



CLINICAL SERVICES FOR KEY POPULATIONS

A Guidebook for Health Care Providers

Abstract

Essential package of STI & HIV services for sex workers, high-risk men who have sex with men and transgender women

National Department of Health 2018

[Email address]

FOREWARD

Sexually transmitted infections (STIs) are not new and in Papua New Guinea, we have long had a problem with the large amount of both acute and chronic infection. When these infections are not treated properly, they are essentially transmitted to others by sexual contact and may lead to complications. The presence of any sexually transmitted infection in an individual also increases the risk of that person getting HIV infection and transmitting it to others. The recent integrated Biological and Behavioural Surveillance done in Port Moresby, Lae and Mount Hagen highlights the high prevalence of STIs among key population in Papua New Guinea.

There have been criticisms of the continued use of syndromic management in the management of STIs in PNG but still at this stage, we are convinced that with the lack of functioning laboratories at most health facilities across PNG, especially in rural areas, syndromic management is still the most effective tool we have. Some centres which have laboratory facilities are using *enhanced syndromic management of STIs*, however, even in these situations, one cannot wait for results to treat clients and limited laboratory tests such as gram stain are not definitive when they do not detect gonococcus. Although the points of care and rapid diagnostic tests for some STIs have been recently available and we need to continue to strive towards this goal, for the present, the syndromic management is still the recommended management system for STIs in PNG. Also, looking after the sexual health of Key Population needs a special skill set among the health care providers, hence the necessity of these guidelines.

STIs continue to be an important cause of morbidity and mortality in PNG, yet there also continues to be a significant imbalance between attention paid to sexual health and STI issues generally and to that paid to issues specifically related to HIV and AIDS. We must remember that HIV is just one of the large number of STIs that remain prevalent in PNG. We as a nation and as a Government Department, must pay more attention to the important issues related to sexual health generally and to STIs specifically.

This series of key population guidelines are designed to guide all health workers in the effective management of STIs among Key Population in PNG



Mr Pascoe Kase
Secretary for Health

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Abbreviations

| | |
|--------|--|
| ART | Antiretroviral treatment |
| FBO | Faith Based Organization |
| FEFO | First Expiry First Out |
| FSW | Female Sex Worker |
| HBV | Hepatitis B Virus |
| HCP | Health Care Provider |
| HIV | Human Immunodeficiency Virus |
| HPV | Human Papilloma Virus |
| HSV2 | Herpes Simplex Virus Type 2 |
| HTC | HIV Testing and Counselling |
| IBBS | Integrated Bio-Behavioral Survey |
| KOH | Potassium Hydroxide |
| KP | Key Populations |
| LGV | Lymphogranuloma Venereum |
| MSM | Men who have Sex with Men |
| NACS | National AIDS Secretariat |
| NCD | National Capital District |
| NDoH | National Department of Health |
| NGO | Non-Governmental Organization |
| NHIS | National Health Information Systems |
| NUIC | National Unique Identifier Code |
| OI | Opportunistic Infections |
| PEP | Post Exposure Prophylaxis |
| PLHIV | People living with HIV |
| PMTCT | Prevention of Mother To Child Transmission |
| PNG | Papua New Guinea |
| POC | Point of Care |
| PPT | Periodic Presumptive Treatment |
| PrEP | Pre Exposure Prophylaxis |
| RPR | Rapid Plasma Reagin |
| RST | Rapid Syphilis Test |
| STI | Sexually Transmissible Infections |
| TB | Tuberculosis |
| TG | Transgender women |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counselling and Testing |
| VDRL | Venereal Disease Research Laboratory |
| WHO | World Health Organization |

Resources used for the guidebook

Clinic operational guidelines and standards (COGS). Comprehensive STI services for sex workers in Avahan-supported clinics in India. New Delhi: Bill & Melinda Gates Foundation and FHI.

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Key Population Program Implementation Guide. Washington (DC): FHI 360/LINKAGES; March 2016.

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1. Background and Rationale

Papua New Guinea (PNG) has a geographically diverse HIV epidemic with certain provinces like the National Capital District (NCD) and highlands reporting higher prevalence. In addition, the epidemic is mixed; while the national prevalence among adults (15-49 years) is estimated at 0.9%, it is 10 times higher in female sex workers (FSW) and seven times higher in men who have sex with men (MSM) and transgender women (TG).^{1,2} The recent World Health Organization (WHO) global estimates confirm that PNG has among the highest estimates of sexually transmissible infections (STI) prevalence observed worldwide.³ A cross-sectional study in antenatal women in three provinces showed high prevalence rates of chlamydia at 22.9 percent, gonorrhoea 14.2 percent and active syphilis three percent.⁴

The recent integrated bio-behavioral survey (IBBS) with key populations (KP) showed that more than half of the FSWs had at least one STI (gonorrhoea/chlamydia/syphilis/hepatitis B), the commonest being urogenital chlamydia in Lae and Mt Hagen (35.3% and 32.5% respectively), and anorectal chlamydia in Port Moresby (31.8%). The next most common STI was anorectal and urogenital gonorrhoea (ranging from 15.1% to 22.6%). Less than half of MSM and TG had at least one STI with urogenital chlamydia being the most prevalent in Port Moresby and Lae (12.3% and 14.5% respectively). The next most common STI was Hepatitis B (11.6% – 13.8%). Urogenital and anorectal gonorrhoea prevalence ranged from 3.6 percent to 7.5 percent. The prevalence of active syphilis ranged from 3 to 8.3 percent among all KP groups. Health care seeking was poor for self-reported STI-related symptoms such as abnormal vaginal discharge in FSW and dysuria in MSM/TG. HIV prevalence in FSWs ranged from 11.9 to 19.6 percent, and 7.1 to 8.5 percent in MSM/TG. A large proportion of KPs had never tested previously for HIV - 32.1 to 43.9 percent of FSWs and 58.2 to 68 percent of MSM/TG. Only 39.3 to 43.9 percent of FSWs were aware of their HIV positive status; of them, most (90%) were linked to treatment; and among those on treatment, viral load suppression was sub-optimal (54.1% to 80%). A total of 53 MSM/TG were diagnosed as HIV positive; 16 were aware of their status, of whom nine were on treatment and seven showed viral suppression.

Targeted interventions for KPs are provided through an enhanced service package implemented in the high HIV burden provinces. The intervention package includes peer-led outreach, free condoms and lubricants, and linking to public/NGO/FBO clinics for STI treatment and HIV testing. In addition, the standard service package available at all provinces mandates advocacy for an enabling environment and promoting access to services for KPs through police awareness, violence redressal and sensitization of health care providers. The United States Agency for International Development (USAID) /FHI 360 supported KP programs implemented in certain areas had also promoted categorization and risk assessment (using a decision tree), STI checks and presumptive treatment for asymptomatic KPs during clinic visits. A new pilot for HIV prevention outreach services is being implemented in the NCD by World Vision International (as principal recipient of the Global Fund for HIV & TB) in collaboration with the PNG National AIDS Secretariat (NACS), the National Department of Health (NDoH), UNAIDS, USAID and WHO. The goal of the pilot is to increase rates of HIV case finding through HIV prevention outreach and long term retention in care, support and treatment among newly diagnosed people living with HIV (PLHIV).⁵ The PNG National STI and HIV strategy 2018-2022 proposes to ensure equitable access to services for KPs across the continuum of STI and HIV prevention, care and treatment; monitor uptake of services through the e-National Health

¹ Joint United Nations Programme on HIV/AIDS (UNAIDS). Global AIDS Report 2017

² Kauntim Mi Tu Multi-Site Summary Report 2018: Key Findings from the Key Population Integrated Bio-Behavioral Survey Papua New Guinea. PNG Institute of Medical Research and Kirby Institute, UNSW Sydney

³ Newman L et al. Global estimates of the prevalence and incidence of four curable sexually transmitted infections in 2012 based on systematic review and global reporting. PloS One 2015; 10

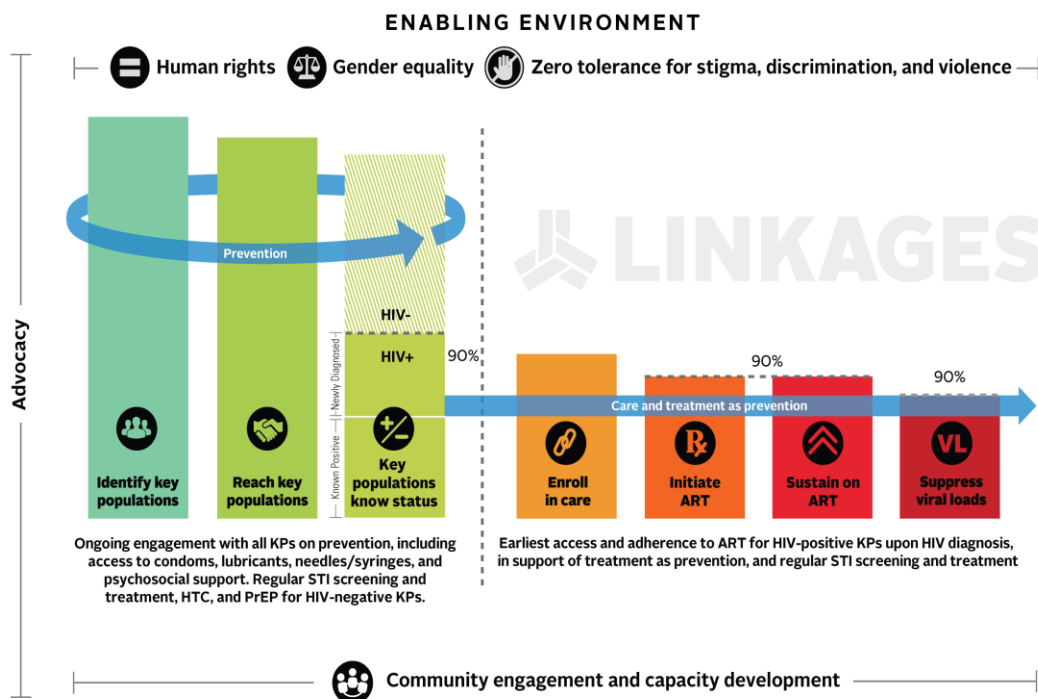
⁴ L Vallely, P Toliman, C Ryan *et al.* Prevalence and risk factors of *Chlamydia trachomatis*, *Neisseria gonorrhoeae*, *Trichomonas vaginalis* and other sexually transmissible infections among women attending antenatal clinics in three provinces in Papua New Guinea: a cross-sectional survey. Sexual Health 2016; 13(5); 420-427

⁵ World Vision PNG. Human Resources Change Plan for New HIV Prevention Outreach at PNG. Draft for comment 22/07/2018

Information System (NHIS) pilot in five provinces which will track STI and HIV health services utilization by KPs using the National Unique Identifier Code (NUIC); and reduce stigma and discrimination at health care facilities by sensitization of health care providers (HCP).

UNAIDS has set ambitious targets to help end the AIDS epidemic: by 2020, 90% of all PLHIV will know their status; 90% of diagnosed PLHIV will be on treatment; and 90% of people on treatment will have viral suppression.⁶ Late detection of HIV positive status, delay in initiation or non-adherence to treatment leads to poor health outcomes and continuing transmission. Untreated curable STIs are known to lead to long-term complications such as sterility, genital malignancies, miscarriages, stillbirths and increased risk of HIV acquisition and transmission. Some common STIs like chlamydia and gonorrhea are frequently asymptomatic, particularly in women. In order to achieve the 90:90:90 targets for KPs, clinical and outreach services should aim to provide the HIV continuum of care, which include prevention services and commodities including STI management for symptomatic and asymptomatic infections for all KPs, periodic HTC for HIV negative individuals, care and treatment for PLHIV as shown in the figure below.

Figure 1: The HIV Cascade of Services for Key Populations



Adapted from: FHI 360/LINKAGES. Key Population Program Implementation Guide. Washington, DC: FHI 360/LINKAGES; 2017

⁶ Joint United Nations Programme on HIV/AIDS (UNAIDS). 90-90-90 An ambitious treatment target to help end the AIDS epidemic.

2. Essential HIV/STI Clinical Services

The guidebook for clinical services for KPs has been developed primarily for health care providers who provide services to KPs. We hope it will also be useful for KP organizations, outreach staff and policy makers. The objectives of the guidebook are to improve the overall quality of management of STIs and the HIV continuum of care. To achieve this, all clinics attending to KP clients should provide the following services:

Essential Package of STI & HIV Clinical Services for FSW, MSM and TG

- Establish communication mechanisms and work in collaboration with peer outreach workers targeting KPs and their sex partners
- Condom promotion and basic prevention education
- Enhanced/syndromic management for patients with STI symptoms
- Management of asymptomatic STIs – three-monthly clinical screening and semi-annual syphilis screening
- HIV testing services, periodic re-testing of HIV negative individuals
- Peer Navigation for facilitating clinic services for PLHIV - initiation of antiretroviral treatment (ART) for newly diagnosed PLHIV, regular follow-ons and adherence to ART
- Partner notification and management
- Reproductive Health Services including contraception, and prevention of mother-to-child transmission (PMTCT) for pregnant FSWs
- Referrals to higher health facilities for STI cases not responding to treatment
- Ongoing monitoring for tracking of health service utilization by KPs and quality of care

Syndromic management of STIs, ART regimes and opportunistic infections (OI) prophylaxis/treatment for KPs should be consistent with the PNG national guidelines. STI clinical management will need to be adapted over time in keeping with local epidemiological information such as etiology of common STI syndromes, STI prevalence in different population groups and antimicrobial susceptibility patterns. In addition to the above, KPs will need other clinical services available to the general population such as post-exposure prophylaxis (PEP) and gender-based violence (GBV).

Other biomedical interventions for KPs may be considered at a later stage. These include:

- **Point-of-care (POC) testing for STIs:** Syndromic management relies on the presence of symptoms/signs of STIs in the absence of laboratory confirmation and lacks sensitivity. In the STI prevalence study among antenatal women at PNG by Valley *et al*, multivariable analysis showed no association between clinical symptoms and STI laboratory diagnosis. This highlights the need for POC tests for STIs which are frequently asymptomatic such as chlamydia and gonorrhoea, particularly for populations where the STI prevalence is known to be high.
- **Cervical cancer screening for FSWs:** Human Papilloma Virus (HPV) is a common infection among FSWs globally. Screening for HPV for KPs can be provided through Well Woman Clinics with on-site laboratories.
- **Hepatitis B vaccine:** HBV vaccine is safe and effective. Many countries now have targeted and population-wide HBV vaccination programs including infant, catch-up and risk group vaccination. HBV vaccine may be considered for MSM and TG, in view of the high HBV prevalence reported in the IBBS.

- **Community-based/self-testing for HIV:** Studies elsewhere have shown that availability of community-based and self testing for HIV have increased the uptake of HIV testing. Community-based testing can be easily provided by mobile clinics at hotspots where a number of KPs congregate.
- **Pre-exposure prophylaxis (PrEP):** WHO recommends that oral PrEP should be offered as an additional prevention choice for KPs at substantial risk of HIV infection as part of combination HIV prevention approaches.⁷

3. Clinic Operations

3.1 Community approaches: Clinics should promote meaningful community involvement in clinic operations by establishing systematic feedback mechanisms from community leaders/members using clinic services. Periodic exit interviews with KP clinic attendees conducted by NGO outreach staff will provide qualitative data on accessibility, acceptability and levels of satisfaction with services. The feedback should be reviewed by NGO and clinic staff and used to improve quality of services.

Community leaders should be encouraged to address stigma and discrimination against KPs, if any, at the clinic and facilitate sensitization programs for HCPs. If these issues are not addressed in a timely manner, clinic attendance will be low and the biomedical interventions will have limited impact.

3.2 Coordination with outreach staff: Clinic staff should explain clinical procedures to outreach staff, so the outreach staff can inform KPs about these before they visit the clinic. Outreach staff who are from the community should be encouraged to avail these services themselves, the experience will help them explain better to KPs.

Clinic and outreach staff should work in a collaborative fashion to ensure optimal utilization of health services by KPs. Joint meetings should be held at least once a month to review monitoring reports and follow-up of clients.

3.3 Staff training and skills: Clinics should aim to provide KP-friendly services. To achieve this, all clinical and support staff should be sensitized to the health care needs of KPs and encouraged to provide confidential and non-judgemental services. HCPs should explain clinic procedures and respect the KPs choice if s/he refuses examination or treatment.

All staff should be trained to carry out their assigned tasks. STI nurses should be trained to provide clinical procedures such as speculum, bimanual, digital and proctoscopic examination in order to diagnose STIs and perform HIV testing/screening. The VCT counsellor should be trained on basic prevention counselling, pre- and post-test counselling. Peer counsellors should be trained in facilitating clinic services, positive prevention and health support for PLHIV.

3.4 Clinic infrastructure: The lay out of the clinic should facilitate physical and audio privacy. Thus separate areas/cabins are required for waiting, examination and counselling. The examination table should be positioned for adequate space and light source at the foot-end so as to be able to view the genitalia properly during speculum and proctoscopic examinations. Locked cabinets should be used to file patient records and only authorised persons should have access to the records. A sample patient flow is shown in *Annex 1*, which may be adapted to suit different requirements at each clinic.

3.5 Clinic equipment and supplies: A suggested list of clinic equipment is given in *Annex 2*. Equipment should be maintained and serviceable at all times. Drugs and other consumable items should be maintained in an inventory with inbuilt mechanisms for re-ordering to prevent stock outs.

⁷ WHO. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. 2016 Update

Drugs and consumables with a defined shelf-life should be stored in a fashion to facilitate the first expiry first out (FEFO) principle.

4. Clinical Management of STIs

Screening, diagnosis and treatment of STIs should be offered routinely as part of comprehensive HIV prevention and care for FSWs, high-risk MSM and TGs (those reporting transactional sex or more than one partner in last three months). The key components of STI management are given below. For further details about history taking and physical examination, please refer to the PNG Standard Management of STIs and Genital Conditions.

- Sexual history taking
- Physical examination including speculum and bimanual examination for FSWs, digital and proctoscopic examination for KPs who report receptive anal sex or anal discharge or symptoms of proctitis.
- Laboratory tests: If the clinic has an on-site laboratory, the following tests are recommended for enhanced syndromic management:
 - Saline and KOH mounts of vaginal swabs
 - Gram stain of vaginal, endocervical, and urethral swabs
 - Syphilis testing using treponemal point-of-care rapid syphilis test (RST) and non-treponemal (VDRL/RPR) tests
- Basic prevention education on the following:
 - Modes of STI/HIV transmission
 - Correct and consistent condom use
 - Compliance with STI treatment
 - Partner notification
- Follow-up care for those with STI syndromes
- Referrals for STI patients not responding to syndromic treatment

4.1 Management of asymptomatic and symptomatic STIs in KPs

Effective control of STIs requires management of both asymptomatic and symptomatic infections as described below.

4.1.1 Screening of asymptomatic infections:

Management of Asymptomatic Infections among Key Populations

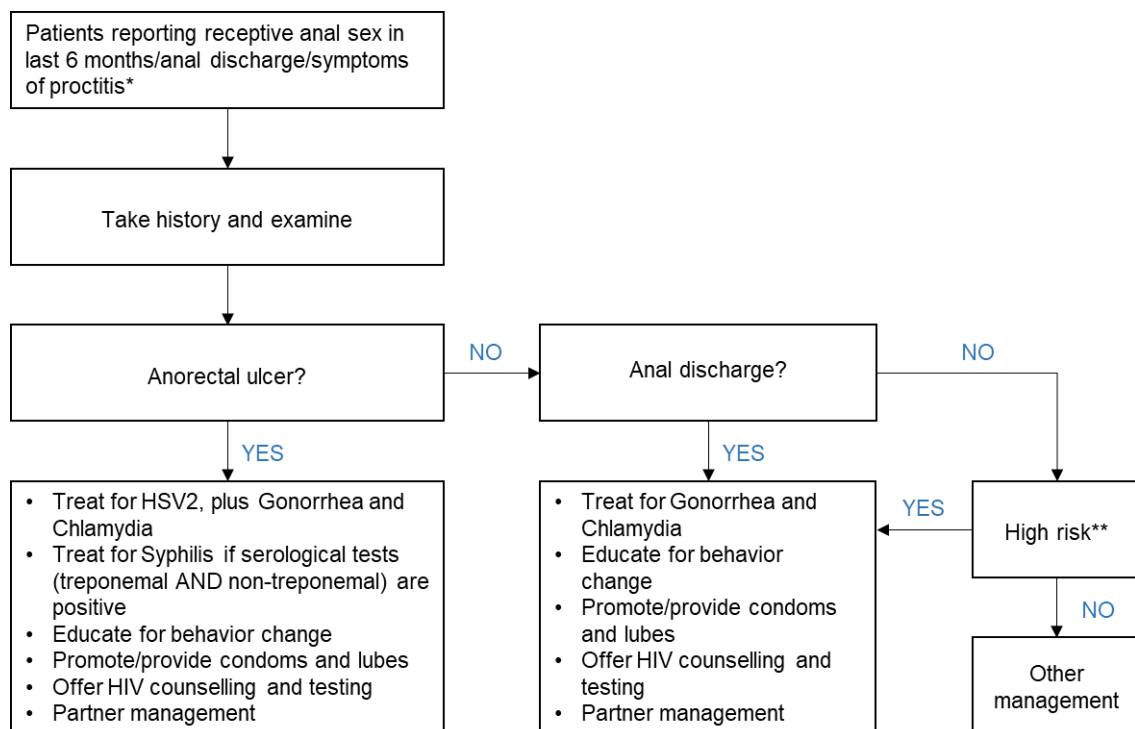
- Three-monthly history taking and physical examination
- Semi-annual serological screening for syphilis

KPs should be encouraged to attend the clinic for STI screening at three monthly intervals. During the visit, clinic staff should take a detailed history and perform an examination including speculum and bimanual examination for FSWs. KPs reporting receptive anal sex and/or anal discharge or symptoms suggestive of proctitis should be offered proctoscopic examination in a way that the community finds acceptable. Discussions with peer outreach workers is the best way to find out about acceptability of proctoscopic examinations and how best to approach the topic with clients. If symptoms or signs of infection are detected, treatment should be given as per the national guidelines.

KPs should be counselled at every opportunity in the clinic (and outreach) on the importance of using condoms. They should be explained that the only way to protect oneself from HIV and STIs is to use condoms correctly and consistently.

4.1.2 Treatment of symptomatic infections: For treatment of symptomatic infections/ STI syndromes, please refer to the PNG Standard Management of STIs and Genital Conditions 2011-2015. Men and women who report unprotected receptive anal sex are at risk of getting sexually transmissible anorectal infections. Management of anorectal infections is shown below.

Figure 2: Management of Anorectal Infections



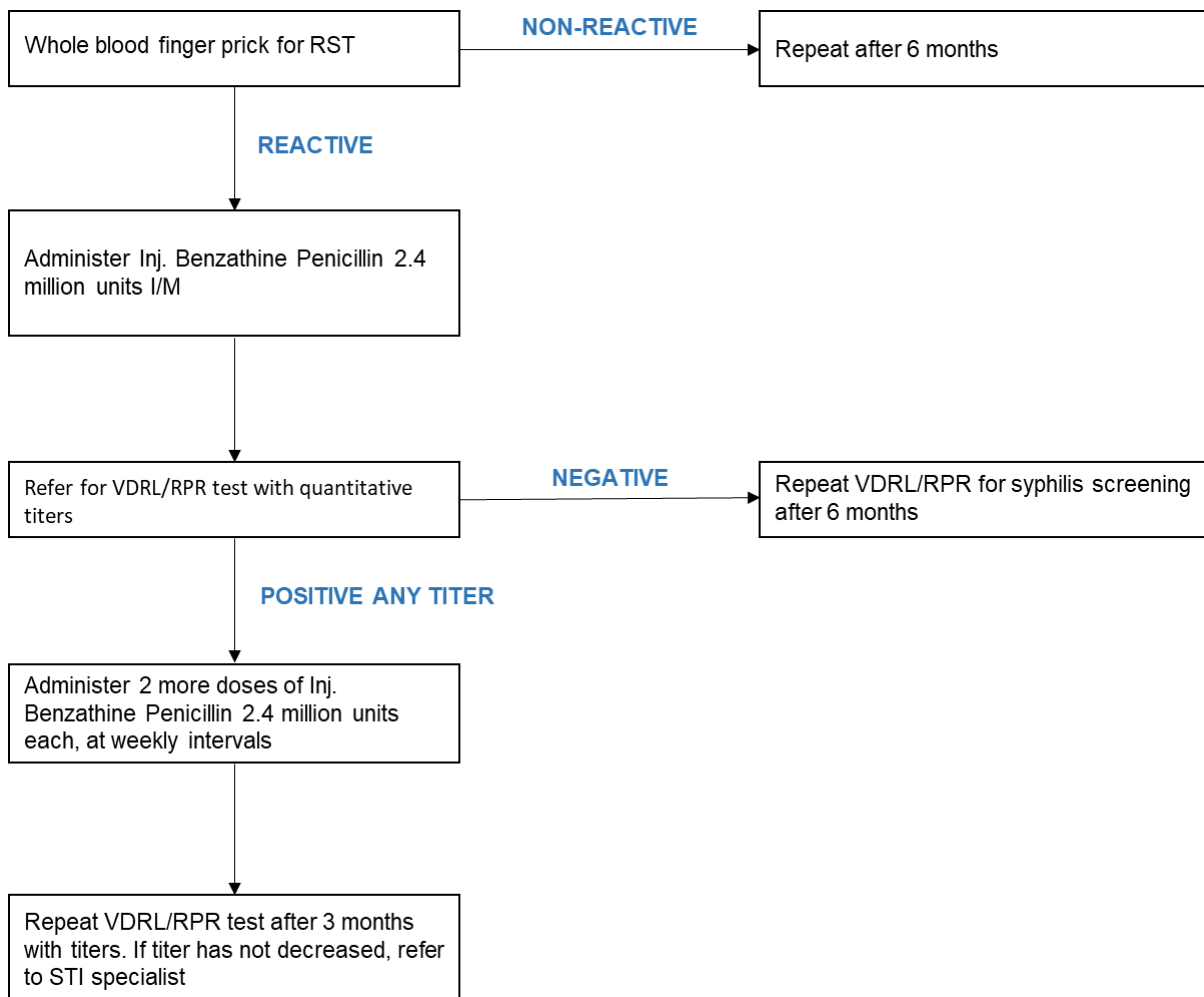
*Symptoms of proctitis include perianal pain, mucopurulent anal discharge, anorectal bleeding and tenesmus
 **Risk Factors: Unprotected anal intercourse in last 6 months, having a partner with STIs, multiple concurrent partners

Management of STI screening/symptomatic visits of FSWs and MSM/TG to the clinic are shown in Annexes 3 and 4 respectively.

4.1.3 Syphilis screening:

KPs should be advised to get serological tests for syphilis at six-monthly intervals. This may be conducted at the same time as HIV testing. The screening test should be done using finger prick whole blood with a POC rapid syphilis test (RST), which is a treponemal test. If the RST shows a reactive result, the individual should be given a dose of Injection Benzathine Penicillin 2.4 million units, and referred for a non-treponemal test such as VDRL or RPR with quantitative titers. If the VDRL/RPR test is positive (any titre) the KP should be administered two more doses of Injection Benzathine Penicillin 2.4 million units at weekly intervals. The VDRL/RPR titre should be monitored on follow-up visits. KPs who had a reactive RST should be screened for syphilis in the future using VDRL/RPR tests only. Management of syphilis screening for KPs is shown below.

Figure 3: Management of Syphilis Screening for KPs



4.2 Laboratory services

Enhanced syndromic management is the use of simple laboratory tests to confirm a syndromic diagnosis. However, STI treatment should not be delayed while waiting for laboratory test results.

If an on-site laboratory is available, the following simple tests should be performed:

4.2.1 Vaginal infections: Vaginal secretions collected by swabs from the posterior fornix of the vagina are used for detection of Bacterial Vaginosis, Trichomoniasis and Candidiasis.

- *Saline wet mount:* Place vaginal secretions on 1-2 drops of normal saline on a glass slide and mix. Place a cover slip and examine under the microscope. If the slide is examined within 10 minutes of sample collection, typical jerky movements of motile trichomonads will confirm a diagnosis of Trichomoniasis.
- *KOH (Potassium Hydroxide) wet mount:* Place vaginal secretions on a glass slide and add 1 drop of 10% KOH. A characteristic fishy amine odor shows a positive 'Whiff Test' which is indicative of bacterial vaginosis. Mix the vaginal secretions and KOH solution, place a cover slip and examine under a microscope for the budding yeasts and pseudohyphae of candida infections.

- *Gram stain*: A Gram stain preparation of vaginal discharge may show Gram-positive spores or pseudohyphae of candida infections. In addition, 'Clue Cells' (Gram-variable coccobacilli attached to vaginal epithelial cells) indicative of bacterial vaginosis may be seen.
- *Amsel criteria for the diagnosis of bacterial vaginosis*: The diagnosis of bacterial vaginosis is based on the presence of at least three of the four criteria mentioned below:
 - homogeneous white to grey adherent discharge
 - vaginal fluid pH of >4.5 (a pH indicator strip of a range 3.8 to 6.0 can be touched to the tip of the speculum after it has been withdrawn from the vagina)
 - positive whiff test
 - clue cells seen on microscopic examination

4.2.2 Cervical and urethral infections: The common cervical and urethral infections are gonorrhoea and chlamydia. A Gram stain of endocervical and urethral swabs is examined under a microscope to look for the presence of many polymorphs which are indicative of any infection. The presence of Gram-negative intracellular diplococci within polymorphs is diagnostic of gonorrhoea.

4.3 Partner management

Partner management is aimed at testing, treating and educating all sex partners of the index case. This is very important because it can break the cycle of STI transmission. In STI parlance, a man is a woman's best friend as regards STI treatment, because a large proportion of women with curable STIs have no symptoms while their male partners are likely to have symptoms such as dysuria, urethral discharge etc. Often patients receive effective treatment, and after they leave the clinic, have unprotected sexual intercourse with the same person from whom they acquired the infection, leading to reinfection. If possible, all sexual partners in the last three months should be treated for the same infections as the index case, even if they have no symptoms.

The importance of partner management should be explained carefully during the patient education session. Partners of KPs diagnosed with a STI syndrome/disease should be notified to attend the clinic. Different ways of partner notification are described in the national STI guidelines – verbally or through card/s given to the index case. We should target all the non-paying regular and casual partners of KPs. When sex partners attend the clinic, they should be treated with respect and a full history taken, followed by examination, diagnosis and treatment. Asymptomatic FSWs attending the clinic for STI screening should be asked if their partners have any STI symptoms such as dysuria or urethral discharge; if yes, then request them to get their partners to the clinic for further management.

Remember – it is against NDoH policy to give medicine for an index case to take home and give to his/her partner. All single/first doses of STI treatment must be given under direct supervision at the clinic.

4.4 Documentation

Clinical history, examination findings, laboratory test results and prescribed treatment for each KP should be recorded on the STI Clinic Patient Record – Form Surv 3. In addition, daily STI clinic registers should be maintained. Clinic/outreach staff should also maintain a diary scheduling follow-up visits by KPs for STI and syphilis screening.

5. HIV Services

The objectives of HIV interventions for KPs are to enable HIV negative individuals remain negative through prevention services, to assist PLHIV who do not know their status to get tested for early diagnosis, and for PLHIV to access and adhere to care and treatment so as to promote positive health and reduce onward transmission. The essential components of HIV services for KPs are given below:

- HIV testing and counseling
- Facilitating access to HIV treatment and care for newly diagnosed HIV positive individuals
- Retention in care and treatment for PLHIV
- Prevention and management of opportunistic infections
- Prevention of mother-to-child transmission for FSWs

5.1 HIV Counselling and Testing (HTC)

HTC is the essential first step in enabling PLHIV to know their status and obtain care, treatment and positive prevention services. For those who test negative, HTC is an important opportunity to link them or re-inforce their linkages with targeted prevention programs and repeat HIV testing at quarterly/six-monthly intervals. A new HIV prevention outreach approach being piloted in PNG envisages HTC as the start point of a HIV intervention package for KPs. In case the KP is not referred by the outreach but directly attends the clinic for other services, s/he should be motivated for HTC by health care providers.

- HTC should always be voluntary and adhere to 5 Cs- Consent, Confidentiality, Counseling, Correct results and linkage to Care.
- HTC should have clear and robust links to HIV care and treatment for PLHIV and prevention services for HIV negative individuals

HTC must always be voluntary and free from coercion in particular by health care providers. HTC for KPs needs to adhere the 5Cs advocated by WHO – consent, confidentiality, counseling, correct results and linkage to care. HTC procedures for KPs should follow national testing algorithms and guidelines for pre- and post-test counseling. Pre-test counseling must provide accurate information about the test, implications of a negative or positive test result and explain *shared confidentiality* (HIV status known to clinic and outreach staff) so the individual can make an informed choice regarding testing. Post-test counseling should address future plan of action depending on the test result and support for disclosing HIV status to partners and others. Couples and partners should be offered voluntary HTC with support for mutual disclosure. VCT/Peer Counselors at clinics should be trained on pre- and post-test counseling.

HTC is offered as a component of a comprehensive KP program, it is important that there are clear and robust links to HIV care and treatment services for those who test positive and to prevention services for those who test negative. HIV testing and POC syphilis testing should be conducted at the same visit. Since HIV testing is conducted at clinics providing STI and counseling services to KPs at PNG, HIV negative individuals should be encouraged to return to the clinic for periodic HIV testing and referred back to the outreach team for ongoing prevention services. The newly diagnosed HIV positive individuals should be referred to the Peer Counselor (hired by Igat Hope and placed at the clinics) and on-site ART center for initiating care and treatment.

5.2 Facilitating access to HIV treatment and care for newly diagnosed HIV positive individuals

Newly diagnosed HIV positive KPs need support to cope with the diagnosis and address various psycho-social barriers in accessing ART services such as stigma and discrimination at health care facilities, fear of disclosure, feeling in good health, and time/economic constraints. Interventions elsewhere have shown that intensified post-test counselling combined with follow-up counselling by community health workers significantly increase the proportion who enrol in HIV care. Thus it is important that VCT/Peer Counsellors at clinics probe and address perceived barriers to HIV care during post-test counselling and refer these individuals to HIV Case Finding Fieldworker (Casework) for follow-up counselling. In addition, Peer Counsellors should facilitate ART enrolment and initiation of treatment for the newly diagnosed PLHIV and upon request, provide support for disclosure to family members and partner notification/management.

5.3 Retention in care and treatment for PLHIV

The ART regimes and periodic CD4, viral load testing for KPs should follow the national ART guidelines. However, discussions

KP PLHIV need support for retention in care and treatment. This can be achieved by one-to-one counseling at clinic and field settings to address barriers to ART visits including perceived stigma and discrimination at health care facilities

with peer outreach workers regarding challenges to retention in care revealed that regular clinic visits entailed long waiting periods and delays in transfer in/out mechanisms for mobile populations. To address long waiting periods, Peer Counsellors should help navigate PLHIV through regular ART clinic visits and, in collaboration with HIV Case Finding Fieldworker (Casework), send reminders to KPs who have missed clinic visits. The Peer Counsellor should be trained in positive health, dignity and prevention for PLHIV including treatment literacy for promoting adherence and retention in treatment. Peer Counsellors should also provide emotional support, nutrition advice and referrals for legal/social services for PLHIV.

5.4 Prevention and management of opportunistic infections (OIs)

An essential part of HIV treatment and care is the management of common OIs such as Tuberculosis (TB). The PNG National Guidelines for HIV Care and Treatment should be followed for OI prophylaxis and management for KPs as for other PLHIV. In addition, clinic staff and peer outreach workers should screen KPs using the WHO-recommended four TB symptom screening algorithm – a current cough, fever, night sweats or weight loss. All KPs, particularly HIV positive individuals, should be screened for TB at every clinic visit. Peer outreach workers should educate KPs about TB symptoms and provide referrals to clinics for TB suspects.

5.5 Prevention of mother-to child transmission (PMTCT) for FSWs

All pregnant FSWs should have the same access to PMTCT services and follow the same recommendations as women from other populations. WHO recommends a four-pronged approach towards a comprehensive PMTCT strategy:

- Primary prevention of HIV infection among women of child-bearing age: For FSWs, these would be the prevention services such as behavior change communication, condom provision and clinical services provided through targeted interventions.
- Preventing unintended pregnancies among women living with HIV: All FSWs should be asked about their child bearing plans. In case she wants to delay pregnancy or does not want any more children, she should be motivated to avail family planning counseling and contraceptive services from the same clinic.
- Preventing HIV transmission from women living with HIV to their infants: The direct interventions to prevent vertical transmission consist of a cascade of services from HTC, ART, safe delivery, safer infant feeding, postpartum interventions, early infant diagnosis and final diagnosis for HIV-exposed infants.
- Providing appropriate care, treatment and support to mothers living with HIV, their children and families.

6. Basic Patient Education

STI/HIV health education is provision of essential information related to the prevention and/or treatment of STIs/HIV and need not take much time. Counselling, on the other hand, requires time to establish trust, assess the person's individual situation and relate prevention information directly to the person's lifestyle. KPs are at high **risk** of STIs/HIV because of unsafe sexual practices which may be difficult to change due to various factors and circumstances that limit their options and increase **vulnerability**. To effectively reduce risk and vulnerability, KPs may need not only specific information about STI/HIV transmission but also support in making changes in their lives.

This section deals only with the essential prevention education to be provided at the clinics. The components of basic STI/HIV education are given below:

- How the infection was acquired through unprotected sexual contact with an infected partner
- Nature of the infections and possible complications if untreated/incompletely treated
- Treatment compliance: How to take the medicine and the importance of completing the full

course of prescribed treatment even if the symptoms disappear or the infection is asymptomatic

- Explain importance of three-monthly clinic visits for STI screening, and periodic HIV and syphilis testing
- Abstinence from sexual activity until cured of STIs
- How to prevent getting infected in the future
- How to use a condom correctly
- Importance of using condoms consistently with clients, non-paying regular and casual partners
- Partner referral and management of regular/casual partners

In addition to health education, the KP should be given a supply of free condoms and lubricants at the clinic.

The box below describes some skills that health care providers should develop for effective communication. Many of these are also useful for history taking and examination.

Skills for Effective Communication

- Welcome your patient warmly by name and introduce yourself
- Assure your patient that privacy and confidentiality will be respected
- Sit close enough to be able to talk privately and comfortably
- Make eye contact and look at the patient when s/he speaks
- Use language that the patient understands
- Listen to the patient and observe body language. Try to understand feelings, experiences, point of view
- Be encouraging. Nod or say “tell me more about it”
- Use open-ended questions
- Provide relevant information
- Try to identify the patient’s real concerns
- Suggest various options to the patient
- Respect the patient’s choices
- Always verify that the patient has understood what has been discussed by having her/him repeat the most important information
- Do NOT
 - Keep moving in and out of the room
 - Encourage other providers to interrupt
 - Write notes continuously as the patient is speaking
 - Make judgemental comments or negative facial expressions

7. Infection Control

The aims of infection control are to:

- prevent HIV/STI transmission in health care settings, and
- protect health care providers

Infection Control in Health Care Facilities

Primary prevention

- Standard precautions to minimize the spread of infection associated with health care and avoid direct/indirect contact with blood/body fluids/secretions/non-intact skin e.g. washing hands before and after patient contact, wearing gloves and other protective devices, managing spills, processing re-usable equipment, cleaning examination and treatment areas and disposal of bio-hazardous waste
- Prevention of unsafe injections
- Prevention of needle stick injuries

Secondary prevention

- Post-exposure prophylaxis is used in health care settings when a health care provider has been accidentally exposed to risk of HIV transmission usually by needle stick injuries

7.1 Hand washing is the single most important procedure in preventing infection. Every clinic should have facilities for health care providers to wash hands between patients and procedures on the same patient. Wash hands for 10-15 seconds with soap and running water and then dry either with a personal towel or air-dry.

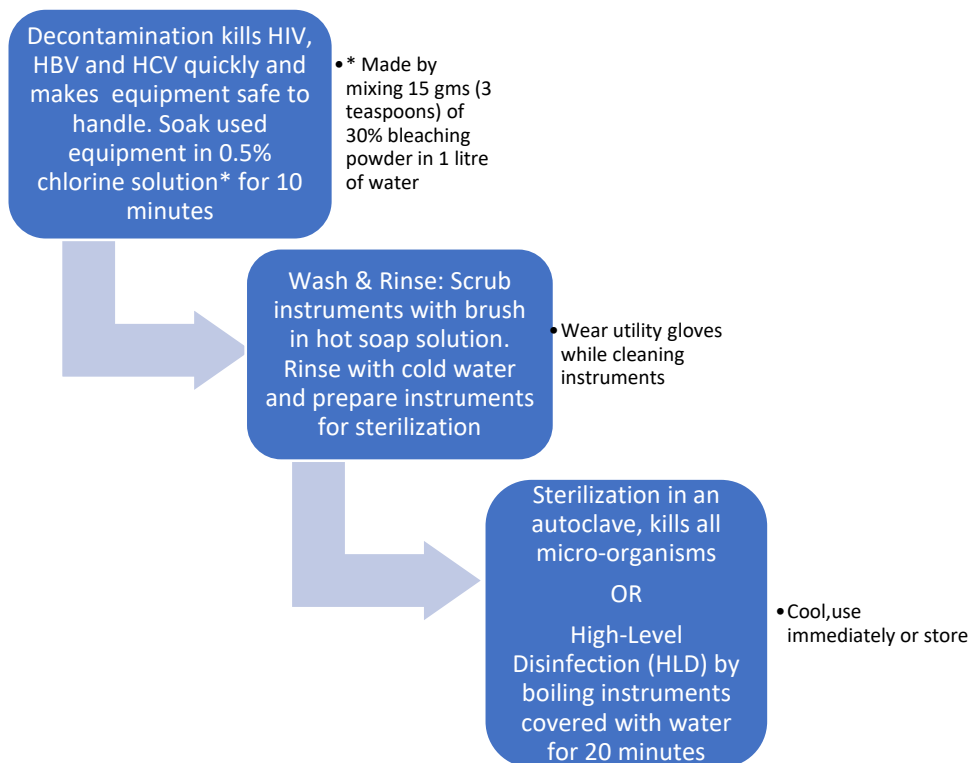
7.2 Use of gloves: Disposable surgical gloves should be worn when the provider is likely to come into contact with mucous membranes or body fluids such as during genital examination or drawing blood (finger prick/intravenous). Heavy duty rubber gloves should be worn while handling used equipment or linen and disposing hazardous waste.

7.3 Managing spills: Use heavy duty gloves while cleaning spills. For small spills (<10 cm diameter), apply absorbent paper towels or a cloth soaked in disinfectant solution. For large spills, pour disinfectant solution such as 0.5 percent chlorine over the spill and then wipe with absorbent paper towels or a damp cloth. Dispose the paper towels/cloth following procedures for infectious, non-sharps medical waste disposal. Clean the area with detergent and water.

7.4 Processing re-usable equipment: All re-usable equipment such as speculums/proctoscopes or reusable gloves that are used in invasive procedures (piercing skin or touching mucous membranes) have the potential to transmit infections.

A three-step method is used to process these instruments after use as shown in the figure below.

Figure 4: Three-step method for processing reusable instruments



7.5 Cleaning examination and treatment areas: Maintaining a clean environment reduces the micro-organisms. Surfaces like floors should be cleaned with a non-phenol based commercial floor cleaner and then dried. Areas that are likely to contain a higher level of micro-organisms such as examination tables and toilets should be cleaned with a disinfectant solution.

7.6 Disposal of bio-hazardous waste: Bio-hazardous wastes are segregated at source depending on its type (sharps, infectious waste, pharmaceuticals) and put into color-coded bags. These should be disposed using standardized procedures laid down for the clinics.

7.7 Safe injection practices and prevention of needle stick injuries: The following steps should be followed:

- Wash hands and wear a glove before administering injection
- A single-use swab may be used to clean the skin
- Disposable syringe and needle to be used
- Check the expiry date and contents of the vial before injecting
- Do NOT recap needles after use
- Dispose of needles and syringes in puncture proof sharps container/needle cutter
- The container should be sealed and removed when it is three-quarters full
- Sharps container should be sent for incineration

7.8 Post Exposure Prophylaxis: For PEP guidelines and drug regimen for healthcare providers who have been accidentally exposed or KPs who are victims of sexual assault, please refer to the National Guidelines for HIV Care and Treatment.

8. Monitoring of clinical services

Monitoring is a regular, methodical process of collecting data to determine the progress and achievements of the program. To provide effective HIV/STI clinical interventions, the clinic should address the health needs of KPs in a community-friendly way and mechanisms should be developed for members of the community to provide feedback on clinic services. The objectives for ongoing monitoring of clinical services are to:

- Track health services utilization by KPs
- Ensure KP-friendly services

8.1 Track health services utilization by KPs: Clinic and NGO management/outreach staff should have joint monthly meetings to review STI/HIV service indicators. Discussions should use data from individual records maintained at the clinic, aggregated monthly reports (KP MIS) and appointment diaries. The most important outcomes of the monthly meetings should be to:

- Identify individuals who were scheduled for STI/ HIV testing/ART services in the last month but did not attend the clinic and make time bound plans for ensuring follow-up of these individuals
- If there has been a significant increase in cases of curable STIs or newly diagnosed HIV positive cases in a particular hotspot, review and strengthen prevention programming and partner notification at the clinic and outreach levels

Examples of health service indicators which need to be monitored on a monthly basis are shown in the table below.

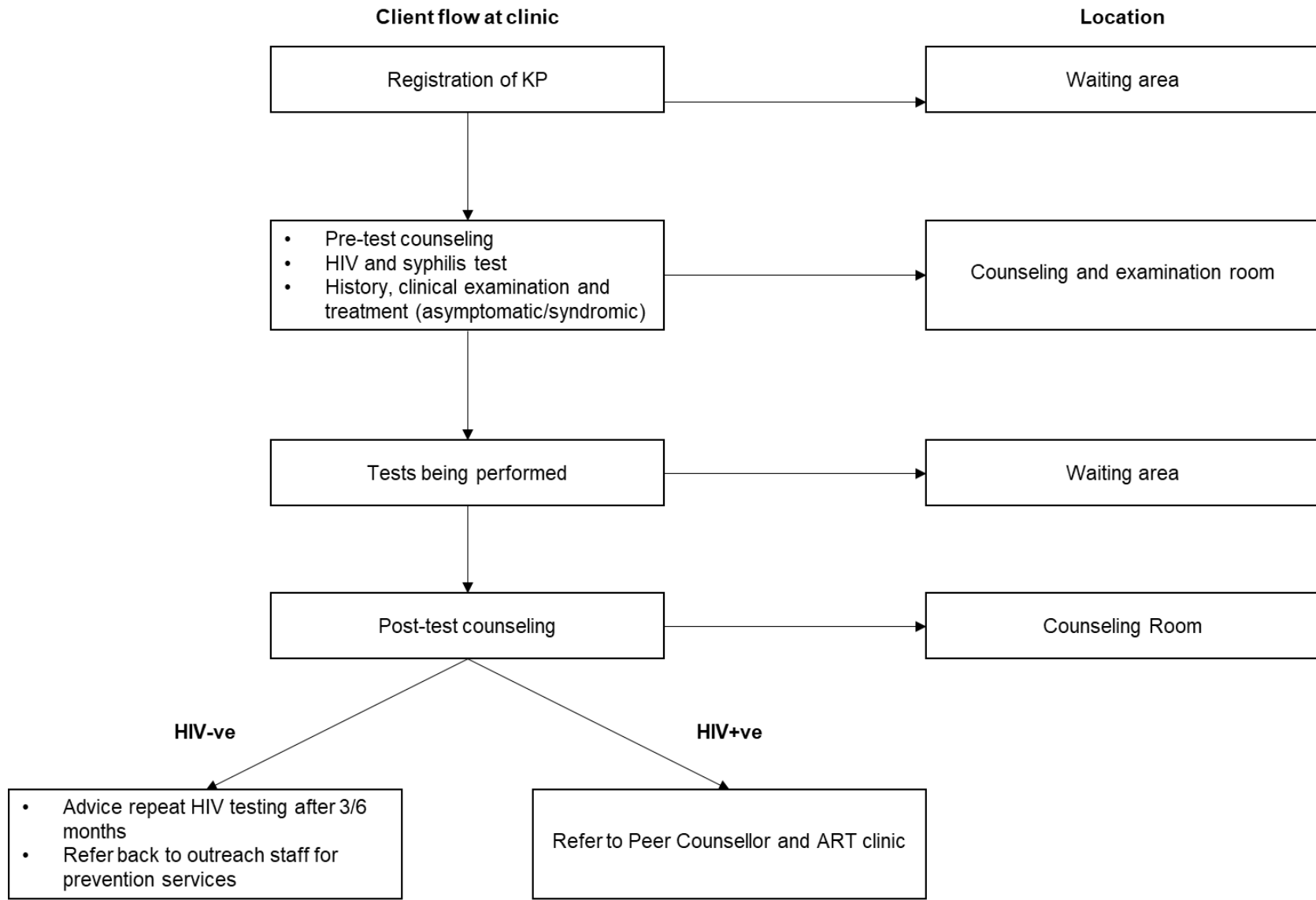
Table 1: Monitoring indicators of STI/HIV services for Key Populations

| | |
|-----------------------|--|
| STI services | Total number of clinic visits by KPs in the last month – <i>first time/repeat visits</i> |
| | Number of individuals who were asymptomatic |
| | Number of individuals with STIs – <i>new cases, follow-up of individuals treated earlier</i> |
| | Number of KPs with STIs whose partner/s attended the clinic for STI management |
| | Number of KPs tested for syphilis – <i>first time/repeat</i> |
| | Number tested positive for syphilis and initiated on treatment |
| HIV testing | Number of individuals scheduled for STI screening/syphilis screening in the last month who did not attend the clinic |
| | Number of individuals tested for HIV in the last month – <i>first time/repeats</i> |
| | Number of Individuals due for HIV testing in the last month who did not attend the clinic |
| | Number of newly diagnosed HIV positive individuals |
| | Number of newly diagnosed PLHIV whose partner/s attended the clinic for HIV testing |
| PLHIV services | Number of newly diagnosed PLHIV initiated on care and treatment |
| | Total number of KP PLHIV on ART – <i>new + old cases</i> |
| | Number of PLHIV due for ART visit in the last month but did not attend the clinic |
| | Number of PLHIV retained on ART for last 6 months ÷ Total number of PLHIV initiated on ART 6 months or more ago |
| | Number of individuals CD4 tested – <i>new/old cases</i> |
| | Number of individuals tested for viral load |
| | Number of individuals virally suppressed among those tested in last month |

8.2 Ensure KP-friendly services: To encourage KPs to use clinical services, we need to ensure that services being provided at the clinic are KP-friendly. Outreach staff should be trained to conduct structured/semi-structured exit interviews for randomly selected KPs attending the clinic with questions related to their experiences and perceptions. The feedback obtained and ways of improving services should be discussed at the monthly meetings between clinic staff and the NGO management.

ANNEXURES

Annex 1: Client Flow



Annex 2: Suggested List of Clinic Equipment

General

1. Access to female/male toilets
2. Fans as needed
3. Private rooms
4. Sink with running water for washing hands, cleaning equipment etc.
5. Electricity supply
6. Waste baskets in all rooms

Waiting and Registration area

1. Clinic record system
2. Lockable filing cabinet
3. Desk and chairs

Consultation and Examination Room

1. Screens for privacy
2. Examination couch- ideally with cut away recess for speculum examination
3. Examination chair- ideally with wheels
4. Rubber mattress, sheets and pillow for examination couch
5. Good examination light- preferably wall mounted or Gooseneck lamp
6. Torch with fresh batteries

General medical

1. Sphygmomanometer
2. Stethoscope
3. Thermometer
4. Tongue depressor
5. Adult weighing scales
6. Medicine cabinet

Instruments

1. Sterilizer or access to sterilization
2. Scissors
3. Instrument tray with cover
4. Cheatle's forceps
5. Cotton ball/cotton tip holder
6. Cusco's vaginal speculum- different sizes
7. Proctoscopes
8. Ovum forceps

Medical supplies- consumables

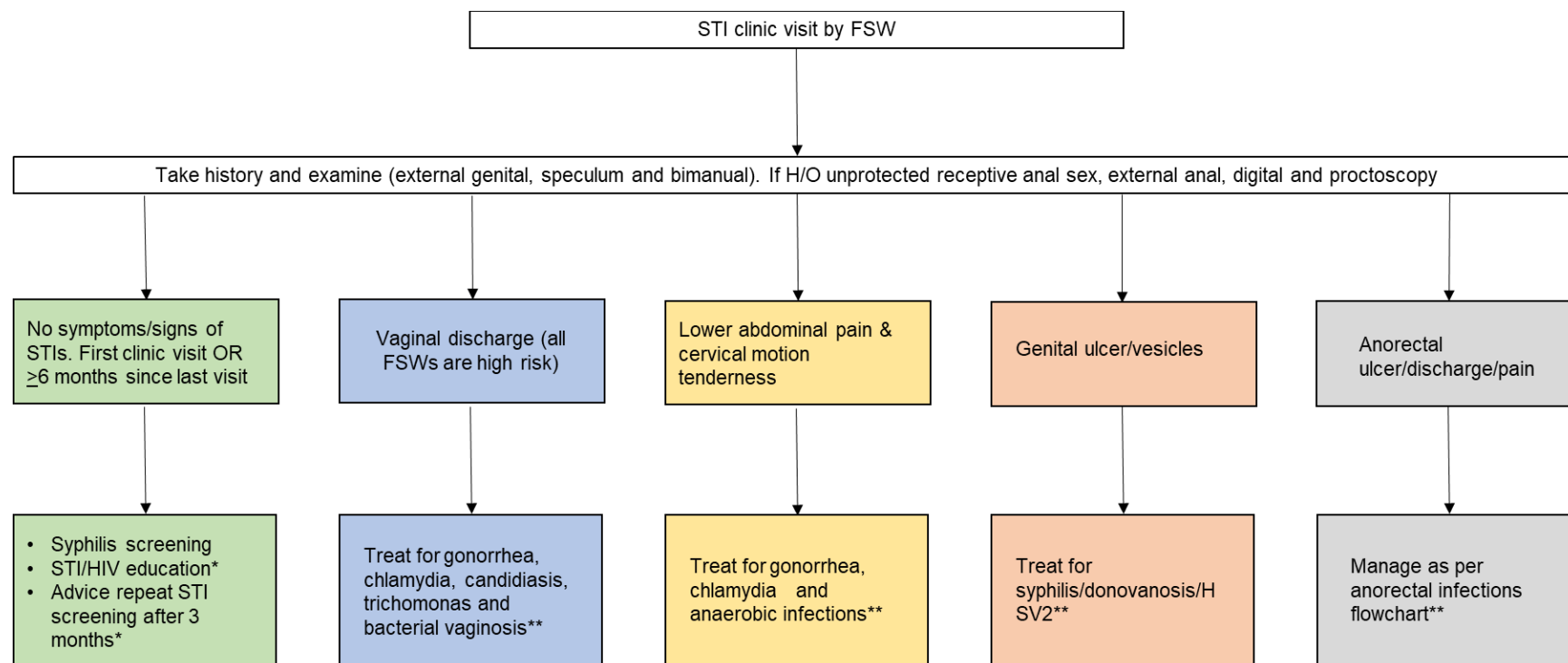
1. Disposable needles and syringes
2. Gauze pads

3. Cotton wool
4. Examination gloves- latex
5. Sterile cotton-tipped applicators
6. Water soluble lubricant for clinical examination
7. Disposable tissues
8. Disinfectant (sodium hypochlorite)
9. Latex male condoms and lubricant pouches
10. Penis models for condom demonstration
11. Sharps disposal containers

Counselling room

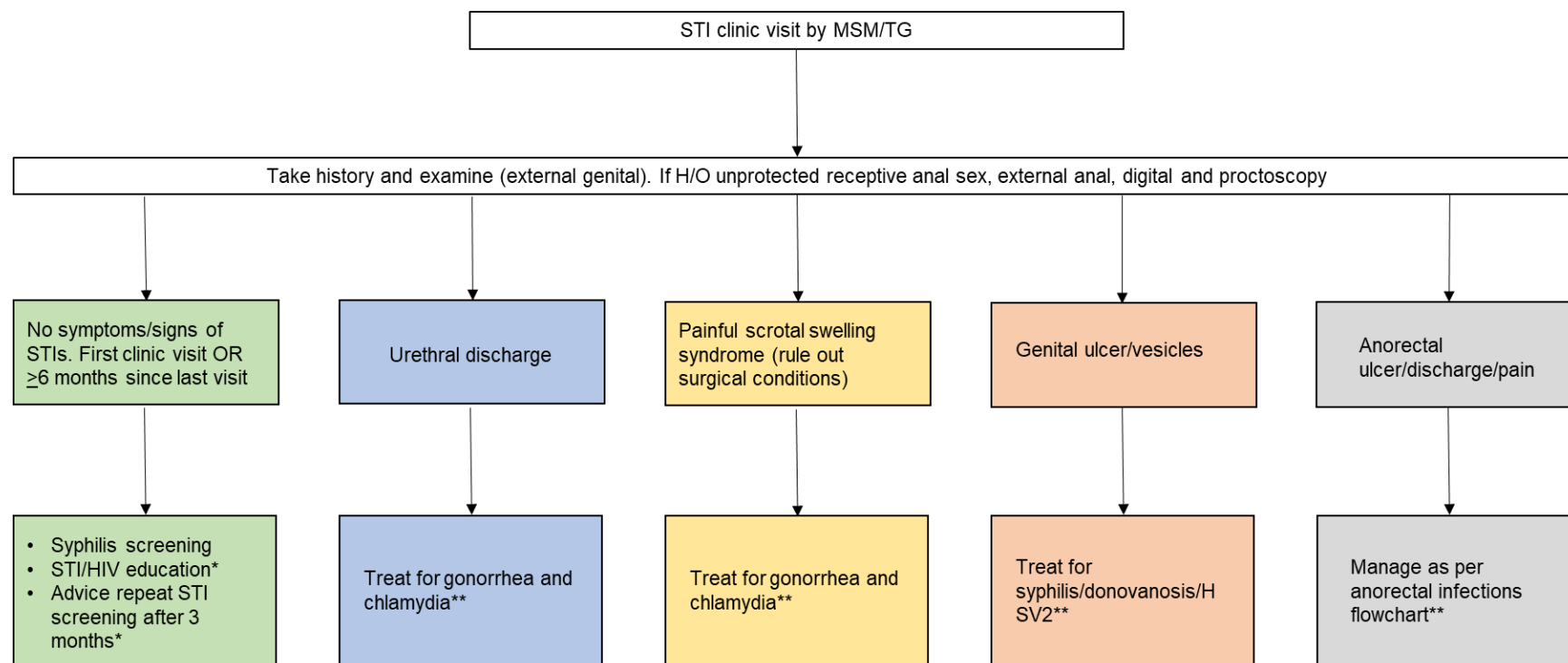
1. Comfortable chairs for patients and counselors
2. Communication aids like flipcharts etc.
3. Whiteboard and markers

Annex 3: STI Management during Clinic Visit by Female Sex Worker



*To be provided for all – whether asymptomatic or diagnosed with STIs
 **Advice partner management and follow-up after a week if symptoms persist

Annex 4: STI Management during Clinic Visit by MSM/TG



*To be provided for all – whether asymptomatic or diagnosed with STIs
 **Advice partner management and follow-up after a week if symptoms persist