RESEARCH SUMMARY
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Fast forwarding health access for female sex workers:

Findings from 1 Indian and 3 African sites

Source:
This policy brief was compiled from a report produced on the Differ project which aims to improve sexual and reproductive health for all women by expanding and strengthening sexual and reproductive health services, and providing and testing targeted interventions for female sex workers in existing health systems contexts. For more information, visit www.differproject.eu

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Background

The "Diagonal Interventions to Fast Forward Enhanced Reproductive Health" (DIFFER) project, in one Indian and three African sites, tests the hypothesis that combining vertical targeted interventions (TIs) for female sex workers (FSW), with horizontal strengthening of health systems, is synergistic, feasible, and more cost-effective than providing them separately. In the **India** site in Mysore, a sex worker collective, Ashodaya Samithi, implements HIV prevention and provides STI services for FSW through targeted clinic and long-established community services. The African sites are the coastal areas of Mombasa, **Kenya**; Tete Province, in north-west of **Mozambique**, where a drop-in "night" clinic is established; and central Durban, **South Africa**.

Methods

Research examined the scope and quality of sexual and reproductive health (SRH) services within **general population health facilities** and **targeted interventions for FSW**, including outreach, and mobile or satellite clinics. The situational analysis aimed to identify ways of improving SRH care and integrating new interventions within existing services. Unmet needs of women in the general population were identified and how these link with those of FSW.

Policy Implications

- **With adequate funding and attention from policy makers, Africa's small-scale services could be expanded and improved, as occurred in India**
- **The optimal mix between targeted and integrated services may vary between context and types of services**
- **For example: Factors such as health workers' stigma and high concentrations of sex work might favour targeted services, while general population clinics might provide specialised services**
- **Policy makers and programme leaders need to select the optimal configuration in each setting**
- **This should be based on a thorough assessment of the context and service needs**

Qualitative techniques included key informant interviews with community informants and focus group discussions with FSW. Quantitative methods comprised interviews with health providers and client exit interviews with women accessing SRH and HIV services.

Acknowledgements:

DIFFER Coordinator:
Prof. Marleen Temmerman

Country Organisations:

Universiteit Gent, International Centre for Reproductive Health, Belgium

Ashodaya Samithi (Ashodaya), India

International Centre for Reproductive Health Association, Kenya

International Centre for Reproductive Health Association, Mozambique

University of the Witwatersrand, MatCH & CHP, South Africa

University College London: Centre for International Health & Development, UK

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Findings about public sector clinic SRH services

In Mozambique, almost all respondents said **clinic services were available** throughout the day, as did a high proportion of those in South Africa (76%; 202/265) and Kenya (69%; 69/100). Conversely, women in India felt that services were not available all the time (82%; 123/150). In Kenya, 28 of the 29 women referred to another provider in the same facility saw that provider the same day, while only 56% of this group did so in India (14/25).

Two thirds of women in Mozambique were presently using **contraception** (62/92), while a third was in South Africa (92/260) and a quarter in India (37/150). The commonest contraceptive used across African sites was 3-monthly injectable (Depo).

Male condoms were also frequently used for family planning, cited by 38.0% of women in South Africa (76/200), 34% in Mozambique (21/62) and 27% in Kenya (27/100). **Female condom** awareness was high in Kenya (90%; 90/100) and South Africa (84%; 222/263), but much lower in Mozambique (30%; 30/99) and virtually unheard of in India. Few of those who heard of the method had actually used it, though a considerable portion said they might use it.

Female sterilisation was the commonest method in India, reported by 21% of women (37/150). In India, almost three quarters were aware that sterilisation was offered, while under 10% of women in Africa sites mentioned this.

In Kenya, 16% of women (16/100) said they would like sterilisation to be available, while in Mozambique a similar proportion requested the **IUD** (16%; 11/71).

Knowledge (77%; 77/100) and use of **emergency contraception** were highest in South Africa, where almost two thirds had heard of this method (62%; 164/263), and 29% had used it (46/161). In India and Mozambique, markedly fewer women had heard of the method.

Most South African women had heard of **medical abortion** (88%; 30/34); while two-thirds had heard of the procedure in Kenya (65/100); and only 19% had in India (29/150).

In all four study countries, more than 90% of women had ever had an **HIV test**. Around half in Mozambique (45/99) and in India (57%; 86/150) had been offered a test during their most recent clinic visit. Only about a fifth were offered testing at the visit in South Africa (17%; 45/263) and Kenya (20.0%; 20/100). Seemingly, HIV testing was routine in family planning clinics in India (98%; 147/150), while it only occurred in 33-56% of family planning clients elsewhere. Similarly, a genital and speculum exam appears routine for Indian women attending family planning, while is infrequent elsewhere. **Cervical cancer** screening is inadequate across sites, and almost no women were asked if they had experienced sexual and gender based violence (SGBV).

An area of strong consensus was the conviction that services for FSW need strong involvement of peers and that FSW involvement is vital to improving access and uptake.

Across sites, key informants from community-based services for FSW noted the substantial capacity gaps in public-sector services, which impede access to SRH services – both for FSW and the general population. In **India**, a marked lack of human resources in the public system necessitates private-sector service provision. Inaccessibility then in SRH services appeared due to costs of private care, with many services simply not offered in the public sector. Government does not have the capacity to substantially improve the health care system on its own. Steps required are: integrated SRH and HIV services within primary care; expanded hours; use of mobile clinics; and increased community workers. NGOs and CBOs play key roles, also in community mobilisation to improve service uptake.

Family planning services were described by key informants as sorely lacking in **Mozambique**. Emergency contraception, although available, is not well known, nor is it actively promoted or explained by providers. Demand for implants as a contraceptive method is high, but it is not yet available. Male condoms are not consistently provided, in particular for HIV and STI care clients, and the distribution of female condoms is irregular.

Gaps in cervical cancer screening were also substantial. Providers are unclear about if termination of pregnancy (TOP) is tolerated and how to attend to women with unwanted pregnancies. Overall, the most important challenges here are: lack of space, resulting in crowded waiting areas and insufficient consultation rooms; poor lighting, ventilation, electricity and water supplies; shortages in medical equipment, such as gynaecological exam beds; and drug-stock outs, and insufficient staff. In **Kenya**, key informants echoed these challenges.

In **South Africa**, key informants highlighted the need for additional training and support for public-sector providers of SRH services. Training on family planning methods was highlighted. Finally, integrating SRH services (e.g. FP, HIV and STI services) would simplify referral streams.

Findings about services for sex workers

In **India** and **Kenya**, health workers believed that only a third of FSW would disclose their work to them. Half the staff in **South Africa** (4/8) felt FSWs would disclose her work to them, while very few providers in **Mozambiqu**e (3/19) believed this. Most health workers in **Kenya** and **South Africa** said the best way to deliver services for FSW was through general population facilities, with only a fifth recommending outreach for FP and HCT services.

Interestingly, in India, the majority of health workers said FSWs require outreach to their work areas. FSW participants across sites cited similar barriers to SRH services as in public-sector clinics (see Box). Barriers lead to non-disclosure of their occupation. Many felt that general measures such as increasing facility opening hours or integrating services would on their own, substantially raise access.

Barriers to FSW accessing SRH services: Common experiences across all sites

- stigma and discrimination from providers
- long waiting times for services
- inconvenient opening hours
- complicated referral procedures
- administrative requirements that do not apply to FSW (e.g. bringing “husband” for STI treatment)

Detailed information was gathered in **India** on the well-established targeted intervention for FSW in Mysore run by Ashodaya. This project has high acceptability and uptake among FSW, and is their preferred access point for SRH services. In particular, the community-run system for accompanied referral counters discrimination and lack of knowledge of how to navigate the system.

Prompt service, an open and non-judgemental environment, and peer counsellors together create genuinely sex worker-friendly services. Indeed, perhaps the greatest contrast between India and the African sites lies in the longevity and maturity of these services. Nevertheless, gaps remain in the range of services offered by Ashodaya. While sexual health and SGBV against FSW are fully addressed, contraception and TOP services need strengthening, and gaps were mentioned in cervical cancer screening, sterilization, antiretroviral therapy and antenatal care, and general health care.

Similarly, in **Kenya,** targeted services for FSW need to be expanded. Present services have high acceptability among FSW, but gaps were noted in family planning and post-abortion care. Many FSW resort to accessing ‘back-street’ abortions or use over-the-counter abortifacients. Better post-abortion care is needed alongside family planning services, as well raised condom availability, particularly in sex work areas. Key informants drew attention to the under-utilisation of STI screening and HIV counselling and testing (HCT) services among FSW, and indicated that cost discourages such access.

In **Mozambique**, the public sector pays scant attention to targeting high-risk populations. Health providers do not actively assess the risk profile of female clients. Indeed, in none of the current public sector SRH services – STI care, HCT, and FP counselling in particular – is the risk profile of clients taking into account when deciding on the services to be provided. Tete-Moatize has, however, a health facility that has been established specifically to provide certain SRH services to high-risk populations. The scope of services and geographical coverage of this TI were limited, but plans are underway to expand these.

From the **South African** findings, comprehensive family planning services are key unmet FSW needs that are not being addressed by existing TIs in Durban. Improved STI screening and treatment could also be prioritised, especially given the finding that FSW tend to self-diagnose and seek over-the-counter medication from pharmacies or use home remedies for STI treatment rather than attend STI clinics. Information on improved condom skills and on menstrual management also emerged as a gap. This could easily be incorporated within existing information packs distributed to FSW by outreach workers. On that note, our review of existing TIs suggests that coverage is low and there is scope for expanding these programmes by recruiting and training additional outreach workers and engaging directly with the FSW community to involve them in building capacity of existing TIs to provide services.

Targeted interventions or strengthened general population services?

Key informants cited mixed views of whether services for FSW would best be provided through TIs or mainstream institutions (or a combination thereof).

In **Mozambique**, public-sector providers claimed to have no problems attending FSW at their clinics, and had no preferences on this topic.

However, in **Kenya**, there was little ambiguity about the benefits of mainstream versus TIs. FSW participants clearly expressed a preference for affordable and comprehensive one-stop services within a TI, which are seen as offering high-quality and respectful treatment (compared to public-sector services). Currently, this population accesses both public- and private-sector services, depending on the nature of the ailment, cost and location, and there was strong evidence of FSW being subjected to stigma and routine violations of confidentiality in the public sector. Donor dependency among NGOs does, however, limit sustainability of TIs for key populations.

FSW participants in **South Africa** were initially divided in their opinions of the best approaches to structuring services. All, however, expressed a desire for services ultimately located within public facilities so that primary health care could be accessed alongside more specialised SRH and HIV services. In other words, the preferred model was one of ‘all services under one roof’, which would reduce stigma against FSWs. Key informants felt strongly that all public-sector clinics should be made “sex worker friendly” by sensitising health workers, although some had reservations about whether the unique needs of FSW would be met by mainstream clinics, even with this additional training.

Policy Implications

The greatest contrast between India and the African sites lies in the longevity and maturity of the services in India. The Indian sites expanded from a few well-functioning sites to reach high coverage and involvement of sex workers.

With adequate funding and attention of policy makers, the existing small scale services in Africa could be expanded and improved as occurred in India.

The optimal mix between targeted and integrated services may vary between context and types of services. Factors such as health workers stigma and high concentration of sex work might favour targeted services, for example. Some more specialised services might best be provided within general population clinics, with well-functional links between these and targeted services.

Policy makers and programme leaders need to select the optimal configuration in each setting, based on a thorough assessment of the context and service needs.