

MINISTRY OF HEALTH

National Centre for HIV/AIDS, Dermatology and STI

GUIDELINES FOR THE IMPLEMENTATION OF STI SERVICES

1. BACKGROUND

Sexually Transmitted Infections (STIs) facilitate HIV transmission by making STI patients either more infectious or more susceptible to HIV infection. This is true for Chlamydia, gonorrhoea, Trichomonas vaginalis and syphilis, chancroid and herpes which cause genital ulceration. STI care is thus an important strategy for AIDS control and prevention. STIs also themselves cause severe pain, disability and illness in women. STI care is therefore itself an important part of health services to reduce morbidity and mortality associated with STI in women.

From the viewpoint of HIV/AIDS prevention, it is recommended to strengthen STI services as a priority for the population groups with the highest prevalence of STI and the highest risk of STI and HIV infection. From the view point of reproductive health for women, it makes sense to integrate STI care in services for women, while attempting to reach the largest possible female population of reproductive age, including the youngest women, who bear the greatest burden of morbidity and mortality associated with STIs. STI care therefore has several aims, and involves different strategies.

2. IMPLEMENTATION OF STI SERVICES

The **National Policy and Priority Strategies for STD Prevention and Control** states that “an appropriate balance of three complementary STI prevention and care strategies shall be developed and implemented within the Kingdom:

- 1) the integration of comprehensive STI care as part of the Minimum Package of Activities (MPA) at the Primary Health Care level, including reproductive health and maternal and child health/family planning (MCH/FP) services, through use of the syndromic approach to STI management where laboratory support is not available;
- 2) special approaches for the early detection and treatment of persons at high risk of acquiring and/or spreading STIs including especially the routine or periodic voluntary testing and screening of high-risk asymptomatic persons; and
- 3) patient care with laboratory support for diagnostic evaluations, as part of the Complementary Package of Activities (CPA), at designated referral hospitals."

These guidelines are to help provinces implement this policy. They describe how to implement STI services of all three kinds.

3. INTEGRATED STI SERVICES FOR THE GENERAL POPULATION

STI care for the general population is part of the Minimum Package of Activities (MPA) delivered by primary health care services.

3.1 The health centre

- *Consultation room*

Where possible, men and women should be attended in separate consultation rooms. Each room should have enough space for medical history taking, IEC and counselling, and for clinical examination. Every effort should be made to ensure confidentiality during consultation.

- *Furniture and equipment*

Desk and chairs for clinical staff and patients to sit and talk; examination table, screen and lamp for clinical examination; a cabinet for written documents and drugs.

- *Small materials and consumables*

Register and Health Information System (HIS) reporting forms; IEC material; condoms and penis model for condom demonstration and distribution; speculums and disposable gloves for examination; syringes and needles, cotton and alcohol for benzathine penicillin injection.

3.2 The services

- *STI case management at primary health care level should follow the syndromic approach*

Syndromic management of STIs is straightforward and effective for symptomatic infections such as urethral discharge and genital ulcer. It is not for women from the general population with complaints of vaginal discharge. Vaginal discharge is mainly indicative of vaginitis, and all women with vaginal discharge should receive treatment for trichomoniasis and bacterial vaginosis. Women with symptoms and signs of yeast infection also need to be treated. In addition, women should be treated for cervicitis on the basis of the risk assessment adapted to the local context.

- *STI management must be combined with IEC and partner notification*

IEC includes condom promotion through condom demonstration and distribution. Notification of the partners of male patients should be strongly recommended.

- *Co-ordination between governmental and non-governmental sectors*

Where STI care is provided by NGOs prior to the implementation of government services, good co-ordination should ensure that services are not duplicated.

- *Regular supply of drugs and consumables*

The credibility of services depends in good part on permanent availability of STI drugs and consumables.

- *Cost-recovery*

Cost-recovery has been introduced, as a contribution to the health centre budget and to clinic staff allowances. But cost-recovery must be balanced against access; it is important to ensure that people are not excluded from treatment because they cannot afford it.

3. 3 The staff

- *Men and women should be preferably attended by male and female staff respectively.*

The Cambodian cultural context is such that health care and IEC for men and for women should preferably be provided by clinic staff of the same gender.

- *A non-judgmental attitude is fundamental when providing STI care.*

- *Competence is equally important*

The quality of services depends mainly on the competence of the staff. Competence is achieved by training, and maintained by regular monitoring and supervision (see below).

3.4 Quality of care (training, monitoring and supervision)

- *Training workshop in STI management*

Short workshops are organised to provide the basics to health care staff. Case studies and role-plays, and clinical training should complement the theory.

- *Clinical training*

Staff will be sent to clinics where lots of patients are attended, either in the government or the NGO sector. Exchanges of staff between provinces should be encouraged. New staff should find opportunities to get acquainted with speculum examination and with non-judgmental interaction with patients.

- *Monitoring tools and supervision*

A standard set of monitoring tools, prepared by NCHADS, in line with the '*Guidelines for the new Health Information System*' (MoH 1997) will be used together with supervision checklists for provincial health supervisors to monitor and supervise integrated STI services in a systematic way. Meetings will be organised once every six months by NCHADS for PAOs to discuss problems identified at supervision and work out solutions together. PAOs will be supervised on a regular basis to ensure that they are effectively and efficiently providing support for STI services.

4. IMPLEMENTATION OF TARGETED STI SERVICES IN HIGH RISK SITUATIONS

Female sex workers and male clients play a major role in the spread of the HIV epidemic in Cambodia. The latest HIV prevalence data have shown that the epidemic is still concentrated in the population groups with the highest sexual risk behaviour, even though it has started to spread into the general population. Sex workers and their clients should therefore be targeted in priority. Besides the Policy, targeted interventions have been endorsed by NCHADS in their National Strategic Plan. Cambodia has the advantage over neighbouring countries that sex work is better tolerated, even though it is illegal. Sex workers are therefore more accessible for prevention interventions. Cambodian men with economic power, or single, or away from their family frequently visit sex workers. Some groups, such as the military, police, and fishermen communities, are either concentrated or easily identified, and therefore more accessible for targeted interventions.

The following guidelines apply specifically to female sex workers and specific groups of men.

4.1 Identifying target situations and priorities

The urgent need to break transmission in high risk situations, where large numbers of sex acts take place among multiple partners, makes it important to focus STI care on concentrations of sex workers and male clients. Male population groups to target as priorities need to be identified at local level, depending not only on HIV and STI prevalence and other epidemiological criteria, but also on accessibility. These two criteria (concentration of sex workers, and accessibility of men) will be used to identify key priority provinces.

In a context of emergency, the Ministry's pragmatic recommendation has been to strengthen existing services, be they Government or NGO.

4.2 Targeting interventions

In high risk situations, HIV spreads between men and female sex workers, with new members in each group constantly at high risk of getting infected. Infected men spread HIV to new sex workers, who then transmit it to uninfected men. STI care will focus on brothel-based FSWs in the first place, who are both easily identified and accessible. Simultaneously, the risks to indirect sex work and their partners should be investigated, along with the feasibility of interventions for them.

A network of Government and NGO implementers will be created under the auspices of NCHADS for sharing of experiences and capacity building, with regular meetings as required.

The supply of drugs will be ensured for implementers participating in this initiative and who have the capacity to monitor their appropriate use.

5. STI CARE FOR BROTHEL-BASED AND INDIRECT SEX WORKERS

5.1 The settings

- *Accessibility of services is essential*

Most of the sex business is concentrated in urban areas. Health services targeting sex workers should be set up not far from sex work areas.

- *There should be a separate clinic for sex workers, or a separate consultation room with a separate entrance.*

Sex workers are a marginalized group. Experience from Cambodia and other countries shows that they care less about social stigma than about a familiar environment with friendly staff and good-quality service. There is also ample evidence that the general population does not like to mix with sex workers. In many provincial towns STI clinics have already been built at NCHADS' request. These clinics can concentrate their services on sex workers. Where separate clinics are not available, settings should be reorganised in order to provide services in a separate area with its own entrance.

- *Indirect sex workers should be attended separately from brothel-based sex workers.* Beer and karaoke girls don't want to be considered as sex workers. Seeking care at the clinic may be easier if they are attended separately from brothel-based sex workers. There may be no need to open a special clinic; offering services at different times of the day/week, depending on their preferences, may be enough.

- *Each clinic should have at least a waiting room and a consultation room for women.* An extra room for storage of drugs, consumable and IEC material is convenient but not indispensable. There should be enough chairs in the waiting room. Waiting time can last over one hour. A TV and video make the place more welcoming and waiting time shorter. Public toilets and drinking water should be available.

- *Although not indispensable, laboratory support is recommended for STI management in sex workers.*

Laboratory diagnosis has the advantage of reducing over-treatment. For example, where RPR testing is available, only patients testing positive require benzathine penicillin. Without testing facilities, all have to be treated. On the other hand, effective laboratory testing requires training, supervision and quality control.

5.2 The services

- *Effective STI management is essential for HIV prevention.*

The pilot management guidelines developed for NCHADS in Sihanoukville under the 100% condom use pilot project are the best option for the time being. The risk of sexually transmitted HIV increases 2 to 5 times in the presence of STIs. Treating STIs effectively has been shown repeatedly over the past few years to reduce the risk of sexual transmission of HIV. Unfortunately, syndromic management of STIs is totally inadequate for *asymptomatic* infections. The risk assessment for cervicitis in

symptomatic patients with complaints of vaginal discharge does not apply to sex workers. Targeted mass treatment at the first visit, followed by routine monthly control and the use of a specific risk assessment for cervicitis are the only alternative for the time being in Cambodia.

- *STI management must be combined with IEC*

IEC includes condom demonstration and promotion. Videos can be shown in the waiting room for further IEC. Sex workers' boyfriends should be invited to attend the clinic (see below).

- *General health care / non-health services ("Integrated care for sex workers")*

Even if STI care is an objective priority for sex workers' health and HIV prevention, it may not be perceived as such by the target group, especially compared with other pressing problems such as physical violence and care for dependants. The problems are likely to vary among work sites. Voluntary counselling and testing for HIV should be offered once specific services for HIV+ patients are in place. Assessing sex workers' personal needs through group discussions and outreach should help define priorities. Addressing some of the issues through the STI clinic or through NGOs is likely to improve sex workers' health seeking behaviour. This is especially true for indirect sex workers who cannot be forced to attend the STI clinic' services.

- *Co-ordination between governmental and non-governmental sectors*

Where interventions for sex workers are being implemented by NGOs prior to the government sector, good co-ordination should ensure that services are not needlessly duplicated.

- *Regular supply of drugs and consumables*

The credibility of services depends on the availability of STI drugs and other consumables. Adequate supplies of drugs must be regularly ordered through the OD pharmacy. Consumable includes disposable injection material and antiseptic for injectable drugs.

- *Cost-recovery*

Cost-recovery has been introduced in Cambodia by the Ministry of Health. Although it is a government policy, it should be weighed against accessibility of services. Sex workers' attitude vis-à-vis cost-sharing may vary among worksites and should be taken into account locally. Assessing sex workers' willingness to share costs is part of building up a relationship of mutual trust between the target population and the clinic.

5.3 The staff

- *Management of the clinic*

STI clinics for targeted services will be managed by the staff of the PAO.

- *Sex workers should be attended by female staff.*

The Cambodian cultural context is such that health care, IEC (and outreach) should preferably be provided by female staff.

- *Friendliness is key*

This is fundamental. Health care workers should be fully aware about the type of population they are going to work with, and willing to interact with sex workers in a spirit of mutual trust.

- *Competence is equally important*

The quality of services depends mainly on the competence of the staff. Competence is achieved by training, both basic and refresher, and maintained by regular supervision (see below).

5.4 Quality of care (training, monitoring and supervision)

- *Training workshop in STI management*

All staff working in the clinic must have at least the basic training in targeted STI services. A short workshop is enough for the basics, especially if health care workers are already familiar with syndromic management. Case studies and role-plays are essential. Clinical training should complement theoretical training.

- *Clinical training*

Staff should be sent to clinics where lots of patients are attended, either in the government or the NGO sector. Exchanges of staff between provinces should be encouraged. New staff would find opportunities to get acquainted with speculum examination and with non-judgmental interaction with patients.

- *Monitoring tools and supervision*

Supervision and monitoring tools, prepared by NCHADS, in line with the '*Guidelines for the new Health Information System*' (MoH 1997) will be used together with supervision checklists for provincial health supervisors to monitor and supervise targeted STI services in a systematic way. Meetings will be organised as necessary by NCHADS for PAOs to discuss problems identified at supervision and work out solutions together. PAOs will be supervised on a regular basis to ensure that they are effectively and efficiently providing support for STI services.

6. STI CARE FOR MEN

Men do not seek care in the formal health sector, regardless of the quality of available services. There are probably several reasons. Men may feel ashamed to seek care for STIs; health care at the health centre is perceived as for women and children; they may ignore the formal health sector altogether, since treatment is on hand at the local pharmacy. Specific studies will be conducted by NCHADS to determine the best way to provide STI services effectively and efficiently to men.

6.1 Military and Police

Military and police have the advantage of having their own premises, as well as their own health care system, although it suffers from chronic shortage of funds. Where health services are refurbished, guidelines under section 3 are applicable. In particular, services for men should be “male-friendly”. Patients should be asked about their preferences.

7. STI CARE WITH LABORATORY SUPPORT AT DESIGNATED REFERRAL HOSPITALS

This section covers the integrated management of STIs where laboratory facilities exist. There can be found in some health centres and STI clinics in addition to referral hospitals.

7.1 The settings

The organisation of space, equipment and consumable should be found in documents related with the Complementary Package of Activities.

7.2 The services

At Provincial and National Hospitals, the combination of clinical and laboratory management of STIs should be applied. At Referral hospitals, STI case management should follow the syndromic approach with laboratory support. Updated recommendations for the syndromic management of symptomatic STIs with laboratory support are available. NCHADS will develop specific guidelines and training manuals for STI care in referral services, in line with those developed for the primary health care level.

For guidelines about IEC, partner notification, co-ordination, management of drugs and supplies, as well as cost-recovery, refer to section 3, above.

Likewise, guidelines with regards to staff and quality of care described in section 3 are equally applicable.

NCHADS
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