Health Care Providers Training Module in Providing Integrated Sexual and Reproductive Health and HIV Services

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List of Acronyms

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ART	Anti Retroviral Treatment
ASHA	Accredited Social Health Activist
CLHIV	Children Living with HIV
EMTCT	Elimination of Mother To Child Transmission of Syphilis and HIV
FSW	Female Sex Worker
FIDU	Female Injecting Drug User
GBV	Gender Based Violence
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HRG	High Risk Group
ICTC	Integrating Counselling and Testing Centre
ICPD	International Conference on Population and Development
IDU	Injecting Drug User
I/M	Intramuscular
IUCD	Intrauterine Contraceptive Device
KP	Key Population
LARC	Long Acting Reversible Contraceptive
MSM	Men who have Sex with Men
MTP	Medical Termination of Pregnancy
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NHM	National Health Mission
NHRC	National Human Rights Commission
NNSW	National Network of Sex Workers
OI	Opportunistic Infections
OST	Opioid Substitution Therapy
PHC	Primary Health Centre
PPTCT	Prevention of Parent-To-Child Transmission
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PoA	Programme of Action
PWID	People Who Inject Drugs
RTI	Reproductive Tract Infection
STI	Sexually-Transmitted Infection
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
TI	Targeted Intervention
VCT	Voluntary Counselling and Testing
VIPP Card	Visualization In Participatory Planning Card

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Preface

Quality, non-discriminatory and inclusive health care is an essential human right for all. Sustainable Development Goal 3 (SDG 3) lays great emphasis on good health and wellbeing which needs to be achieved by 2030 across the globe. The objective of the SDG 3 is incomplete and unattainable without strong and resilient health systems that understand the holistic sexual and reproductive health needs and right of women accessing health facilities. It is important to understand and address the sexual health needs of the marginalized communities and ensure an enabling environment for access to health facilities. It is also equally important to understand the risk and vulnerability to HIV/AIDS of those women who visit health care facilities for their reproductive health needs like contraception and ante-natal care.

Access to health for the key population is particularly challenging due to the lack of awareness among health care providers on the specific issues and challenges they face. Ignorance, judgmental attitudes and insensitivity about their life situations by the health care providers often drive key populations away from health services. Similarly, women accessing the public health facilities for their contraception and other sexual and reproductive health needs are often not provided with the necessary information, counselling and services to diagnose their HIV status and provide necessary services.

India HIV/AIDS Alliance in collaboration with UNFPA and Gujarat State AIDS Control Society is implementing the Sampoorna project to strengthen the capacities of public health facilities and community outreach activities in providing integrated SRH and HIV services.

The integration of HIV and Sexual and Reproductive Health (SRH) services in the healthcare system increase the potential to access and increased uptake of services, better client satisfaction, improved coverage and reduced cost to women and less costly services, and improved realization of Sexual and Reproductive Health Rights (SRHR). Ultimately, integration leads to improved dual health outcomes related to SRH and HIV, such as treatment for HIV/STI infections, addressing the unmet need for unintended pregnancies and maternal mortality, cervical cancer screening and treatment and addressing gender-based violence.

This training module ‘Health Care Providers training module on SRH-HIV Integration’ aim at strengthening the capacities of medical and paramedical service providers at public health facilities. The curriculum addresses concerns at two levels - one is increasing knowledge of health care providers on essential emerging HIV interventions such as PrEP, PEP and SRH intervention like cervix cancer, updated contraception choices like Antara injectable etc. The second level focus is on sensitizing the HCPs on issues of the key population through their human stories, games and activities that will help them to understand the issues from the 'community perspective'. This will help them respond to their needs on humanitarian grounds. However technically sound the manual may be, its effective use during the capacity building activities with the health care service provides will result in the desired outcome of providing quality SRH-HIV integrated services to all women visiting these health facilities.

Ashim Chowla
Chief Executive
Alliance India

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Chapter 1: Introduction

Background:

The integration of HIV and Sexual and Reproductive Health (SRH) services in the healthcare system increase potential to access and increased uptake of services, better client satisfaction, improved coverage and reduced cost to women and less costly services, and improved realization of Sexual and Reproductive Health Rights (SRHR). Ultimately, integration leads to improved dual health outcomes related to SRH and HIV, such as treatment for HIV/STI infections, addressing the unmet need for unintended pregnancies and maternal mortality, cervical cancer screening and treatment and addressing gender-based violence.

India HIV AIDS Alliance is implementing a pilot project (Sampoorna) on the strengthening of integration of SRH and HIV services at the medical college and community level. Sampoorna project would contribute towards achieving the SDGs 3, 5 and 17 through innovation of integrating SRH products and services in the HIV interventions and will ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action (PoA) of the International Conference on Population and Development (ICPD) and the Beijing Platform for Action and the outcome documents of their review conferences.

The project leverages on the experience of Alliance India projects of working with key population for improving access to HIV and SRH service and innovations such as community-based testing through Samarth clinics, addressing immediate SRH needs of women in sex work and Gender-based violence (GBV) for retaining women for a long time in HIV care and support programme.

Objectives: The objectives of the project are as follows:

1. To strengthen SRH-HIV integration at the facility and medical college level in 6 districts of Gujarat.
2. To pilot interventions for community-level integration of SRH and HIV services in 3 selected districts of Gujarat.
3. To facilitate policy-level integration at the levels of monitoring for SRH-HIV programs, training and availability of supplies in the state.
4. To document the intervention and prepare a clear roadmap for rolling out integrated SRH-HIV services in other states of India and initiate actions in lessons for other states.

Purpose

As part of the objective to strengthen SRH-HIV integration at public health facilities and medical colleges in 6 districts of Gujarat, training for service providers at these facilities is planned. The service providers will include doctors from Obstetrics & Gynecology, dermatology, and other key departments, paramedics, PGs and interns. Staff from ART centres and Integrated Counseling and Testing Centers (ICTCs) will also be included for relevant sessions. Refresher training will be provided in the 2nd year for 1 day at all medical colleges. NACO/ SACS and NHM would be consulted for identifying the resource persons for training, representatives from the CBO's would be taking sessions on the community needs of key populations.

To build the capacities of health care providers in providing comprehensive and qualitative SRH-HIV related services a two-day training module has been developed. This manual is intended as a facilitators' guide to orient healthcare providers on the sexual and reproductive health (SRH) needs of women at risk of HIV, especially female sex workers, women living with HIV, and young women. It also aims to train the service providers for effective implementation of integration of sexual and reproductive health (SRH) and HIV services for these populations. Not only they are more vulnerable to sexual and reproductive ill-health and HIV due to their risk practices, they also face stigma and discrimination at health care facilities, preventing them from accessing healthcare services. This module is aimed at sensitizing health care providers towards vulnerabilities of these populations, and consequent risk behaviours and unmet needs related to sexual and reproductive health. This should lead to improved access to comprehensive SRH health care and an increase in uptake of the services.

Objectives

The main objective of the module is to introduce the key concepts of SRH and ensure effective responses to the SRH needs of women at high risk of HIV, especially female sex workers, women living with HIV and young women. The specific objectives include enabling the participants to:

- Recognize diverse SRH needs of the women at risk of HIV.
- Successfully transfer the knowledge gained to develop a model for the provision of comprehensive SRH services to women at risk of HIV, especially female sex workers.

The module includes sessions on sexual health such as sexuality, gender issues and their impact on sexual health, need for integration of SRH and HIV services, benefits, challenges and recommended strategies based on international experience. It also addresses specific thematic areas of sexual and reproductive health (sexually transmitted infection, family planning, mother and child health) in the context of female sex worker. It seeks to engage participants in a participatory process.

How to use this manual

The facilitator(s) are required to read all the topics covered in these modules before the commencement of the training to have a comprehensive understanding of the scope of each topic and its relevance, besides the sessions that they will be facilitating.

Prior to the training, facilitators will need to consider and discuss how they will use the module to develop the knowledge and capacity of the participants. The sessions are meant to engage the participants in a participatory learning process based on adult learning principles. Facilitators are encouraged to:

- Identify participants' needs and what is important to them.
- Provide real-life situations and emphasize the application of learning to real problems.
- Provide activities that require the active participation of participants.
- Use a variety of training techniques.
- Establish an atmosphere of respect and understanding of differences.

- Provide opportunities for sharing information.
- Discuss and analyze participants' experiences.
- Engage participants as valued resources and encourage them to participate and share their experiences.

Each session follows the following arrangement, although facilitators may choose to adapt the sequences and timings as per the requirements of the training:

Time: duration of the session.

Training aids/materials required: A suggested list of materials required during the training including audio-visual equipment, stationery, handouts, reference materials, pre and post-training assessment forms and feedback forms.

Learning objective(s): Describes the desired learning objective to be achieved by participants by the end of the session.

Methodology: Describes step-by-step participatory methods that will be employed to engage participants in the learning process.

Facilitator's note(s): Notes to provide the facilitator with useful information on the topic or tips for facilitating an activity.

There are handouts for participants to share specific information with the participants. If needed, information from the chapter on Facilitator's Resources can be given as handouts. A list of reference is given at the end.

Pre and post-training assessment: Participants are required to complete a pre-training questionnaire at the start of the training. A post-training questionnaire will also need to be completed at the end of the training. These will be analyzed is to assess the progressive learning of the participants and measure the effectiveness of the training in enhancing their competency in applying the learning in their respective areas of work.

Feedback forms: Feedback forms will be provided to participants at the end of each day. Participants' feedback will help the team of facilitators and organizers to respond to significant issues highlighted, and also to take correctional measures if participants reflect difficulties in comprehension or perceive problems in application.

Suggested Schedule

Duration	Topics	Objective	Methodology/materials
		DAY 1	
30 mins	Registration		*Organizers*
30 mins	Welcome and Introduction of participants		*Organizers/facilitators*
15 mins	Pre-training assessment	*Assess the knowledge of the participants*	*Pre-test questionnaire*
30 mins	Overview of Alliance's SRH Programs Objectives of the Workshop	*Give an overview of Sampoorna Intervention*	*PowerPoint presentation (Alliance representative)*
15 mins	**Tea break**		
SEXUAL AND REPRODUCTIVE HEALTH FOR FEMALE SEX WORKERS			
30 mins	HIV Epidemic and Key Populations	▪ *Current Status of HIV Epidemic in India* ▪ *What are key populations and why addressing their needs is important to overcome the HIV epidemic?* ▪ *What are important national strategies to control HIV epidemic?*	▪ *PPT and group discussion*
30 mins	Sexual Identity and Behaviour	▪ *What is sexuality, sexual identity and sexual behaviours?* ▪ *How does sexuality impact overall health of a being?*	▪ *PPT, group discussion and group activity*
60 mins	Basics of SRH	▪ *What is sexual and reproductive health: Brainstorming and discussion* ▪ *What are sexual and reproductive health rights: PowerPoint presentation* ▪ *How attitudes and beliefs impact SRH and rights: Group activity*	▪ *Group work and presentation, and group discussion*

Duration	Topics	Objective	Methodology/materials
45 mins	**Lunch break**		
60 mins	Sexual and Reproductive Health Rights (SRHR)-HIV Integration	▪ *Identify common components of SRH and HIV programming: Discussion* ▪ *Rationale, benefits and challenges of SRHR-HIV integration: Group activity and PowerPoint presentation*	▪ *PPT and group discussion* ▪ *Group Activity*
15 mins	**Tea break**		
60 mins	Vulnerabilities, Risks and SRH Needs of Women at Risk, especially Female Sex Workers	▪ *Identify SRH risks and vulnerabilities of FSW* ▪ *Gender-based violence* *Group activity* ▪ *Presentation by the participants*	▪ *Group work and discussion*
15 mins	Questions from parking lot		
45 mins	Feedback from participants	▪ *Feedback forms*	
	DAY 2		
30 mins	Recap		
60 mins	Sexually-Transmitted Infections	▪ *What is Syndromic management of STI, Rationale and components* ▪ *What are the important aspects of Menstrual Hygiene* ▪ *Cervical Cancer: Vulnerability of key population, Prevention and screening*	▪ *Quiz and group discussion*
15 mins	**Tea break**		
120 mins	Contraception, Safe Abortion and Protecting Fertility	▪ *Contraceptive needs of Key population, different contraceptive options including emergency contraception* ▪ *Safe abortion and post-abortion counseling* ▪ *Protecting fertility among sero-concordant or discordant HIV couples*	▪ *Case study and group discussion*

Duration	Topics	Objective	Methodology/materials
45 mins	**Lunch break**		
45 mins	Maternal and Newborn Health	▪ *Basic care during pregnancy and child-birth: Case study and group discussion* ▪ *EMTCT*	▪ *Case study and group discussion* ▪ *Power-point presentation*
45 mins	Improving Access to HIV-SRH Integrated Services:	▪ *Identifying barriers to accessing various SRH services* ▪ *Strategies for improving barriers identified*	▪ *Group work and presentation.*
15 mins	**Tea break**		
30 mins	Developing Action Plans	▪ *Facility-based action plan to ensure access to comprehensive SRH-HIV services*	▪ *Group work and presentation.*
45 mins	Post-Training Assessment	*Post-training questionnaire*	
45 mins	Feedback from participants	▪ *Feedback form*	
15 mins	Wrapping up and Vote of Thanks		

Chapter 2: Session Plans

Session 1: Welcome and Introduction

Objectives: To introduce the participants and the facilitators, to record expectations from the training and to provide background and overview of the training.

Time: 1 hour.

Training aids/materials required:

- LCD projector.
- Laptop.
- Flip chart.
- Post-its/VIPP Cards.
- Marker pens.
- Copies of pre-training questionnaires for each participant.

Methodology: The following steps describe the process to be followed during this session.

Step 1: Introductions (5 minutes)
The facilitator welcomes the participants and conducts a round of introductions.

Facilitator's note:

The facilitator may select an icebreaker from the section on *Icebreakers and Energizers* provided in Annex 3 to help participants to get to know each other.

Step 2: Listing expectations; setting ground rules (10 minutes)
VIPP Cards/post-its are given to participants, asking them to write their expectations from the workshop. The facilitator posts these cards on a board and reads aloud the main expectations. She/he talks about the expectations that will be addressed during the workshop, giving reasons for those, if any, that are not going to be taken up. Participants are encouraged to set ground rules for the duration of the training.

Facilitator's note:

Ground rules could include the following:

- Agree to disagree – everyone has the right to his or her opinion.
- Be respectful to each other.
- One person speaks at a time.
- Raise your hand to share a point.
- Start and finish on time.
- Turn off cell phones or put them on silent mode.
- Check email and text messages only during breaks.
- Provide constructive and friendly feedback.

Step 3: Overview of the programme (15 minutes)
The facilitator introduces the context of this training workshop against the national program, outlining the relevance of the key thematic areas.

Step 4: Objectives of the workshop (5 minutes)
Using a PowerPoint presentation, the facilitator explains the specific objectives of the workshop.

Step 5: Pre-training assessment (25 minutes)
Participants are requested to complete a pre-training assessment and informed that a similar post-training assessment will also be conducted at the end of the training program. The facilitator explains that this simple assessment is not a test, but an exercise that will help assess the progressive learning of the participants and aid in measuring the effectiveness of the training.

The facilitator also informs the participants that they will be given a brief and simple feedback form at the end of each day's session. The importance of completing the feedback from the participants is to be emphasized, as this feedback will help the team of facilitators and organizers to respond to their concerns, as well as to help plan the next days' sessions appropriately.

Session 2: HIV Epidemic in India and Key National Responses

Learning Objectives
This session educates participants on the current trends and priorities in the national response to HIV. Participants will discuss the latest prevalence information and identify populations that are most vulnerable and at risk of contracting HIV. This session will:

- Increase participants' understanding of the dynamics of the HIV epidemic in India.
- Strengthen participants' understanding of the role of key populations in the HIV epidemic dynamics and to the HIV response.
- Increase understanding about why addressing the health needs of key populations is critical to stopping the spread of HIV, while also ensuring that key populations have access to the best standard of health care and support.
- Introduce the participants to some of the key national strategies for HIV prevention.

Time: 30 minutes.

Training aids/Materials required

- Laptop and projector to show PowerPoint presentations based on Handouts 1.
- Flip chart /White board.
- Handout 1: 'HIV Epidemic in India'.

Methodology: PowerPoint Presentation and group discussion.

Step 1: Introduction (5 minutes)
Introduce the session by sharing how India is a signatory to the UNAIDS goal to eliminate mother-to-child transmission (EMTCT) of HIV and syphilis by 2020 and to end the AIDS epidemic by 2030. Explain to the group that this session is to refresh their basic knowledge on the dynamics of the HIV epidemic. Ask the following questions in the plenary:

- Who can get HIV?

Elicit some responses from the participants and note them down on a flip chart. Lead a discussion on the reasons for their responses. Ask them if someone can recap the different modes of HIV transmission. Relate the modes of transmission to the responses to the first question. Explain that it is not the person per se but the unsafe practices, such as unsafe sex, unsafe injecting practices or lack of universal precautions in the clinic, that put a person at risk of acquiring the HIV infection.

Step 2: PowerPoint Presentation (25 minutes)

Project the PowerPoint presentation based on the *'Handout 1: HIV epidemic in India,'* covering the following information:

1. National HIV prevalence among adults and among specific key populations (broken down in terms of sex workers, men who have sex with men transgender people, and people who inject drugs, and by age within these groups, if possible).
2. What are the main factors driving HIV in India/state? What are key populations? Why focus on key populations to control the HIV epidemic?
3. Relevant information from the NACP, including national strategies/guidelines. This will cover 'Targeted Intervention and its rationale,' 'PPTCT' and 'Test and Treat All'.
4. What are the universal precautions to reduce the risk of HIV transmission in your clinic?

Facilitator's note:

India has a concentrated HIV epidemic, which means HIV prevalence is substantially higher among key populations. Explain how groups who are more vulnerable to HIV infection are called key populations (KP), clarifying definitions of key population groups. These populations are called *key populations* because they are *key* to the epidemic dynamics—they are most likely to be exposed to HIV infection, and therefore most likely to transmit HIV; and more importantly, because they are *key* to HIV response—experience around the world shows that wherever resources are focused on these populations and wherever they take leadership roles in HIV response, there has been a greater and sustained impact on the epidemic. Discuss bridge populations and other vulnerable groups such as adolescents and young persons and wives of men who have sex with men or who inject drugs.

Ensure that HIV drivers include structural factors such as lack of access to education, health services, or justice; stigma and discrimination; criminalisation of practices and groups; legal barriers; violence, and so on. Being a member of KP adds an extra layer of stigma to one that is caused by HIV. The existing negative attitudes and laws that criminalize their behaviour (e.g. anti-sex work laws) make it difficult for them to exercise their human rights, including accessing health services. Remind the participants that sex workers, men who have sex with men, transgender people, and people who inject drugs are not segregated from the rest of our communities. They are active members of society and regularly interact with the general population. Reinforce the fact that key populations have the same human rights as everyone else, and health care providers must provide quality and appropriate services to key population groups as they do to all their clients. Adopting and practising universal precautions can reduce the risk of transmission of infection in clinical practice and allow health care workers to provide stigma-free services.

Conclude this session by reinforcing the point that certain populations are at higher risk of HIV transmission and thus are also essential partners in an effective response. Addressing the health needs of key populations is critical to stopping the spread of HIV, while also ensuring that key populations have access to the best standard of health care and support.

Handout 1: HIV Epidemic and Key Populations

HIV prevalence in India has been steadily decreasing over the last two decades, but still, India has the third-highest number of people with HIV. According to the India HIV Estimates Report 2019, brought out by joint efforts of the National AIDS Control Organisation (NACO), Indian Council of Medical Research and Ministry of Family Welfare and Health, Government of India:

Adult national HIV prevalence is estimated to be 0.22%[1] and 23.49 lakh people are estimated to be living with HIV in India, with Children living with HIV (CLHIV) comprising 3.4% of the total PLHIV estimates. HIV-infected women (15+ years) constituted around 44% of the total estimated 15+ years PLHIV.

[1]National AIDS Control Organization & ICMR-National Institute of Medical Statistics (2020). India HIV Estimates 2019: Report. New Delhi: NACO, Ministry of Health and Family Welfare, GoI.
Accessible at http://naco.gov.in/sites/default/files/INDIA%20HIV%20ESTIMATES.pdf

Table 1: Status of the HIV/AIDS Epidemic in 2019

1.	Adult (15–49 years) HIV prevalence (%)	Total	0.22 [0.17–0.29]
		Male	0.24 [0.18–0.32]
		Female	0.20 [0.15–0.26]
2.	Number of people living with HIV (lakh*)	Total	23.49 [17.98-30.98]
		Male	22.70[17.37–29.97]
		Female	9.94 [7.61–13.00]
		Children	0.79 [0.58–1.05]
3.	HIV Incidence per 1000 uninfected population	Total	0.05 [0.03–0.09]
4.	New HIV Infections (thousands)	Total	69.22[37.03–121.50]
5.	Decline in new HIV infections since 2010 (%)	Total	37.4
6.	EMTCT needs (thousand)	Total	20.52[14.98–28.13]

Source: Adapted from India HIV Estimates 2019 Report

There are clear decreasing trends with HIV prevalence decreasing by 37 percent since 2010 and by 86 percent since 1997 when HIV prevalence was at peak. However, even now new infections stand at estimated 69.22 thousand, translating into 190 new infections every day and eight new infections every hour. This indicates more efforts are required toward HIV prevention.

HIV epidemic in India is a concentrated epidemic which means HIV prevalence is higher in certain population groups. These population groups are collectively known as key populations and include:

- Female sex workers (FSW).
- Men who have sex with men (MSM).
- Transgender (TG) and Hijra.
- People who inject drugs (PWID).

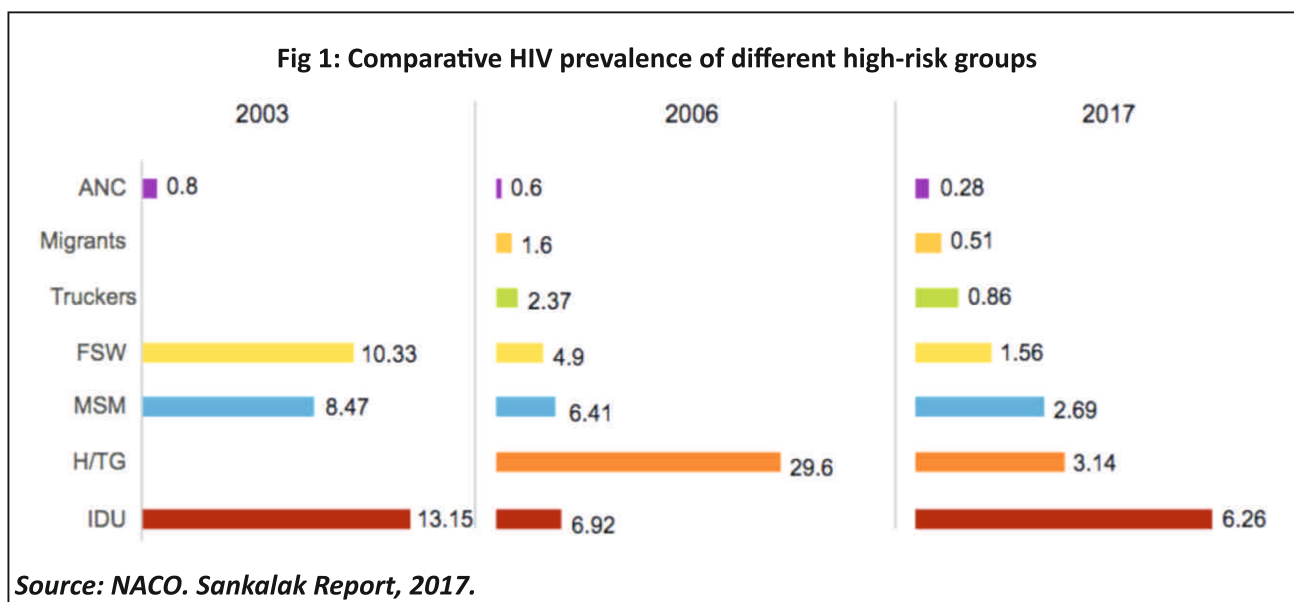
These populations are called *key populations* because they are *key* to the epidemic dynamics—they are most likely to be exposed to HIV infection, and therefore most likely to transmit HIV; and more importantly, because they are *key* to HIV response—experience around the world shows that wherever resources are focused on these populations and wherever they take leadership roles in HIV response, there has been a greater and sustained impact on the epidemic.

In addition to these groups, the bridge population constituting of men who are forced to live away from home for long periods are also vulnerable as they end up having unprotected sex with key populations. They include

Truckers and Migrants and are known as Bridge populations and as they may transmit HIV infection to their partners in the general population when they return home. Other vulnerable groups include young people and wives/partners of MSM and PWID.

Trends of HIV prevalence among these groups are shown in the figure below:

Fig 1: Comparative HIV prevalence of different high-risk groups



Source: NACO. Sankalak Report, 2017.

There is a decreasing trend of HIV prevalence in all these groups from 2003 to 2017 but it is still much higher than the national adult prevalence of 2.2 per cent.

Risk behaviours like unsafe sex and injecting practices put the key populations at risk of acquiring HIV and STI. These practices include unprotected anal, oral, vaginal sex, multiple partners and sharing needles while injecting drugs with an HIV infected person. Reasons for these high-risk practices are multiple vulnerabilities they face such as poverty, lack of access to education, health services, or justice; stigma and discrimination; criminalisation of practices and groups; legal barriers; violence, and so on. Becoming HIV positive adds an extra layer of stigma to one that is caused by being a member of a KP. The existing negative attitudes and laws that criminalize their behaviour (e.g., anti-sex work laws) make it difficult for them to exercise their human rights, including accessing health services. Pandemics such as Covid 19 enhance their vulnerability due to increased financial stress and gender-based violence, and poorer access to healthcare services such as contraception and safe abortion. Following a submission made by the National Network of Sex Workers India (NNSW India) to the National Human Rights Commission India (NHRC India) in August 2020, the NHRC has recognized and included the recommendations of sex workers in its Advisory on rights of women in COVID.[2] Recommendations include recognition of sex workers as informal workers, providing them access to welfare schemes, protection from GBV, and increased access to STI/HIV prevention services.

Key populations are active members of society and regularly interact with the general population. They are not segregated from the rest of our communities and have the same human rights as everyone else. They have the right to access quality services as per need.

[2]Human Right Advisory on Rights of Women in Context of Covid 19. October 2020, National Human Rights Commission India (nhrc.nic,in)

Stigma and discrimination occur not only because of our attitudes and beliefs but also due to fear of getting HIV infection. Understanding their vulnerabilities and needs, and adopting and practising universal precautions can reduce the risk of transmission of infection in clinical practice and allow health care workers to provide stigma-free services to key populations as well.

Session 3: Sex and Sexuality

Learning Objectives:
By the end of this session participants will be able to:

- Strengthen their understanding of the terms "sex" and "sexuality".
- Define sexuality and understand different aspects of sexuality.
- Understand the difference between sexual orientation, sexual identity and sexual behaviour.

Time: 45 minutes.

Training aids/Materials required:

- Flip chart.
- Markers.
- PowerPoint presentation.
- LCD projector.
- Screen.
- Laptop.
- Copies of Sexuality Matrix exercise.
- Handout 2.

Methodology: Brainstorming, PowerPoint presentation, group activity.

Activity 1: Understanding Sex, Gender and Sexuality

Step 1: Brainstorming and Q&A; 10 minutes
Explain that understanding the basics of sexuality and its different aspects will help us understand the population at risk better and also address our own biases and attitudes. Write the word 'Sex' on white board or flip chart and ask participants what they understand by these terms. Invite them to share any thoughts ideas and/or feelings that come to mind. Record their responses on flip chart.

Follow this with the terms 'Gender', and 'Sexuality' and similarly record the responses. Hold a discussion on the following questions:

- What is the difference between sex and gender?
- What do you understand by transgender and transsexual?
- What is the difference between sex and sexuality?
- What are the different aspects of sexuality?

Step 2: PowerPoint presentation; 15 minutes
Using power point presentation, present the WHO definition of sexuality and further clarify the aforementioned terms (see the section on sexuality, sexual and gender Identity in Facilitator Resouces). Explain that sexual orientation and gender roles are fluid, experienced across a continuum that can change over a person's lifetime. Emphasize that many different sexual and gender identities are subjected to stigma and discrimination, fueled by the stereotypes maintained by societies and communities (Homophobia), making it difficult for them to

express their sexuality the way they want. People tend to hate or fear what they do not understand. For them, homosexuality takes over all other aspects of an individual and becomes his/her complete personality. Remind the participants that sexual orientation is just one part of the personality, other aspects including his/her values, work-life, family life, hobbies, interests, and spiritual interests.

These varied experiences and issues related to sexuality can impact people in significant ways. Sexual and reproductive health decisions (for example, the decision to have or not have children, when to have them, to get married or not, to choose a sexual partner, or to have one's husband/wife chosen by a family or community) cannot be isolated from issues of sexuality. This makes it even more important to understand and address sexuality.

Handout 2: Sex, Gender and Sexuality

'Sex' refers to the biological differences between females and males. These include anatomical differences (genitals and internal sex organs), such as the presence of a vagina or penis; genetic differences as in a person's chromosomal makeup (XX or XY or intersex); hormonal differences (testosterone/estrogen) and physiological differences such as menstruation or sperm production. Sex can also be used to describe physical acts of sex that includes but is not limited to penetrative penile-vaginal intercourse, oral sex, anal sex, masturbation, or kissing.

'Gender' is used to describe the traditional social roles for males and females. **Gender Identity** describes how someone feels on the inside, and **Gender Expression** describes how someone chooses to present their gender to the world. There are three gender variations:

- **Cisgender** - a person who identifies with the sex they were assigned at birth. For example, a person who was assigned as a male at birth, and identifies as male, or vice versa.
- **Transgender** - a person whose gender identity does not match the sex they were assigned at birth. For example, a person who was assigned as a male at birth, but identifies as female, or vice versa. A person who changes from one side of the biological sex spectrum to the other through undergoing hormone replacement and/or sex reassignment surgery is known as **transsexual.**
- **Gender Fluid** - a person whose gender identity is not fixed and/or shifts depending on the situation. These people don't feel the need to act according to the sex they were assigned at birth and the associated traditional social roles.

Some transgender people might have surgery, take hormones or change the way they look or dress to align their body with how they identify, but not all transgender people can or want to do this. Being transgender is not dependent on one's physical appearance or medical procedures. Hence, the importance of not reducing a person to their genitals (whether they have a penis or vagina).

'Sexuality' is the part of a person expressed through sexual activities and relationships. It is represented in how an individual thinks, feels and acts about his or her own body and about that of others, in sexual behaviours and sexual identity.

WHO defines sexuality as:

> 'Sexuality is a central aspect of human being throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. It is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always

experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors. A personal sense of sexual well-being is essential for sexual health'.[3]

Three of the most common aspects used to describe sexuality are:

- **Feelings and fantasies:** who we fall in love with, who we are attracted to, who we think about when we are aroused, and who we intimately connect with.

- **Behaviours:** include any form of sexual contact (kissing, touching, oral sex, vaginal sex, anal sex etc.), flirting, who we date, and have relationships with.

- **Identity:** is the label or description of our sexuality. Sexual identity is how a person chooses to describe or label his or her sexuality. It's important to refer to a person's sexuality by their chosen label. There are many different labels that a person can choose (e.g., gay, lesbian, queer, drag queen, *kothi*, *panthi*, etc.), including not choosing a label at all!

Several different elements contribute to an individual's sexual identity, such as the person's sexual orientation, sexual behaviour and preferences and gender identity. Sexual and gender identities are not static. Individuals can identify in many different ways and can keep changing their sexual and gender identity throughout their lives.

Sexual Orientation refers to who an individual is sexually attracted to; whether he or she is attracted to people of the same gender, a gender other than their own, or to more than one gender.

- **Heterosexual** - A person attracted to people of the opposite sex.

- **Homosexual** - A person attracted to people of the same sex (men who have sex with men, lesbians). Same-sex sexual/romantic relations may occur one-off, in specific phases or consistently throughout life.

- **Bisexual** - The word 'bi', meaning 'two', refers to a person's attraction to both genders (male and female).

- **Asexual** - Asexuality is the absence of sexual attraction. For example, some asexual people are in romantic relationships where they never desire sex, and some are not in romantic relationships at all.

- **Pansexual** - 'Pan', meaning 'all-inclusive', refers to a person's attraction to multiple genders. Some pansexual people describe their attraction as being based on chemistry rather than gender, but everyone is different.

- **Questioning** - Some people may be unsure about their sexuality and/or are exploring it, so might identify as 'questioning'.

[3]http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

- **+ many more variations of sexuality!**
  Sexuality is not necessarily black or white. Instead, it can be thought about on a continuum or in shades of grey.

Activity 2: Sexuality Matrix: Sexual Orientation and Sexual Behaviour (20 min)

Ask the participants which of the two persons listed below is more likely to be at risk of contracting and transmitting HIV:

a. **Homosexual man with consistent use of condoms.**
b. **Heterosexual man with multiple partners and occasional use of condoms.**

Explain that sexual behaviour or practice does not depend on sexual orientation but on tendency of person to take risks.

This can be further understood through the overleaf activity.

'Sexuality Matrix' Exercise

Read the row against the column and if you agree with the statement mark “+” for 'Yes' and “-“ for 'No'. Don't mark according to what you think is ideal or morally right but what is <u>*possible*</u> with regard to at least some proportion of men of any sexual orientation. If you have any queries ask your facilitator.

	Men with Heterosexual orientation	**Men with Homosexual orientation**	**Men with Bisexual orientation**
Loves or sexually attracted to	opposite-sex person	same-sex person	both-sexes
May have sex with same-sex person			
May have sex with opposite-sex person			
May be 'masculine'			
May be 'feminine'			
May have anal sex (peno-anal)			
May not want to have anal sex			
May have oral sex (peno-oral)			
May not want to have oral sex			
May have peno-vaginal sex			
May be monogamous (single partner)			
May have multiple partners			
May rub against a person (without consent) in a bus or train			
May have sex with a person in public places (park, beach, etc.)			
May have sex with another person without consent (rape)			
May have sex with an adult, with consent, in a private place			
May sexually abuse a child (male or female)			
Might have been sexually abused by a male as a child			
May get married to a female			
May live together with a sexual partner			
May receive money to have sex with a person			
May pay money to have sex with a person			
May watch cricket			
May be living with mother, father, and sister/brother			
May be a 'good' person			
May be a 'bad' person			
May belong to “upper socioeconomic class”			
May belong to “lower socioeconomic class”			

Once everyone has completed the forms ask them to count the "+" they scored. Now discuss each behaviour and allow the participants to change their score, if they so wish.

Ask the participants what they learnt from this activity? Is high-risk behaviour practised only by persons of one particular sexual orientation? Explain that risk behaviour is not limited to homosexuals. Similarly, a woman engaging in high-risk behaviour does not have to be a sex worker.

Conclude the session by reinforcing the fact that sexuality is diverse, fluid and an essential part of an individual. Every person has the right to express his/her sexuality the way they are comfortable with. High-risk behaviour is not limited to homosexual persons but may be practised by persons of any sexual orientation.

Session 4: Basics of Sexual and Reproductive Health

Learning Objectives:

By the end of this session participants will be able to:

- Refresh definitions of sexual health and reproductive health and enlist various components of sexual reproductive health.
- Discuss the relationship between attitudes/beliefs and sexual and reproductive health.
- Describe sexual and reproductive health rights.
- Discuss how violation of rights in daily life impacts the sexual and reproductive health of an individual.

Time: 1 hour.

Session Overview

Activity 1: Sexual Reproductive Health and Rights– Definitions.
Activity 2: Attitudes, Beliefs and Sexual Reproductive Health.

Training aids/Materials required

- Flip chart.
- Chart paper.
- Sticking tape.
- Markers for each participant.
- PowerPoint presentation.
- LCD projector.
- Screen.
- Laptop.
- Attitude statements.
- Handout 3.
- Handout 4.

Methodology: Brainstorming, power point presentation, group activity.

Step 1: Brainstorming; 10 minutes

Invite participants to describe what the terms 'Sexual health' and 'Reproductive health' mean to them. Let them speak out the terms and phrases that represent their idea of sexual health or reproductive health and list their responses on the flip chart. Explain just as "good" personal health has physical, emotional and social dimensions, sexual and reproductive health also have similar dimensions. Encourage the participants to reflect and discuss all these dimensions of SRH. Ensure all aspects of sexual and reproductive health are included in their responses as given in Handout 3.

Step 2: Interactive Presentation (20 minutes)

Using power point presentation, present the WHO definitions of sexual and reproductive health through power point and facilitate a discussion on how these two are related, with sexual health being a necessary part of reproductive health (Provide Handout 3). Emphasize that Sexual and reproductive health includes, choice of sexuality, choice of reproduction as well as maternal, newborn and child health (MNCH) which refers to the health and well-being of women during pregnancy, childbirth and post-delivery, and the health of newborn babies and children until the age of five. Let the participants reflect on everyone's ability to exercise these choices.

Continue the presentation to present sexual and reproductive health rights. Explain that in an ideal environment, we would all have access to the education, services and social support we need to live healthy, fulfilling sexual and reproductive lives as envisioned in the Universal Declaration of Human Rights (UDHR), the first international statement on human rights to be adopted by United Nations General Assembly on 10 December 1948 and to which India is also a signatory and is thus committed to upholding these rights for every individual. Within twelve basic human rights, there are human rights on people's sexuality and reproduction and we call them 'sexual rights' or 'reproductive rights' respectively. Explain the difference between sexual rights and reproductive rights (SRHR): Sexual rights are human rights that let people decide about their sexuality freely and responsibly. Reproductive rights are the rights of people to decide whether to give birth to a child or not, without discrimination, coercion or violence as well as rights to have a pleasurable sexual life.

These rights allow everyone to control their own sexuality and reproduction, with due regard for the rights of others and within a framework of protection against discrimination. (WHO, 2006a, updated 2010).

The International Planned Parenthood Federation (IPPF) summarized these sexual and reproductive rights that are derived from international human rights conventions and UDHR. The government is bound by international law to protect and fulfil these rights. (Provide Handout 4).

Ask the participants again to reflect on whether everyone is free to exercise these rights and if not, why not? Do our attitudes, beliefs and societal norms form a barrier for certain people to access these rights? To examine our own attitudes and biases, carry out the following activity.

Handout 4: Sexual Health and Reproductive Health

Sexual Health

Sexual health is defined by the World Health Organization (WHO) as 'the state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. It requires a respectful approach to sexuality and sexual relationships as well as having the possibility of safe and pleasurable sexual life free from coercion, discrimination and violence.'

To understand sexual health better, broad consideration of sexuality is a must as an individual's sexuality underlies important behaviours and outcomes related to sexual health. A personal sense of sexual well-being is essential for sexual health.[4]

For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled *(WHO, 2006a).*

Reproductive health

The World Health Organization (WHO) defines reproductive health as, "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its functions and processes at all stages of life." Reproductive health, therefore, implies that people can have a responsible, satisfying and safe sex life and that they can have children and the freedom to decide if, when and how often to do so. Sexual health is a part of reproductive health.

Sexual and reproductive health, therefore includes choice of sexuality, choice of reproduction as well as maternal, newborn and child health (MNCH) which refers to the health and well-being of women during pregnancy, childbirth and post-delivery, and the health of newborn babies and children until the age of five.

[4]http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

To ensure sexual and reproductive health, men and women have the right to be provided with information and access to safe, effective, affordable and acceptable methods of family planning of their choice, and access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy child. In addition to the antenatal, skilled child birth and post-natal care, the interventions should include newborn care, emergency obstetric and newborn care, safe abortion services, and the prevention of HIV and other sexually transmitted infections, exclusive breastfeeding for infants up to six months; vaccines and immunization; oral rehydration therapy and zinc supplements to manage diarrhea; treatment for the major childhood illnesses; nutritional supplements (such as vitamin A); and access to appropriate ready-to-eat foods to prevent and treat malnutrition.[5]

Sexual Health	Reproductive Health
Sexual Pleasure Love Sex by Choice Partner by choice Sex without violence, coercion and fear Expression of sexuality and gender without shame, stigma, and fear Safe sex, protected from STI/HIV/unintended Pregnancy Availability of condoms, lubricants and contraceptives Early Diagnosis and treatment of STI/HIV.	Able to choose whether and when to have children, with whom and how many Contraception Condoms, lubricants and contraceptives Safe motherhood (care during pregnancy, delivery, prevention of HIV transmission to baby, and post-natal care including postpartum contraception; safe abortion; breastfeeding, and immunization of the baby) Early diagnosis and treatment of STI/RTI/HIV Infertility treatment and treatment of gynecological problems Diagnosis and treatment of cancers related to sexual and reproductive health.

Hand-out 4: Sexual and Reproductive Health Rights[6]

1. Everyone has the right to life and this should not be put at risk by pregnancy and childbirth.

2. Everyone has the right and freedom to control their own sexual and reproductive lives, e.g., the right to decide whether or not to be sexually active.

3. No one should be discriminated based on race, poverty, sex or sexual orientation, marital status or religious or political opinion. This means everyone has the right to access SRH services.

4. Everyone has the right to privately and confidentially make their own decisions about their sexual and reproductive life and to have these decisions respected.

[5]International HIV/AIDS Alliance (2010), 'Integration of HIV and sexual and reproductive health and rights: Good Practice Guide'

[6]IPPF guide to SRHR

5. Everyone has the right to access information and education on SRHR and this includes the right to know about the benefits and availability of SRH services.

6. Everyone has the right to choose when and whether they want to marry and have children. This covers the right to choose the partner, the right to choose which type of contraception you want to use, and the right to choose whether you will breastfeed your child or not.

7. Each person has the right to decide on the number, timing and spacing of their children if they choose to have children.

8. Everyone has the right to attain the highest possible standards of sexual and reproductive health. This includes avoiding unwanted pregnancies, STIs, and sexual violence, and freedom from harmful practices like genital mutilation, bride price, and gender role stereotypes.

9. Everyone has the right to access new technologies that have the potential to improve health.

10. Any individual or organization has the right to advocate for SRHR issues.

11. Everyone has the right to be free from degrading treatment, including to be treated with respect and consideration when accessing health services.

12. Everyone has the right to have a satisfying, safe and pleasurable sex life, the right to be free from coercion, pressure or violence from a partner.

Our attitudes, values, beliefs and practice impact sexual reproductive health and can become barriers in attaining good health. To explain this, carry out the group activity below.

Step 3: Activity: Attitudes, Beliefs and Sexual Reproductive Health (30 min)
Write 'Agree', 'Disagree', and 'Not sure' on three cards and stick each card to a different corner of the room.

Ask the participants to stand up. Explain to them that you will read out different statements and, that after each statement, the participants have to move to an area with the sign that reflects their personal opinion on that statement.

Read aloud the statements from the cards prepared beforehand. Once the participants have taken their position, ask one or two volunteers under each sign why they took that particular position. Encourage the participants to share their perspective without being judgmental and use this opportunity to correct any misconceptions that come up during the discussion.

Statements that can be used to test attitudes:

1. Having sex before marriage is wrong.

2. Homosexuality is a sin.

3. Anal sex is wrong.

4. Women who inject drugs should not have children.

5. The only acceptable method of family planning for women living with HIV is tubectomy.
6. If a Sex worker becomes pregnant, she should undergo an abortion.
7. A woman can have as many partners as she wants.
8. Women should enjoy sex.
9. If a drunk or a 'high' woman gets raped, it is her fault.
10. Abortion is acceptable only if there has been a rape.
11. A doctor refuses to provide STI services to a young male sex worker and reports him to his parents.
12. Anyone engaging in sex work deserves to have HIV.

Discuss the statements about sexual and reproductive health and rights. Explain that a supportive social and cultural environment promotes gender equality and upholds the sexual and reproductive health rights of people of any gender or sexuality. Everyone must understand that other people have rights too, and should respect them.

Ask the group who agreed with above mentioned statements to reflect and state which sexual and reproductive rights were violated in these examples and how that becomes a barrier to providing quality health services. Some of the rights getting violated in the above scenarios include:

- Right to sexuality.
- Right to health care and treatment.
- Right to decide whether or not to have a child.
- Right to equality and be free of discrimination.
- Right to information and education.
- Right to life.

Discuss other ways a person's sexual reproductive rights could be violated (e.g., sex against will, refusal of contraceptives to young unmarried girls by the health care provider, banning of sex education by schools, forced sterilization or abortion, denial of abortion services). Talk about how violations of sexual and reproductive rights can take many different forms and how some of these violations are so common they are typically overlooked, excused, or seen as culturally 'normal'.

Wrap up the session by stressing how the realization of SRHR is important for attaining good sexual and reproductive health. Responsibility for protecting, and fulfilling human rights rests not only on government but on every single person. Moreover, as health care providers, we should be aware of our beliefs, biases and attitudes, and ensure that these do not prevent us from providing the right services as required by every client visiting our clinic.

Session 5: Sexual Reproductive Health and HIV Integration

Learning Objectives:

By end of the session, the participants will be able to:

- Explain the common components for SRHR and HIV programming and the rationale for integrating the two.
- Describe the advantages and challenges of integrating SRHR and HIV services.
- Explore the opportunities for maximising service access for Female sex workers through integrating HIV and SRH services.

Time: 1 hour.

Training aides/Materials required:

- Flipchart.
- Chart paper.
- Sticking tape.
- Markers for each participant.
- PowerPoint presentation.
- LCD projector.
- Screen.
- Handout 4: SRH-HIV Integration.

Methodology: Brainstorming, Group work and discussion, power point presentation.

Step 1: Brainstorming and power point discussion; 15 minutes
Draw two intersecting circles on a flip chart. Ask the participants to recall components of sexual and reproductive health listed in the last session and think which of these components are common to HIV programming. Invite one volunteer from the participants to come forward and list the components of SRH services in one circle, those of HIV services in the other, and the components that are common to SRH and HIV in the overlapping section. Encourage the group to support the volunteer.

Present key linkage areas for HIV and SRH interventions through a Power Point presentation. Draw the participants' attention to the fact that while implementing targeted interventions for female sex workers, the participants are already dealing with several aspects of SRH. By integrating components from the two programs, more comprehensive support can be provided to FSW (See Handout 5/Facilitator's Resources for **Key Elements of linkages between HIV/AIDS Sexual Reproductive Health Services** -Fig 1).

Step 2: (Group Activity) 30 minutes
Divide the participants into three groups. From the following list of questions, assign each group with one topic to work on:

1. Why should SRHR services be linked with HIV programming and what are the potential platforms for linkages?

2. What are the benefits of integrating SRH and HIV prevention programming?

3. What are the challenges of SRHR/HIV integration?

Ask the participants to reflect on these questions in the context of a sex worker. Let the smaller group discuss the topic among themselves, noting down their suggestions on a chart. After 15 minutes, each group presents their findings to the larger group. Facilitate discussion in a larger group on all three topics.

Step 3: (Power point presentation) 15 minutes

Complete the discussion with Power Point presentation (15 min). Include important lessons learnt from national/international experience for successful integration of SRHR and HIV services for women at risk and share some successful case studies on integration (Handout 4). These linkages can be two-way; HIV services through the general health system and conversely, reproductive health services through Targeted interventions or STI/HIV clinics.

Facilitator's notes

Inform the group that a joint directive from the National AIDS Control Organization (NACO) and National Health Mission (NHM) was issued by the Government of India in July 2010 to facilitate the convergence of HIV and reproductive child health services at the district level. Several steps were outlined for ensuring delivery of HIV related services to people through the general health system. These services include the universal screening of pregnant women for HIV, nutrition and birth spacing and breastfeeding counselling at Integrated Counselling & Testing Centers (ICTC), safe delivery of HIV positive women, provision of STI/RTI services at public healthcare facilities especially to clients from TI, ICTC services at 24X7 PHCs, and OI (opportunistic infections) treatment, care and support services to the PLHIV at the government hospitals, referrals and provision of ART services at the sub-district level through link ART centres, condom promotion, and Information, Education and Communication, provision of OST to injecting drug users and screening for HIV-TB co-infection. The District AIDS and Prevention Control Units (DAPCU) at the district level are responsible for ensuring smooth convergence at the district level.[7]

Sum up the session by pointing out that there are strong barriers to accessing SRHR services for women working as sex workers. Providing these services through STI clinics (Suraksha clinics) can improve access dramatically since TIs are their first point of contact and have an established outreach. Service providers at STI clinics and ART centres must keep in mind the SRH needs of the women attending and ensure the unmet needs are addressed in a stigma-free environment. Similarly, clinics providing SRH services should be sensitive to the needs of young women, women engaging in sex work or IV drugs and those living with HIV and provide STI/HIV prevention services as appropriate.

Handout 5: Integration of Sexual and Reproductive Health and HIV services

"*Integration refers to one or more components of SRHR programming being integrated into one or more components of HIV programming; or vice versa. This includes referrals from one service to another, with the overall aim of providing more comprehensive support".*[8]

[7]NACO (2012). Operational Guidelines, District AIDS Prevention and Control Units.

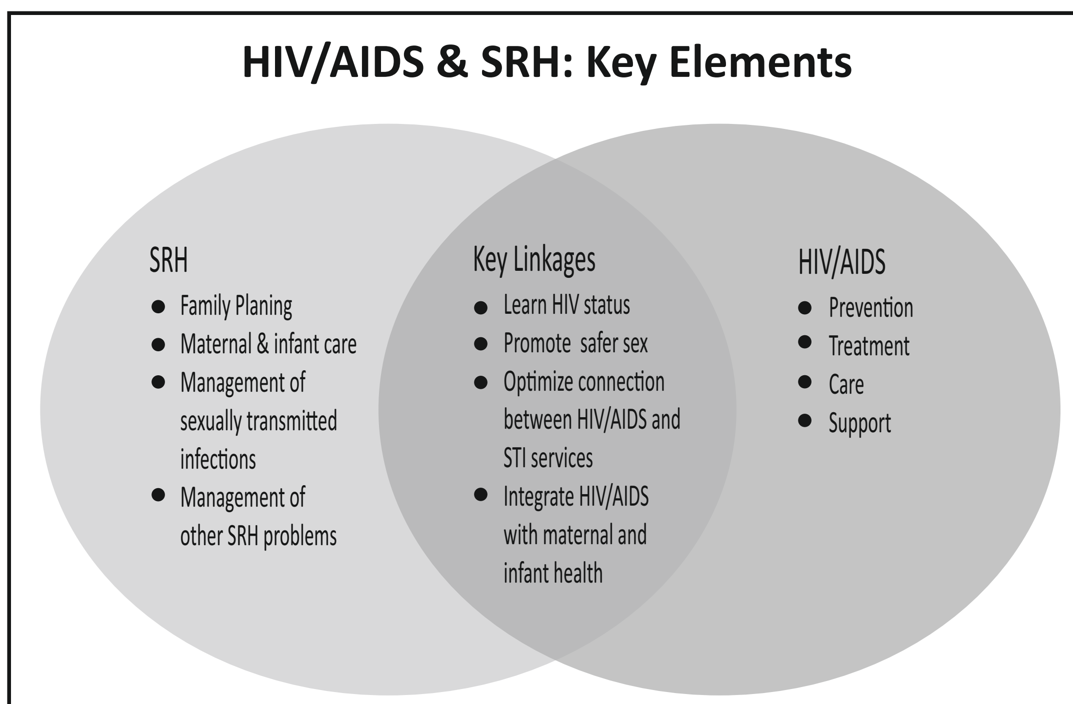
[8]WHO, USAID, FHI (2012). Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services.

7. UNFPA. What is the evidence of effectiveness of SRH/HIV integration. Evidence Brief.

Integration aims to improve the dual health outcomes related to SRH and HIV, such as HIV/STI infections, AIDS-related deaths, unintended pregnancies and maternal mortality, cervical cancer and gender-based violence. India, as part of national commitments to strengthen linkages between SRHR and HIV strategies, has enacted laws and policies, as well as improvements in health systems and integrated services. A joint directive from National AIDS Control Organization (NACO) and National Rural Health Mission (NRHM) was issued by the Government of India in July 2010 to facilitate the convergence of HIV and reproductive child health services at the district level. Several steps were outlined for ensuring delivery of HIV related services to people through the general health system.

The diagram below shows the main components of SRH and HIV services and the key linkages:

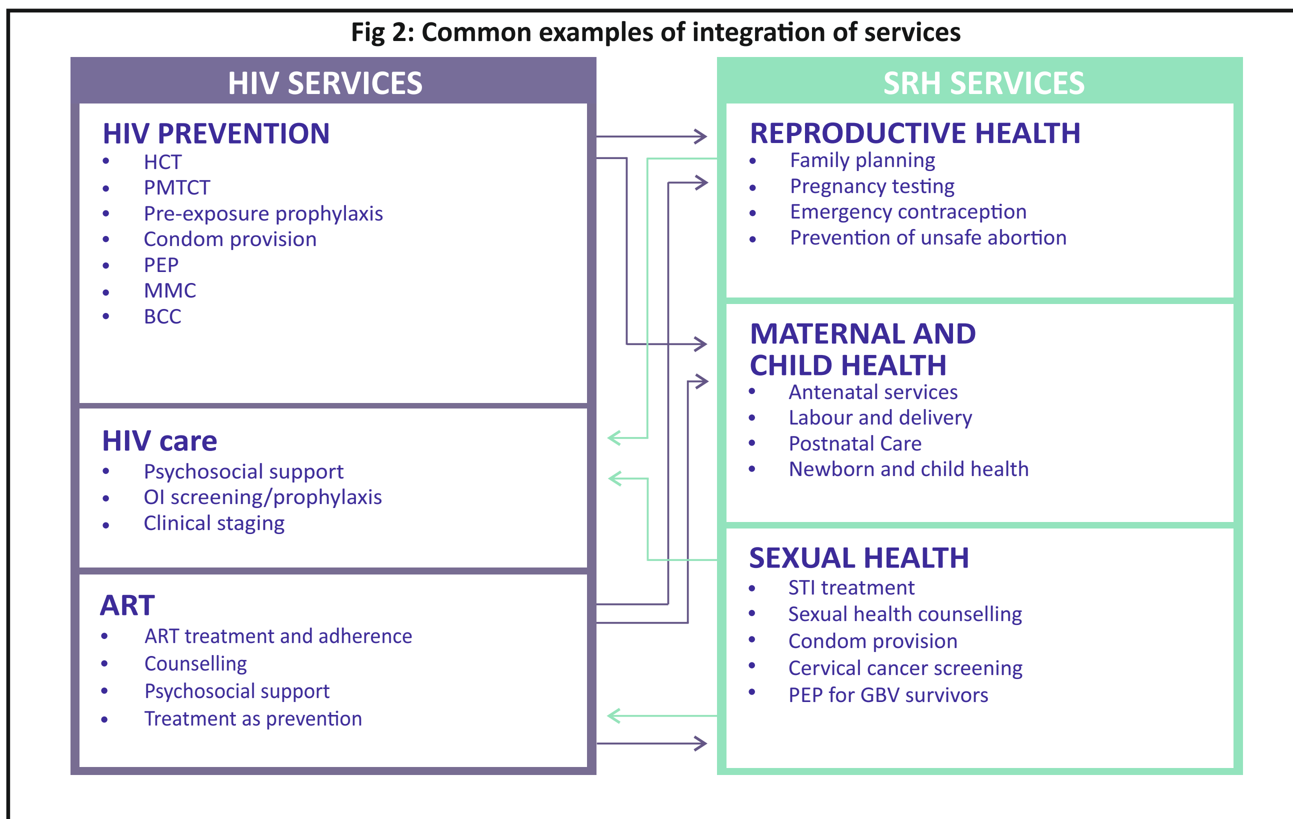
Fig 1: Key Elements of linkages between HIV/AIDS and Sexual Reproductive Health Services



Source: Adapted from WHO (2005), 'Sexual and reproductive health and HIV/AIDS: a framework for priority linkages'

To provide comprehensive services to women engaging in unsafe sex, a two-way approach is necessary – combining support and services for HIV and SRHR. Integration can be bi-directional, i.e., SRH programmes can include HIV services and HIV programmes can include SRHR services (Fig 1). The integration of SRHR and HIV services can be quite challenging and need the partnership of community groups and organization, governments and international donors for successful implementation.

Fig 2: Common examples of integration of services



Some of the platforms that can be used for integrating SRH and HIV services in India's public health system include:

S. No.	Facility/Program	Services to be added	Target group
1.	Family Planning/MNCH services	Education/counseling on STI/HIV	More suitable for married women
		Safer sex promotion, free condoms	
		STI diagnosis and management including syphilis test	
		PMTCT and VCT services	
2.	ART centers	SRH information	All type of clients
		SRH services if ART centers located in major secondary and tertiary facilities	
3.	HIV programmes (prevention/care and support centers)	SRH information	Key populations (PWID, FSW, MSM), migrants, clients/partners of sex workers
		SRH services	

Integration helps not only increase access and uptake of key HIV and SRH services, reduced stigma related to HIV and key population and improved quality of care, but also in increased effectiveness and efficiency of national programmes due to decreased duplication of efforts and competition for scarce resources.

Additional information can be accessed at:

1. WHO (online), 'Sexual and reproductive health'. Available at: www.who.int/reproductive-health/hiv/docs.html

2. WHO (2008), 'Integrated health services – what and why?', Technical Brief 1. Available at: www.who.int/healthsystems/service_delivery_techbrief1.pdf

Session 6: Vulnerabilities, Risks and SRH Needs of Sex Workers

Learning Objectives:

By end of the session, the participants will be able to:

- Identify the social, cultural and economic factors that enhance the risk of sexual reproductive ill-health among women, especially female sex workers and adolescent girls.

- Describe the sexual reproductive health needs of female sex workers.

Time: 1 hour.

Training aids/Material required:

- Flipchart.
- Chart paper.
- Sticking tape.
- Markers for each participant.
- PowerPoint presentation.
- LCD projector.
- Screen.
- Handout 5.
- Case studies (4).

Methodology: The following steps describe the process to be followed during this session.

Step 1: Brainstorming; 10 minutes
Introduce the session by explaining that the risk of acquiring HIV and SRH-ill-health and HIV varies among people and some groups of population such as young people, women, especially female sex workers, men who have sex with men, *hijra* and transgender people, and people who inject drugs have high vulnerability and risk of acquiring HIV. Discuss the difference between risk and vulnerability. Ask the participants if they can list the reasons for this enhanced risk of HIV and other SRH problems. Note down the responses and complete the list through power point presentation, if needed.

Ensure that issues such as biological factors, economic compulsions, sex work, the culturally embedded power imbalance between men and women exposing women to increased violence, coercion and stigma, gender violence, and lack of family support are covered in the discussion (See Facilitator's Resources for details).

Step 2: Gender Violence; 15 minutes

Discuss how gender-based violence is persistent and widespread, cuts across all classes, can happen in the privacy of home, or in public, is used to subordinate and/or punish women and anyone else who is perceived to have transgressed gender norms, and is difficult to prevent or mitigate because social institutions see it as 'normal.' (See facilitator's Resources).

Step 3: Group work; 15 minutes

FSW have the same sexual and reproductive needs as any other woman – such as the need for safe sex, to have satisfying sexual relations and to be able to decide whether or not to have children. However, due to many factors, social, economic, legal or biological, these women may experience greater vulnerability to SRH-related ill-health than other community members. The following exercise will help examine these vulnerabilities and their impact on SRH.

Divide the participants into four groups and provide each group with one of the following case studies. Ask the participants to discuss the case study within their small group and answer the questions accompanying the case study (15 minutes).

Case Studies

Case study 1: Rita, 30 years old, has been working as a sex worker for the last three years. She uses condoms with all her clients but her boyfriend refuses to use the condoms. Having missed her periods for two months, she visited the local clinic and was told she was pregnant. She was also tested for HIV and was found to be positive. The doctor advised her to undergo an abortion. Rita wanted to keep the baby and so went to consult another doctor who gave her the same advice. Rita decided not to visit any medical facility and continued with her pregnancy without medical supervision. She had a home delivery during which the baby died. Rita's own health has also deteriorated.

Case study 2: 19-year-old Rashmi is from a village in Orissa. Last year her father, who was the only bread-winner in the family, passed away. Her mother sent her to Ahmedabad with their neighbour, Mehtab, to earn a living. Mehtab works in Ahmedabad and Rashmi is now living with him and has sexual relations with him. They do not use condoms. Rashmi does not want to get pregnant at this stage so she contacts the Accredited Social Health Activist (ASHA) to take advice for family planning and to get oral pills. However, the ASHA tells her that unmarried girls should not be sexually active and sends her back without any advice or pills.

Case study 3: Rani is a beautiful young girl of 20 years and is engaged in sex work. She has 8-10 clients daily. Two days ago, she accompanied a client to a hotel and to her horror she was forced to have group sex with four men. None of them used a condom. Later she went to the police to complain but the sub-inspector at the police station refused to file a complaint and rather made some lurid comments about her making false charges after having had all the fun!

Case study 4: Anita is a 24-year-old beautiful girl and wishes to go abroad for higher studies. Her parents cannot afford the expenses so she has been engaging in sex work to support her higher education. However, she is unable to negotiate condom use with her clients and has come to your clinic for contraceptive advice.

Questions

Questions:

- What are the high-risk behaviours and associated risks?
- What are the factors responsible for the health risks? List out all the biological, social, cultural or economic factors that may be applicable.
- What are the sexual and reproductive health needs of the person in the case study?
- What can be done to address the needs identified?
- How the natural disasters/pandemic like COVID does worsens the vulnerability of key population?

The participants may be provided with charts with the following table drawn to record their responses:

High-Risk Behaviour	Associated Risks	Vulnerabilities	SRH Needs	Action Required

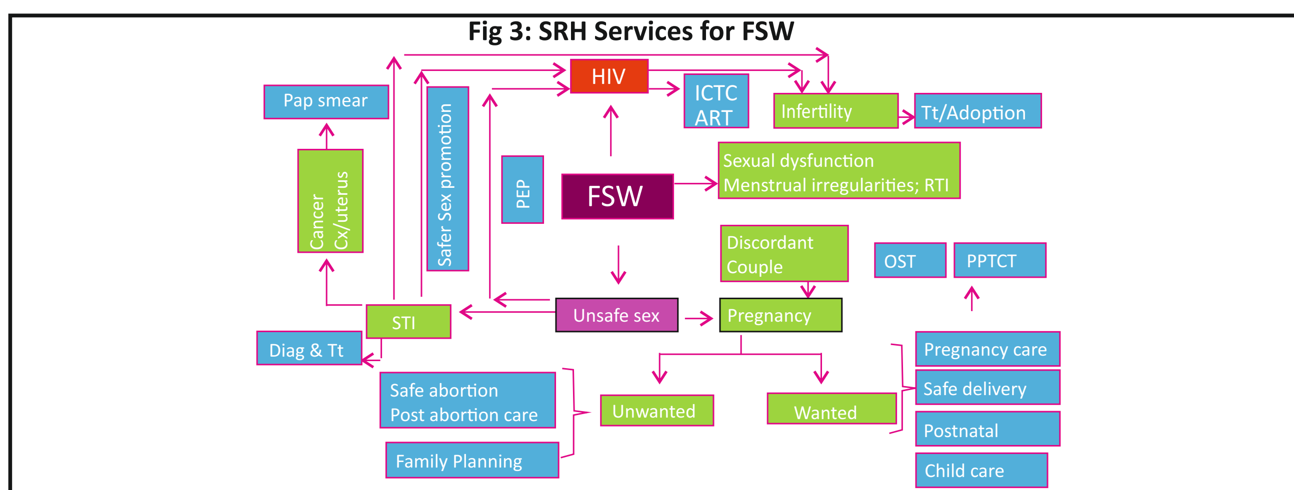
Step 4: Group presentations; 20 minutes
Invite a representative from each group to present their responses to the larger group.

Facilitate discussion within the larger group about risks, vulnerabilities and needs concerning sexual reproductive health.

Step 5: (Powerpoint slide) 5 minutes
Summarize the SRH needs of FSW, keeping the above risks, vulnerabilities and behaviours in mind:

Conclude the session by explaining that while FSW has a range of SRH needs just like any other woman, they may also face additional problems that are specific to their high-risk behaviours and experiences as a sex worker. These needs may vary depending upon their age, type of sex work or HIV status; e.g., younger FSW might have a higher need of family planning than an older one while a pregnant HIV positive woman might need information on how she can improve her health during pregnancy and prevent transmission of infection to the baby through early initiation of ART.

Fig 3: SRH Services for FSW



SRH needs of adolescent girls:

- Changes during adolescence, menstrual cycle and menstrual hygiene.
- Conception and pregnancy and safe motherhood.
- Contraceptive choices.
- RTI and STI.
- Safe abortion services.

Session 7: Sexually-Transmitted Infections

Learning Objectives:

By the end of this session, participants will be able to:

- Understand why STI control is important for HIV prevention.
- Update their knowledge on STI services provided to key population.
- Discuss the rationale and various components of syndromic case management.
- Refresh and update their knowledge and skill of screening for Cervical carcinoma.

Time: 1 hour.

Training aids/Materials required:

- Flip chart.
- Power Point presentation.
- LCD projector.
- Laptop.
- Screen.
- Question box.
- Question slips.

Methodology: Quiz and interactive discussion

Step 1: Preparing question bank for quiz
For this session, prepare individual question slips in advance using the list of questions below. Fold each slip and keep it in the question box.

Introduce the session by talking about how sex workers are at risk of getting STI, the relationship of HIV with STI, the STI burden in India and how treating STIs in high-risk individual is part of our national strategy for HIV prevention. If a woman comes to your clinic, it is an opportunity to promote safe sex and condom use, thus bringing about a behavior change. Inform the participants that the session will help refresh their knowledge of STI management through a quiz.

Set ground rules for the quiz.

Step 2: Quiz; 30 min
Divide the team into four groups. Inform them that each team will get three questions each and there will be three points for the correct answer, 1 if the answer is incomplete and 0 if incorrect. If the correct answer is given by a different group, that group earns 2 bonus points.

Invite one volunteer from the first group to pick up one slip out of the question box. Let him/her read aloud the question and allow them a couple of minutes within the group to discuss and respond. If unable to answer, invite replies from other groups. If needed, correct and supplement the information using power point slides.

Repeat the process with the next group in rotation until all questions are taken up.

List of quiz questions:

1. STIs are most common in which age group?
A. Teens and young adults up to age 24 B. People ages 30 to 45 C. People 60 and older D. All of the above.

2. As long as a person has no symptoms of an STI, he or she:
A. Cannot pass on an STI B. Doesn't have an STI C. A and B D. None of the above.

2. Which of these is a health problem that can be caused by STIs in women?
A. Pelvic inflammatory disease (PID) B. Ectopic pregnancy C. Higher risk for cervical cancer D. All of the above.

3. Which is the most common STI caused by bacteria?
A. Gonorrhea B. Syphilis C. Chlamydia D. Genital warts.

4. One symptom of genital herpes is:
A. Tingling or burning in the genital area B. Painful blisters in the genital area C. A and B D. None of the above.

5. To lower your risk of getting an STI:
A. Use a male condom B. Don't have multiple sex partners C. As a young person, delay having sexual relations as long as possible D. All of the above

6. **A woman can have vaginal discharge due to:**
A. Unprotected sex. B. Poor menstrual hygiene C. Poor personal hygiene. D. All of the above

7. **Which major organ can be affected by untreated syphilis?**
A. Heart B. Brain C. Liver D. A and B

8. You can get herpes from a toilet seat.
A. True B. False

9. What are different means you can use to diagnose STIs? Which one you will choose and why?

10. What is syndromic case management (SCM)? What are its advantages and limitations?

11. What are the different steps for SCM of STI?

12. Ritika, 28 years old, comes to your clinic with pain lower abdomen for the last 4 days and history of off and on vaginal discharge for 3 years. How will you manage?

Discuss each quiz answer in detail and correct any misinformation the group has. Explain that STI treatment is provided based on the syndrome and NACO has developed and distributed colour-coded packs. Explain that treatment is not complete unless:

- Partner is treated for the same syndrome.
- Information and counselling on safe sex is provided.
- Provision of condom.

Advocating correct and consistent use of condom is not enough. Ensure the woman has access to condoms and also has the skills to negotiate condom use not only with casual clients but also with regular partners.

Ensure participants understand that every vaginal discharge is not an STI. Personal and menstrual hygiene is important to avoid reproductive tract infections. They should discuss the advantages and disadvantages of different absorbents (menstrual cloth, sanitary pads, tampons and menstrual cup) with their clients.

Cervical Cancer: Explain why it is important to screen FSW for cervical cancer. Factors such as multiple partners and unprotected sex make FSW vulnerable to HPV infection which can lead to cervical carcinoma over time. Share the results from the Koshish study (carried out by India HIV AIDS Alliance in Andhra Pradesh and Gujarat) where 5.6 percent of the women living with HIV had abnormal Pap Smear. Discuss screening protocols, procedures and HPV vaccination schedules (see Facilitator's Resources).

Session 7: Family Planning and Protecting Fertility

Learning Objectives:
By the end of this session, participants will be able to:

- List and describe the methods of family planning options available with a special focus on women using drugs.
- Differentiate between emergency contraception and abortion.
- Discuss ways in which HIV positive FSW can be supported to bear children.

Time: 1.5 hours.

Material:

- Flip chart.
- Chart papers.
- Markers.
- Power Point presentation.
- LCD projector.
- Laptop.
- Screen.
- Case studies.
- Handout 6.

Case study and Group discussion

Methodology: Case study and Group discussion.

Step 1: Group-work on case studies
Divide the participants into 4 groups and provide each group with one case study each. Instruct the participants to take 10 minutes to study the case and discuss the questions given at end of each case study. Write down the answers on a chart paper.

Case Studies

Case study 1: 25-year-old Shanti has been married for 3 years and has one child. She had copper-T inserted after the birth of her first child. Shanti supplements the family income through sex work. Two months back she tested positive for HIV. She has been advised by her family doctor that she should get copper-T removed as it is not a safe option for HIV positive women and to go for tubectomy instead. Shanti is now worried because even though she does not want to have a child at this time, she is sure she would like to have another child in future. She comes to you for advice.

Questions: What are Shanti's reproductive rights?
What alternative options for birth control can be offered to Shanti?

Case study 2: Radha, a 24-year-old female, comes to your clinic saying that she had unprotected sex the night before when she was high. She is now worried about pregnancy. She is clear that she does not want to have children yet. What would you tell her?

Case study 3: Sandhya has not had periods for the last two months. She has a one-year-old baby and her periods are irregular. She often has sex without the use of condoms. Initially, she was not bothered about it as they have been irregular for quite some time. For the last couple of weeks, however, she has been having morning nausea and so she is worried. She does not want to have children. What are her options?

Case study 4: Sushila is 30-year-old woman, married for the last 4 years. Her husband is HIV positive and he has been using condoms to prevent HIV transmission to Sushila. The couple wants to have a baby and come to you for your expert advice.

Step 2: Group 1 presentation and discussion; 20 minutes
Once each group has finished the group work, invite the first group to present their case and contraceptive options they have suggested for this woman. Remind the participants that a sex worker, like any other woman, has the right to decide whether or not to have children when to have children and how many. To exercise this right, she needs to have the right information and resources. Women who do not want children at the moment, use birth control methods, while others may need support if they want to have children in ensuring conception is safe.

Ask other groups if they want to add to the options suggested by the presenting group. Facilitate participatory discussion on various contraceptive options describing their mode of action, merits and demerits, potential risks and where to access them. Discuss the suitability of various contraceptive options to FSW keeping in mind her lifestyle. **Long-term contraceptives** like implants, injections or intrauterine contraceptive devices (IUD) may be a better choice. Use of **dual methods of protection and women-centric contraceptives** should be promoted. Discuss the methods of choice if she were living with HIV and on ART.

Explain that copper-T does not need to be removed if a woman using this device gets HIV infection. She can safely continue using copper-T unless she has a cervical infection.

Share Handout 6 on Contraceptive Options with the participants.

Handout 6: Family Planning Options

Family planning methods can be temporary – those that allow for return to fertility when the couple wants to have a child; or, permanent – those that are used when the family is complete.

Temporary Methods

Natural methods: These methods are generally not very reliable.

a. **Lactation Amenorrhea Method (LAM):** Breast feeding the newborn regularly has a natural tendency in suppressing ovulation and is a natural birth control option for women. This works only if the woman is exclusively breast feeding, her menstruation has not resumed and the baby is less than 6 months old.

b. **Fertility awareness**, wherein a woman keeps track of days when she is most fertile and abstains from sex on those days. This requires a strong understanding and awareness of a woman's monthly cycle and changes in her body.

c. **Cervical mucus method**, wherein the thickness and stickiness of the cervical mucus indicates days of fertility, also requires a careful understanding of a woman's own body.

d. **Withdrawal method** is where a man pulls his penis out of a woman's vagina before ejaculating. This method requires a strong level of trust and experience between sexual partners. There are also risks involved, as pre-ejaculation can also cause pregnancy. Neither of these methods prevents HIV or STI transmission.

Barrier methods: These create a physical barrier between the genitals, preventing HIV infection or re-infection, STI infection and pregnancy (also known as dual protection- double protection from pregnancy and STI/HIV transmission).

a. **Male condoms** prevent the semen from coming in contact with the vaginal wall and when used consistently and correctly, are almost 100% effective. Male condoms remain the most inexpensive contraception method and TIs provide condoms at no cost to members of high-risk groups across the country. Male condoms are made of latex which can be damaged if used with oil-based lubricants. Therefore, only water-based lubricants should be used.

b. **Female condoms** are also highly effective and allow for women to maintain control over contraception. However female condoms are expensive and not freely available. Other barrier methods exist, but are less accessible than condoms and do not provide dual protection.

c. **Diaphragm, cervical cap and cervical shield** prevent sperm from reaching the egg but do not protect from HIV or STI transmission. The diaphragm is a shallow latex cup that is inserted into the vagina before sex. The cervical cap is a small thimble-shaped latex cup that works similarly. Both the diaphragm and the cervical cup come in different sizes and women must be "fitted" by a doctor to find the right size. The cervical shield is made of silicon and uses suction to fit the cervix. All three can be used with spermicide (sperm killing gel) and should be left in for 6-8 hours after intercourse to prevent pregnancy and be taken out between 24 and 48 hours after intercourse. However, the use of spermicide can increase the risk of HIV infections and is not recommended.

Oral contraceptive pills: These contraceptives contain hormones (progestin alone or in combination with estrogen) and regulate the fertility of women by preventing ovulation. Other than being easy to use, hormonal contraceptives are reversible, allowing women to regulate their fertility until they are ready to have children. However, these do not prevent STI and HIV infections, so women should be advised to use male or female condoms as well.

a. **Combined Oral contraceptive pills** are the most accessible of these options. These pills must be taken daily for 21 days every month, usually at the same time each day. If more than two pills are missed, the pack should be discarded and a new cycle started once menstruation ends. When used properly they are also highly effective in preventing pregnancy. The pills can cause nausea and vomiting in some women but that decreases after some time. However, these are contraindicated in certain medical conditions so a doctor should be consulted before starting on oral pills. Once the pills are discontinued, there is an immediate return of fertility. The pills can be started after 6 months of delivery and should be avoided in the first 6 months by a breast feeding woman.

b. **Non hormonal oral contraceptive pills: Centchroman** (INN: Ormeloxifene), sold under the brand names **Saheli** and available in the government health facilities by the name **Chhaya**, is a weekly oral contraceptive. It is a non-steroidal, non-hormonal method, taken twice a week on fixed days for the first three months, followed by once a week thereafter. Safe for breastfeeding women. Works by creating asynchrony between developing zygote and endometrial maturation leading to prevention of implantation (Asynchrony in the form of slight increase in transport of zygote through oviducts, acceleration of Blastocyst formation and suppression of endometrial proliferation and decidualization). It does not alter basal or peak FSH/LH levels and also no effect on the production of estrogen or progesterone. Besides contraception, it is also clinically useful in the management of DUB, mastalgia and fibroadenoma and has promising therapeutic efficacy in a variety of cancers including breast cancer. Due to estrogenic activity, this drug also has anti-osteoporotic and cardio-protective activity.

Hormonal Injectable contraceptives are long acting reversible contraceptives (LARC) given every three months, and by a trained health care provider. The method is available in the public health system by the name Antara Injection (Medroxy progesterone acetate) and is given deep I/M by a trained doctor/staff nurse/ANM. This type of hormonal contraceptive is better suited for people who are unable to take a pill daily and do not plan on becoming pregnant for at least three months. It may be a better option for women who may have trouble

remembering the pill. Injectable contraceptives are good for breast feeding mothers. They are given at 6 weeks of postpartum period and do not affect the quality and quantity of breast milk.

Implants are plastic rod containing hormone that is placed under the skin of the upper arm and the hormones prevent the ovulation and thereby the pregnancy. This can last for 4-7 years and require a health practitioner to administer or place the implant. This method is best suited for women who know they do not want to have a child for an extended period. They are presently available in the private sector and are not available in the government sector facilities.

***Emergency contraceptive pills*:** Emergency contraceptive pills are high dose hormonal pills that can be taken up to 72 hours after unprotected sexual intercourse to prevent pregnancy and are also called 'morning after pills'. These pills mainly work by preventing or delaying the release of egg from ovary and may also affect the wall of the womb preventing the fertilized egg to settle in the womb. It is not abortion as the pill helps avoid conception. They are considered fairly effective but do not provide 100% protection. The sooner the pill is taken after unprotected sex, the better it works. If taken within 24 hours of unprotected sex, the risk of pregnancy is decreased by 95%.

There are no major side effects of pills but some women may experience vomiting, headache and breast tenderness. Following the pill, the next period may be disturbed. If the periods do not start in 3 weeks after taking the pill, check for pregnancy. The pill does not cause any harm to the fetus and the baby born would be normal. The emergency pill should be used only for an emergency or as a backup method and for regular contraception other methods of family planning should be adopted. It is important to advise the use of condom for dual protection.

Intrauterine contraceptive devices (IUCDs) are either **hormonal (using progestin called LNG-IUS)** or **non-hormonal (using copper)** and are inserted into the uterus through the vagina by a health professional. All public sector health facilities have the availability of Copper containing IUCD 380 A (effective for 10 years) and IUCD 375(effective for 5 years). Copper IUCDs work by either preventing fertilization (copper acts as a natural spermicide, progestin prevents sperm from fertilizing with the egg) or preventing implantation. IUCDs are considered highly effective, are long-lasting and reversible. Copper IUCDs can also act as emergency contraceptives and can interrupt fertilization up to five days after intercourse. Side effects of copper IUDs may include spotting in between periods, menstrual irregularities and occasionally, increased bleeding in some women. IUDs do not protect from STIs. Infections must be ruled out before inserting IUCD. They are found to be safe and effective in women who are HIV positive.

Hormonal IUDs can remain in a woman's uterus for up to five years. They are presently not available in the government health facilities.

IUCDs can be the method of choice for women who lack control over sexual relationship with husband or sexual partner, especially spouses/partners of IV drug users or the women who use drugs. Side effects of copper IUCDs may include spotting in between periods, menstrual irregularities and occasionally, increased bleeding in some women. IUDs do not protect from STIs. Infections must be ruled out before inserting IUD. They are found to be safe and effective in women who are HIV positive.

Longer-acting hormonal injection, now available as Antara injection in government health facilities as stated previously or an IUCD can provide reliable pregnancy protection without daily or coitally dependent action by the woman. These are good options for women wanting to have children in the future but whose drug habit or lack of control over condom use with their partner might interfere with the regular pill or condom use.

Permanent Methods:

These methods do not protect from STI/HIV infections so the use of condom should be advocated.

a. ***Male sterilization,*** (vasectomy), is a minor surgical procedure cutting the vas deferens, the duct carrying sperms. Male sterilization has no effect on sexual desire and performance, men are still able to ejaculate, and their semen simply does not contain sperm. The procedure is reversible.

b. ***Female sterilization*** *(Tubectomy)* refers to the ligation of fallopian tubes (known as tubal ligation) and requires major surgical intervention. Tubal ligation can now be done with minimally invasive surgery, by making a small incision in the abdomen. The success rate of Tubectomy reversal is very low. The government of India allows for female sterilization after the birth of one child.

   (Adapted from Family Planning handbook of providers, WHO)

Step 3: Group 2 presentation and discussion; 15 minutes
Invite Group 2 to present their case and their suggestions. Again keep in mind her reproductive rights and advice accordingly.

Facilitate a quick discussion on emergency contraceptives (pills and copper-T). Discuss the mode of action, mode of administration and side effects of the emergency contraceptive pills, and precautions, if any. The doctor must counsel the woman on how an emergency contraceptive pill is a safe way of avoiding unwanted pregnancy following an unprotected sexual encounter. The pill must be taken within 72 hours after the sexual encounter for it to be effective.

Inform the participants that in this age of digital technology, most women are aware of emergency contraceptive pill and there is anecdotal evidence that many women at risk just make it a habit of procuring i-pill from the chemist and consuming it after every unsafe sexual encounter. Therefore, it is important to provide information on side effects of frequent use and emphasize that the pill should only be used as a back-up method. ***She must be counselled on other methods of family planning and motivated to start regular contraception to avoid the future risk of unintended pregnancy.***

IUCD can also be inserted within five days of sexual intercourse as an emergency contraceptive. It does not allow conception to occur.

Step 4: Group 3 presentation and discussion; 20 minutes
Invite group 3 to present their case and the options that Sandhya has. Discuss where Sandhya can avail safe abortion services if her pregnancy is confirmed. Discuss also the barriers to access to safe abortion, and post-abortion care including family planning. Women should be advised to abstain from sex for 5-7 days until vaginal bleeding has stopped. Inform her that it is safe to start the family method of her choice immediately after abortion. Copper-T can be inserted as soon as infection or injury to the genital area is ruled out. Share MTP law with the participants. Discuss the availability of surgical and medical methods of abortion at all government health facilities up to the level of PHC and that MMA are the safe methods for termination of pregnancy up to 9 weeks of gestational age.

Facilitator's notes

Explain Sandhya's right to have the pregnancy terminated as per Medical Termination of Pregnancy (MTP) Law. Our goal is to prevent unsafe abortion (abortion by unskilled personnel or self-induced) considering this is the leading cause of maternal morbidity and mortality, and treatment of complications places a huge economic burden on the public healthcare system. Unintended pregnancies and abortions are a direct result of the unmet need of contraceptives. This is because women want to avoid pregnancy but are not using modern methods of contraceptives due to ignorance, misbeliefs, lack of access to family planning, or opposition by the partner to use contraception. Reducing the unmet need for modern contraception is an effective way to prevent unintended pregnancies, abortions and unplanned births. Therefore, it is important to offer family planning services in the immediate post-abortion period.

Step 5: Group 4 presentation and discussion; 10 min

Invite group 4 to present their case study, which is different from the above as Sushila desires to have a child but is unable to conceive. Remind participants of the right of every woman to exercise reproductive choices and the right to bear a child if she so desires. Facilitate the discussion on the reasons a sex worker, desirous of having children, may find it difficult to conceive.

Explain different options available for enhancing fertility (fertility drugs, artificial insemination and IVF), especially if one or both partners are living with HIV. If the couple is unable to conceive despite treatment, the option of adoption can be explored. Conclude the session that no woman should be denied the right to have children because of her drug using or HIV status.

Session 9: Maternal and Newborn Care

Learning Objectives:

By the end of this session, participants will be able to:

- Understand the specific care needs of FSW during pregnancy.
- Recall and explain updated guidelines on the Prevention of Parent to Child Transmission of HIV and breastfeeding practices for drug-using mothers.

Time: 1 hour.

Material:

- Flip chart.
- Chart papers.
- Markers.
- Power Point presentation.
- LCD projector.
- Laptop.
- Screen.
- Case studies.
- Handout.

Methodology: Brainstorming, interactive discussion. The following steps describe the process to be followed during this session.

Introduce the session by informing the participants that this session is going to be a quick recap of antenatal care, focusing on what specific care female sex worker and women living with HIV need to take.

Step 1: Brainstorming and interactive discussion on case study: 10 minutes

Project the following case history on the screen and request one volunteer to read it aloud.

Shama, 26 years old, is having amenorrhea for the last 2 months. She has not visited a doctor until now. For the past 3-4 days, she has been complaining of headache and dizziness and therefore has come to your clinic for treatment. Her pregnancy test is positive. How will you proceed for management?

Note down the participants' responses on a flip chart. Facilitate a quick recap of antenatal, natal and post-natal care of mother and newborn (including danger signs to watch out for).

Step 2: Case study continued; 10 minutes
Referring back to the above case, inform the participants that while taking Shama's history, they find out that she is a sex worker and lives in a brothel. There is no social support system for her. How will the management change? Lead a discussion on case management.

Facilitator's notes

Explain to the participants that pregnancy care essentially remains the same as that of any other woman or as in case 1 above. However special attention needs to be paid to Shama's vulnerability to STI and HIV. Therefore, while taking history, explore the prevalence of unsafe sex, whether this is a wanted or unwanted pregnancy, her ability to come for regular follow up visits and to maintain a good diet, her understanding about pregnancy and sex, and her birth plan, etc. Some specific management points include examination, testing and treatment for STI and HIV as appropriate; information and counselling on safe sex, pregnancy care including follow up visits and danger signs; developing the birth plan; and care of newborn including breastfeeding.

Step 3: Case study continued and PowerPoint presentation; 20 minutes
Ask the participants what would be the line of management if Shama is found to be HIV positive and record their responses. Keep in mind that HIV positive women have the right to decide whether or not they want to have children. HIV positive women are more likely to have complications like premature labour; fever; infections, babies with low birth weight; and infections after birth. Infections after birth may cause more difficulty for HIV positive women if their bodies are less responsive to the antibiotics usually given to treat such infections.

- All HIV positive pregnant women must be referred to ICTC and lifelong ART started irrespective of their CD4 count.

- At the time of delivery, Nevirapine prophylaxis must be given to both mother and baby to prevent transmission of infection to the baby from mother. In the absence of ARV therapy during pregnancy, the risk of a woman having an HIV-infected child is between 25 to 35 percent.

Explain national commitment to **eMTCT** (elimination of syphilis and HIV from parent to child) and present national guidelines for the prevention of parent to child HIV transmission (PPTCT) through PowerPoint presentation and share **Handout 7**. Finally discuss breastfeeding guidelines and rationale for exclusive breastfeeding and why it should be started soon after the birth of the baby, even in HIV positive mothers.

Handout 7 Elimination of mother-to-Child Transmission of Syphilis and HIV

India has an estimated 23.49 lakh people living with HIV.[9] In 2019 alone, around 87,000 new HIV infections were detected and 69,110 AIDS-related deaths occurred. An estimated 20.52 pregnant women were in need of PPTCT interventions, without which nearly 25-45% of their children would acquire HIV infection through the vertical transmission route. The National Strategic Plan for HIV/AIDS and STIs (2017-24) has been developed with the vision of zero new infections, zero AIDS-related deaths, and zero discrimination.

Route of HIV transmission to the baby:
The most common route of HIV infection among the paediatric age group is from mother to child during pregnancy (5%-10%), during delivery (10%-15%) and during breastfeeding (5%-20%). The overall risk of HIV transmission from mother to child if breastfeeding up to 18-24 months is 30%-45%.

Elimination of new HIV infections among children is based on a **four-pronged strategy**:

- Primary HIV prevention of women in childbearing age group (Information, counselling, STI treatment and HIV testing).
- Prevention of unintended pregnancies among Positive Pregnant Women (PPW) (family planning and safe abortion).
- Prevention of parent to child transmission of HIV infection (early detection, triple ARV and exclusive breastfeeding).
- Provision of care, treatment, and support of HIV positive women and their families.

Early detection leads to elimination:
Early detection of HIV and initiation of ART in the first trimester will reduce viral transmission. All pregnant women should be counselled for HIV testing during their first contact with health facilities. A triple-drug ARV for more than 24 weeks with good adherence during pregnancy, which would be continued during delivery, breastfeeding and life- long will reduce mother to child HIV transmission to less than 5%.

Recommended ART Regimen consists of *Tenofovir (TDF) 300mg + Lamivudine (3TC) 300mg + Efavirenz (EFV) 600mg single FDC pill One pill/day.*

Care during labour and delivery:
Universal work precautions are strongly recommended while conducting delivery for all pregnant women, irrespective of their HIV status. In the case of women living with HIV, vaginal delivery is conducted with minimal vaginal examinations, avoiding an episiotomy, instrumental delivery, foetal blood sampling and artificial rupture of membrane unless indicated. The umbilical cord is clamped soon after birth, and the cord is not milked. Caesarean section is recommended only if there is an obstetric indication.

Infant prophylaxis:
All infants born to women living with HIV must be initiated on Nevirapine (NVP)/Azidothymidine (AZT) prophylaxis. The prophylaxis should be initiated immediately after birth and continued for 6-12 weeks as per the mother's duration on ART during pregnancy and if the mother if breast feeding.

Co-trimoxazole prophylaxis(CPT) must be initiated from 6 weeks and continued till 18 months irrespective of the HIV status of the baby. CPT must be stopped at 18 months, if the child is tested negative, and continued till five years along with ART if the child's HIV status is positive.

[9]NACO/ICMR/MoFWH, GoI. India HIV Estimates 2019 Report.

Feeding guideline:

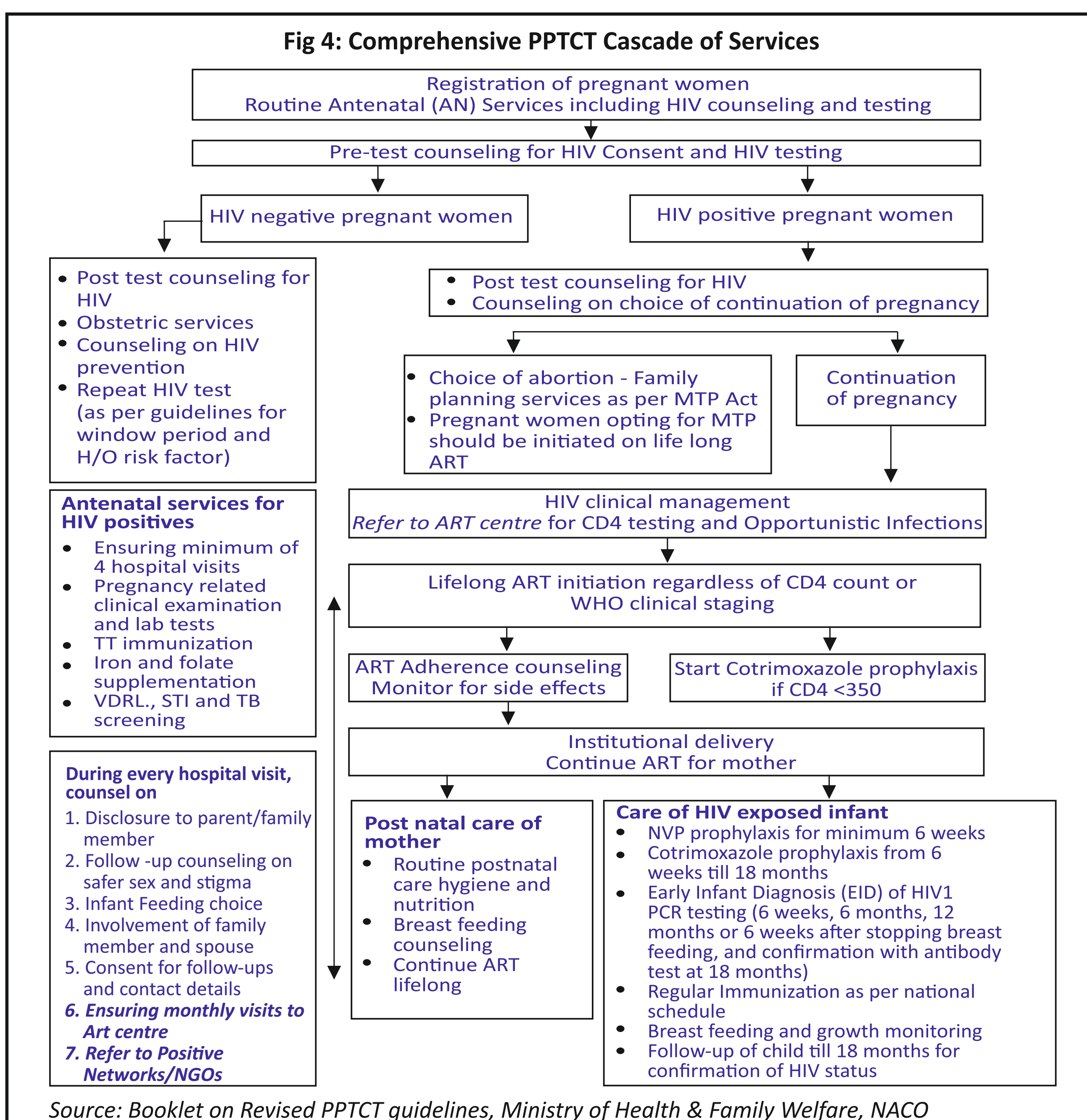
Exclusive breastfeeding for the first six months is the recommended feeding option as per the global (WHO) and national guidelines. Exclusive artificial feeding is the option only if the mother is not alive, otherwise, the mother is not willing to give exclusive breastfeed and AFASS criteria is fulfilled (Affordable, Feasible, Acceptable, Sustainable and Safe).

HIV Exposed infants (HEI) Testing:

HEI needs testing as per the national guidelines at 6 weeks, 6 months, 12 months and at 18 months. HIV confirmation is done as per age criteria, six weeks after cessation of breastfeeding.

Syphilis: Similar to HIV, mother-to-child transmission is the main cause of syphilis in children. The prevalence of syphilis among ANC in India is 0.10% (2017). Syphilis in pregnant women causes miscarriages. Morbidity and mortality are high among children born with congenital syphilis. A routine test for syphilis is recommended for all ANC women. Early diagnosis and treatment with penicillin reduce vertical transmission of syphilis.

Fig 4: Comprehensive PPTCT Cascade of Services



Source: Booklet on Revised PPTCT guidelines, Ministry of Health & Family Welfare, NACO

Session 10: Improving Access to SRH services

Learning Objectives:

By end of this session, the participants will be able to:

- Identify the barriers to access to SRH and HIV services.
- Develop strategies to improve access to the SRH and HIV services in their facility.

Time: 45 minutes.

Training aids/Material Required:

- Flip chart.
- Markers.
- Charts and markers for participants.
- Power Point presentation.
- LCD Projector.
- Screen.
- Laptop.
- Handout 8.

Methodology: Group work and interactive discussion.

Step 1: Group work; 30 minutes
Divide the participants into four groups and give each group two SRH components from the following list:

- Promoting Safe Sex.
- Supporting Satisfying Sexual Life.
- Sexually Transmitted Infections (STI) and Reproductive Tract Infections (RTI).
- HIV Prevention, Diagnosis and Treatment.
- Family Planning.
- Safe Abortion.
- Maternal and Child Health.
- Protecting and Enhancing Fertility.
- SRH Related Cancers.

Draw the table below on a chart paper and give it to the participants. Ask the participants to:

a. List out SRH services required under each SRH component (e.g., for promoting safe sex: behaviour change information, negotiation skills, provision of male and/or female condoms and lubricant; see Handout 9 for the complete list).

b. Map whether or not the service is available at their facility.

Once completed, ask the groups to share the lists with the larger group. Display the lists so that participants can refer to it, if needed.

S. No.	SRH Component	Service Required	Services Available at your Facility (Y/N)	What can be done for service not available		Action plan for add on services*	Timeline
				Referral to	Add on at the facility		

Handout 8: Comprehensive Service Package

SRH needs of women may vary depending upon their age, involvement in sex work, social status or HIV status. Not everyone will require all the services listed below and services tailored to the local needs can be added to the existing service package of targeted intervention for FSW. This comprehensive package of services should include information, support and services related to the following:

- Full range of options to prevent HIV, STIs and unwanted pregnancy and provision of commodities including condoms (both male and female), lubricants, supplies for dual protection, sanitary napkins and even clean syringes and needles, if injecting drugs.
- Counselling and IEC for building skills on safer sex practices including for anal sex (such as risk reduction and skills to improve condom efficacy and to negotiate condom use with partners). Behaviour change communication should be tailor-made.
- Information on specific SRHR issues such as STI, cervical cancer and infertility.
- Support to female sex worker who are pregnant and HIV positive with access to the full range of services for PPTCT, ANC, post-natal care and maternal, newborn and child health.
- Empowerment on sexual and health rights.
- Sex worker-friendly family planning options, including a full range of appropriate contraception (such as long-lasting contraceptives) and male and female condoms. Sex worker may need support for preventing pregnancy with the client and plan a family with a partner.
- Sexual violence-related services, including post-exposure prophylaxis in relation to rape or sexual assault.
- Negotiation skills to deal with stigma and criminalised status (e.g. sexual harassment by police).
- Access to safe and confidential abortion and post-abortion care, including in cases of unsafe or illegal abortion.

(Source: HIV/SRHR Integration for Key Populations: A review of experiences and lessons learnt in India and Globally. International HIV/AIDS Alliance)

Step 2: Group work, presentation by group and discussion; 30 minutes

Once all the services are listed, ask each group to discuss among themselves the following issues:

- I. How many services are available at your facility? If some service is not available at your facility (such as ART and PPTCT/EMTCT for pregnant woman), where can it be accessed?
- ii. What services are not available at all in the district?
- iii. What key services are missing or not being accessed?
- iv. What are the barriers to access these services?
- v. What changes are required to improve the access?

Once completed, let the group present their discussion points to the larger group. Facilitate the discussion on the barriers and strategies to improve the access to services. Not only should the services be community-friendly in terms of suitable hours and place of service delivery, but the service providers must also be sensitized to the vulnerabilities and SRH needs of the sex workers.

Share the handout with recommended strategies from international experience (Handout 9).

Handout 9: Barriers for Access to Services and Recommended Strategies for Improving Access:

1. Discrimination by service providers.
2. Lack of gender-sensitive "Sex-worker-friendly" services. These may include unsuitable opening hours and unsafe location; male service provider with whom women may not be comfortable discussing SRH issues; exclusion of pregnant lady from OST programmes, if drug user.
3. Household responsibilities and lack of family support/ social networks/ financial resources.
4. Lack of privacy and confidentiality and thus fear of being identified and stigmatized.
5. Increased likelihood of facing stigma and discrimination if a woman is involved in sex work as well or is HIV positive.
6. Lack of correct and complete information by the service provider e.g., even though the Government of India policy is that any woman can seek female sterilization after one child, many providers refuse the surgery for women with less than three children. Similarly, a woman who is HIV positive is not given IUD, even if she is well.

Recommended Strategies for SRH Services to Sex Workers:

Identify the magnitude of the problem and the needs of sex workers in your area. It is preferable to start with the integration of selected services that are priorities for the community and are relatively easy to implement.

- Community outreach, education on SRH issues and empowerment on sexual and reproductive health rights. This can be done through pre-existing outreach team of the TIs, ASHA and/or ANM. They should be well trained in risk reduction and sexual reproductive health and rights.

- Provide access to women-controlled safe sex devices such as female condoms, and long-acting contraceptives such as hormonal contraceptives or intra-uterine contraceptive devices. Emphasize on dual protection.

- Deliver comprehensive health care services (including STI/reproductive health/pregnancy care/family planning) directly or through referral. Improve access to these services through making them women-friendly (delivering female-friendly services at locations accessible to women, having women-only spaces or women-only timings for service delivery, support of sex-worker peers at service delivery points).

- Develop relevant IEC materials and ensure their availability and access to women.

- Crisis response system linked to sex workers (violence, sexual and psychological abuse etc) so as to address violence which is a significant obstacle to accessing SRH, HIV and harm reduction services. These teams can also provide support in protecting the women from human rights violations and prosecution by the police.

- Formation of community-based support groups e.g., street-based, home-based or brothel-based sex workers).

- Establish linkages to other services (e.g. mental health support, night shelters, income generation programs, etc.).

- Involve spouses and partners through holding joint meetings/events with them partners or couple counselling.

- Capacity-building of the health care team to provide gender-sensitive and intensive interventions.

- Advocacy for change in legislation/policies that act as a barrier to the provision of women-friendly services for the FSW.

- Joint planning and reviews between HIV and SRH program managers at state and district level.

Step 3: Developing Action Plan; 50 minutes

Ask the participants to stay in their group and develop an action plan for improving the access and availability of service. The action plan will include:

1. For services available at your facility but low access: List action points to reduce barriers to access. Can community monitoring be added as the community can play a vital role in monitoring, client satisfaction surveys, joint surveys, advocacy and creating an enabling environment?

2. For services that are not available at your facility: Can these be provided through referral to the nearby facility?
   Or can your facility add on these services?
   What action is required for this purpose? Think of timelines, resources required and roles and responsibilities of different stakeholders. What support is required?

Invite each group to present their action plans for discussion in a larger group and finalization of the plan. The plan will need to be presented to the facility administrator for approval. Make sure responsibility for ensuring its implementation is also fixed. Regular follow up, meetings with administrator and other stakeholders and monitoring plan should be included.

Chapter 3: Facilitator's Resources

HIV Epidemic and Key Populations

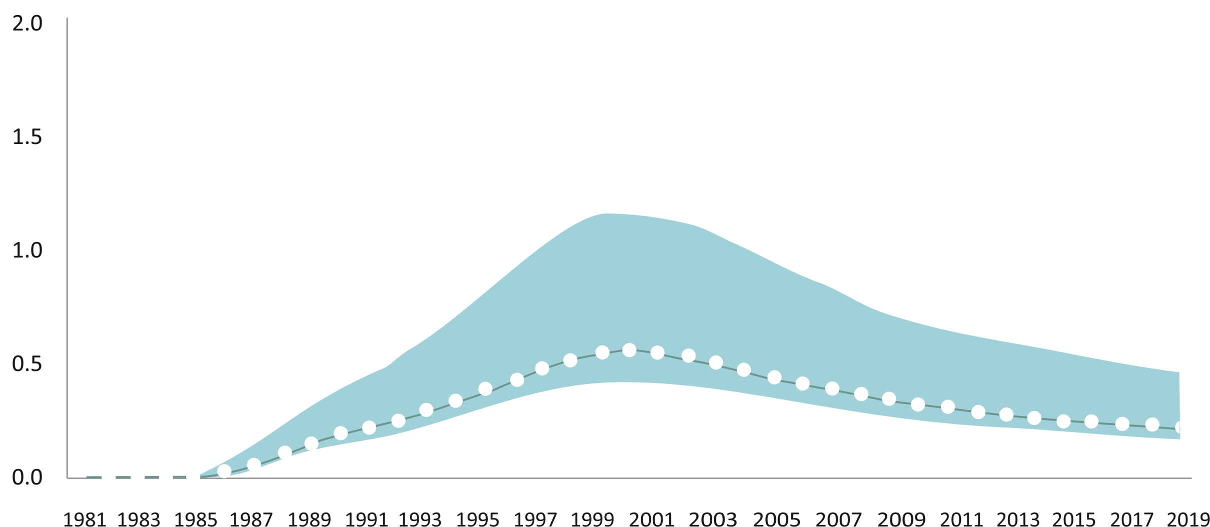
India has the third highest number of HIV cases globally. In 2019 at the national level, an estimated 23.49 lakh people were living with HIV (PLHIV), with an adult (15–49 years) HIV prevalence of 0.22% (0.17–0.29%).[10] Children living with HIV (CLHIV) comprised 3.4% of the total PLHIV estimates. HIV-infected women (15+ years) constituted around 44% of the total estimated 15+ years PLHIV. Around 20.52 thousand pregnant women were estimated to be in need of the prevention of mother-to-child transmission (PMTCT).

There is a clear decreasing trend, with HIV infections in 2019 having declined by 37% since 2010 and by 86% since reaching the peak in 1997. AIDS-related deaths in 2019 have declined by 66% since 2010 and by 78% since attaining peak mortality in 2005.

Mizoram was estimated to have the highest adult HIV prevalence (2.32%), followed by Nagaland (1.45%) and Manipur (1.18%). Other States/UTs with an estimated adult HIV prevalence that was higher than the national average included Andhra Pradesh (0.69%), Meghalaya (0.54%), Telangana (0.49%), Karnataka (0.47%), Delhi (0.41%), Maharashtra (0.36%), Puducherry (0.35%), Goa (0.27%), Punjab (0.27%), Dadra and Nagar Haveli (0.23%), and Tamil Nadu (0.23%). Maharashtra had the highest estimated number of PLHIV (3.96 lakh), followed by Andhra Pradesh (3.14 lakh), Karnataka (2.69 lakh), Uttar Pradesh (1.61 lakh), Telangana (1.58 lakh), Tamil Nadu (1.55 lakh), Bihar (1.34 lakh) and Gujarat (1.04 lakh). Together, these eight States constituted 72% of the total PLHIV estimates in the country.

Nationally, there were 69.22 thousand estimated new HIV infections in 2019. This translates into 190 new infections every day and eight new infections every hour.

Fig 5: Trends of HIV Prevalence in India from 1981 to 2019



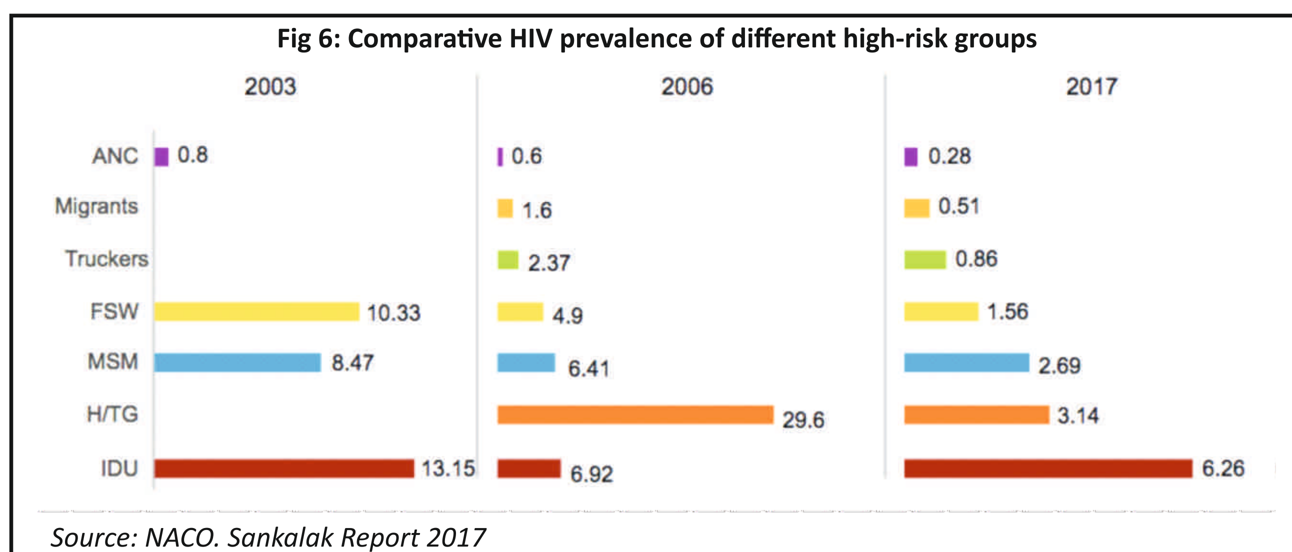
Source: India HIV Estimates Report 2019, NACO/ICMR/MoFWH

[10] National AIDS Control Organization & ICMR-National Institute of Medical Statistics (2020). India HIV Estimates 2019: Report. New Delhi: NACO, Ministry of Health and Family Welfare, GoI.
Accessible at http://naco.gov.in/sites/default/files/INDIA%20HIV%20ESTIMATES.pdf

Key Populations

Much of the HIV transmission in India occurs within groups or networks of individuals who have higher levels of risk due to a higher number of sexual partners or the sharing of injection drug equipment. They include female sex workers, men who have sex with men, transgender and *hijras*, people who inject drugs and people living with HIV and are collectively known as Key Populations (KPs). Trends of HIV prevalence among these groups are shown in the figure below.

Fig 6: Comparative HIV prevalence of different high-risk groups



Source: NACO. Sankalak Report 2017

There is a decreasing trend of HIV prevalence in all these groups from 2003 to 2017 (from 10.33, 8.47, 13.15 in 2003 among FSW, MSM and PWID respectively to 2.69, 3.14 and 6.26 in 2017). However, it is still much higher than in the general population where adult prevalence is 0.28 in 2017 and was estimated to be 0.22 in 2019. Thus India has a concentrated HIV epidemic.

Key populations exist across all socioeconomic and sociocultural sections and are an integral part of society. However, they get socially and economically marginalised due to many reasons and are therefore more vulnerable to acquiring and transmitting STIs and HIV/AIDS.

1. Men who have sex with men (MSM) exist across social groups (age, education, marital status, class, caste, race, faith, location, occupation). Male-to-male sexual/romantic relations may occur one-off, in specific phases or consistently throughout life. Socio-legal stigma leads to economic exclusion and leads to many MSM engaging in exploitative sex work.

   WHO and international mental health bodies no longer list homosexuality as a mental disorder. HIV risk factors for MSM include unprotected penetrative sex (anal, oral, vaginal) with multiple partners which are further increased under influence of drugs, alcohol. Other health concerns that accompany HIV risk include STIs, TB, HBV, HCV, rectal injuries and mental illness.

   Factors increasing their vulnerability to HIV include low condom use due to unwillingness on part of partners/clients for protected sex, fear of violence by partners/clients or trust in specific partners/clients (close relationship). Socio-economic distress (destitution, need for livelihood) and need to finance substance use (drugs, alcohol) can push them to sex work. Socio-legal stigma (social attitudes), criminalization, Invisibility, discrimination by service providers impact health services access (preventive, treatment).

2. Transgender: This is an umbrella term used for men who are biologically male but identify as either women or as both men and women. As per the IBBS report in 2014. In some of the urban states, the HIV positivity among transgender women is as high as 40%. Health care stigma towards transgender people, unavailability of special wards for transgender people in hospitals, lack of specific skills of doctors to perform sexual reassignment surgeries, high cost of these surgeries are some of the barriers for the transgender person for accessing health. In some of the prominent studies, it has been notified that almost 50% of transgender women face major mental health issues including substance dependence and also acute depression.[11] All these factors increase their vulnerability to SRH and HIV.

3. Female sex workers: Women from all sections of society may engage in sex work, for example, rural or urban, highly educated or with low education, married or unmarried or widowed. They may have been trafficked or forced into sex work to support their or spouse's habit of drug use. Depending upon from where they operate, they are classified as brothel-based, street-based, lodge or *Dhaba*-based or home-based. HIV risks include penetrative unprotected vaginal, anal or oral sex. The risk is increased with pre-existing STI and if under influence of drugs or alcohol. If pregnant, vertical transmission of HIV and syphilis to newborn baby can happen. Vulnerabilities include the inability to negotiate condom with clients/partner, economic compulsions, fear of violence from the client, pimp or partners, criminalisation and stigma and discrimination.

4. People who inject drugs: The HIV risk in this group is due to unsafe sex and injecting practices (sharing needles and syringes with an infected person). Sex work to support the drug habit increases their risk. Vulnerabilities include social stigma, discrimination by service providers, socioeconomic deprivation, criminalization and violence.

National Strategies for Control of HIV/AIDS:

To combat the HIV epidemic, the National AIDS Control Programme (NACP–I) was launched in 1992. The program has evolved over the years and four phases have been implemented. Major milestones include:

MILESTONES

- **1986 : first case of HIV detected, AIDS task force set by ICMR.**
- **1990 : medium term plan launched for 4 states & 4 metro.**
- **1992 : NACP 1 launched & NACB constituted.**
- **1999 : NACP 2 begins, SACS established.**
- **2002 : NACP adopted.**
- **2004 : ART started.**
- **2007 : NACP 3 launched for 5 years.**
- **2012 : NACP 4 launched for next 5 year.**

[11] Know Violence Study by UNDP and ICMRW).

Some of the important strategies that have helped reverse the epidemic include:

1. **Targeted Interventions (TI):** Since India has a concentrated epidemic, HIV prevention has focused on interventions with key populations (FSW, MSM, TG and PWID) and bridge populations (Migrants and Truckers). Acknowledging the stigma discrimination faced by these populations and that barrier to accessing health services exist for them, services for STI/HIV prevention and care are offered to them at the community level in a safe environment. They are provided with information, means and skill they need to minimize HIV transmission and improving their access to care, support and treatment services. The package of services include:

    i. Behaviour change communication.
    ii. Screening and treatment for STI.
    iii. Condom and lubricant distribution-free and social marketing.
    iv. Creating and enabling environment.

2. **Sexually Transmitted Infection (STI) and Reproductive Tract Infection (RTI) Control and Prevention**: Early diagnosis; appropriate and complete treatment of STI/RTI reduces the transmission rate of HIV infection by more than 40 percent. Syndromic Case Management (SCM), with minimal laboratory tests, is the cornerstone of STI/RTI management under the National AIDS Control Programme. Suraksha clinics have been set up in coordination with NHM at government hospitals. Regular check-ups for key populations are done and STIs are treated with colour coded packs.

3. **Elimination of Parent to Child Transmission of HIV and Syphilis (EPTCT):** EPTCT includes a strategy for reducing vertical transmission of both HIV and syphilis from mother to child in line with the global commitment of eliminating vertical transmission of HIV and syphilis by 2030. The program now includes:

    a. Detection and treatment of **syphilis in pregnancy as part of STI prevention program.**
    b. **Prevention of mother to child transmission of HIV (PMTCT)** aimed at reducing vertical transmission of HIV from mother to child. PMTCT has four-prong strategy:

        i. Prevent HIV infection among women.
        ii. Prevent unintended pregnancies among women living with HIV.
        iii. Reduce mother-to-child transmission of HIV by antiretroviral treatment or prophylaxis, safe delivery and infant-feeding counselling.
        iv. Provide care, treatment and support to the woman living with HIV to keep her healthy.

Infants exposed to HIV are tested under the Early Infant Diagnosis (EID) programme and linked to ART centres if found positive.

4. **Care, Support and Treatment for HIV:** A healthy lifestyle with a regular routine, positive thinking and family support helps people living with HIV (PLHIV) in better management of the infection. In this, the health care system and community-based organisations/faith-based organisations work together in providing medical care, counselling, economic and legal support to people living with HIV/AIDS and their families. The services provided under NACP include:[12]

   i. Laboratory services for CD4 Testing, Viral Load testing, Early Infant Diagnosis of HIV in infants and children up to 18 months of age.
   ii. Free first line & second line Anti-Retroviral Treatment (ART) and paediatric ART through ART Centres and link ART Centres, Centres of Excellence & ART plus centres. By September 2015, there were 519 functional ART centres, 1073 Link ART centres and 52 ART plus centres have been established. Centers of excellence have been set up in medical colleges and provide treatment for complicated OI, training and research services as well.
   iii. Nutritional and psycho-social support through community and support centres; More than 350 such centres have been established countrywide.
   iv. HIV-TB coordination (Cross-referral, detection and treatment of TB coinfection).
   v. Treatment of opportunistic infections (OI).

5. **Test and Treat All: Early detection is the key to ensuring quality life for those living with HIV:** An early diagnosis of positive HIV status helps prevent and significantly delay morbid conditions associated with HIV/AIDS. To end the AIDS epidemic by 2030, the goal of 90-90-90 has been adopted:

   a. 90% of people know their HIV status.
   b. 90% of people with known HIV positive status access treatment.
   c. 90% of people receiving treatment have suppressed viral loads.

In line with WHO guidelines, current national policy is to encourage people with risk behaviour to test early and start treatment for HIV as soon as detected to be HIV positive, irrespective of his or her CD4 count. This will help the patient live healthier life longer.

Other strategies include:

- Focusing on IEC strategies for behaviour change in HRG, awareness among the general population and demand generation for HIV services.
- Blood Transfusion Programme.
- Reducing stigma and discrimination through Greater involvement of PLHA(GIPA).
- The de-centralizing rollout of services including technical support.
- Integrating HIV services with health systems in a phased manner.
- Mainstreaming of HIV/AIDS activities with all key central/state level Ministries/departments will be given a high priority and resources of the respective departments will be leveraged. Social protection and insurance mechanisms for PLHIV will be strengthened.

[12] Annual Report 2015-16, National AIDS Control Organization

Risks, Vulnerabilities and SRH Needs of Female Sex Workers

Some people are less able to manage their exposure to STIs, HIV or unintended pregnancy than others. This can put them at greater risk of HIV infection and other SRH problems.

Risk refers to the probability or likelihood that a person will become infected with HIV and encounter other SRH problems. Particular behaviours and practices, such as unprotected sex and sharing injecting equipment, increase the risk of acquiring HIV. The degree of risk depends on many factors, such as the HIV status of a person's sexual partners, and genital health.

Vulnerability refers to the range of factors that reduce a person's ability to avoid risk. For example, sexual feelings and needs, gender norms, lack of information, poverty, lack of access to services and commodities such as peer education, condoms or other contraception, all increase a person's vulnerability to HIV and other SRH problems. Stigma, discrimination and other human rights violations, criminalization of certain sexual behaviour, sex work and injecting drugs increase vulnerability to HIV by making one excluded from society or secretive about the sex s/he has and limiting their ability to access or use STI/HIV prevention, treatment and care support services. These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.

Vulnerability factors differ for different population groups, and key populations (MSM, Hijras, female sex workers, people who inject drugs) are at substantially higher risk due to a variety of factors. Among the general population, women are more vulnerable and this vulnerability increases even more for younger women and sex workers. These factors include:

Biological factors:[13] HIV is transmitted twice as easily from men to women as from women to men due to higher exposure of vaginal mucosa to male secretions. STIs and RTIs further increase the probability of acquiring HIV.

Cultural and gender norms: Relationship dynamics between men and women and culturally embedded gender inequalities make it difficult for women to practice safe sexual practices. Women are expected to submit to men's sexual needs and control their own sexual behaviour; inequality between men and women affecting decision-making, choice and access to resources, with men deciding about when to have sex, whether or not to use contraception; higher acceptance of violence towards women; lesser opportunities for education.

Economic factors: Poverty, lack of employment and financial dependence on men, Women's ability to use sexuality to earn a higher income than other available work may increase the risk of infection.

In addition to the above, sex workers face:

Stigma and discrimination: Sex workers experience stigma and discrimination demonstrated through physical and verbal abuse, and often criminalization. The focus on HIV/STI prevention omits other SRH needs such as family planning and MNCH.

Criminalisation of sex work: Only 21% of countries have anti-discrimination laws that protect the rights of sex workers.[14]

[13]8. UNAIDS (2010): 'Report on Global AIDS Epidemic 2010. Available at: www.unaids.org/documents/20101123_GlobalReport_em.pdf

[14]10. UNAIDS and WHO (2009), 'AIDS epidemic update'. Available at: http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf

Societal attitudes: Social attitudes result in moralistic or punitive approaches to stop sex work rather than meet the SRH and HIV needs of sex workers. This ensures that a large proportion of sex workers are invisible and difficult to reach and do not access the required services.

Violence: Emotional, psychological and physical violence is common (see the section on gender violence) and is exacerbated when sex work is forced underground e.g. selling sex in more hidden, unfamiliar areas, limiting the ability to develop solidarity with other sex workers to build support and social capital, and negotiate with health and social service providers.[15] Lack of legal protection from the police and judiciary, even where sex work is legal due to societal attitudes or related activities such as soliciting for clients being illegal, making sex workers less likely to make a complaint to the authorities if they have experienced violence. Lack of understanding of sex workers' rights further compounds the situation.

Since many of them work as street sex workers, the likelihood of inconsistent condom use increases.

For **young adolescent girls**, vulnerabilities enhancing the HIV risk include lack of comprehensive sexuality, life skills and rights education, and services for SRH and HIV; negative cultural attitudes to young people's sexuality, resulting in stigma and discrimination; unequal power relations with adults leading to abuse; sexual abuse, violence, exploitation, coercive sexual experiences and early marriage; violations of rights, including a lack of participation in decisions that affect them; curiosity and desire to experiment; peer pressure; unavailability and inaccessibility to contraceptive counselling, screening for STI/HIV and treatment for young children[16]; desire to have sex and increased libido. These vulnerabilities may lead to unintended pregnancy, higher maternal and infant morbidity and mortality, and STIs including HIV.

SRH needs and action needed to address these unmet needs, therefore, varies with different groups. The young adolescents require comprehensive sexuality and life skills education and services tailored to their needs; acceptance of their sexuality and protection from sexual abuse and exploitation; information on the physical, emotional and hormonal changes; SRH education including contraceptive counselling and access to condoms; RTI, HIV treatment and care for children and young people living with HIV.

For women, it is important to ensure equality in sexual and reproductive decision-making, an equal share of resources and promoting economic independence for women; increase access to a choice of contraceptives, condoms and comprehensive SRH services; address gender-based violence.

For sex worker, counselling on preferred contraceptives, condoms and other safer sex methods (intrauterine devices alone may increase risk of HIV/STI infection); discussion of the impact of hormonal pills, injections or implants on menstrual bleeding; counselling for sex workers who want to conceive but ensure that their regular partner is the father or if they are HIV positive; Counselling on sex work during pregnancy and reducing the risk of STIs and HIV for the mother and foetus; discussing anti-violence strategies with sex workers, providing support for collectivisation and creation of safe spaces and link up with sex-worker friendly legal, health and support service providers; supporting the mother to attend antenatal care, and plan for where she will deliver, costs and care for the baby after it is born.

[15] International HIV/AIDS Alliance (2008),'Sex work, violence and HIV. A guide for programmes with sex workers.' Available at: www.aidsalliance.org/includes/Publication/Sex_%20work_violence_and_HIV.pdf

[16] 9. UNAIDS (2008), 'Report on the global AIDS epidemic'. Available at: http://data.unaids.org/pub/GlobalReport/2008/JC1511_GR08_ExecutiveSummary_en.pdf

Gender Violence

Gender-based violence, or violence against women and other vulnerable groups like LGBTQ people such as MSM and transgender persons, is a major public health and human rights problem throughout the world. It is commonly perpetrated by men and is a widespread human rights violation.

Domestic violence or intimate partner violence: One of the most common forms of gender-based violence is that perpetrated by an intimate partner (husband, lover or male partner) against a woman. "Intimate partner violence is actual or threatened physical or sexual violence or psychological and emotional abuse directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner." (Saltzman, et. al., 1999).

Violence may occur in various forms (adapted from WHO TEACH-VIP, 2005):

- **Physical:** *slapping, kicking, burning, strangulating.*
- **Sexual:** *coerced sex through force, threats.*
- **Psychological:** *isolation, verbal aggression, humiliation, stalking.*
- **Economic:** *with-holding funds, controlling victim's access to health care, employment, etc.*

Domestic violence is frequently invisible since it happens behind closed doors, and effectively when legal systems and cultural norms do not treat as a crime, but rather as a 'private' family matter, or a normal part of life.

Studies show that worldwide, between one quarter and one-half of all women have been abused by intimate partners and between 40-70 percent of all female murder victims are killed by an intimate partner.

The purpose of domestic violence is to establish and exert power and control over another. Violence against women has been recognized as having its roots in the subordinate role of women in private and public life in most contexts. The United Nations Declaration on the Elimination of Violence Against Women describes violence against women as "a manifestation of historically unequal power relationships between men and women". At the same time, violence is one of the "crucial social mechanisms by which women are forced into subordinate positions compared with men".[17]

According to international law, the rights violated by domestic or intimate partner violence include core fundamental rights that are protected under international law, such as the right to life and to bodily integrity.

Sexual violence occurs throughout the world, although in most countries there has been little research conducted on the problem. Sexual violence is perceived as a private matter and so it is difficult to estimate the extent of this kind of violence. Sexual violence is divided into three categories:

1. Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed;

2. Attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure;

[17]The United Nations Declaration on the Elimination of Violence Against Women.

3. abusive sexual contact[18]

"The act of forcing (or attempting to force) another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstances to engage in sexual behaviour against her/his will.. . it includes a wide range of behaviours from violent forcible rape to more contested areas that require young women to marry and sexually service men, not of their choosing." (Heise, Moore and Toubia, 1995).

Often, people who coerce their spouses into sexual acts believe their actions are legitimate because they are married.Sexual intercourse against one's consent will be called rape by any person regardless of their relationshi p to the victim, in any setting. But, the law has been slow to criminalize rape within marriage. Rape by a stranger can be highly traumatic but is usually a one-time event and is clearly understood as rape. Marital rape is likely to happen repeatedly.

Violence and key populations

Key population members are frequently regarded as easy targets for harassment and violence for several reasons. They are considered immoral and deserving of punishment. Criminalization of sex work, homosexuality, and drug use contribute to an environment in which violence against key populations is tolerated, leaving them less likely to be protected from it. Violence against sex workers, for example, from police, local criminals, boyfriends, or occasionally clients is considered to be 'normal' or "part of the job" and sex workers do not have access to justice. As a result, key population members are often reluctant to report incidences of rapes, attempted (or actual) murders, beatings, molestation, or sexual assault to the authorities. Even when they do report, their claims are often dismissed.

Rape may also be used to punish people for transgressing social or moral codes. Rape of women is also used as a weapon of war, as a form of attack on the enemy. Rape of MSM and transgender person is a common way to punish them for their dissident gender and sexual identities. In certain parts of the world, lesbians are subjected to what is called 'corrective rape', with the intention of changing their sexual preference.

Laws related to rape and sexual harassment in India

- Section 375 and 376 of Indian Penal Code addresses rape in India; Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) *Act*, 2013; Protection of Children from Sexual Offenses (POCSO)Act, 2012.

- The Indian Penal Code continues its restrictive recognition of sexual violence as heterosexual rape and offences against the modesty of women. As a result, men or transgender persons are not seen to be likely to be raped.

- The Indian law on rape is itself problematic in its traditional interpretation of sexual intercourse, the absence of sensitive procedures and medico-legal collection protocols, evidentiary requirements of signs of resistance to prove 'no consent', and the failure to take sexual violence seriously where a relationship exists between the survivor and the accused.

- Continuing social stigma associated with sexual violence based on notions of chastity and purity that the legal system perpetuates, has led to reluctance on the part of survivors and their families to report sexual violence or even seek other support services, hindering any possible assistance to the survivor in terms reducing trauma and the risk of HIV infection.

[18]CDC, 2007

- The response of the State in providing for the survivor has also been limited. Indian law does not provide for post-violence medical attention or counselling of survivors, or post-exposure prophylaxis if there is risk of contracting HIV.

HIV and violence

- Social tolerance of violence against women prevents women from discussing the issue, leaving or confronting an abusive situation or seeking help. Discrimination associated with HIV heightens such tolerance.

- Women are often the first member of a household to discover their HIV status, through antenatal testing. This can result in blame, violence, and rejection from partners or in-laws, family, friends, and community.

- Exposure to re-infection by the refusal by sexual partner, particularly husbands and regular boyfriends, to use condoms, can endanger key population members life due to HIV-related complications;

- Fear of disclosure of status may prevent a key population member, particularly if they are women, from accessing available ICTC, PMTCT programmes, and using safer infant feeding options, as a woman who doesn't breastfeed her child may be suspected of being HIV positive.

- During the rape, because of the force used, it is very much more likely that there will be tears to the lining of the vagina, something that will greatly increase the probability of transmission of STIs including HIV. During unprotected and forced anal sex the risk of transmission is even higher.

- During forced sex, younger women are especially vulnerable to injury to sexual organs and infections because their genital tracts are not yet fully mature, their vaginal secretions are not so copious, and because they are more prone to lacerations or tears of the vaginal lining.

- There is an additional difficulty of negotiation of the use of condoms or contraception in violent relationships.

Integration of Sexual and Reproductive Health Rights (SRHR) and HIV

Sexual and reproductive health include choice of sexuality, choice of reproduction as well as maternal, newborn and child health (MNCH) which refers to the health and well-being of women during pregnancy, childbirth and post-delivery, and the health of newborn babies and children until the age of five. The Sustainable Development goal of health for all cannot be realized unless sexual and reproductive health is attained for all men and women. Every person has the right to be provided with information and access to safe, effective, affordable and acceptable methods of family planning of their choice, and access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy child. A comprehensive service package for SRH can be provided through joining family planning/maternal child health services with HIV prevention and treatment services.

"Integration refers to one or more components of SRHR programming being integrated into one or more components of HIV programming; or vice versa. This includes referrals from one service to another, with the overall aim of providing more comprehensive support".[19]

Rationale

Unintended pregnancy, HIV and other STI infections are related to sexual behaviour and the underlying message for SRH and HIV programs remains the same – safe sex. Moreover, sexual and reproductive ill-health and HIV have similar root causes, such as gender inequality, poverty, stigma and discrimination, rights violations, and criminalization and legal issues. Integration of HIV and SRH services can address these root causes of vulnerability and help in reaching out to more people, especially the marginalized communities. Integration gives an individual an opportunity to access a wider range of services through a 'one-stop shop' than what they would have received through solely HIV or SRH programming. There is a reduction in stigma and discrimination related to HIV or sex work or drug use. The programs are strengthened due to more efficient use of human and financial resources, increasing cost-efficiency. Health care providers providing SRH services to the general population can help prevent, early detect and support those who are at risk of HIV (such as adolescent girls, pregnant women and women engaging in unsafe sex for pleasure or commercial reasons) if sensitized, thus providing an **opportunity to reach** this population with HIV prevention, treatment and care Similarly, people living with HIV can be reached at HIV services for sexual and reproductive health care including contraception, infertility treatment, STI management, cervical cancer screening and antenatal care.

Ultimately, integration aims to improve the dual health outcomes related to SRH and HIV, such as HIV/STI infections, AIDS-related deaths, unintended pregnancies and maternal mortality, cervical cancer and gender-based violence.[20]

Integration has been supported at the highest policy levels such as the 2006 and 2011 Political Declarations of the United National General Assembly Special Sessions on HIV/AIDS, the SADC Protocol on Health, the SADC HIV and AIDS Strategic Plan and the Maputo Plan of Action on Sexual and Reproductive Health and Rights. This has, in turn, led to national commitments to strengthen linkages between SRHR and HIV strategies, laws and policies, well as improvements in health systems and integrated services.

This can include providing the right information and counselling, promoting safe sex, and screening and treatment of STI and their complications.

To provide comprehensive services to women engaging in unsafe sex, two-way approach is necessary – combining support and services for HIV and SRHR. Integration can be bi-directional, i.e., SRH programmes can include HIV services and HIV programmes can include SRHR services. The integration of SRHR and HIV services can be quite challenging and need the partnership of community groups and organization, governments and international donors for successful implementation.

Integrated services can be provided through

1. **One-stop-shop** providing comprehensive service package. e.g., Kenya AIDS NGO Consortium's (KANCO programme) drop-in-centres providing HIV services (HIV counselling, testing, prevention, care and support) and SRHR services (such as STI screening and treatment, family planning services, safe abortion, MNCH services and PPTCT).

2. **Referral** where HIV service centre provides information and referral for SRH services e.g., India HIV AIDS Alliance's Mythri clinics in Andhra Pradesh (Outreach workers, counsellors and HCP were trained on SRH needs of sex workers and appropriate referrals were made for SRH), and

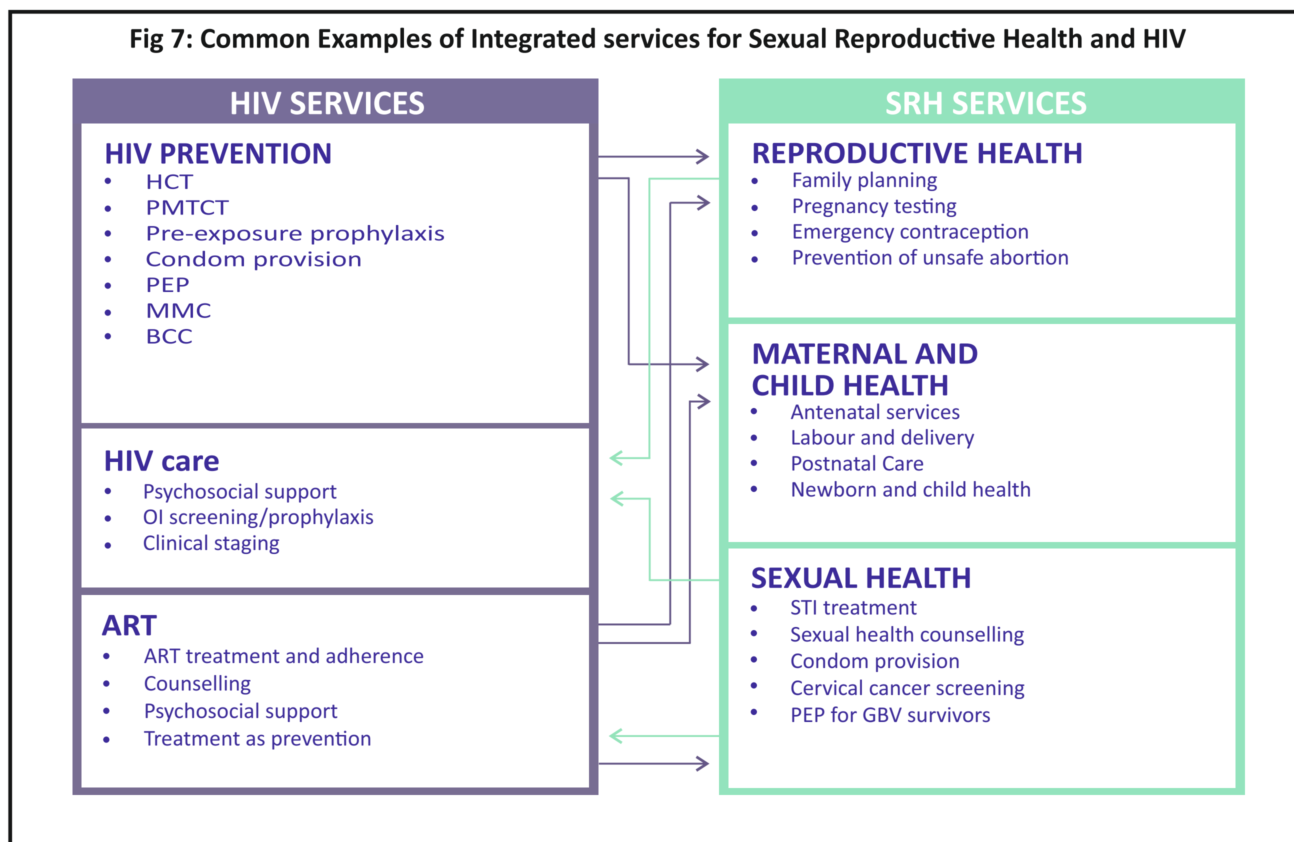
[19] WHO, USAID, FHI (2012). Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services.

[20] UNFPA. What is the evidence of effectiveness of SRH/HIV integration. Evidence Brief.

3. **Physical and functional integration** that include providing different services in the same room or different rooms of the same facility by two different providers or same provider at different times.

Any combination of these strategies could be used. Common examples of integration of services include the following:

Fig 7: Common Examples of Integrated services for Sexual Reproductive Health and HIV



Examples of Bi-directional Integration:

Fig 8: Examples of Bi-directional Integration

From SRHR to ⇨ HIV	From HIV to ⇨ SRHR
Family planning into HIV counseling and testing	HIV counseling and testing into family planning programs
Family planning into prevention of mother -to-child transmission	HIV counseling and testing into antenatal care including congenital syphilis
Family planning into HIV treatment, care and support	HIV treatment and care into community based reproductive health interventions
STI management including cervical and other cancer screening into HIV treatment, care and support	HIV treatment and care into post-partum care canters
Antenatal care into HIV treatment care and support	Antiretroviral therapy into SRHR service delivery programs
Preventing violence against women and girls into PMTCT programs	Promotion of male involvement in HIV prevention into SRHR services for men

Some of the platforms that can be used for integrating SRH and HIV services in India's public health system include:

S. No.	Facility/Program	Services to be added	Target group
1.	Family Planning/MNCH services	Education/counseling on STI/HIV	More suitable for married women
		Safer sex promotion, free condoms	
		STI diagnosis and management including syphilis test	
		PMTCT and VCT services	
2.	ART centers	SRH information	All type of clients
		SRH services if ART centers located in major secondary and tertiary facilities	
3.	HIV programmes (prevention/care and support centers)	SRH information	Key populations (PWID, FSW, MSM), migrants, clients/partners of sex workers
		SRH services	

In concentrated epidemics, it may be more effective to integrate SRH services in HIV programming that are already established for the key populations.[21]

Some successful examples of integrating SRH and HIV services include:

Gambi is a government centre, with 25 polyclinics on the same site. It joins services for SRHR (such as family planning, STI prevention, ANC and MNCH), HIV (such as HCT, ART and TB screening) and harm reduction (such as needle and syringe exchange, OST and Hepatitis screening). Services are delivered through in and out patients, health posts and mobile units. Women requiring maternal/child health services are referred to the MNCH polyclinic. Integration involved staff training (including in non-discrimination) and support group meetings. The lessons include that a centre's leaders must be committed to integration and, where possible, core SRHR services for women with high-risk behaviour (such as screening for cervical cancer) should be free.

Uganda: Network Support Model in Uganda trains people living with HIV on prevention, care, treatment and support. It offers community-based palliative care and adherence counselling and HIV prevention services. Some of these trainees are selected as Network Support agents who accompany and empower PLHIV for accessing community-based government health facilities for services such as family planning, STI, PPTCT, etc.

[21]International HIV/AIDS Alliance (2010). Integration of HIV and sexual and reproductive health and rights: Good Practice Guide.

Kenya: KANCO, running HIV program for sex workers provides services for HIV and STI prevention and treatment (information counselling, condom education and provision, HIV testing and counselling, STI screening and management, OI management, referral for ART, TB screening and referral). They have integrated services for family planning, PAP smear, breast examination and group empowerment activities. In addition, they have established support groups for those who are living with HIV and self-help groups to set up income generation activities. KANCO reports that they have reduced risk practices and there is greater uptake of HIV testing and other health services for self and partners as well. Major learning is that the service delivery should be flexible and adaptable. Programmes must also have medical, psychosocial and behavioural components, and friendly, non-judgmental attitudes.	**India:** a. India HIV AIDS Alliance in Andhra Pradesh provided counselling and STI services through Mythri clinics (Clinics based in drop-in-centre) to the key population for the Avahan program. These clinics also provided information and counselling on dual protection, condoms and oral pills, and referral for HIV testing, ART, PPTCT, safe abortion and other reproductive health needs. b. Social Awareness Social Organization, Imphal, Manipur, has added SRHR services to their HIV prevention and harm reduction program for women who use drugs and spouses of men who use drugs. Services include safe sex information and counselling, free condoms, syringe and needle exchange, STI diagnosis and management, HIV counselling and treatment, abscess management and hepatitis C testing and treatment at drop-in-centres and provide referrals for HCT, ART, MCH, OST, PMTCT, detoxification and legal aid. The medical services at the drop-in-center are provided by a female doctor and service providers are trained on the needs of women. A women-friendly environment at drop-in-centre, frequent group sessions to engage the women in HIV/SRHR and advocacy with doctors at government hospitals is needed for the success of the program.

Benefits of SRHR and HIV Integration:[22]

- Improved access to and uptake of key HIV and SRHR services.
- Better access of people living with HIV to SRHR services tailored to their needs.
- Reduction in HIV-related stigma and discrimination.
- Improved coverage of underserved/vulnerable/key populations.
- Greater support for dual protection.
- Improved quality of care.
- Decreased duplication of efforts and competition for scarce resources.
- Better understanding and protection of individuals' rights.
- Mutually reinforcing complementarities in legal and policy frameworks.
- Enhanced program effectiveness and efficiency.
- Better utilization of scarce human resources for health.

[22]UNFPA. What is the evidence of effectiveness of SRH/HIV integration. Evidence Brief

Challenges to be addressed in integrating SRH/HIV :[23]

- Overburden on existing services must be avoided so as not to compromise service quality but to ensure integration actually improves health care provision.
- Managing the increased workload for staff who take on new responsibilities, and increased costs initially when setting up integrated services and training staff.
- Combating stigma and discrimination from and towards health care providers has the potential to undermine the effectiveness of integrated services no matter how efficient they are in other respects. Judgemental attitude of service providers may drive the young people, PLHIV and key populations away.
- Reaching those who are most vulnerable but least likely to access services, such as young people and key populations such as, sex workers and men who have sex with men.
- Providing the special training and ongoing support required by staff to meet the complex SRH needs of HIV-positive people effectively.
- Ensuring community members are aware of their SRHR.

Recommendations for SRH-HIV integration:

Based on international learnings on the integration of these services, recommendations include:[24]

- Adopt a participatory and right based approach. Involving affected communities at all levels of programming and promoting their rights is a vital strategy to decrease stigma and discrimination (related to both HIV and KP vulnerability) and increase access to comprehensive support.

- It is not necessary to go for comprehensive integration right from the beginning, but might be preferable to start with the integration of selected services that are priorities for the community and are relatively easy to implement so as not to strain the over-stretched health systems.

- Recognize and respond to the significant diversity among people who engage in unsafe sexual behaviour and their HIV/SRHR needs.

- Promote HIV/SRHR integration at all levels, including building an enabling environment for sex workers. For example, raising awareness about key population's rights; training of staff and service providers at all levels.

- Ensure effective and creative service delivery for HIV/SRHR integration (community outreach to create demand, flexible services delivery mechanisms).

- Ensure the quality, confidentiality and 'key population friendliness' of referral systems and services.

- Advocacy for change in legislation/policies that act as a barrier to the provision of women-friendly services for the sex worker, women who inject drugs, and HIV positive women.

[23]International HIV/AIDS Alliance (2010). Integration of HIV and sexual and reproductive health and rights: Good Practice Guide

[24]HIV/SRHR Integration for key populations: A review of experiences and lessons from India and globally

Sexually Transmitted Infections

Reproductive tract infections (RTI) are infections of the genital area and include the infections acquired through sexual contact (sexually transmitted infections).

The global burden of STIs is high, with more than 1 million curable sexually transmitted infections (STIs) occurring each day. According to WHO global estimates for 2016, there were roughly 376 million new infections of the four curable STIs – chlamydia, gonorrhoea, syphilis and trichomoniasis.

Prevalence and incidence vary between regions, and are higher in developing countries (for instance, syphilis occurs 10 – 100 times more in developing countries). In terms of age, STIs are most frequent among the age group of 15-44 years, with new infections occurring during adolescence. In terms of gender, STIs occur more frequently among females than males between the ages of 14 and 19, and slightly more frequently among males after the age of 19.

Teenage girls, men and women with multiple partners, sex workers, and men and women whose job force them to be away from their families or regular sexual partners for long period have a higher risk of contracting STIs.

What is more, symptomatic STIs are only the tip of the iceberg. Most STIs are asymptomatic and if untreated, may cause long term complication (such as urethral strictures, pelvic inflammatory disease, infertility, endometrial and cervical cancer, poor pregnancy outcomes, involvement of heart and brain, vertical transmission to baby) and increase the risk of acquiring and transmitting HIV.

Risk of HIV, as well as STI, is through unprotected sexual intercourse. If a person has STI, not only the risk of acquiring and transmitting HIV increases, STI also leads to early progression of HIV disease to AIDS.

STI are a big public health challenge because of their rapid spread and economic and social burden for a country. Services for STI may not be available or are inaccessible due to attached stigma, poor health-seeking behaviour of clients, cost and difficult to reach populations (such as sex workers and MSM).

General approaches to STI management include:

Traditional clinical: Clinician takes history and does clinical exam, then uses his knowledge and past experience to diagnose a specific STI and treat.

Limitations include:

a. Studies show that clinicians using their judgment get the diagnosis wrong in up to 50% of cases since different STIs can cause similar symptoms and signs.

b. Mixed infections are common and only one of them may be diagnosed.

c. Failure to treat an infection may lead to development of complications and continued transmission.

Laboratory assisted: After clinical assessment, lab tests are used to diagnose STI/s and then treat accordingly.

Limitations include:

a. Requires skilled personnel, consistent support and supplies, which may not be available at the primary level.

b. Expensive for the patient.

c. The results of tests are not immediately available, so treatment for the infection does not begin on the same day and some patients may not return for treatment.

d. Unreliable for the diagnosis of some STIs and etiological diagnosis that tests for a single causal agent may miss other STIs.

Syndromic management: Syndromic management is based on the identification of consistent groups of symptoms and easily recognizable signs (syndromes) and the provision of treatment that will deal with the majority of organisms responsible for each syndrome. It does not depend on laboratory diagnosis and so no laboratory equipment or trained personnel is required.

SCM is so designed that the service providers can treat patients for STIs in the course of their normal patient contact at the time of first visit only. Any service provider who has been trained in history-taking, examination and the use of flowcharts for STI case management can confidently diagnose and treat patients with STIs. Makes STI care more accessible as it can be implemented at the primary health care level.

SCM responds to the patient's symptoms, is highly sensitive and does not miss mixed infections, provides comprehensive care for STI, giving opportunity and time for education and counselling on treatment compliance, risk reduction, and provision of condoms.

Six components of comprehensive care through SCM include:

- To make a correct diagnosis through history and clinical examination.
- To provide correct treatment for the STI syndrome.
- To educate on the nature of the infection, safer sexual behaviour and risk reduction.
- To educate on treatment compliance.
- To demonstrate the correct use of condoms and provision of condoms.
- To advise on the need to treat the patient's partners and to issue a referral card.

Limitations of SM:

a. It does not cover asymptomatic infections.

b. There may be over treatment in some patients.

Early diagnosis; appropriate and complete treatment of STI/RTI reduces the transmission rate of HIV infection by more than 40%. Syndromic Case Management (SCM), with minimal laboratory tests, is the cornerstone of STI/RTI management under the National AIDS Control Programme.

Suraksha clinics have been set up in coordination with NHM at government hospitals. The clinics provide:

- Free quarterly regular check-ups for key populations.
- Syndromic management of STIs with colour coded packs.
- Presumptive treatment for asymptomatic infection (gonorrhoea and Chlamydia) every six months.
- Condom demonstration and provision.
- Information, counselling and referral to ICTC for HIV test every 6 months.

Menstrual Hygiene: Lack of menstrual hygiene is one big contributing factor to reproductive tract infection. The risk of RTI further increases if sex workers engage in unprotected sex during the menstrual period. A range of absorbents are available (Disposable sanitary pads, biodegradable sanitary pads, home-made pads made from cloth, gauze and cotton, tampons, menstrual cups) and each has its own advantages and limitations. Correct use and disposal of absorbent is more important than the type of absorbent used. The *sanitary pads* and tampons must be changed frequently (at least once in 4-6 hours), even if the pad is not fully soaked to avoid infections and bad odour.

If menstrual pads made of cloth are being reused, they must be washed and dried in the sun before reuse. Many times to hide them from others these clothes are dried in damp hidden places. As these clothes remain moist they provide excellent breeding ground for infection-causing organisms. Disposal pads can be an environmental nightmare in the long run as they have plastic and do not decompose for hundreds of years. Their proper disposal by burning in incinerators or burial must be advocated. Alternately biodegradable sanitary pads may be used but are expensive.

Tampons, if forgotten inside the vagina can lead to toxic shock syndrome. In some places sex workers insert cotton in the vagina to soak menstrual blood. This is preferred because the cotton remains inside and the client cannot see anything from outside. But care has to be taken to properly take out all the cotton pieces from the vagina so that all pieces of cotton are out of the vagina, otherwise, serious infection can follow.

Menstrual cup is a safe option that is not an absorbent but is a type of cup or barrier worn inside the vagina during menstruation to collect menstrual fluid. The cups are safe when used as directed, and no health risks related to their use have been found.

Cervical Cancer: Persistent infection with Human Papilloma Virus (HPV) can lead to cervical and anal cancers, with HPV having been found in over 99% of cases of invasive cervical cancer (*Sankaranarayanan 2008*). The virus is sexually transmitted and has more than 100 subtypes. It is estimated that more than 50% of the sexually active population globally is infected with one or more subtypes of genital HPV; however, the infection resolves by itself in most cases. Only a few high-risk subtypes (mostly subtype 16 and 18) can trigger abnormal growth in the infected cell and lead to the development of cervical cancer.

It takes about 12-15 years for the infection to progress to invasive cancer. HIV, smoking, multiple births, early initiation of sex and long-term use of hormonal contraceptives are some of the co-factors that increase the risk of progression from cervical HPV infection to invasive cancer. There is evidence to suggest that women with HIV are likely to have ***carcinoma cervix*** at a younger age. During the long period taken for progression to invasive cancer,

the abnormal cervical cells pass through several precancerous changes offering us a unique opportunity for detection of precancerous lesions. If detected early, treatment of precancerous lesions can drastically reduce the incidence and mortality of cervical cancer.

A weakened immune system due to HIV puts women living with HIV (WLHIV) at a higher risk of HPV infection. There is evidence that WLHIV have a higher incidence of HPV infection, especially with cancer-inducing subtypes. They also have a higher viral load of HPV, and HPV infection progresses more rapidly to cancer. Worldwide, infection with HPV among WLHIV varies between 55 to 30% (Clifford 2006). In a study in Mumbai (Isaakidis 2013), HPV DNA was detected in 32% of the WLHIV studied. With decreasing CD4 counts, the prevalence of HPV infection increases the infection is more persistent and progresses rapidly. There is up to a 10-fold risk of having an abnormal pap smear among HIV-infected women than uninfected women, with a higher risk of these lesions progressing to invasive carcinoma. In a cross-sectional survey of 786 WLHIV conducted by Koshish, (a programme implemented by India HIV/AIDS Alliance for improving the sexual and reproductive health of WLHIV and most-at-risk populations), 5.6% had an abnormal pap smear.

Anti retroviral therapy (ART) does not appear to have much impact on reducing the progression of cervical dysplasia.

Cervical cancer is the most common cancer among women in India and the leading cause of cancer-related mortality. It is estimated that 134,420 women are diagnosed with cancer of the cervix every year and 72,825 women die, with India contributing to over a quarter of deaths due to cervical cancer worldwide. This is unfortunate, considering cancer of the cervix is preventable and also completely curable if detected early. With more than a million women living with HIV in India, who have now increased longevity due to improved access to ART, more HIV positive women are likely to develop cervical cancer.

Screening for Cervical Carcinoma:

Annual screening is recommended for women with HIV or at high risk of HIV. Screening is started from age of 21 (or 5 years after they become sexually active) or from the time they are detected HIV positive. In the general population, the test is recommended once in three years while The American College of Gynecologists (ACOG) recommends cervical screening of HIV-positive women once during the first year after HIV diagnosis and annual screening thereafter. Screening methods include:

1. **Papanicolaou** (**pap**) **smear:** Conventional screening method for cervical cancer is Pap smear. The test, though simple, requires trained cytology technicians and pathologists, and good health infrastructure and is not widely available in India. Even in the places where the test is available, uptake of the test remains low because of low awareness, high associated cost and multiple visits required to the health facility, since the test is not a point-of-care test.

2. **Visual inspection with acetic acid (VIA) or Lugol's Iodine (VILI) and HPV-DNA studies** have recently been studied for use in low-resource countries including India (*Sankaranarayanan 2007, Isaakidis 2013*). These studies have shown that VIA is more sensitive than VILI. The VIA is not only a reliable, simple, acceptable, feasible and cost-effective tool for screening but can also improve access to effective treatments of diagnosed cervical cancer. The advantage is that the results become available immediately, allowing for the lesions to be treated in the same visit. Recently, the **Government of Tamil Nadu** has introduced the VIA test[25] in primary healthcare centres (PHC), with plans to scale up to the entire state.

[25]htt://www.tnhsp.org/screening-cervical-cancer-and-breast-cancer

3. **HPV-DNA test** that detects the presence of high-risk HPV subtypes was found to be the most effective screening method in reducing incidence and mortality of cancer cervix in a large community-based trial in India. The sample is taken by inserting a swab in the vagina and can be self-collected. But, the test is expensive. Low-cost rapid tests have been developed but not yet commercially available.

There is evidence that the screen and treat programmes using VIA or HPV test are effective in preventing cervical cancer among HIV positive women (Denny 2005). Though HPV test is more sensitive than VIA, its cost can be prohibitive. VIA could be used as a primary screening method in the HIV-infected women since it is low cost and can be made widely available to most at-risk populations through nurses and midwives.

Apart from introducing the screening at PHC, there is an opportunity to integrate cervical cancer screening at ICTC, ART centre and the STI clinics of Targeted Interventions. There is a network of these clinics already available in all districts with high-prevalence HIV; expanded services to WLHIV and most-at-risk populations will help increase utilization of these clinics.

Primary prevention of HPV should be recommended through correct and consistent use of condom and HPV vaccine to reduce the incidence of genital warts and cervical cancer. Male circumcision is associated with decreased incidence of cervical cancer in the female partner but its role in reducing HPV transmission is not yet known.

Recently, two vaccines, one quadrivalent (against subtypes 16, 18, 6 and 11) and one bivalent (against subtypes 16 and 18) have been developed that provide more than 95% protection against HPV. The vaccines are effective only if given before the woman is infected with these subtypes of HPV. According to the CDC, preteen girls should be vaccinated at age 11 or 12 in a series of three shots over eight months. Young women can get the vaccine through age 26 and young men through age 21 if they haven't already been exposed to HPV.

The efficacy and safety of vaccine among HIV positive women is not yet known and requires more research.

Family Planning and Fertility Management

Family planning refers to the adoption of methods that allow the couple to choose when to have children and how many. Family planning benefits include improved maternal and child health, reduced maternal and neonatal mortality, increased productivity, and improved economic and social status of women. Every woman has the right to choose whether or not to have children, when to have and how many to have. Service providers must keep this right in mind while providing this service and ensure no woman is denied family planning options because of her age, sexuality, social or economic status.

The only contraceptive methods that provide double protection, (i.e., simultaneous protection against HIV and STI infection as well as unintended pregnancy) are the consistent and correct use of male and female condoms. However, women may not always be in a position to negotiate condom use with their partners. Under those circumstances, it is recommended that **dual methods of protection** be used through the consistent and correct use of male condoms in combination with another contraceptive method. This will enable the woman to have control over her fertility and provide 100 percent protection.

Women must be informed of all contraceptive options available along with their merits and demerits and help them choose the right option as would suit them best.

Safe Abortion and Post-Abortion Counseling

Abortion is a way of ending pregnancy before the fetus is mature, either through medicines or through surgery. The World Health Organization defines unsafe abortion as 'procedure for terminating a pregnancy that is performed by an individual lacking the necessary skills, or in an environment that does not conform to minimal medical standards or both.' Almost half the abortions performed worldwide are estimated to be unsafe and a leading cause of maternal deaths and ill-health. Abortions are responsible for 13% of annual maternal deaths globally. Consequences of unsafe abortions may include increased economic burden on poor families due to health costs and decreased productivity; long-term health problems, such as infertility; and considerable costs to already struggling public health systems.

Poverty, lack of access to quality services, stigma and discrimination at health facilities and unmet need for family planning are some of the important reasons for unsafe abortion. Unintended pregnancy and consequent abortions result when women do not want to be pregnant but are not using modern methods of contraceptives due to ignorance, misbeliefs, lack of access to family planning, or opposition by the partner to use contraception. Reducing the unmet need for modern contraception is an effective way to prevent unintended pregnancies, abortions and unplanned births.

In India, abortion is legal and as per the Medical Termination of Pregnancy (MTP) Law, a woman can have an abortion up to 20 weeks of pregnancy (5 months) with her consent. If she is below 18 years of age, consent from her guardian is required. Moreover, after 12 weeks (i.e., after the first 3 months) of pregnancy, the opinion of two medical practitioners is required to obtain abortion and only those with experience in obstetric care can provide the service.

As per law, only a qualified registered medical practitioner can provide abortion services in a hospital or clinic approved by the government to ensure safe and hygienic conditions. It is important to have an abortion by a qualified doctor in a government-approved facility to avoid any complications.

Abortion is a safe procedure but the risk of complications increases if it is performed after 12 weeks. It is safest if done before 8 weeks of pregnancy. Medical abortion can be done in up to 9 weeks of pregnancy after which surgical abortion is offered. Chances of incomplete abortion increase if more advanced pregnancy is terminated medically, requiring surgical removal.

Rarely, women may experience heavy vaginal bleeding or damage to the wall of the womb or cervix during surgical bleeding, more so if the abortion is being carried out between 12-20 weeks of pregnancy. This will require treatment through surgery.

Post-Abortion Care and Counselling

There is more risk of complications two weeks after the abortion than at the time of the abortion. These include infection, and vaginal bleeding if the abortion was incomplete and some tissue is left in the uterus. Therefore, it is important to go back to the doctor for follow-up if pain or bleeding persists or there is a fever.

The womb is soft and enlarged following abortion and takes 4-6 weeks to come back to its original size depending upon the duration of pregnancy at the time of termination. Maximum involution takes place in the first 7-10 days. Sex should be avoided until the bleeding has completely stopped as it may cause injury to the internal organs and increase the chances of infection. If there is an injury or infection of the genital organs, sexual activity should be resumed only after the healing is complete.

Women must be counselled to adopt the family planning method of their choice before resuming sex. Use of a condom along with an intrauterine contraceptive device (IUCD) or a hormonal contraceptive is the best option available. The pills can be started immediately after abortion while IUCD, vaginal ring or tubectomy can be started once infection is ruled out and genital injury, if any, has healed.

Infertility

Infertility is the inability to produce a child even after 12 months of unprotected sex. FSW may have reduced levels of fertility due to repeated STIs. Sexual desire may also be reduced if she or her partner is HIV positive. HIV can cause reduced sperm count and motility, and/or an increase in abnormal sperm forms. ART for HIV can improve sperm count and motility. The presence of pelvic inflammatory disease following any previous STI or infections of the reproductive tract caused by medical procedures can also lead to infertility. It is important to provide screening and treatment for STI and protect from infection during abortion or delivery to protect fertility. If a woman is unable to conceive, provide treatment and counselling support to enable the couple to have a child, including adoption and assisted reproduction, if available.[26]

The decision to have a child should be based on clear, accurate and up to date information, especially if one or both partners are HIV positive. The following options should be offered:

If both the partners are HIV positive, they should be advised to have sex during the fertile period of the menstrual cycle (10-18 day) to reduce chances of re-infection. Chances of transmission of HIV are low if the viral load is low, so if needed, ART should be initiated. Water-based lubricants should be used during sex to prevent friction and damage to the tissue lining the vagina and the head of the penis, thus further reducing the risk of HIV transmission or acquisition.

If only one partner is HIV positive (discordant couple), assisted reproductive techniques can be used. These include:

Artificial insemination

When only the woman is HIV positive, her partner's semen can be injected into the woman's vagina, eliminating the risk of HIV transmission for the male partner. This is a safe and inexpensive procedure, and the couple can be taught to try the procedure on their own. The man ejaculates in a clean container and this semen is then self-inseminated in the woman's vagina using a plastic syringe. The procedure should be carried out during the fertile period of the reproductive cycle.

Sperm washing

If the male partner is HIV positive, sperm washing provides a safe method for conception. It involves separating the sperm from the seminal fluid that is infected by the virus. The washed sperm is then tested for HIV and it is injected into the woman's uterus. The method is only available in leading infertility hospitals across the country and is quite expensive.

In-Vitro fertilization

The egg is fertilized with sperm in a laboratory and the embryo is then implanted in the womb where it develops and matures further. This is a good procedure when both people are HIV positive. This procedure is also available in infertility clinics outside the government set-up but can be expensive.

[26]WHO, UNFPA (2006). Sexual and reproductive health of women living with HIV/AIDS: Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings

Sex work during pregnancy

If the woman so desires, it is usually safe to have sex during pregnancy. Usually, there is no risk to the foetus from sex during pregnancy. The baby is fully protected by the amniotic sac and the strong muscles of the uterus. There's also a thick mucous plug that seals the cervix and helps guard against infection. The penis does **not** come into contact with the foetus during sex. Many women find that their desire for sex fluctuates during certain stages in the pregnancy. During the late stages, some women find it difficult to have sex due to their larger body size. On the other hand, some women find sex more pleasurable. Certain sexual positions may be more comfortable during pregnancy than others. Positions in which the pregnant woman is on top or on her side will avoid putting additional weight or pressure on her abdomen.

However, women must ensure protection during sex work to avoid contracting any STI/RTI as infection during pregnancy can worsen pregnancy outcomes. Number of clients could be reduced during the first trimester or last weeks of pregnancy to avoid miscarriages due to contractions during orgasm, and premature delivery due to a contraction stimulating chemical in semen respectively.

Prevention of Parent-to-Child Transmission of HIV (PPTCT)

HIV can be transmitted to the baby from an HIV infected mother during pregnancy, delivery or breastfeeding. In absence of any intervention, the risk of the baby acquiring HIV infection is 20-45%. Around 20.52 thousand pregnant women were estimated to need prevention of mother-to-child transmission (PMTCT) as per the India HIV Estimates report of NACO.

A four-pronged strategy[27] is recommended for the prevention of HIV transmission from parent to child. These include:

1. Prevent HIV infection among women.
2. Prevent unintended pregnancies among women living with HIV.
3. Reduce mother-to-child transmission of HIV by antiretroviral treatment or prophylaxis, safe delivery and infant-feeding counselling.
4. Provide care, treatment and support to the woman living with HIV to keep her healthy.

As per the Revised National Guidelines on PPTCT (released in January 2014), a triple-drug[28] regimen of antiretroviral drugs (Tenofovir, Lamivudine and Efavirenz) is given to all HIV-positive pregnant women irrespective of their CD4 count. The ART is continued life long to ensure better health for the woman. This provides early protection against mother-to-child transmission in future pregnancies and avoiding drug resistance.

The baby is also given Nevirapine daily from the time of birth for 6 weeks and thereafter Co-trimoxazole syrup is started once daily to prevent any infections. Co-trimoxazole is continued until the HIV status of the child is confirmed at 18 months of age. All children born to HIV positive mothers (exposed child) must be followed up regularly at the ART centres.

Exclusive breastfeeding should be given for the first six months.

[27] http://www.who.int/reproductivehealth/publications/linkages/fp_hiv_strategic_considerations.pdf?ua=1
[28] NACO (2014). National Guidelines for Prevention of Parent-to-Child Transmission (PPTCT) of HIV.

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Pre-Training and Post-Training Questionnaire

1. Which of the following is NOT necessarily included in SRH interventions?
   a. Nutritional support.
   b. Condom distribution.
   c. Gender based violence and/or crisis counseling.
   d. Fertility treatment.

2. Sexual and reproductive health includes:
   a. Emotions.
   b. STI diagnosis and treatment.
   c. Desires and physical pleasure.
   d. Infertility.
   e. All of the above.

3. A street-based female sex worker living with HIV is pregnant, and is in her first trimester. She wants to keep the child. As her physician, you should advise her to
   a. Opt for an abortion as she will transmit HIV to the child.
   b. Access PPTCT services to ensure that she minimises the risk of transmitting HIV to the child and then opt for sterilisation to avoid the future risk of pregnancy.
   c. Access PPTCT to ensure the safety of her child to be; access ART services for herself to manage the current pregnancy safely, and manage her own HIV infection; and access family planning counselling services and goods, so that she can be in charge of her fertility.
   d. None of the above.

4. A woman living with HIV has come to the local health care facility for the delivery of her baby. As the attending doctor you
   a. Refer her to the district hospital as you do not want to take the risk of possible HIV transmission among your other patients.
   b. Refer her to the district hospital as you do not have the necessary equipment and supplies to protect yourself from getting infected with HIV.
   c. Practice universal precaution and infection control protocols and deliver the baby at your facility.
   d. None of the above.

5. Universal declaration of human rights says that all human being irrespective of their age, sex, sexual orientation, ethnicity, religion, or wealth should enjoy all rights equally. However, in practice, some rights are more important than others for specific groups of people.

   □ True □ False

6. The sexual and reproductive health needs of female sex workers are _____________ than the sexual and reproductive health needs of other women.
   a. Vastly different.
   b. Somewhat different.
   c. No different.

7. Universal precautions should be used *only* when caring for people with HIV.

   □ True □ False

8. Please read the statements below carefully and tick the response that is nearest to what you *feel*.
   a. Women with HIV should not have children; it puts both the child and the mother at risk.
      □ Yes □ May be □ No
   b. If women could be prevented from selling sex for money, HIV would not have spread.
      □ Yes □ May be □ No
   c. Same sex activity is imported from western cultures.
      □ Yes □ May be □ No

9. What essential component of Syndromic case management is missing below:
   a. Establishing diagnosis through history and clinical examination.
   b. Treatment of STI with appropriate drugs.
   c. Information and counseling on risk reduction and provision of condoms.
   d. ______________________

10. Benefits of integrating sexual reproductive health (SRH) and HIV services include:
   a. Increased uptake of services.
   b. Increased outreach.
   c. Increased efficiency of healthcare system.
   d. All of the above.

11. Which of the following viral infections is associated with an increased risk for cervical cancer?
   a. Influenza.
   b. Human papillomavirus (HPV).
   c. Hepatitis.
   d. Human immunodeficiency virus (HIV).

12. Which of the following statements about Emergency contraceptive pill i(ECP) s true.
   a. ECP use is not safe in women who are HIV positive or on ART.
   b. ECPS can not be used more than once in the same cycle.
   c. Fetus is not harmed if woman accidentally takes ECP when pregnant.
   d. It is safe to have unprotected sex the day after taking ECP.

13. Health care providers cannot offer anything for women experiencing violence.

   □ True □ False

Answer key

1. a
2. e
3. c
4. c
5. False
6. c
7. False
8. a: no; 8b: no; 8c: no
9. Partner treatment
10. d
11. b
12. C
13. False

Note:

Note:

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