STIs and reinforce condom use. The main clinical components of the ESP included enhanced syndromic case management, provision of regular check-ups and presumptive treatment for asymptomatic infections.

The ESP recommended that SWs with STI symptoms be managed based on the syndromic case management stated in the Department of AIDS Control (DAC) guidelines. As syndromic management depends on the presence of symptoms, it misses asymptomatic STIs in women. Protocols were therefore developed in the ESP to screen and manage asymptomatic STIs. Regular check-ups with speculum and bimanual examination helped identify some of these asymptomatic infections when clinical signs were present. Presumptive treatment (PT) of asymptomatic infections on the first visit and then every six months intended to treat the infections missed by other methods and address high STI prevalence and frequent re-exposure. These protocols were compiled in shaping Aastha's essential clinical service package.

Aastha's ESP for SWs comprised a range of monthly clinical services, including effective treatment of SWs with STI symptoms, PT to cure asymptomatic infections in new SWs and repeat PT to those who had not accessed clinical service in the last six months, partner notification and management, syphilis screening and VCT services. The ESP was the basic essential clinical services package provided to all new SWs registering with Aastha, as they were especially vulnerable to STIs. All new SWs were provided the ESP within seven days of registration.

Aastha defined the following as the core elements of a comprehensive clinical package of HIV prevention services for SWs and their partners:

- Regular screening of symptomatic/asymptomatic STIs and management
- STI and HIV counseling and prevention activities
- Laboratory services - syphilis/HIV testing
- Proactive partner management - STI/HIV counseling, management and prevention activities
- Referral - care and support, family planning, tuberculosis, gynecology, medical/surgical emergencies

STI Services

Regular Screening of Symptomatic / Asymptomatic STIs and Management

Laboratory Services Syphilis/HIV Testing

STI and HIV Counseling & Prevention Activities

Proactive Partner Management - STI / HIV Counseling, Management & Prevention Activities

Referral - Care & Support, FP, TB, OBGY, Medical / Surgical Emergencies

Aastha's clinical ESP, offering a comprehensive range of services, was designed to have a maximal impact in preventing STI and HIV/AIDS. While each standalone service was useful in addressing HIV in SWs, together they formed a package and had the greatest impact when delivered as a whole. By formulating an ESP at the very beginning of the project in 2004, Aastha enabled SWs to access appropriate and non-discriminatory HIV prevention, care and treatment.

2. INNOVATIONS IN STI/HIV SERVICE DELIVERY

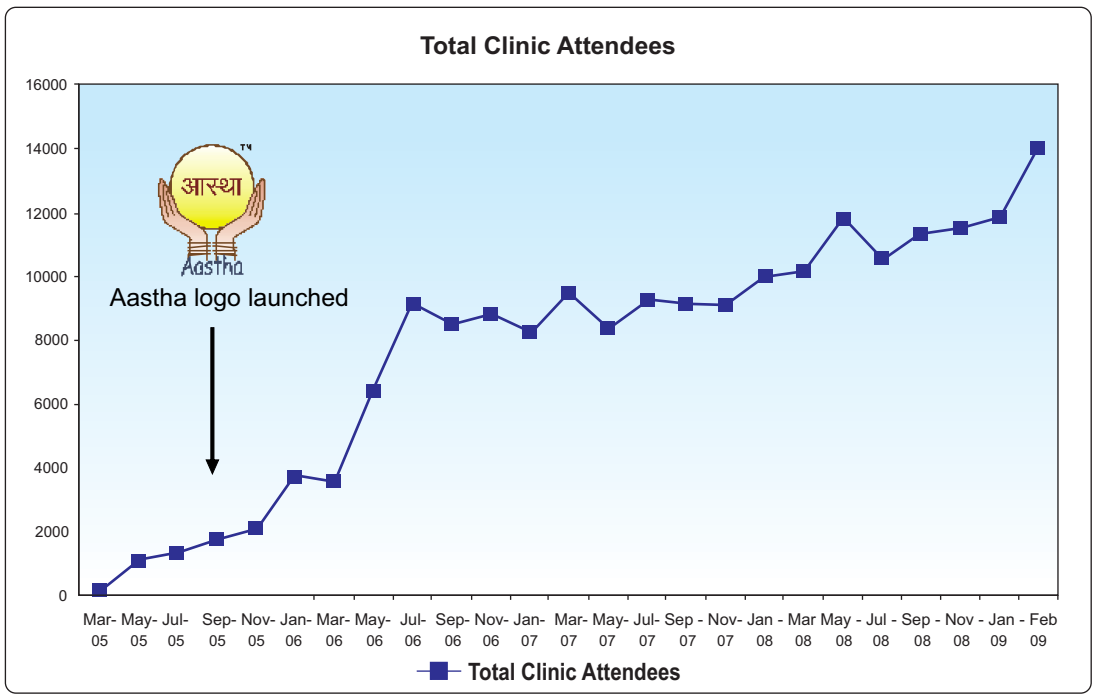
2.1 Branding and demand generation through niche marketing

Aastha recognized that capturing the attention and imagination of SW groups, developing and sustaining their trust, and ensuring their involvement required any project to create a unique identity for itself. Suitably, Aastha used communication and marketing strategies that appealed to SW groups without inviting attention from the general community and enabled community members to develop their own “Aastha brand”.

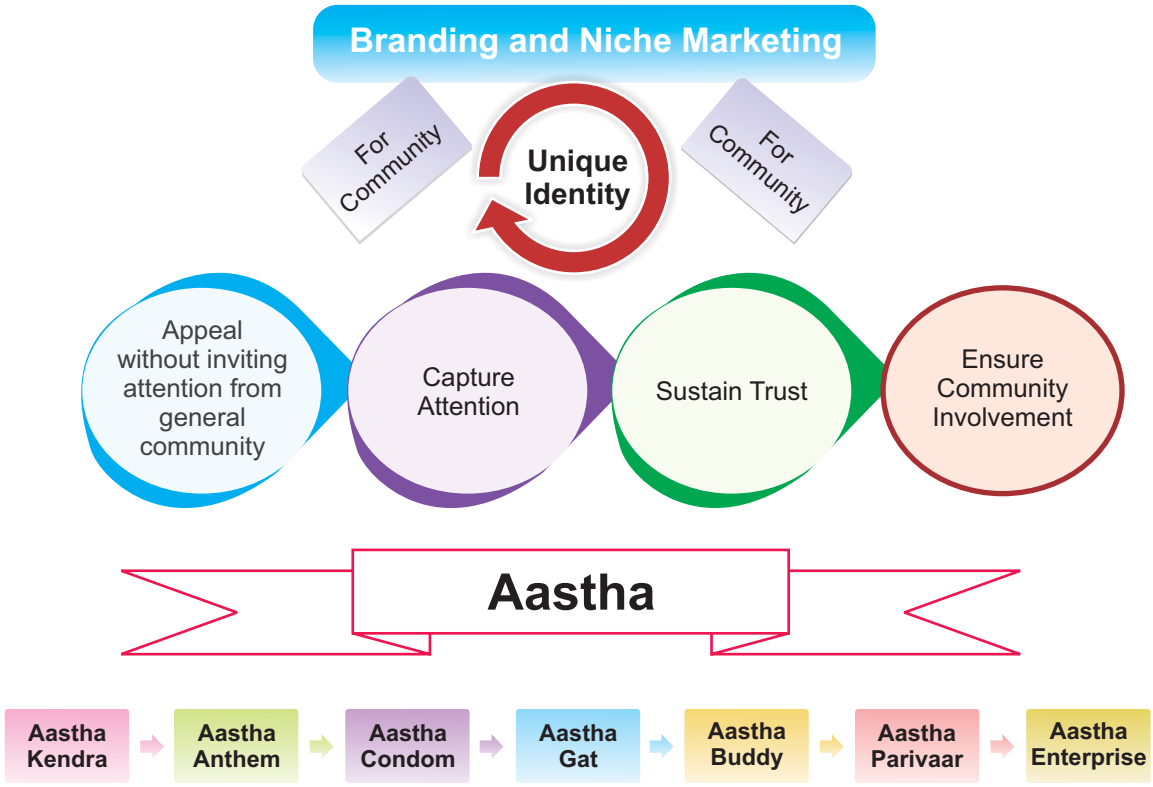
A contest was conducted among SW peer educators (PEs) to identify a single name for the project, and a painting competition was held to design the logo. The name 'Aastha' (meaning, to care about) and the logo were created by SWs. The brand was formally launched in November 2005. The name and the logo prominently featured on the signage at project sites, project services and products, lapel pins, behavior change communication (BCC) materials, jackets and caps for PEs, identity cards and health cards. These brand-building efforts were further complemented by communication and counseling field activities that resulted in increased ownership, access and demand for services.

The strategic behavior communication (SBC) approach developed by Aastha consciously avoided billboards, prominent signage and labeling of health facilities as 'STI clinics'. Instead, focus was placed on interpersonal communication (IPC), using specially developed, branded material that promoted dialogue and interaction.

Outcome of branding and niche marketing:



Aastha's branding strategy for clinical and non-clinical services reached-out specifically to SWs in a friendly, stigma-free environment, without drawing attention from the general public. Efforts were aimed at increasing brand recognition within the SW community, and services were built around creating brand value. By targeting brand communication selectively at SWs, the project ensured that the brand did not create stigma for the SW community. Even the mobile clinic used by the project is a blue-colored van with the Aastha logo, and it is difficult to know from the outside that the van is a mobile STI clinic.



Aastha's niche marketing began with setting-up a safe space for SWs - the Aastha drop-in center (DIC), or more popularly known as the Aastha Kendra. The Aastha Kendras or Aastha centers were positioned as one-stop shops for services related to SWs, ranging from STI screening and treatment to helping them open bank accounts and facilitating school admissions for their children. The Aastha Kendra became the focal point for all services, including STI screening and treatment, strategic behavioral communication sessions, distribution of Aastha condoms and membership to Aastha Gat or support group.

The Aastha Kendras were thus marketed as one-stop shops offering superior quality health and other services. They were positioned as safe zones where SWs could meet, share and discuss their clinical and non-clinical needs. This set-up was achieved after a well-planned review of the existing issues concerning accessibility of STI services by SWs. None of the Aastha Kendras carry any signage that markets it as a clinic for SWs, thereby avoiding attention from the general population. Aastha communication strategies were also based on IPC and dialogue, thus avoiding billboards and prominent signs with 'STI clinics' written on them.

The Aastha logo was actively used across all project activities — Aastha Kendras, mobile clinics, outreach camps, PE uniforms, lapel pins, hand bands and SBC material. Some other examples of how branding and niche marketing were used include Aastha condoms, Aastha anthem, Aastha Atmavishwas (which was a large-scale event with 15,000 sex workers coming together), Aastha Parivaar (federation of SW CBOs), Aastha Atmanirbhar (event for the SWs) and Aastha enterprise (income generating activity for the SW).

The Aastha project won recognition and trust of stakeholders, gatekeepers, external providers, government functionaries, police and local leaders.

A meeting being conducted in Aastha Kendra

Branding, niche marketing and setting up of Aastha Kendras led to increased uptake of STI services from these centers.

2.2 Community participation in delivering clinical services

Community approaches and coordination with outreach services formed the backbone of Aastha's service provision. The Aastha NGO clinics promoted meaningful involvement of SWs in clinic operation and management. Strong communication links between staff and the community were developed to increase community involvement. The clinics formalized community participation in programs by specifying how community members could participate in developing, managing and monitoring the program. Clinic staff, project outreach teams and PEs were selected from within the SW community. The clinic team collaborated closely to ensure that the community had a sound understanding of the project. The clinic staff explored the community's perceptions about clinic activities and assessed the effectiveness of outreach activities and the community's satisfaction with clinic operations. They also regularly spent time in the community with project outreach staff and PEs and held meetings with them to discuss and coordinate clinic activities. Examples of some topics discussed at such meetings include:

- Community satisfaction with clinic services (clinic hours, privacy, cleanliness, etc.)
- Patient compliance with medication and treatment
- Patient follow-up
- Acceptability and effectiveness of counseling messages
- Questions raised by the community, for example, about health issues

Aastha went beyond the generally understood concept of peer education - from service delivery to site management - and introduced peer counselors and peer nurses. While the lead counselor was responsible for maintaining the quality of counseling, the peer counselor (selected from the community) was responsible for establishing links between the community and the counseling providers. Peer nurses provided on-site support to the nurses and doctors at health camps and satellite clinics, prepared SWs for speculum examination, provided first aid to SWs and helped the staff nurse in sterilization of equipment and distribution of medicines.

Aastha's clinic outreach model fostered the development of Clinic Advisory Committees (CACs), which involved SWs in clinic and community mobilization activities. Aastha introduced the concept of CAC to ensure that the selected SWs regularly monitored the performance of clinic teams, thereby integrating the community's feedback into the project's medical component. Robust coordination between outreach and clinic teams resulted in outreach workers (ORWs) and PEs mobilizing SWs to visit the clinic regularly.

The SW community played a crucial role at every stage. Clearly, community engagement was one of the cross-cutting strategies followed by Aastha to ensure sustained progress.

2.3 Customization of STI service delivery models : Outreach clinic model

SWs differ in their typologies, working hours, priority toward health and proximity to the clinic from their home/workplace. The static clinic model of service delivery, which involves a fixed clinic providing services at fixed hours, is therefore inadequate in providing clinical services to SWs.

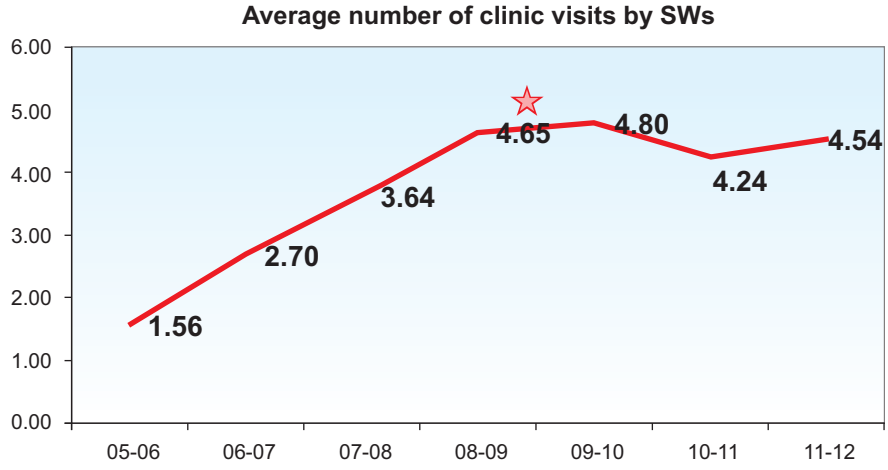
The Aastha project designed the outreach clinic model of service delivery to supplement the static clinic and reach out to maximum SWs with clinical services. This model was developed

based on the initial feedback gathered from SWs through PEs, focus group discussions and anecdotal evidence. In this model, clinical services are taken closer to SWs when they are unable to access services at the static clinic, common reasons for which include unsuitable clinic timings, distance to the clinic from their home/workplace and the low priority given to health. The outreach clinic model has shown potential in increasing SWs' access to clinical services.

As a need-based model of service delivery, the outreach clinic model does not have a fixed clinic structure. The clinic can be operated at any convenient and suitable place on-site, for example, the home of a PE/SW, a temple or the green room of a bar. The day and timing of the clinic is also not fixed, and the frequency of the clinic can vary from once a month to once a week.

The site(s) for the outreach clinic and the day and timing of operation are jointly decided by clinic and outreach teams together at the beginning of each month. The outreach team, along with the SWs on the site and the clinic team decides on a suitable place for the clinic. Once decided, the outreach team informs the SWs well in advance about the place, day and timing of the outreach clinic. On the day of the clinic, the outreach team visits the site a few hours before the start of the outreach clinic and motivates SWs to access clinical services. The clinic team arrives at the designated site 15 minutes before the clinic is scheduled to begin operation and sets up the clinic.

Outreach clinics being conducted in a mobile van and in a brothel room



Average number of clinic visits by SWs increased with the establishment of the outreach clinic model

☆ *In 2010–2011, the regular STI screening protocols were changed from monthly to quarterly. Despite the protocol change, SW attendance for regular STI screening consistently stayed high.*

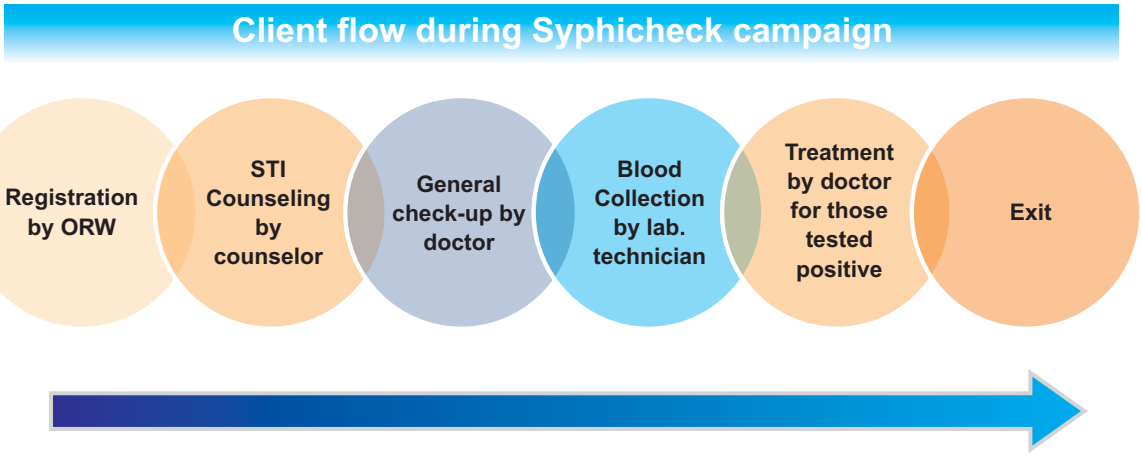
3. CAMPAIGN TO SCALE UP SYPHILIS SCREENING

3.1 Point of care test for syphilis (Syphicheck campaign)

The World Health Organization (WHO) estimates that 12 million new cases of syphilis occur every year globally. The reported syphilis prevalence varies widely among female SWs (FSWs) in India, ranging from 3.1 percent to 51.0 percent, depending on geographic location, sex worker typology and laboratory definition of syphilis.

Despite the widespread availability of rapid plasma regain (RPR) tests through Aastha-supported clinics and recommendation for semi-annual screening, project monitoring data indicates that only 10–15 percent SWs in project catchment areas accept routine syphilis screening each quarter. Results from a qualitative assessment pointed to the fear of venepuncture (both the needle stick and the amount of blood drawn) and the reluctance to wait one hour for results in fixed clinic settings as the main reasons for the low screening coverage. SWs often failed to follow-up on results and treatment. Health care providers also reported operational difficulties in RPR testing at mobile clinics, citing inadequate illumination for blood drawing and the need to transport samples to distant laboratories after late night sessions.

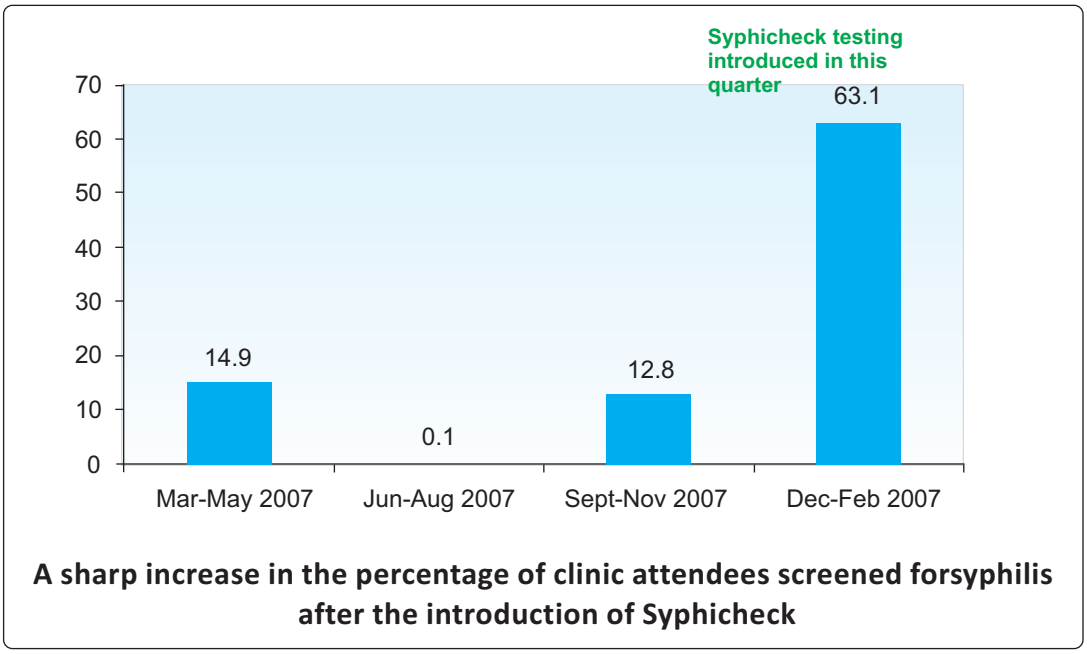
In response, a health campaign, known as Syphicheck campaign, was designed and implemented during a three-month period, from December 2007 through February 2008, in Mumbai and Thane in Maharashtra. Expanded health check-ups were offered at all project-supported clinic sites, including static clinics, satellite clinics (scheduled times at a private practitioner's clinic space) and mobile clinics (conducted at houses, bars, and rooms in brothels and lodges). In addition to the routinely offered STI check-up services and general health care, SWs were also offered check-ups for blood pressure and hemoglobin level, blood type determination, and syphilis screening (point of care with RPR confirmation) during the campaign period. All these services were provided free of charge.



The test results were recorded on a health card that was given to the client/patient. Stakeholders, such as brothel owners, bar managers, pimps and members of the SW community, were engaged in the planning process for the campaign. Before the launch, clinic-based staff, outreach staff and PEs distributed promotional materials and IPC messages about the importance of syphilis screening and the availability of a new test that used finger prick blood and made results available within 15 minutes. Additional mobile clinics were planned to ensure maximum geographic coverage in the areas of active sex trade, as determined by prior mapping exercises.

Syphilis screening was carried out on the whole blood obtained through a finger prick, using an immunochromatographic rapid test (point of care [POC]) to detect antibodies to T. pallidum (Syphicheck-WB). Positive rapid test results were confirmed by RPR testing (Agappe Diagnostics Ltd, Kerala, India) in accordance with the recommended WHO algorithm. RPR testing was performed on-site at fixed clinics. Samples from satellite and mobile clinics were transported to the fixed clinic laboratory in cold boxes and stored at 2°C to 8°C. RPR testing was conducted within 24 hours of sample collection. Internal quality controls were ensured for Syphicheck-WB and RPR kits, and an external quality assurance system was established for RPR testing, with the Topiwala National Medical College in Mumbai as the reference laboratory. SWs who tested positive on both Syphicheck-WB and RPR were treated for syphilis with oral doxycycline (100mg) t.d.s. for 14 days and azithromycin (1g OD STAT), as per national guidelines. All positive cases were followed up through PEs to ensure compliance to treatment.

% clinic attendees screened for Syphilis



A sharp increase in the percentage of clinic attendees screened forsyphilis after the introduction of Syphicheck

In total, 31,395 SWs attended clinic services during the three-month intervention period. The uptake of POC rapid syphilis screening among SWs attending clinic services during the three-month intervention period stood at 63.1 percent, which was more than four times higher than the monthly average uptake of 14.3 percent at clinic sites during the preceding nine-month period.

Among the 19,809 SWs who accepted rapid syphilis testing, 598 tested positive (3.0 percent prevalence of lifetime syphilis infection). Of those who tested positive with the rapid test, two-thirds accepted a confirmatory RPR test, with a reactivity rate of 85.3 percent (any titer) and 40.5 percent for active syphilis (RPR titer 1:8).

With its innovative approach, Aastha pioneered large-scale application of rapid diagnostic tests for syphilis screening of high-risk populations in mobile settings outside of a research environment.

Rapid POC treponemal tests have been evaluated for performance in multiple geographic areas and have shown to be a cost-effective tool for syphilis screening in antenatal clinic settings, at STI clinics and in field conditions when carried out by low-skilled paramedics. These tests are particularly useful for SW populations in developing countries because they can be performed by trained non-laboratory personnel using whole blood specimens obtained by a finger prick, with results available within minutes. In addition, the storage of test kits at room temperature (up to 30°C) and lack of need for electricity or laboratory equipment make them ideally suited to mobile clinic conditions. As the rapid treponemal test kits directly addressed the main barriers to syphilis screening identified by both SWs and health care providers during the pre-intervention assessment, they were introduced along with a general health-screening package to increase attendance at clinics and increase uptake of syphilis screening.

The introduction of rapid tests dramatically increased - by more than fourfold - the uptake of syphilis screening among female, male and TG SWs at STI service sites during the intervention period. Using the POC tests (rapid syphilis tests) at STI clinics helped overcome the barriers of limited laboratory capacity for syphilis screening, logistical difficulties of blood transport, and the high-risk groups' fear of blood being drawn. As the intervention was planned with a broad range of stakeholders in a participatory manner, it increased the subsequent support and buy-in from the community. Also, with results generally available within 15-30 minutes, SWs were more likely to agree to the test. Nevertheless, only two-thirds of the SWs who tested positive on the initial rapid test agreed to RPR confirmatory testing.

4. STRATEGY TO SCALE UP VOLUNTARY COUNSELLING AND TESTING

4.1 Regular HIV testing and early counseling through public-private partnership ICTCs

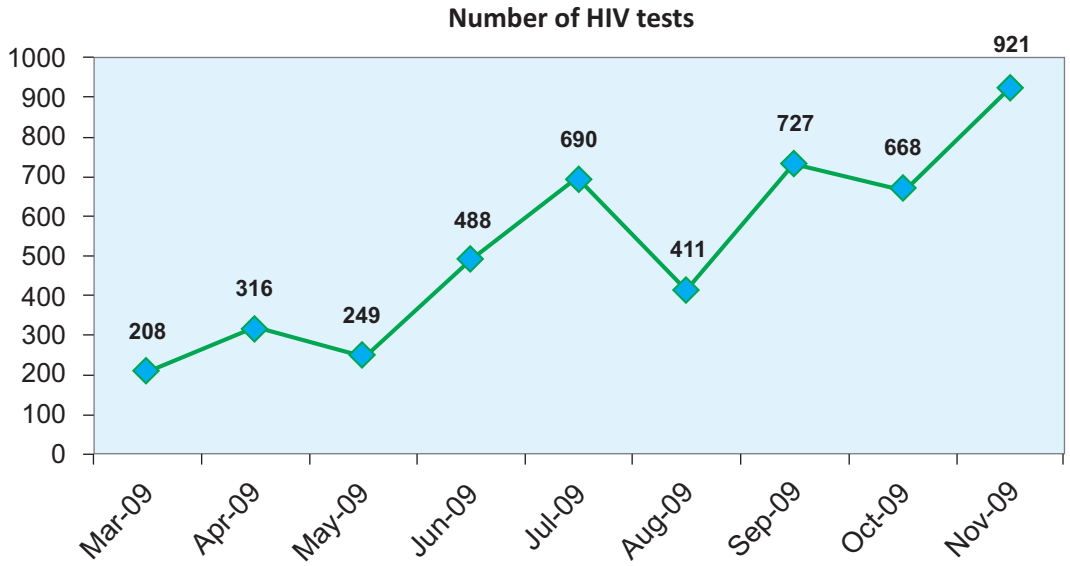
Early counseling and regular HIV testing were introduced in the second phase of the Aastha project after reviewing the community's need for redesigned Integrated Counseling and Testing Centre (ICTC) services. SWs' low uptake of HIV testing offered by government-run ICTCs resulted from a host of reasons, including heterogeneous typologies based on solicitation sites, workplace, gender, language and culture; control by stakeholders, such as brothel owners, madams and pimps; restricted service hours of government facilities; distance to counseling and testing centers; and the stigma and discrimination faced by SWs from service providers.

The community's feedback was incorporated in developing a redesigned ICTC strategy based on public-private partnership (PPP) between NACO and Aastha partners for referral services. In March 2009, ICTCs were set up in all project clinics in collaboration with NACO. The Aastha ICTCs were established as per national guidelines in response to the community's expressed need for regularization of HIV counseling and testing.

Focused communication material and counseling encouraged SWs to avail early counseling services and regular HIV testing and understand its importance. On-site clinical laboratory services were made available at project-run clinics, and staff (laboratory technician, counselor) training and capacity building was undertaken. Standard operating procedures (SOPs) for HIV testing, quality control and infection control were made available. Each laboratory maintained its equipment in good working condition, with an annual maintenance contract being put in place. Documentation of tests and internal as well as external quality control mechanisms was incorporated.

Establishing a PPP model for ICTC enabled Aastha to provide the infrastructure and environment needed to test a higher number of beneficiaries from the high-risk population. Familiarity with the Aastha system helped SWs regularly access HIV counseling and testing services. Any SW interested in getting counseled or tested could more easily access these services from one of the Aastha ICTCs. Trends suggest that the number of SWs getting themselves tested increased significantly after the introduction of PPP ICTCs. This increase in health-seeking behavior also reflected in the steady scaling up of HIV counseling and testing services in a short period of time.

The ICTCs were equipped with infrastructure, training, monitoring tools like external quality assurance scheme (EQAS) mechanisms and internal reporting formats like daily monitoring sheets. EQAS mechanisms and internal quality improvement tools helped maintain the quality during testing. A quality assurance mechanism for PPP ICTCs was set up at every level and facilitated through monitoring, improvement and training of staff members. As a form of monitoring mechanism, External Quality assurance system (EQAS) samples were sent to government-run hospitals on a quarterly basis to ensure maintenance of quality during testing.



The Aastha project was the first to integrate positive prevention by leveraging and collaborating with existing government systems to set up PPP ICTCs in project-run clinics, ensuring provision of quality HIV counseling and testing services. This model is highly replicable in all settings where laboratory services and clinic staff (laboratory technician, counselor) are available and a PPP is possible. The PPP ICTC model has been sustained in the post-transition phase; all the interventions have been handed over to the Government and ICTCs are functional within clinics.

4.2 The Vivek initiative to scale up voluntary counseling and testing for HIV

In March 2009, ICTCs were set up in Aastha project clinics in collaboration with NACO as a PPP initiative. Despite the widespread availability of VCT services through project-supported static clinics in Mumbai and Thane districts and recommendations for regular screening, project monitoring data indicated that only 1.5 percent SWs in project catchment areas accepted routine VCT at static clinics since the time it was made available in project clinics over a 10-month period.

Traditional VCT-related barriers such as low perceived risk of HIV infection; lack of access to free testing; general negative perception about testing services; stigmatizing beliefs coupled with the fear of discrimination if diagnosed HIV positive; shortage of counselors and their competency; concerns about confidentiality; and delay in returning HIV test results hampered effective access to and uptake of VCT. In addition, the SWs' heterogeneous typologies based on solicitation sites, workplace, gender, language and culture; control by stakeholders such as brothel owners, madams and pimps; restricted service hours of facilities; distance to counseling and testing centers; and stigma and discrimination faced by SWs from service providers further contributed to the low uptake of HIV testing by high-risk groups.

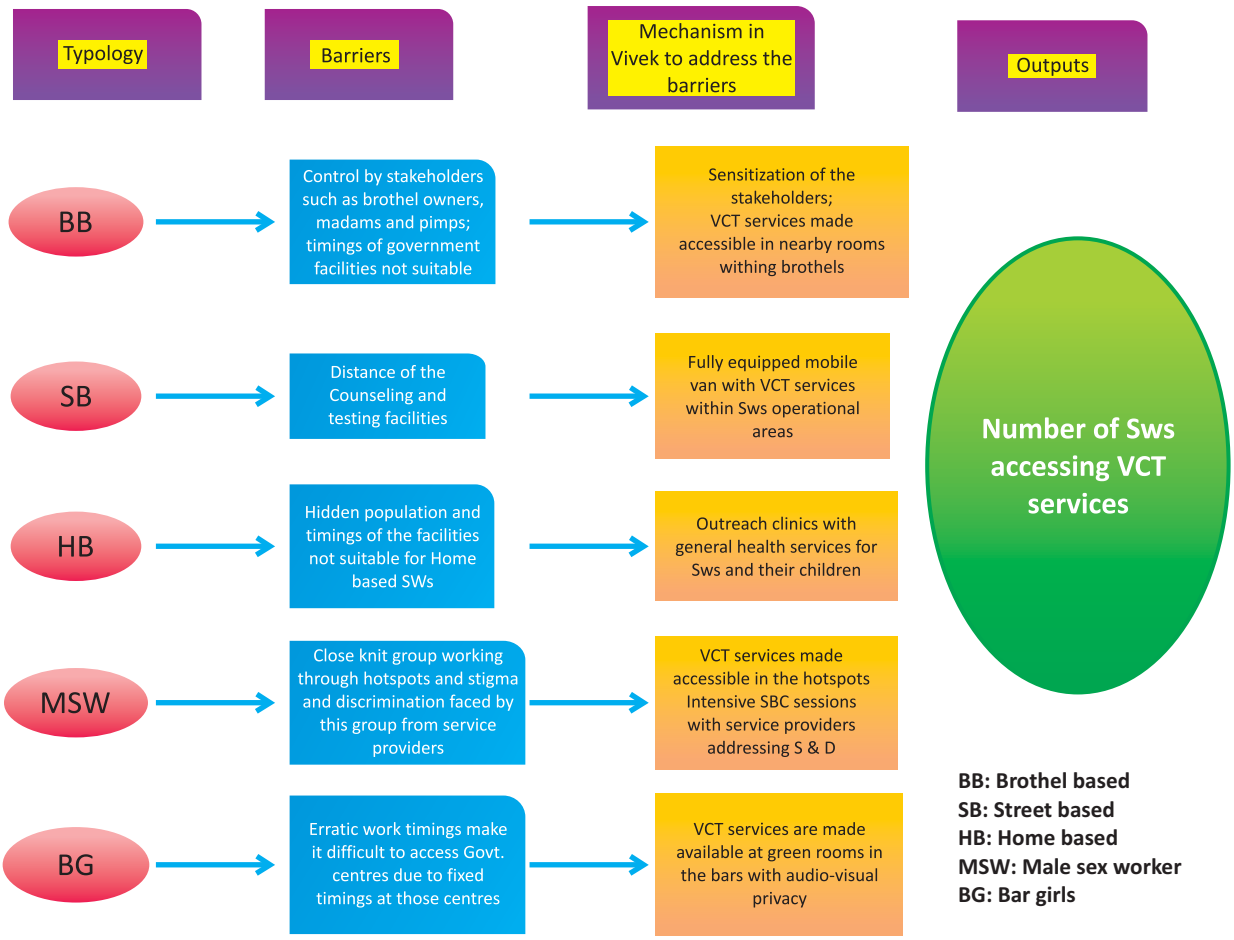
Aiming to counter these barriers to access and uptake, FHI 360 Aastha implemented an initiative named Vivek (meaning, conscience) to increase early and regular uptake of counseling and testing for HIV. Vivek involved intensification of voluntary counseling and testing services for a period of one month, operationalized in outreach settings for male and female SWs. The strategy synchronized demand generation through strategic behavior change communication and improvements in access through outreach activities. Vivek was a unique strategy as it customized for each typology to address the barriers specific to that particular group. It addressed these barriers, including through optimum timings and location for implementing the strategy, to improve access to VCT services.

The intervention was conducted four times — December 2009 (Vivek 1), July 2010 (Vivek 2), December 2010 (Vivek 3) and June 2011 (Vivek 4).
The flow of events during the implementation of Vivek initiative was as follows:
1. SBC and outreach activities: Outreach clinics were preceded by intensive SBC activities, such as one-to-one communication, to motivate and create demand for VCT among SWs. Outreach planning included the presence of an outreach team comprising PE, ORW and community volunteers (CVs) from the site(s).
2. Activities at the clinics (pre-test, testing, post-test, referral): Planning at the clinics included the presence of a trained clinic team comprising a doctor, a nurse, counselors and a laboratory technician. Logistic requirements included uninterrupted supply of HIV testing kits, gloves, needles and syringes, vacutainers and micro tips. The flow of events at the clinics was: i) pre-test counseling and informed consent; ii) testing; iii) post-test counseling; and iv) referral to care and support services. All the identified PLHIV SWs were linked systematically with government care and treatment services, while those who tested negative were provided post-test counseling and advised six monthly re-testing.
3. QA activities and monitoring: The ICTCs were equipped with infrastructure, training, monitoring tools such as EQAS and internal reporting formats like daily monitoring sheets.

Customization of VCT services for different typologies formed the essence of the Vivek initiative. For brothel-based SWs, the outreach team organized suitable VCT infrastructure in a nearby room of a brothel. The SBC activities for this SW typology focused on them being healthy to ensure a better life for their children and being financially secure. In order to make VCT services accessible to bar girls, the outreach team organized suitable infrastructure for HIV counseling and testing in bar settings. VCT services were made available with audio-visual privacy at green rooms (changing/dressing room, place where bar girls dress up) within the bars, after prior permission from bar managers. The SBC activities for this typology focused on “beauty as a hook”, which essentially provided beauty tips to bar girls and emphasized staying healthy as a means of staying beautiful, which is an important need of bar girls.

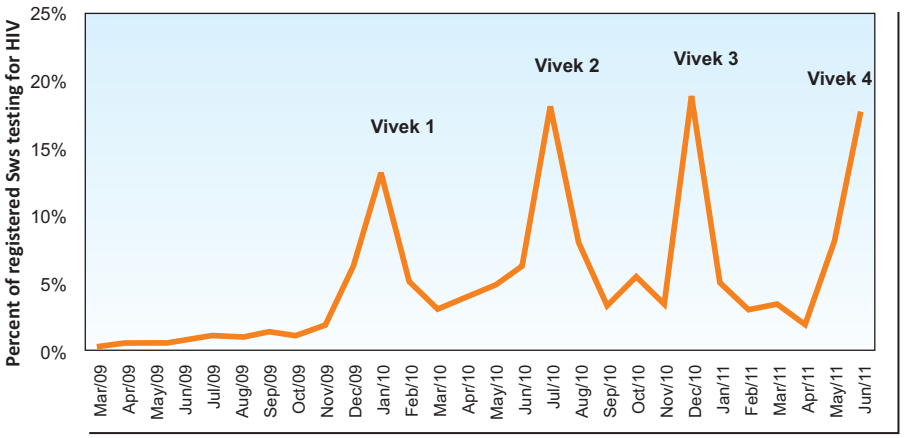
Outreach clinics were operationalized with general health services for street-based SWs and their children. For home-based SWs, it covered school admissions for their children; opening bank accounts; help in securing ration cards, which are needed to avail subsidized food items from government stores; and offering literacy classes and other vocational training in crafts, such as tailoring and making jewelry, candles, incense sticks, chocolates and bags, among others. For male SWs, intensive SBC sessions with service providers were conducted to address the issue of stigma and discrimination. Outreach clinics were conducted in hotspots where the male SWs were easily accessible. In this way, Vivek identified the felt need of each particular typology and addressed its specific needs.

Conceptual framework of typology specific VCT services



Customized operationalization of outreach testing strategies dramatically increased the uptake of VCT services for HIV. Notably, these results were consistent across all typologies

Trends in HIV testing among SWs in Mumbai-Thane district (March 2009–January 2011)



A marked increase in the uptake of HIV testing after the implementation of customization approaches

Aastha developed and defined the program monitoring indicators and established a management information system (MIS) to periodically gather data on the different indicators related to program inputs and outputs. Similarly, the program developed an ICTC tracking sheet that collected information on SW particulars like identification number, eligibility and details of HIV testing. Program monitoring and ICTC tracking sheet data were collected on a monthly basis by the implementing NGO at the site level and later aggregated into table formats and consolidated by Aastha. The Aastha staff provided technical support to the implementing NGOs to ensure integrity and quality of data as well as flow of data and maintenance of MIS. A total of 18,834 SWs (89 percent of the registered population) underwent HIV testing from March 2009 to February 2012. A total of 54,252 HIV tests were conducted during this period. The average number of tests conducted per month increased to 4,589 during the Vivek initiative period, compared to a monthly average of 1,000 tests in non-Vivek periods (during September 2009–February 2012).

Vivek was pioneered, conceptualized and implemented by FHI 360 Aastha the first time in December 2009. It was followed by a process of continuous improvement in outreach-clinic coordination and planning, capacity building of staff, logistic arrangements and developing a monitoring plan for Vivek. The ICTC tracking sheet was introduced at this stage to ensure quality assurance and improvement.

Subsequently, the State Government and other Avahan partners adopted the Vivek strategy at different geographical sites. Vivek has since been successfully replicated by government-managed interventions in Mumbai and the rest of Maharashtra as well as by other State lead partners at their intervention sites.

Aastha's customized demand generation approach has thus increased the uptake of regular HIV counseling and testing services by SWs and continues to be used as an integrated strategy in the post-transition scenario by the Government.

Additional information: www.fhi360.org/resource/new-dimensions-hivaids-programming-aastha

5. INITIATIVES TO EXPAND CARE, SUPPORT AND TREATMENT SERVICES

5.1 Sex worker-specific continuum of care system

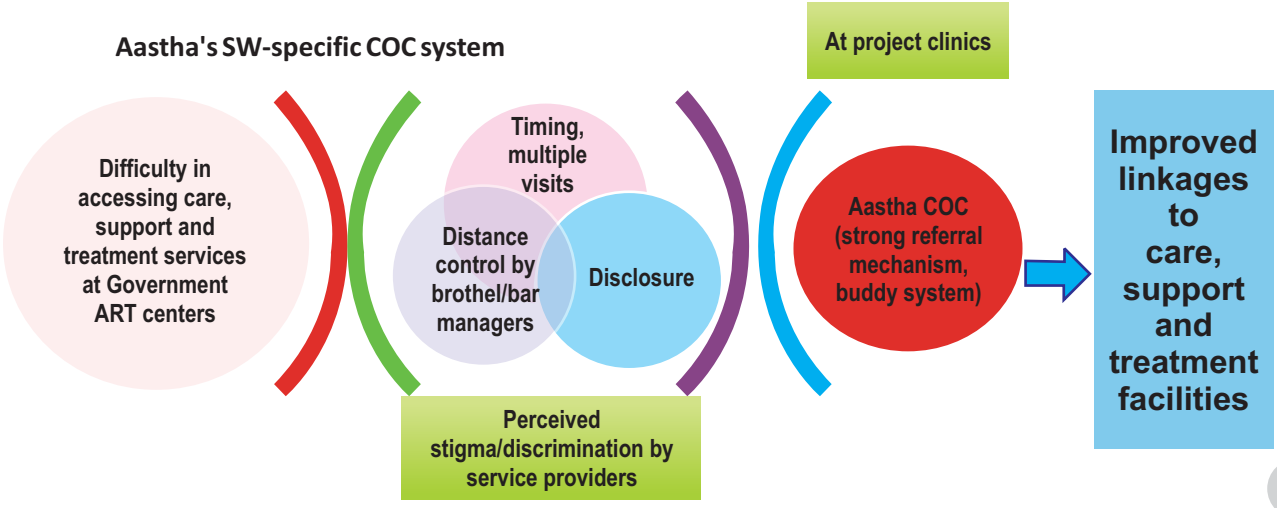
Given the thrust on scaling up positive prevention, a holistic system of prevention, care, treatment and support services, customized to the needs and living conditions of SWs, is a prerequisite for long-term, sustained control of the HIV epidemic. Although continuum-of-care (COC) systems have existed for the general population, such a system was not structured for PLHIV Sws.

A rigorous approach to voluntary HIV counseling and testing among SWs feeds into a strong network of care and treatment services for HIV-positive SWs. Nonetheless, the constraints that prevent SWs from accessing counseling and testing services also hold back PLHIV SWs. Some of these include logistic constraints, such as long travel time, odd hours of work and a strong perception of stigma in the larger community and the service providers toward SWs in general and the HIV positive in particular.

Internal and external monitoring meetings and feedback from the community helped the project team realize that PLHIV SWs were not able to access existing health services. They needed more than just treatment for opportunistic infections (OIs) and ART. Aastha's COC system was thus established to systematically link PLHIV SWs with care and treatment services. Aastha COC system is based on a strong network of referral services, which cater to the needs of PLHIV SWs. It fills the wide gaps in care and treatment services, specifically addressing the constraints and needs of PLHIV SWs.

The success of Aastha's COC system goes beyond sustained intervention by the counselor (and outreach where the status is disclosed). It focuses on the active involvement of PLHIV SWs themselves in Aastha's positive prevention strategy.

Aastha's COC framework caters to the needs of PLHIV SWs through the essential components detailed below.



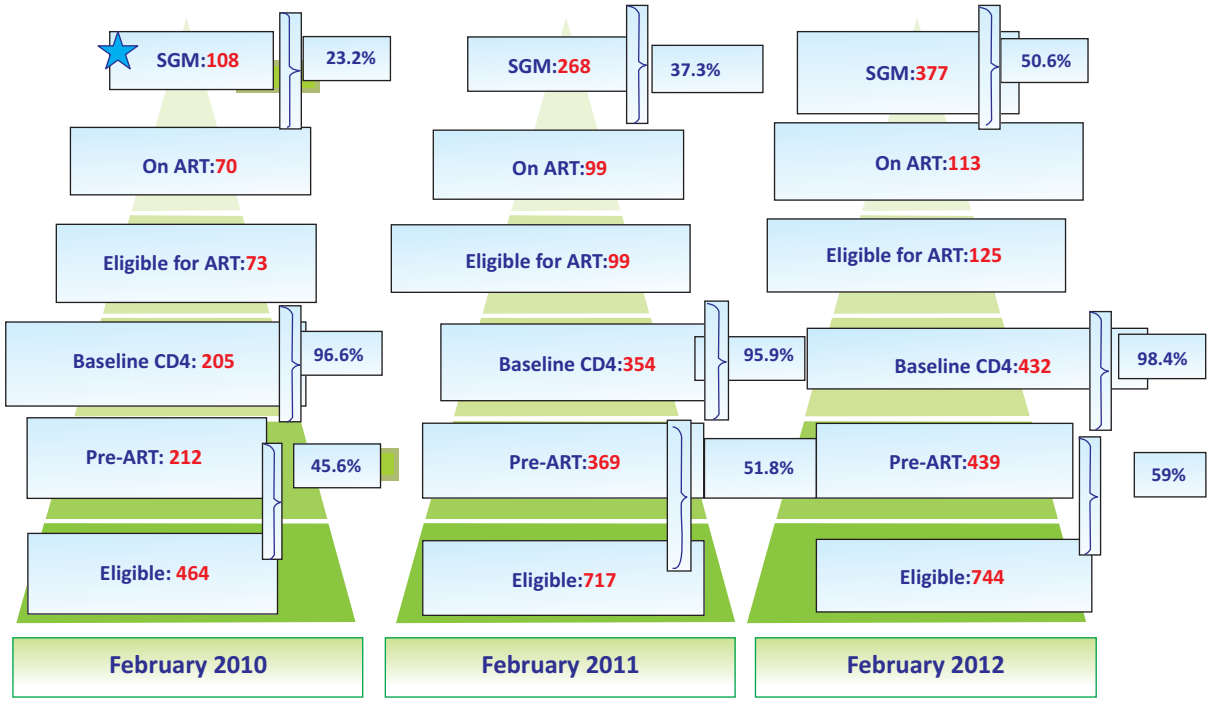
Strong system of referral services: As Aastha is predominantly an HIV/STI prevention project; it cannot directly provide every service needed by a PLHIV SW. Moreover, services like ART, CD4 testing, management of OIs, nutrition supplements, etc., are available at government health facilities free of cost. Referral to government health facilities not only makes the services available to PLHIV but also ensures sustainability of services. Aastha's COC framework is based on strong advocacy and networking system, linking the PLHIV SWs with specific local service providers such as Community Care Centers (CCCs); hospitals; hospices that provide tertiary care; and centers providing treatment for higher OIs like TB, prevention of parent-to-child transmission (PPTCT), DOTS, CD4 testing and baseline investigations, among others. This referral system is supported by a strong follow-up system (by counselor, Aastha Sakhi, ORW, PE) to ensure that PLHIV members avail the referral services regularly and on time. Targeted interventions (TIs) should especially factor in budgetary allocations for the accompanied referrals.

Dedicated SBC sessions on stigma and discrimination: Use of SBC is critical in communicating not only the significance of HIV prevention but also the importance of regular STI screening, ART adherence, support group membership, condom use and health seeking behavior by PLHIV SWs. Aastha with its focus on linking prevention programming with care and treatment services, has a redesigned SBC strategy and a repository of SBC material, focusing on stigma and discrimination against PLHIV SWs. Experience has shown that use of SBC is critical in encouraging disclosure and enabling SWs to come together in support disclosure. Continuous dialogues, using SBC and Interpersonal Communication (IPC) methods, on stigma and discrimination were imperative. 'Communication hooks were used to involve SWs into meaningful discussions on the basis of topics which she could relate with. Hence, money, beauty and love are extensively used as communication hooks

Some pre-requisites for a robust COC system include strengthening existing linkages with CCCs, hospitals and ART centers to help PLHIV avail care and treatment. The outreach team members, who accompanied SWs to clinics, facilitated these linkages. Aastha's COC system was further enhanced to include psychosocial support for PLHIV SWs through the formation of PLHIV support groups and selection of Aastha Sakhis (treatment buddies), who were identified and trained to accompany PLHIV SWs to ensure adherence to treatment. The COC system was further improved by focusing on capacity building of the outreach team and the counselor. The uptake and quality of COC services was regularly reviewed through the PLHIV tracking sheet and the counselor's register.

Uptake was also strengthened through SBC sessions for PLHIV. When the need for psychosocial/economic support was felt by the outreach team and expressed by the community, a strategic decision was made to form PLHIV groups. Its objective was to address stigma and increase adherence to treatment, especially ART. Bringing together PLHIV SWs also helped in facilitating disclosure beyond the counselor and the Aastha Sakhi. Aastha's COC

system introduced PLHIV diary as a tool to track PLHIV SWs' uptake of care and support services provided through referrals. A strategic decision was made to form PLHIV groups. Its objective was to address stigma and increase adherence to treatment, especially ART. Bringing together PLHIV SWs also helped in facilitating disclosure beyond the counselor and the Aastha Sakhi. Aastha's COC system introduced PLHIV diary as a tool to track PLHIV SWs' uptake of care and support services provided through referrals or the project.



SGM: Support group meeting

Aastha's COC cascade

The PLHIV diary provides information on all the PLHIV SWs registered with the project since the beginning. Every PLHIV identified by the project is listed in the PLHIV diary. Profile information and the services provided to PLHIV SWs are mentioned on a separate sheet for each PLHIV. The profile information includes Aastha unique ID number; typology; status (active/dropout/expired); category (pre-ART/on-ART); month of detection as HIV positive; age at the time of detection; status of disclosure - ate and with whom; ART information - date of pre-ART registration, date of conversion to ART and date started on ART CD4, with information about the date of first and second CD4 testing and CD4 count. Aastha has, for the first time in India, combined a prevention project with care and treatment services in HIV programming. A strong referral service, dedicated staff, psychosocial support from community members, support from other PLHIV members and the treatment buddy system make this model highly replicable.

5.2 Buddy system

One of the major challenges to Aastha's COC has been disclosure by PLHIV SWs. As per national guidelines, the counselor is aware of the HIV status of every person who gets tested as he or she is responsible for post-test counseling (Disclosure). Counselors communicated to SWs about the significance of disclosing their status to the outreach team and linking with Aastha's care and treatment system. However, the SWs were wary of disclosing their HIV status to anyone.

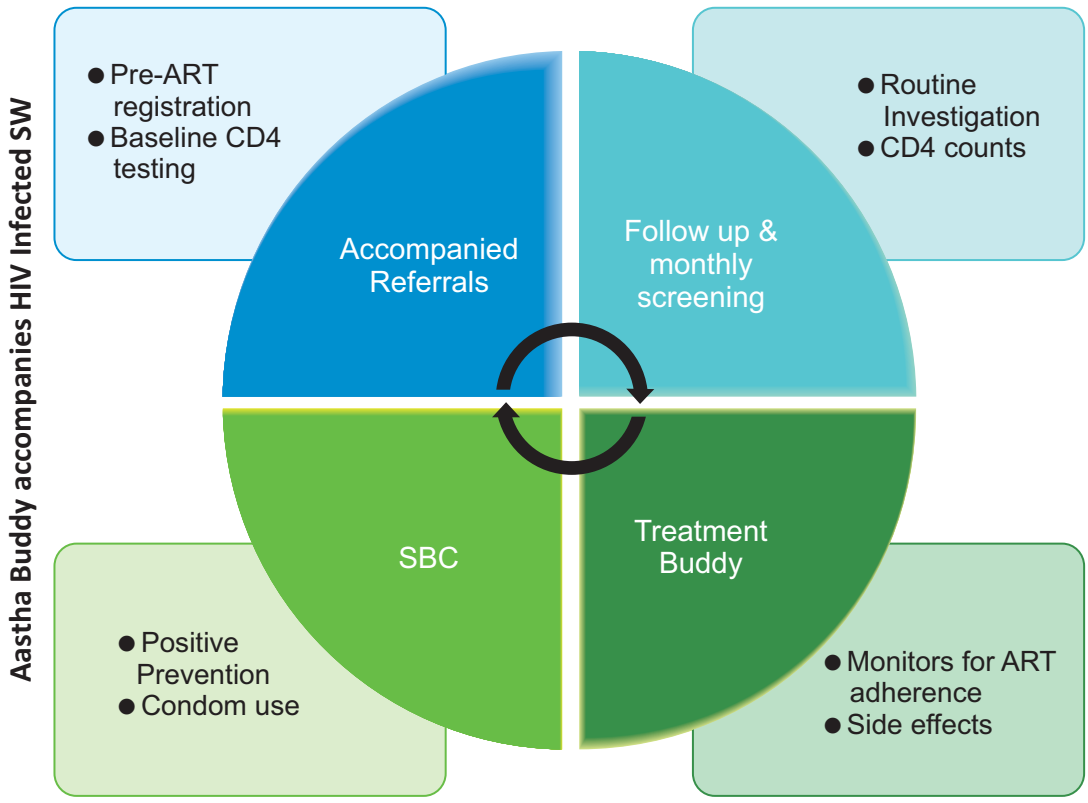
Lack of awareness and myths lead to grave fear of HIV not only among PLHIV SWs, but also among non-PLHIV SWs and their regular partners/stakeholders. Fear of others getting to know their HIV-positive status often prevented PLHIV SWs from accessing care and treatment services. Given this context of continuous fear and stigma associated with HIV, disclosure of HIV status to the outreach staff and the doctor treating the SWs, as per NACO guidelines, became especially problematic. Consequently, the project could not provide dedicated support, care and treatment to PLHIV SWs. Also, given their odd hours of work, long travel time and the fixed timings of ART centers, PLHIV SWs often skipped their visit to ART centers. Many on-ART PLHIV SWs did not have their medicines on time and even skipped visits to the clinic. The several other requirements of PLHIV SWs, such as treatment of OIs, their basic management, prevention and early detection of TB and management of STIs, also did not get the requisite attention. As a response to this situation, Aastha encouraged PLHIV SWs to disclose their status to a treatment buddy or Aastha Sakhi/Sangini/Mitra.

The Aastha buddy, or Sakhi, is a member who a PLHIV SW may choose, apart from the counselor, to disclose his/her HIV status to. He or she (the buddy) may be from the outreach staff or/and from the community. The role of the Aastha buddy/Sakhi extends to assisting the SW in all matters he/she may require support in, including visits for pre-ART registration, ART adherence, CD4 testing, emergency visits to hospitals, monitoring side effects, legal assistance and support in referral services. After the counselor, it is the Sakhi who forms an important link in the follow-up mechanism, followed by the outreach team (depending on who the PLHIV has chosen to disclose to). The Sakhi makes home visits, especially when the PLHIV member does not visit the project counselor or the Aastha clinic on a monthly basis. The Aastha Sakhi proves an important support for the counselor in the follow-up mechanism.

Aastha buddy/Sakhi/Sangini/Mitra assist the PLHIV in determining his/her needs and how best to meet these needs. Aastha buddy also provides accompanied referrals to PLHIV SWs if needed. Based on disclosure, ORW and PE assist the Aastha buddy in providing accompanied referrals to PLHIV SWs. If members of the PLHIV support group volunteer at the ART center, they can also assist patients with referral arrangements for the required services as well as patient education and support. The referral staff maintains confidentiality about each patient and protects the confidentiality of patients' records. Each and every member of the Aastha

project signs an oath of confidentiality. The referral staff assists the patient in determining needs and how they can be met, covering the following areas: health care, including positive prevention and nutrition; economic support/employment; mental health; PLHIV support group; recreation and leisure; legal assistance; spiritual support; material support and home-based care.

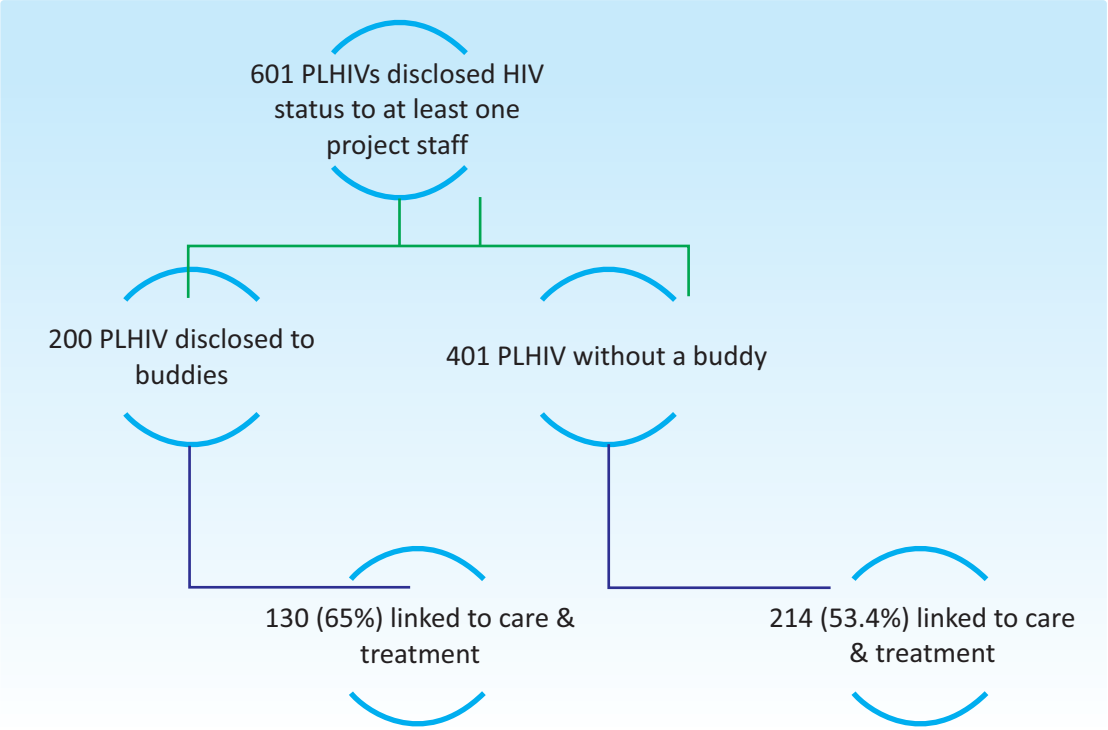
Aastha's COC buddy system



Integrating the buddy system into COC enables SWs living with HIV to access care & treatment services

A strong referral service, dedicated staff, psychosocial support from community members, support from other PLHIV members and the buddy system are essential components of Aastha's strategy to empower PLHIV members. Regular counseling and use of SBC materials, combined with SWs' faith in program benefits, led to increased disclosure to the outreach team or to Aastha Sakhi/Sangini, which in turn increased linkages to care, support and treatment services.

Disclosure of HIV status to the Aastha buddy



The chart shows that during January 2010–October 2011, 601 SWs had disclosed their HIV status to at least one project staff. Of the 601, 200 (33 percent) disclosed their HIV status to a buddy; of these 200, 130 (65 percent) were linked to care and treatment.

Aastha's focused approach integrating the buddy system into the COC framework enabled HIV-positive SWs to access care and treatment services. Buddies help PLHIV SWs to understand the significance of care and treatment, strengthen follow-up and reduce ART loss-to-follow up. The buddy system is easily replicable in interventions where dedicated staff and strong referral mechanisms are in place. Encouraging disclosure among buddies is critical for improved COC services.

Aastha's buddy system, involving introduction of treatment buddies to accompany PLHIV SWs and ensure adherence to treatment, has been sustained in the post-transition phase, where all TIs are handed over to the Government.

Additional information: www.fhi360.org/resource/new-dimensions-hivaids-programming-aastha

6. INTEGRATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES WITH STI/HIV SERVICES

6.1 Addressing family planning needs of female sex workers

According to the WHO, unsafe abortion accounts for 12 percent of all maternal or pregnancy-related deaths in Asia, claiming the lives of 38,000 women each year. Unsafe abortions are among the major preventable causes of maternal morbidity and mortality in India. To complicate matters, many abortions are not reported, making the available statistics on abortions in India of varying reliability. According to the Consortium on National Consensus for Medical Abortion in India, the number of medical termination cases increased by 78.9 percent from 1995 to 2000. This signifies a significant amount of unmet need for family planning (FP) services among women in the reproductive age group. According to the Aastha FP-HIV screening data, women in high-risk groups (such as SWs) reporting abortions in 2011 stood at 3 percent.

FSWs have many of the same reproductive health needs as other women. However, given the high frequency of sexual activity, their chances of conception are very high compared to a woman with a single partner. In sex work, the onus of remaining within the non-reproductive, non-familial, pleasure-giving domain rests on the sex worker rather than the client. FSWs are made responsible for taking precautions against and managing the consequences of unprotected intercourse. As unintended and terminated pregnancies are common among FSWs, making them aware of and access FP services is critical to their well-being.

In 2005, Aastha commenced client-initiated FP counseling services as part of the HIV counseling and STI management package of services. This included need-based provision of information on contraceptive options and referrals for FP methods. Clients were also given reproductive health services like pregnancy tests if needed. With this initial intervention, the project reached more than 3,000 FSWs with pregnancy tests; referred 600 FSWs for medical termination of pregnancy (MTP); and conducted hemoglobin tests on 3,500 FSWs from 2004 to 2010. In the same time period, over 100,000 counseling sessions were conducted to address safe sex practices, including FP options.

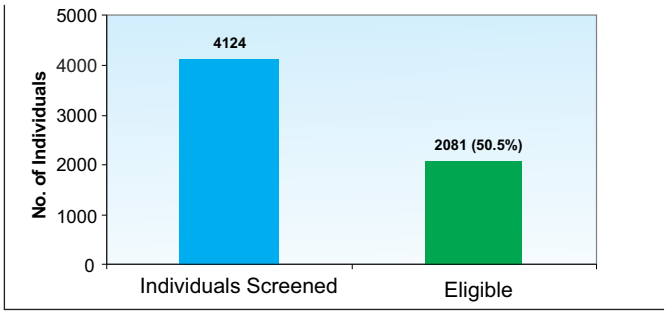
In December 2010, the Aastha team expanded and strengthened the integrated model by offering provider-initiated FP screening, counseling and referrals to all eligible FSWs of ages 18–49 years at Aastha sites. Instead of providing FP information and referrals only to clients who requested it, every FSW present at an Aastha health care setting for HIV prevention services was screened for her FP needs by the health care provider. The team implemented the following activities to introduce the new provider-initiated model:

- Training of doctors, counselors, nurses and ORWs on FP for most-at-risk populations and to screen FSWs for unmet FP needs using a specially designed screening tool
- Development of customized client communication materials and provider job aids
- Provision of FP counseling and orientation to FP methods from a basket of choices
- Referrals based on the FP method chosen by a FSW

Formats and reporting guidelines customized to productively document the process and outcomes of FP-HIV interventions were developed. During January–June 2011, a total of 9,656

unique individuals visited the Aastha clinic for STI/HIV services. Of these, 4,124 (43 percent) were screened for their FP needs.

Percentage Sex Workers Identified as Eligible for FP Counselling



Of the 2,081 FSWs identified as eligible for FP needs, 1,813 FSWs (87 percent) reported that they were in a relationship with a regular partner or spouse:

- 62.5 percent reported being married and living with husband
- 21 percent reported relationship with a regular partner/lover
- 3.6 percent reported being married and living with husband and in relationship with a regular partner/lover

Of the 4,124 FSWs screened for FP needs:

- 124 FSWs reported having undergone abortion in the last one year
- 164 FSWs reported current pregnancy

Of these, 27 FSWs reported the current pregnancy as unwanted

Characteristics of FSWs who accepted condoms as their FP method

Of the 1,830 FSWs who accepted condoms as an FP method, 1,637 FSWs (89 percent) reported being in a relationship with a regular partner or spouse.

- 64 percent *reported being married and living with husband*
- 25 percent *reported relationship with a regular partner/lover*

In addition to the above, 185 FSWs (9 percent) were referred for oral contraceptive pills (OCPs), 10 FSWs (0.05 percent) for injectables, 55 FSWs (3 percent) for female sterilization, and 52 FSWs (2 percent) for intrauterine contraceptive device (IUCD).

Aastha pioneered the FP-HIV integration model successfully while working with high-risk groups, thereby ensuring that FSWs had increased access to STI/HIV prevention and reproductive health services under one roof. The use of Aastha logo and the niche marketing of Aastha Kendra as a center for women, with no apparent connection to STIs/HIV/FP, made FSWs feel comfortable while accessing services. Integration of FP-HIV services led to increased access to and uptake of contraceptives, increased HIV testing and condom use and improvement in overall quality of services.

Aastha set up the integration model with a tailored SBC package and a SOP detailing the FP-HIV implementation process, thereby contributing to ease of replication. The model is highly replicable in TI settings with trained staff and a strong referral mechanism for FP services

Additional information: FP-HIV Monograph

7. PARTNER MANAGEMENT

7.1 Proactive partner notification

The goal of reaching all SWs with quality STI services requires continuous motivation and counseling of community members to seek and access STI services and adhere to the treatment regime. One of the most difficult components of STI management is notification and treatment of partners, which can be greatly improved by delegating responsibility (with consent of the patient) to peer and outreach workers.

The Aastha project offered health education and counseling to all the patients who received STI treatment, including patients treated for asymptomatic STIs. It followed the 'four Cs' approach — **c**ondom demonstration and promotion, **c**ompliance with treatment, **c**ounseling and education and **c**ontacting partners for treatment. In the case of SWs, partner referral and treatment pertain to regular partners and boyfriends. The counselor encourages and helps the 'index patient' by convincing his/her partner to take a recommended STI treatment. In this way, partners of those identified as having any STI are traced, informed of their probable exposure to the infection and offered medical and counseling services, thereby breaking the chain of transmission. In Aastha, partner notification was done whenever an STI was diagnosed.

To improve partner notification and treatment, the various STI-related services were carried out by different personnel, ranging from professional counselors and medical doctors to community members and peers from the community. Not all of these personnel are located in the clinic, nor do they perform their respective roles in one place. This realization opened up avenues to develop and deliver STI management services as a joint effort between clinic staff and outreach teams. With good communication and coordination (frequent meetings between clinic and outreach teams), this joint approach increased the overall efficacy of partner management. Partner referral card and partner clinic encounter forms were developed for effective partner notification and treatment.

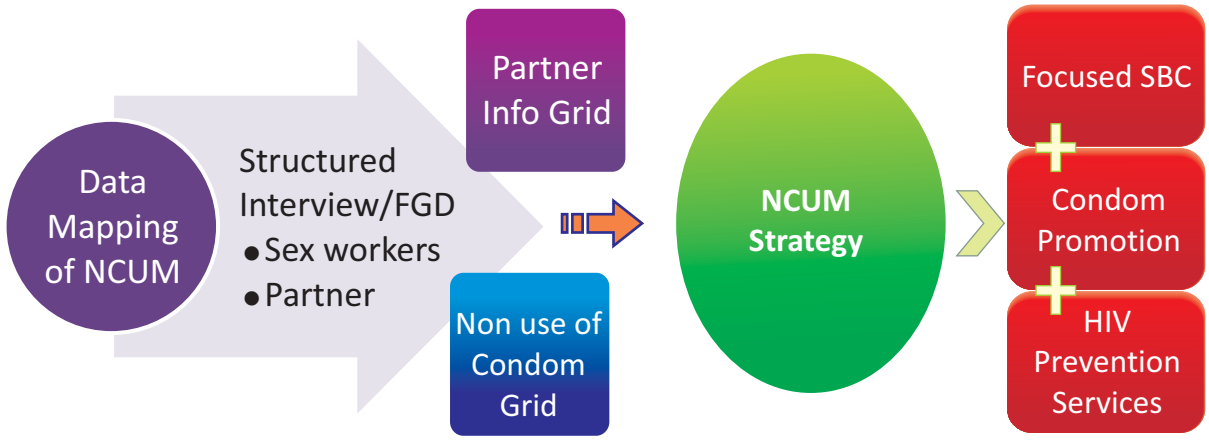
Aastha focused on providing services and made special efforts toward proactive partner tracing and management. Focused counseling was undertaken to address individual vulnerabilities. If an SW was deemed to be at a higher risk of acquiring STIs as per the set criteria (for example, recurring STIs after treatment completion), partner tracing and notification with treatment was set as high priority.

Setting up a process for partner notification and treatment is an important public health activity, highly replicable and much needed in HIV prevention programs.

SWs face several barriers to safe sex practices, including condom use with certain types of sexual partners. Although a single unprotected sexual act can lead to HIV infection, very few HIV prevention programs have so far focused on promotion of condom use in such partners. While efforts to convince SWs to consistently use condoms with non-regular partners have been very successful, there has been only moderate success in similar efforts with regular partners/*pyarwaala*.

Regular sexual partners are probably the most difficult group to reach with condom promotion and HIV prevention services, including voluntary counseling and testing services. Here, the challenge was twofold: to reach the partners of SWs and design a prevention intervention for them. Aastha strategically approached these non-condom using men (NCUM) with a newer HIV prevention strategy.

To begin with, a partner information grid was prepared to elicit information on all possible partners.



The types of partners identified were: regular partner/*pyarwaala* (boyfriend, lover), husband, local police, local shopkeeper, brothel owner/manager, pimp, high-paying clients, permanent customer and taxi driver.

Based on findings, the NCUM typologies were broadly categorized into:

- Power structure, comprising brothel managers, babus, brothel owners
- Regular partners
- Customers
- Vendors, comprising shopkeepers in and around brothels and *feriwaalas* (door-to-door salesmen)

A grid with all potential responses to non-use of condoms was prepared and used in the field to elicit response.

Types of sexual partners

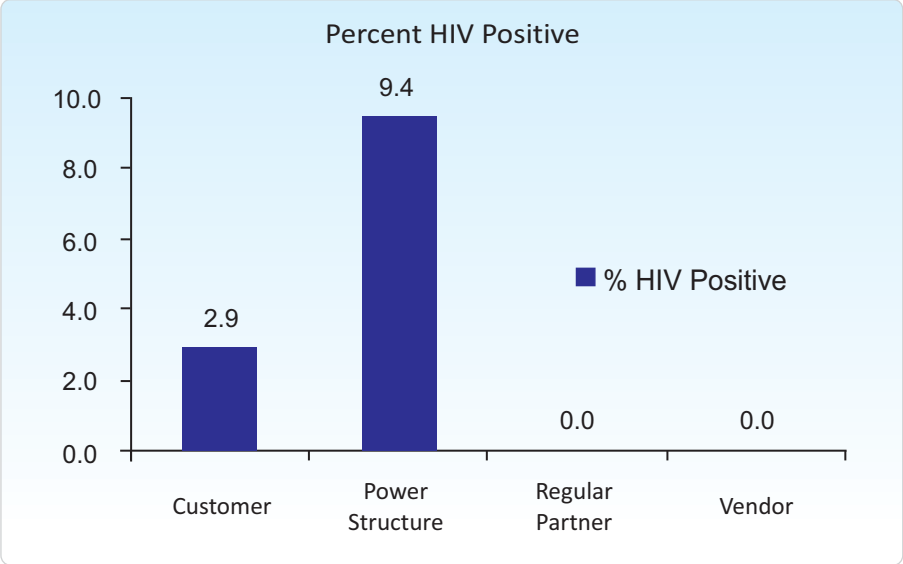
Type of sexual partner with whom condom not used	Description
Customer paying higher money	Some SWs have sex without condom with customers who pay more money than demanded.
Regular partner/pyarwaala	Most interviewed SWs denied using condoms with their regular partners, who demand sex without condom most of the time. It is difficult to profile the regular partners in terms of their profession as most SWs are either unaware or unwilling to disclose their profession. Also, the same regular partner visits other SWs as well.
Regular customer	Sws sometimes have sex without condom with their regular paying customers due to their familiarity with them.
Local shop owners/vendors	Due to familiarity, and also as a favor, sometimes SWs agree to have sex without condom with local vendors.
Local goons	Instead of the goons, the errand boys of the goons force SWs to have sex without condom. SWs have no other choice than to give in to their demands.
Local politician/corporator's men	Specifically in Turbhe, a brothel area in Navi-Mumbai these men have sex without condom with SWs.
Local politician/corporator's men	Specifically in Turbhe, a brothel area in Navi-Mumbai these men have sex without condom with SWs.
Customers under the influence of alcohol	Many customers under the influence of alcohol force SWs to have sex without condom.
Others	Many SWs owe a debt to brothel managers, and to pay off this debt, they do not deny sex without condom if a customer demands it. When a SW does not receive a customer for a long time, she becomes desperate to earn money and agrees to have sex without condom if a customer demands it.

A total of 132 NCUM were mapped during the implementation period of one month. During the pilot phase, 132 NCUMs were identified and the findings were incorporated in the larger program. The NCUM approach has been incorporated by all the implementing agencies.

Categorization of NCUM

NCUM	Total
Customer	34
Power structure (brothel managers, babus, bar managers)	53
Regular partner	38
Vendor	7
Total	**132**

HIV Positivity in NCUM



Special efforts were put in place to proactively trace NCUM, and an NCUM service package consisting of focused strategic behavior counseling, condom promotion and distribution and HIV prevention services, including provision of VCT services, was provided. The strategy also helped in understanding the different typologies of NCUM and identifying HIV-positive individuals. All those identified HIV positive were linked to care, support and treatment services through Aastha's COC mechanism.

8. SUSTAINABILITY STRATEGY FOR SERVICES

8.1 Post-transition support

As per the MOC signed between BMGF and NACO/Department of AIDS Control (DAC), all the TIs that were being implemented by FHI 360 Aastha had to be transitioned to Government funding by March 31, 2012, to ensure sustainability. In pursuance of this plan, a pre-transition assessment of the Aastha TIs was carried out by government agencies in December 2011. All the TIs were transitioned to the Government from April 1, 2012. It was also agreed that post-transition support (PTS) would be provided for a period of one year to the Government — Maharashtra State AIDS Control Society (MSACS), Maharashtra District AIDS Control Society (MDACS) and Technical Support Unit (TSU). This would ensure that the transitioned TIs retain their peak performance and Aastha's expertise gets transferred to the Government.

The PTS strategy put together a team of Program Officers (POs) and Technical Officers (TOs); the team, constituted at FHI 360 level, would regularly visit the transitioned TIs for mentoring and providing technical assistance. About five to six visits were conducted to each TI every month for hands-on technical assistance by this team.

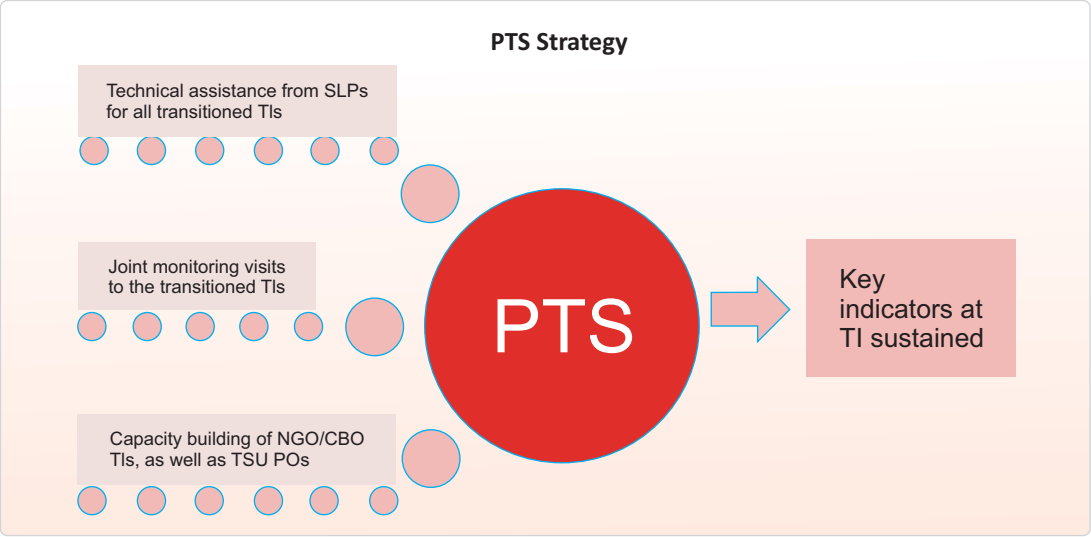
A second line of support for mentoring TIs and monitoring indicators was put in place by introducing FHI 360 consultants. Almost one joint monitoring visit, along with MDACS and MSACS, was conducted to each TI to identify issues and provide on-field technical assistance on SBC, STI treatment and management, national monitoring mechanisms and tools and monitoring and evaluation (M&E) formats. A total of 40–45 individual visits were conducted each month by the Aastha team to provide technical assistance.

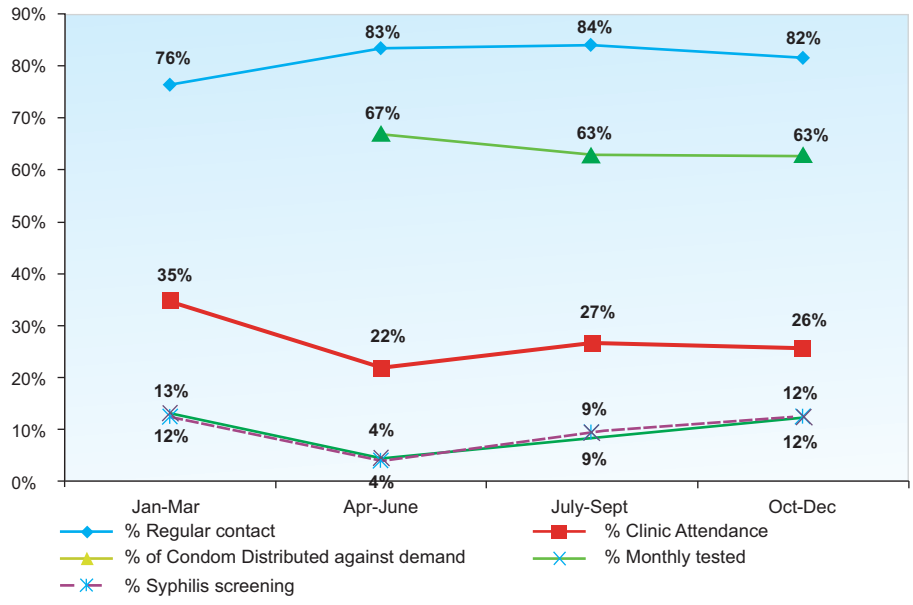
The post-transition strategy involved joint monitoring visits by program officers of TSU and Aastha to the transitioned interventions to ensure:

- Onsite mentoring and handholding of transitioned TIs on program components
- Provision of technical assistance to all transitioned TIs on specific thematic issues
- Training of TI staff and preferred providers (PP) — modular (NACO) training of TI staff (project manager, ORW, PE) and training of PP doctors on STI management
- Training of PO-TSU on STI management, advanced excel, data analysis, community strengthening
- Continued technical assistance on organizational development and resource mobilization

The capacity of TI staff was regularly enhanced to ensure the necessary program management skills. Regular mentoring activities helped institutionalize good practices.

Aastha's post-transition strategy





Data indicates that performance on key TI-level indicators continued to be sustained after transition

The TIs continue to perform on all key indicators as before. This is evident across bothFSW and MSW TIs as well as geographic regions. The data validates the fact that the goals of transition and post-transition support were truly achieved

9. QUALITY ASSURANCE MECHANISMS

9.1 Internal and external mechanisms and checks

Aastha started with the aim of developing health-seeking behavior among SWs by creating an enabling environment and increasing access to health services. The project put in place parallel strategies such as outreach, community mobilization, SBC sessions and a well-equipped clinical team. The clinical model included STI testing and treatment, redesigned ICTC services and superior COC, which led to Aastha's recognition as a niche brand among SWs as well as the Government.

Successful coordination between outreach and clinic teams remains one of Aastha's most defining features. The clinic team comprises doctors, counselors, nurses and laboratory technicians and community members, who serve as peer nurses. The outreach and clinic team coordination was initiated when ORWs and PEs started mobilizing SWs to visit clinics regularly. This approach was further enhanced when the outreach team took the initiative of monitoring SWs' clinic visits for STI treatment, counseling, regular HIV testing and adherence to the prescribed treatment. A robust MIS system, which enabled easy tracking by PEs and ORWs, made this possible. Internal and external quality assurance processes constantly focused on strengthening the outreach-clinic team coordination to ensure the project's sustainability.

The Aastha clinics were supported by integrated HIV counseling and testing centers manned by skilled and qualified technicians. In addition to HIV tests, RPR tests for syphilis, hemoglobin estimation, blood grouping and urinary pregnancy test were also carried out. Although internal quality assurance systems were put in place along with regular in-house coaching and refresher training of laboratory technicians, it was deemed essential to have an external quality assurance system (EQAS) to add value and credibility to the services offered by Aastha laboratories. All Aastha PPP ICTCs took part in the EQAS designed by NACO and as directed by district AIDS control organizations (MDACS and MSACS). In addition to EQAS, all PPP ICTCs also followed internal quality assurance measures defined by Aastha.

The EQAS team, comprising a lecturer and a facilitator from the microbiology department of a medical college, made visits to Aastha laboratories. With one visit each quarter, every laboratory had the EQAS team visiting them four times a year. The EQAS teams carried panel tests with them, for which the test results were known only to EQAS team members. Laboratory technicians at Aastha clinics would conduct tests on the panel samples, and the results would be matched with the key available with EQAS team members.

All Aastha ICTCs set up under the PPP scheme participated in NACO-designed EQAS. Each ICTC was assigned a State reference laboratory (SRL) for EQAS. Aastha ICTCs sent 20 percent of all

positive and 5 percent of all negative samples collected in the first week of every quarter for cross-checking to the SRL once every quarter. SRL sent 'coded' samples from reference laboratories to the Aastha ICTCs twice a year for testing. The SRLs for Aastha ICTCs in Mumbai and Thane are listed below.

For Mumbai district ICTCs:

- T.N.M.C & B.Y.L Ch Nair Hospital - Asha Mahila Sanstha (AMS) and Rashtra Swasthya Prabodhini (RSP)
- L.T.M.M.C & L.T.M.G Sion Hospital - Nagri Sewa Prabodhini (NSP), SHED Aastha Clinic (Dharavi), CORO for Literacy and The Humsafar Trust (HST)
- Seth G.S. Medical College & KEM Hospital – Social Activities Integration (SAI), Vijay Krida Mandal (VKM) & M/S Sanmitra Trust

For Thane district ICTCs:

- AFMC Pune

The EQAS team rated the laboratory technician's performance on the correctness of procedure and interpretation of results. Based on observations, the laboratory technician's necessary skill building was done at the site level (technical assistance and on-site coaching). The report was also shared with the technical officer at FHI 360, who would then plan capacity building activities accordingly. EQAS thus helped identify technicians in need of special attention and capacity building. Mentoring and monitoring of these technicians was done on a regular basis.

In addition to EQAS, a clinic quality monitoring tool (CQMT) was developed and introduced as a means for establishing standards, assessing and monitoring clinic performance against these standards, and ensuring that they were consistently and correctly applied. CQMT would assess clinic performance, community involvement and coordination with outreach, STI clinical management, referral network and clinic operation. The assessment team, comprising technical officers (STI) of the main implementing partners, visited each clinic facility on a quarterly basis. Additionally, the technical officers (STI) of FHI 360 themselves visited each clinic at least twice a year for CQMT. There was decentralization of quality monitoring, and each clinic administered the CQMT on a monthly basis. The record of monthly CQMT was filed at the NGO level.

Applied by the intervention doctor and technical officers, the CQMT measured clinics' performance against set standards. It highlighted any lacunae or problems and indicated solutions for them to ensure quality clinical care. Results from CQMT helped assure the continued quality of an activity and generated ideas for quality improvement. *It also helped in* establishing and using a client-focused, problem-solving approach to test and implement solutions to the problems affecting quality.

To ensure quality laboratory services, quality assurance/quality improvement (QA/QI) was also introduced to set quality standards and assess and monitor the laboratory's and the counselor's performance against these standards.

The QA/QI checks for ICTCs included two checklists:

1. The general STI and ICTC laboratory QA/QI checklist assessed the STI and ICTC laboratory procedures, training status, availability and adherence to SOPs, infection prevention measures and documentation.
2. The pre-/post-HIV test and follow-up counseling QA/QI checklist assessed the HIV pre-test and post-test counseling SOPs and adherence to them, training status of the counselor, follow-up care counseling and documentation.

The assessment team, which visited each clinic facility bi-annually, comprised the technical officers (STI) of the main implementing partners and FHI 360. The QA/QI tool measured the performance of the STI and ICTC laboratory and the counselor against set standards. It pointed to any shortcomings in the laboratory and counseling processes and indicated solutions for quality improvement.

Additional information: Aastha Continuous Quality Approach Cyclical Quality Improvement for Prevention Interventions with High-Risk Groups (ACQUA)

http://www.fhi360.org/sites/default/files/webpages/India_Aastha_Cont_Quality/the_acqua_process.html

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