

REPRODUCTIVE SEXUAL HEALTH

**THE EMERGENCE OF
A STRATEGIC FRAMEWORK**

**SAMRAKSHA
2009**

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A STRATEGIC FRAMEWORK

ಸಂರಕ್ಷೆ
SAMRAKSHA
Adding Life To Years

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Acknowledgement

We would like to thank Sir Dorabji Tata Trust and JRD Tata Trust for their generous and continuous support to this programme right from its initiation. We would also like to thank MacArthur Foundation whose support in the development and growth of this programme was enormous. We would also like to thank Ms. Dipa Nag Chowdhury, Ms. Poonam Mutreja and Ms. Jasmine Pavri for their guidance and support. A special mention needs to be made of Dr. Chris Bakshi for her significant role in conceptualizing the programme.

This programme owes a lot to the dedication and commitment of Dr. Anuradha Srivatsa, Dr. Hemamalini Raghavan and Dr. Latha Manjunath, and we deeply acknowledge their contribution. We also appreciate the creative efforts of counselors, outreach staff and community volunteers who brought recognition to reproductive sexual health in the community.

First published in 2009. For private circulation only



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ABBREVIATIONS

ASHA	:	Accredited Social Health Activist
AIDS	:	Acquired Immuno Deficiency Syndrome
HIV	:	Human Immunodeficiency Virus
NRHM	:	National Rural Health Mission
NURM	:	National Urban Renewal Mission
RTI	:	Reproductive Tract Infections
RSH	:	Reproductive and Sexual Health
STI	:	Sexually Transmitted Infections
WWC	:	Well Woman Clinic



INTRODUCTION

Samraksha started working in the field of HIV in 1993, at a time when there was little understanding of either the HIV epidemic or its links with other health and development issues. HIV interventions at that time focused on testing, awareness generation and blood safety. Samraksha's early work in HIV spanned three main areas: focused prevention with groups at higher risk such as women in sex work, men who have sex with men (MSM) and transgender populations; HIV awareness and risk education with vulnerable groups such as men in prisons, women in vulnerable workplaces, youth in hostels and construction workers; and counseling, care and support for those affected by HIV.

The earliest prevention initiative was offering counseling services wherever HIV testing was being done. In Bangalore, in 1994, there were only two places, Victoria Hospital and Bowring Hospital, where HIV testing was offered. This was done by the 'Skin and VD' department along with services for Sexually Transmitted Infections (STI). Service uptake, however, was low among women. This was not surprising, as women who came to access services reported lewd remarks, sexual innuendos and sexual harassment at both the clinic and the laboratory. STIs were seen as evidence of not just "high risk behavior" but "immoral behavior" and seeking services for it was highly stigmatized.

At this time, Samraksha's preventive interventions with women in sex work were throwing up different patterns of risk among the women. Sex work was not confined to open sex workers who were based on streets or brothels. Part-time sex work existed among women in other professions: women in garment factories, beauty parlours, flower vendors, housemaids, sales girls and other petty vendors on the street. Within the urban slums, patterns of risk behavior, both commercial and transactional were reported widely. Not all women knew about STIs, and even if they identified STIs in themselves, there were few facilities for them. The state-run STI services were largely shunned by all women. Some of the open sex workers, especially those with florid STIs, accessed private practitioners. Most others just waited for it to remit or went to quacks who put them on a round of Penicillin injections. Some women also used practices recommended by quacks and friends which were unhygienic and often harmful. Existing services also did not attempt partner treatment, which is a critical component for managing STIs.

As Samraksha's work with women in sex work grew in Bangalore, proper medical consultations and treatment for STIs became critical. There was some advocacy with the STI consultants in the government hospitals but most women remained extremely reluctant to seek services there. Therefore, a Women's Reproductive Health Programme was conceptualized which could reach out to the women in sex work in their primary identity of "women" without categorizing them by risk behavior. The primary focus was Reproductive



Tract Infections (RTI) especially STIs among women. With time, the programme recognized the need to involve men and it took a more generic name: Reproductive and Sexual Health Programme. Men were first reached out to as partners, with women being the primary clients. As more and more non-sex workers started using the services, a separate service for men as well as couple counseling services were started.

This programme converged with and strengthened Samraksha's existing HIV interventions across the spectrum of reducing risk, vulnerability and impact of HIV on women. It addressed both the biological and psychosocial aspects of women's health. Women at different levels of risk with varying levels of risk perception and willingness to accept their risk behavior could be reached in their primary identity as 'women'. Many women who were vulnerable to HIV due to a lack of information could be reached through this service. Early detection and appropriate management succeeded in reducing the impact of STI and RTI on these women which included women living with HIV.

What evolved was a model of RSH service continuum that was holistic, sensitive and non-stigmatizing, which motivated and sustained health seeking behavior among women. This model worked in urban and rural settings, both in partnership with government organizations and as a stand-alone. It has potential for replication and scale-up.

These interventions evolved in response to emerging needs and newer components got layered on. Retrospective reviews of what worked and why, led to some conceptual frameworks. This document will describe this model and the processes that led to its development.



THE WELL WOMAN CLINIC

In 1996, the Well Woman Clinic(WWC) was established, which marked the beginning of Samraksha's Reproductive and Sexual Health stream of intervention. This started as a clinic based service and gradually expanded its scope and access to include outreach components. It also evolved certain simple components of service delivery which helped in personalizing the treatment to the client's context.

Operationalizing Sensitive, Non-stigmatising, Holistic Services

The concept of a Well Woman Clinic (WWC), was brought into Samraksha by Dr. Chris Bakshi. She was a gynecologist and senior genitourinary specialist with specialization in STI management from the UK. She spent 6 months with Samraksha as an Action Health volunteer and helped set up the clinic.

The distinctive aspect of the clinic was a focus on wellness, rather than illness. The clinic promoted the idea that women should have regular check-ups including speculum examination, even in the absence of any symptoms, since it was seen widely in clinical research and practice that many of the RTIs including STIs could remain undetected in women, because they were asymptomatic. This focus was also able to promote early detection and management of many STI/RTI.

The 'Well Woman' concept was particularly beneficial in the context of the vulnerable populations that Samraksha was working with. By focusing on woman's wellness, the clinic became a non-stigmatizing space, where women could access services without being identified by their risk behavior. Thus, women in sex work, women who were involved in transactional or multiple-partner sex, women who were aware of or suspected their partners' risk behavior and women who had no risk perception at all, could all access services at the centre. Sensitive probing on risk behavior, uniform processes of risk assessment without any presumption based on occupation and preserving confidentiality at all stages were some of the practices that led to building trust among the women. Sex workers felt comfortable bringing their friends and recommending the clinic's men's service to their clients. Mothers felt safe bringing their daughters.

Another unique feature of this clinic was its combined focus on Reproductive and Sexual Health (RSH). In mainstream health services, these two areas were vertically segregated: STI services were stand- alone services under the Skin Department without any connection with other RTIs which were not sexually transmitted; reproductive health services in hospitals and maternity homes had no facilities to screen for STIs.





The range of services also contributed to the non-stigmatizing environment, since the clinic could be seen as a women's clinic. It is interesting to note that with this identity, the clinic was able to attract women with different profiles. Although a majority of the women who reported for services were married, there were also unmarried and single women, who started accessing services. A rapid scan of the case sheets over a period of three years revealed that while most of the women reported as housewives or as those involved in other home-based work, there were also women who accepted and accessed the service in their identity of sex workers.

The clinic also used laboratory-based diagnostic methods, which helped in the management of more atypical and resistant infections. While syndromic management has been widely adopted in India in HIV prevention services because of its cost effectiveness, evidence is emerging regarding the need for etiological diagnosis as a back up. Studies reflect that there are variations between syndromic and etiological diagnosis, and relying only on syndromic management can lead to over diagnosis and over treatment (Remez, 2003; White RG et al, 2008 ; Clark JL et al, 2009). The growing consensus is that while syndromic case management allows for the integration of STI/RTI services right at the PHC level, periodic treatment reviews which compare diagnosis and prescriptions against simple laboratory tests are also necessary.

Samraksha's own experiences reflect this. Backing syndromic management with laboratory services, led to more accurate diagnosis and management, especially of some of the atypical or resistant cases. Good treatment outcomes in these situations encouraged continued service seeking from the clients. This proved to be an important factor in sustaining service seeking.



EXPANDING THE SCOPE AND PROMOTING ACCESS

Creating Accessible Points of Service Access

The Well Woman Clinic began as a centre-based service, but gradually an outreach component was added. This initially took the form of one-off community camps which were conducted when the demand for services stepped up in response to reproductive and sexual health education. Gradually, in some of the communities, a more systematic weekly clinic was run with local doctors who were trained by the WWC clinic staff. This helped to provide a sense of continuity and also encourage adherence and follow-up.

For about 5 years there was a partnership between Samraksha and the Bangalore Municipal Corporation when the concept of 'Well Woman Clinic' was integrated into 55 health centers which were part of the India Population Project 8 (IPP8). Samraksha trained the whole team including lab technicians, link workers and doctors on the basic concept of the Well Woman Clinic and offered support at the field level. Samraksha also functioned as a referral centre to which the doctors from these centers sent clients who had not responded to the syndromic treatment. After the end of IPP8, many of the centers continued to offer these services, despite losing the support of link workers in the field. The partnership continued for another 5 years in three centers. Here Samraksha continued to offer special weekly clinics, outreach education and support to the local doctors.

In the rural areas, village level health camps were backed up by a more regular weekly service at the Taluka hospital. Most of these clinics were managed by the government doctors themselves. Young doctors, trained in the Indian systems of medicine like Ayurveda, Unani, Siddha and Homeopathy (AYUSH) had been recruited in the Primary Health Centres (PHC) and were enthusiastic about integrating RTI management including treatment of STIs into their practice. Samraksha trained them in syndromic case-management of STI and RTIs and they provided the services at the PHCs. Many of them not only appreciated the training they received in this area, but also the chance to practise it as the outreach team and community volunteers were regularly making referrals to them.



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Outreach to Promote Reproductive Sexual Health Consciousness in the Community

An intensive community outreach was necessary, since women's health-seeking specially for the RSH concerns was governed by gendered social norms which gave scant importance to this. The outreach programme promoted RSH consciousness in the community through innovative means: story-telling, magic, games, exercises, discussions and education sessions. The education sessions within small groups were planned and developed into different modules to cover different topics like contraception, menstruation, STI/RTI, HIV, pregnancy and childcare using an interactive methodology.

Through this process, Samraksha was able to promote community ownership of the issue and also make the community realize its own potential to act as an agent of change. The outreach programmes helped identify and mentor 120 volunteers in the rural areas. Young women - both married and unmarried - who had an interest in reproductive and sexual health related issues and commitment to the community were developed as volunteers and trained.

These volunteers were initially service-centered and saw their primary responsibility as mobilizing people for the clinics. Gradually, they became more community-centered, initiating informal discussions on RSH issues in the community, motivating follow-up and adherence and even advocating with Panchayat Raj Institutions for more services for women. There was also a more informed referral to the service following the training, with about 15 percent of the clinic referrals made by the volunteers. (Latha BC, Badiger N and Iyengar S, 2007).

Community outreach also created an increasing demand for services. There were about 50 requests for clinics, either for new clinics in a village or follow-up clinics in older villages. These were made by influential members of the village: panchayat members, anganwadi teachers, school teachers, RMPs and village leaders, including religious leaders. All requests were backed by an offer to support the service in all ways, showing a move from interest and demand towards ownership and action.

The twin strategy of RSH promotion in the community and capacity building within the public health systems helped to sustain the change, once the organization phased out of direct service delivery. At a formal handing over ceremony, the community initially expressed dismay at the thought of the organization's phasing out; but immediately afterwards, they gathered forces and committed to ensure the continuation of services. The local PHC doctors agreed to continue providing services including drugs. The volunteers are continuing to educate, motivate and refer women to these services.



PERSONALIZING TREATMENT

The strength of this continuum was that it did not limit itself to medical services and the doctor's consultation. It created a space for the women to discuss their condition, understand the treatment plan and connect the information to their own reality. Within the Well Woman Clinic, the counseling sessions provided this space. In the outreach clinics, with high client loads, this was not always possible. Therefore, Samraksha developed and refined the concept of health advice as a critical part of these service.

Health advice was conceived as something between health education and counseling. It provided information to the women on their condition and the measures they needed to take to stay healthy. This was done in the context of their lives. It was also a space where women could ask questions and clarify their doubts. Health advisors could be field staff or community volunteers who went through a brief training.

Health advice had a positive impact in multiple ways. It provided the necessary health education but explored its uptake in the client's personal context. It was very beneficial in the area of partner treatment, giving an opportunity to explore with the client on how to achieve the end result of not getting re-infected and planning a winning strategy. Choices on whether to bring the partner to the clinic, or take him to a referral clinic elsewhere, or take a partner dose back for him were made by the women after considering their relationship with the partner and the situation at home.

These services were also useful in promoting more accurate clinical diagnosis in the syndromically managed STI/RTI clinics, by overcoming barriers for speculum examination. Speculum examination is a necessary part of syndromic management, but it has not been a common practice in India. So it provoked a lot of resistance initially, especially among asymptomatic women. There were fears of pain, damage to the cervix, secret sterilization, loss of virginity and concerns about cleanliness and hygiene. When women were asymptomatic, they saw no need to go through such a procedure. Health advice was useful in increasing the acceptability of the idea.

Later, the programme also developed this concept further, to a structured pre-examination counseling, where the concept was explained and demonstrated using a life size mannequin and different sizes of speculum.s Procedures to ensure cleanliness and hygiene were also explained in detail. Women were encouraged to ask questions and clarify their misconceptions. Counselors also shared other case stories in order to increase confidence of the clients.



The impact of health advice and pre-examination counseling was quite dramatic. When analyzing the acceptance levels among with women in the WWC, over a period of three years, it was seen that the acceptance of speculum examination increased from 77 % when there was no health advice or counseling to 82 % with the additional element of health advice and increased to 99.8 % when a structured pre-examination counseling was introduced (Hemamalini, Vimla M and Iyengar, S, 2007).

Health advice has now emerged as a good strategy that personalizes the service and the treatment to the context of the woman and gives a good experience of care. This is a crucial factor in promoting adherence and sustaining health seeking behavior. It is also an empowering concept, which reduces the distance between medical professionals and clients. It promotes a high level of help seeking and an informed and self-motivated adherence to treatment.





INVOLVEMENT OF MEN

Male involvement in Samraksha's reproductive and sexual health services was earlier limited to a referral to the hospital-based STI clinics and at best, some health advice. Some women felt taking home medication would be more viable as their partners would not agree to go to the STI services. But gradually, a demand for services for men grew. Women felt that if men could also first receive services from Samraksha including counseling, they could subsequently motivate them to go to the hospitals for services. Men themselves walked in to the WWC and asked for services. However, despite the demand expressed, male sexual health clinics started in the community had poor uptake for much of the same reasons that women had expressed: they were reluctant to access a stand-alone STI service. The term Male Sexual Health Clinic was considered stigmatizing, and men also preferred the anonymity of a more distant service rather than one in the same community.

Weekly Well Men Clinics began operating within the premises of the WWC. Later, an outreach men's clinic was also started in one community on demand. The need for anonymous service for men was further underscored when Samraksha started a RSH Helpline service, and many men started using this service to seek more information on sexual dysfunctions, doubts regarding masturbation and safe sex.

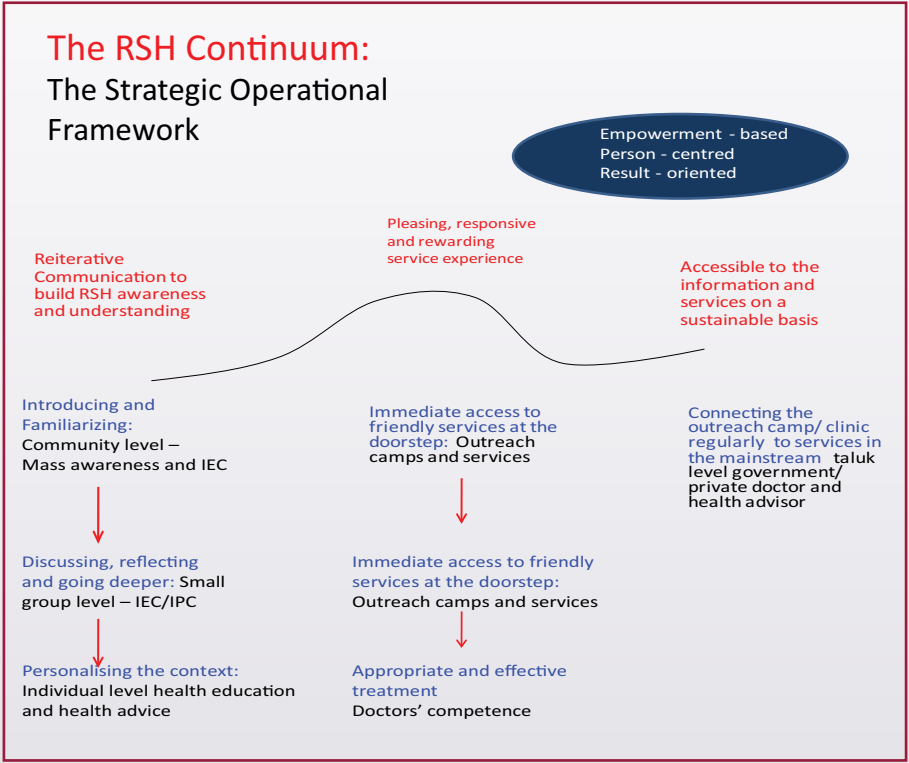
This was a significant step in promoting men's involvement in reproductive and sexual health. While the number of men accessing services increased sharply, it helped women motivate their partners to personally seek services with them. Couple counseling picked up, and since the clinic had not projected itself specifically as a STI service provider, couples started accessing services for problems like infertility, sexual dysfunction and sometimes even unconsummated marriages. This gave an opportunity to reach HIV and STI related information and services to them. Some of these problems including infertility were often related to untreated STIs. These conditions were reversed through successful STI management, These good outcomes spread by word of mouth, and led to patient to patient referrals.

Within this space of couple counseling, some people even disclosed their risk behavior, in the presence of their partners. These disclosures were helpful in facilitating more open discussions between partners as they jointly worked towards behavior change.



A CONTINUUM OF REPRODUCTIVE AND SEXUAL HEALTH SERVICES: THE MODEL

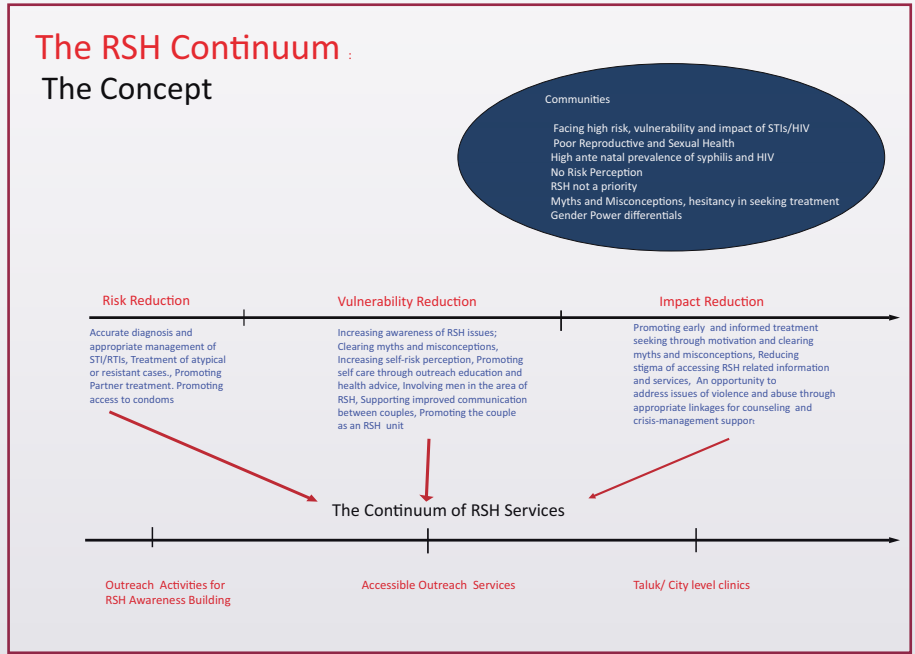
The primary learning from this experience was that reproductive and sexual health cannot be ensured through a single service but needs a continuum of services, which can reduce risk, vulnerability and impact of HIV and STI on women. More importantly, the need was to focus not just on the supply side but also on the demand side. The women needed to be motivated to seek the service. Even where they were convinced of the need, there was a hesitation in seeking help for RTI/STI because most women reported having had poor or unpleasant experiences in the health care setting and this created a block. The process of drawing out the women into the service, involving them in it and giving them a good experience of the service was critical.





This model of a continuum of reproductive and sexual health services consisted of a multi-pronged approach, where reproductive and sexual health related information was introduced and continuously reiterated in the community. With multiple levels of communication moving from the group to the individual, there was scope for deeper discussion. Mass awareness programmes introduced and familiarized the community to the issues of reproductive and sexual health. Building on this familiarity and using a funneling approach, more in-depth discussions with individuals and in small groups opened up spaces for personalizing the information to the contexts of the women. These led to the creation of a demand for services. Personalization and positive experience of the service motivated further service seeking.

This entire spectrum of services has the potential to reduce the risk, vulnerability and impact of HIV on women. Promoting early service seeking, accurate diagnosis and treatment reduces the risk of HIV and other STIs. An increasing awareness of reproductive and sexual health issues empowers women towards self-care.





All these allows women to gradually bring in their partners into the treatment fold; it also improves communication between partners. As women and partners start accessing services more regularly, stigma related to service seeking is reduced. Regular service seeking becomes a habit and the impact of many STT/RTI is reduced



CONCLUSIONS

Recent programmes like the NRHM, NURM and NACP III reflect a welcome recognition by the government of the importance of RSH and a commitment to strengthen these services. While the scale-up of services has the potential of bringing many women within the fold of reproductive and sexual health service seeking, it is very important to understand the entire social milieu within which women's health seeking behavior operates. This will help in making appropriate environmental modifications to ensure good service uptake and optimum utilization.

Samraksha's experience shows that providing reproductive and sexual health services as a continuum is a viable strategy and many elements of this approach can be scaled up within the national programmes. Within these new schemes, there are different cadres of workers, ASHAs, USHAs and Link Workers, all based in the community, who can promote an RSH consciousness through sensitive mass awareness strategies. Some of these health workers can also be trained as health advisors who can give personalized health advice, within the public health service. This has potential to start off a continued cycle of timely service seeking and good outcomes, which can gradually create community norms for early service seeking.



REFERENCES

1. Remez L (2003) Syndromic Diagnosis of Reproductive Tract Infections Leads to Substantial Unnecessary Treatment in Vietnam. *International Perspectives on Sexual and Reproductive Health Vol. 29*
2. White, RG Moodley P, McGrath N et al (2008). Low Effectiveness of syndromic treatment services for curable sexually transmitted infections in Rural south Africa *Sex Transm Infect doi:10.1136/sti.2008.032011*
3. Clark JL, Lescano AG, Konda KA, Leon SR, Jones FR, et al. (2009) *Syndromic Management and STI Control in Urban Peru. PLoS ONE 4(9): e7201 doi:10.1371/journal.pone.0007201*
4. Hemamalini, Vimla M and Iyengar S (2007) Pre-examination Counseling for Better Management of Asymptomatic Sexually Transmitted Infections. *Oral Presentation at Eight International Congress on AIDS In Asia Pacific, Colombo*
5. Latha BC, Nagaveni B and Iyengar S (2007) Vulnerable Women as Agents of Change. *Poster presented at the Fourth Asia Pacific Conference for Reproductive and Sexual Health. Hyderabad.*
6. Sanghamitra Iyengar (2007) NamArogya: The Reproductive and Sexual Health Programme of Samraksha. *Internal Document. Unpublished. Samraksha*



Samraksha started in 1993 as the HIV/AIDS sector of larger development organization, Samuha. Now an independent charitable trust, its goal continues to be to prevent the transmission of HIV and reduce its impact on the people vulnerable to and affected by it. Its current areas of operation are Raichur, Koppal, Gadag, Haveri, Dharwad and Uttara Kannada districts of Karnataka.

Samraksha believes that individuals and communities, if armed with information and power, can and will take responsibility to halt the spread of the epidemic. It believes that it is critical to empower entire communities to act.

It also believes that it is the right of every person living with HIV and AIDS to access care and support services in public, private and social sector. It is the responsibility of individuals, communities, private sector and the state to ensure this. Its belief in a prevention to care continuum has led to a range of initiatives across this spectrum.

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