INTERNATIONNAL TRAINING COURSE ON SEXUALLY TRANSMITTED INFECTIONS CASE MANAGEMENT SKILLS

A Training Course for Clinician

MODULE 10: PREVENTIONS AND CONTROLS STI IN ADOLECENT MSM AND SEX WORKERS

(1.5 Hours)

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Module 10:
Preventions and controls STI for adolescent MSM and sex workers

Topics covered in this module

In this module you will learn about the following:

1. Definition
2. Prevention and controls STI in Adolescent MSM and Sex workers
3. Fact about prostitution in Thailand
4. Why sex workers are vulnerable to STIs/HIV
5. Why we need to screen STI/HIV in SW
6. STI/HIV Prevention and control model in SW
7. STI screening and STI case management in FSW
8. Characteristics of STI screening services for SW

Learning activities

1. Lecture activities
2. Case-based learning activities
3. Discussion
4. Field visit and observation of outreach activities

Learning objectives

At the end of this module, participants will be able to:

1. Understand the situation of SW in Thailand
2. Understand STI/HIV prevention and control model for SW in Thailand
3. Explain STI screening and STIs case management for SW in Thailand
4. Understand characteristics of STI screening services for SW in Thailand

Definition of sex worker

Sex workers are those who are female, male or transgendered adults or young people who receive money, shelter or goods in exchange for sexual services, either in a regular basis or occasional circumstance.

Definition of Adolecent

who are female, male 10-24 years olds

Definition of MSM

The term “men who have sex with men” (MSM) describes a heterogeneous group of men who have varied behaviors, identities, and health-care needs

Adolescents

In the Thailand, prevalence rates of many sexually acquired infections are highest among adolescents and young adults For example, the reported rates of chlamydia and gonorrhea are highest among females during their adolescent and young adult years, and many persons acquire HPV infection at this time.

Persons who initiate sex early in adolescence are at higher risk for STDs, along with adolescents residing in detention facilities, those who use injection drugs, adolescents attending STD clinics, and young men who have sex with men (YMSM). Factors contributing to this increased risk during adolescence include having multiple sexual partners concurrently, having sequential sexual partnerships of limited duration, failing to use barrier protection consistently and correctly, having increased biologic susceptibility to infection, and facing multiple obstacles to accessing health care.

Despite the high rates of infections documented in the adolescent population, providers frequently fail to inquire about sexual behaviors, assess STD risks, provide risk-reduction counseling, and ultimately, screen for asymptomatic infections during clinical encounters. Discussions concerning sexual behavior should be appropriate for the patient's developmental level and should be aimed at identifying risk behaviors (e.g., multiple partners; unprotected oral, anal, or vaginal sex; and drug-use behaviors). Careful, nonjudgmental, and thorough counseling is particularly vital for adolescents who might not feel comfortable acknowledging their engagement in behaviors that place them at high risk for STDs.

Screening Recommendations

Routine laboratory screening for common STDs is indicated for sexually active adolescents. The following screening recommendations summarize published federal agency and medical professional organizations' clinical guidelines for sexually active adolescents.

- **Routine screening for *C. trachomatis*** on an annual basis is recommended for all sexually active females aged <25 years . Evidence is insufficient to recommend routine screening for *C. trachomatis* in sexually active young men based on efficacy and cost-effectiveness. However, screening of sexually active young males should be **considered in clinical settings serving populations of young males with a high prevalence of chlamydia (e.g., adolescent clinics**, correctional facilities, and STD clinics) and should be offered to YMSM (see Special Populations, MSM) .
- **Routine screening for *N. gonorrhoeae*** on an annual basis is recommended for all sexually active females <25 years of age . Gonococcal infection is concentrated in specific geographic locations and communities. Clinicians should consider the communities they serve

and might choose to consult local public health authorities for guidance on identifying groups that are at increased risk. Screening should be offered to YMSM (see MSM section).

- **HIV screening** should be discussed and offered to all adolescents. Frequency of repeat screenings of those who are at risk for HIV infection should be based on level of risk . Persons who test positive for HIV should receive prevention counseling and referral to care before leaving the testing site.
- **The routine screening of adolescents who are asymptomatic for certain STDs (e.g., syphilis, trichomoniasis, BV, HSV, HPV, HAV, and HBV)**.
- **cervical cancer screening begin at age 21 years**. This recommendation is based on the low incidence of cervical cancer and limited utility of screening for cervical cancer in adolescents .

Primary Prevention Recommendations

Primary prevention and anticipatory guidance to recognize symptoms and behaviors associated with STDs are strategies that can be incorporated into any or all types of health-care visits for adolescents and young adults. The following recommendations for primary prevention of STDs (i.e., vaccination and counseling) are based on published federal agency and medical professional organizations' clinical guidelines for sexually active adolescents and young adults.

- **The HPV vaccine**, bivalent, quadrivalent, or 9-valent, is recommended routinely for females aged 11 and 12 years and can be administered beginning at 9 years of age .
- **The HBV vaccination** series is recommended for all adolescents and young adults who have not previously received the hepatitis B vaccine .
- **The HAV vaccination** series should be offered to adolescents and young adults who have not previously received the HAV vaccine series.
- Information **regarding HIV infection, testing**, transmission, and implications of infection should be regarded as an essential component of the anticipatory guidance provided to all adolescents and young adults as part of health care .
- **Health-care providers who care for adolescents and young adults should integrate sexuality education into clinical practice**. Providers should counsel adolescents about the sexual behaviors that are associated with risk for acquiring STDs and educate patients regarding evidence-based prevention strategies, all of which include a discussion about abstinence and other risk-reduction behaviors (e.g., consistent and correct condom use and reduction in the number of sex partners). handouts, pamphlets, and videos) can reinforce office-based educational efforts.

MSM

The term “men who have sex with men” (MSM) describes a heterogeneous group of men who have varied behaviors, identities, and health-care needs . Some MSM are at high risk for HIV infection and other viral and bacterial STDs because MSM may practice anal sex, and the rectal mucosa is uniquely susceptible to certain STD pathogens. In addition, multiple sex partners, substance use, and sexual network dynamics of MSM increase risk for HIV and STDs in this population. The frequency of unsafe sexual practices and the reported rates of bacterial STDs and incident HIV infection declined substantially in MSM from the 1980s through the mid-1990s. However, since that time, increased rates of early syphilis (primary, secondary, or early latent), gonorrhea, and chlamydial infection and higher rates of sexual risk behaviors have been documented among MSM.

Approximately two thirds of the cases of primary and secondary syphilis diagnoses in Thailand are in MSM, particularly those in ethnic minority groups . Increased syphilis screening in MSM demonstrated a doubling of early syphilis detection; however, 71% of the syphilis diagnoses occurred when the patient sought care for symptoms . Acute HIV infection has been associated with a recent or concurrent STD, including syphilis, among **men** and several studies have demonstrated that early syphilis is associated with HIV infection among MSM . Factors associated with increases in syphilis among MSM have included substance abuse (e.g., methamphetamine), having multiple anonymous partners, and seeking sex partners through the internet .

Gonococcal infection in MSM has been associated with similar risk factors, including having **multiple anonymous partners and abuse of substances, particularly crystal methamphetamine** .

rectal gonorrhea and chlamydia screening in MSM might be a cost-effective intervention in certain urban settings .

MSM remain at highrisk for HIV and transmission in Thailand.

screening

- **HIV serology**, if HIV status is unknown or negative and the patient himself or his sex partner(s) has had more than one sex partner since most recent HIV test.
- **Syphilis serology** to establish whether persons with reactive tests have untreated syphilis, have partially treated syphilis, are manifesting a slow serologic response to appropriate prior therapy, or are serofast.

- **A test for urethral infection† with *N. gonorrhoeae* and *C. trachomatis* in men who have had insertive intercourse§** during the preceding year (testing of the urine using NAAT† is the preferred approach).
- **A test for rectal infection† with *N. gonorrhoeae* and *C. trachomatis* in men** who have had receptive anal intercourse§ during the preceding year (NAAT of a rectal specimen is the preferred approach).
- **A test for pharyngeal infection† with *N. gonorrhoeae*** in men who have had receptive oral intercourse§ during the preceding year (NAAT of a pharyngeal specimen is the preferred approach). Testing for *C. trachomatis* pharyngeal infection is not recommended.

† **Regardless of condom use during exposure**.

HPV infection and HPV-associated conditions (e.g., anogenital warts and anal squamous intraepithelial lesions) are highly prevalent among MSM. **The quadrivalent vaccine is recommended routinely for MSM through age 26 years** the efficacy of this vaccine in preventing HPV associated diseases in men aged >26 years is unknown.

All MSM should be tested for HBsAg to detect chronic HBV infection. Prompt identification of chronic infection with HBV is essential to ensure necessary care and services to prevent transmission to others . Screening among past or current drug users should include HCV and HBV testing. **Vaccination against hepatitis A and B is recommended for all MSM in whom previous infection**

Sexual transmission of HCV can occur, especially among MSM with HIV infection. Serologic screening for HCV is recommended at initial evaluation of persons with newly diagnosed HIV infection.

Transgender Men and Women

Persons who are transgender identify as a gender that is not congruent with the sex they were assigned at birth. Transgender women (“trans-women” or “transgender male to female”) identify as women but were born with male anatomy. Similarly, transgender men (also referred to as “trans-men” or “transgender female to male”) identify as men but were born with female anatomy. However, transgender persons might use different and often fluid terminology to refer to themselves through their life course. Gender identity is independent from sexual orientation. Persons who are transgender might have sex with men, women, or both and consider themselves to be heterosexual, gay, lesbian, or bisexual. Prevalence studies of transgender persons in the overall population have been limited and often based on small convenience samples.

Recommendations

Clinicians should assess STD- and HIV-related risks for their transgender patients based on current anatomy and sexual behaviors. Because of the diversity of transgender persons regarding surgical affirming procedures, hormone use, and their patterns of sexual behavior, providers must remain aware of symptoms consistent with **common STDs and screen for asymptomatic STDs on the basis of behavioral history and sexual practices.**

Fact about prostitution in Thailand

Several reasons for entering into sex business among Thai SW;

1. Lack of employment opportunities for well-paid jobs.
   Many of SW have low education, so that it very difficult for them to make good income. In order to have better life for themselves and their family, they decide to take a short cut to make a lot of money by selling sex. Interestingly, some parents are willing and encourage their daughters to enter into sex business and perceive that this is a way their daughter can show appreciation to the parents.
2. Some of uneducated rural women are deceived by someone/mafia. A common reason these people use to deceive them is to work in a restaurant, spa, hair dressing store, massaging places in urban area such as Bangkok, Phuket, Samui, and Pattaya.
3. Even though prostitution is illegal in Thailand, but the law has been seldom enforced and some police officers get benefits from this business, so that sex trading still exists.
4. Values of Z generation
   Due to the new values of materialism among young Thai generation, some of them are willing to engage in sex trade to meet their needs. Even though, some of them are educated and have regular job, they still work as part time sex workers.

Why sex workers are vulnerable to STIs/HIV

1. Unable to control its prevalence because sex trading is illegal so that there is no law/regulation to control sex establishment owners/workers with their sexual activities (condom use enforcement, rights to refuse clients).
2. Lifestyle risks (violence, substance use).
3. Lack of prevention knowledge and limited access to information and the means of prevention
4. Negative attitude toward condom use, especially with steady partners and husband.
5. Lack of awareness (susceptibility and severity) of STI and HIV transmission.
6. Stigmatization to access health care system for screening and treatment
7. Limited access to health services, STI clinics under the Provincial Health Office (PHO) have been closed nationwide, so that STIs screening had been decreased dramatically. The main purpose of STIs clinic under the PHO was

to monitor STIs situation including screening STIs for SW and providing treatment for STIs clients (cover both general people and SW). To receive STIs screening services, SWs are supposed to go to general/community hospitals, however, the purpose of STIs services in these hospitals are mainly for symptomatic patients which is different from STIs clinic under PHO. In addition, during this transitional period the work culture of the hospital and the lifestyle of SW are different, the Department of Disease Control try to advocate/empower staff of general/community hospitals to provide special friendly STIs screening services to these vulnerable groups.

8. Gender-related inequalities and inequity to negotiate the condom use.
9. Barriers to access health service due to sexual abuse and exploitation, including trafficking and child prostitution

Why we need to screen HIV/STIs in sex worker

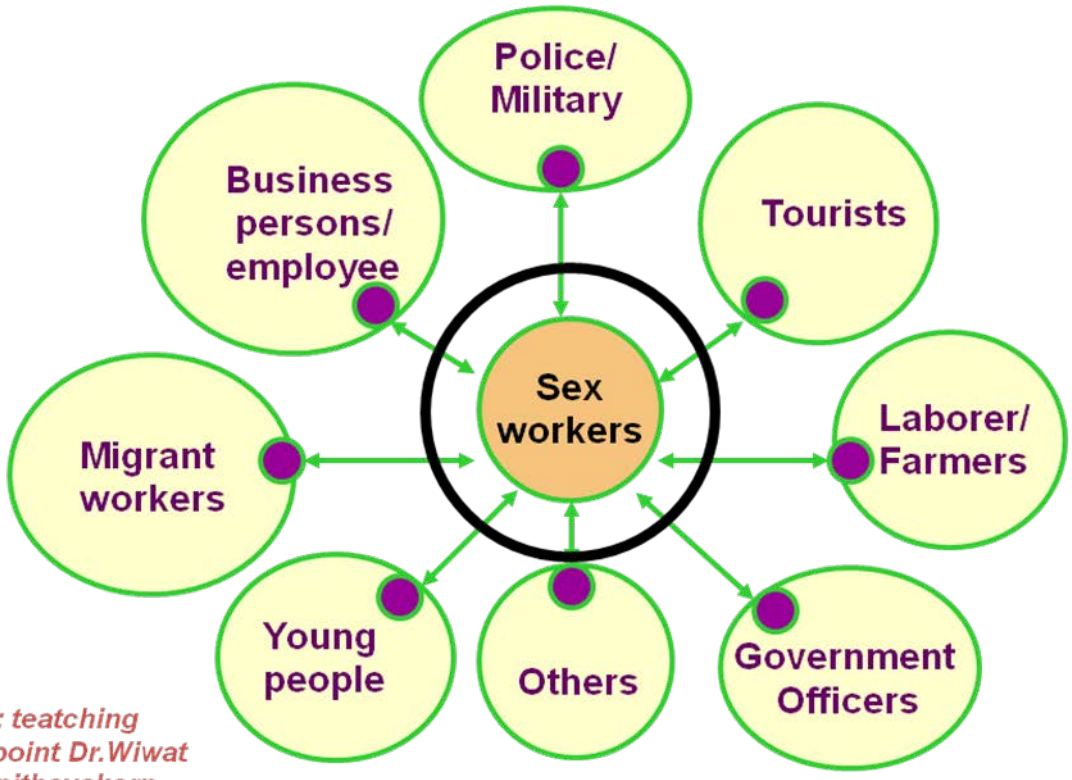
There are many reasons that why we need to screen HIV/STIs among sex worker as the following:

- Condom use is not 100% effective. Normal breakage rate during vaginal intercourse with properly applied high-quality latex condoms produced in the United States is about **2%;** complete slippage occurs about **1%** of the time.
- The higher number of sex partners, the higher rates of infection. However the higher of sex partner, the more money that they could make. High risk, high benefits.
- STI especially gonorrhea and chlamydia in women are asymptomatic, but screening could early detect STIs and early treatment can help prevent complication and transmission to clients.
- STI screening monthly is:
  - a tool for checking safer sex (biomedical parameter) better than behavior surveillance
  - an access to condom, counseling and BCC (behavior change communication) to practice safe sex.
- Half of FSW have husband/steady partner, among these partners condom use are rarely used.
- Some clients like to rub penis against genitalia to make it hard before wearing condom. Skin to skin contact could lead to some infection such as gonorrhea, chlamydia and herpes.
- Adolescents and children who work in the sex trade are especially vulnerable to STIs due to the cellular immaturity of the female vagina and cervix, as well as an inferior ability to negotiate for safer sex and higher risk of violence and abuse
- There are always new sex workers engaging in sex industry and these new comers are lack of a condom used negotiation skills with clients.
- Due to a reduction in HIV/AIDS and STIs prevention budget, outreach and prevention activities especially among sex workers has been declined for example a project of a 100% condom use. In addition, a pattern of sex business has been changed. In the past, the majority of sex trading is direct sex workers working in brothel which was visible but nowadays, many of them are indirect sex worker working in karaoke, massage, restaurant etc. Many of them do not accept that they are sex worker and denied to receive

STIs screening. These situation results in the increased STI and HIV incidence and prevalence among sex workers.

- Effective and successful STI/HIV control and prevention in a SW can prevent STI/HIV in >100 clients and their wives.

Type of clients by their careers



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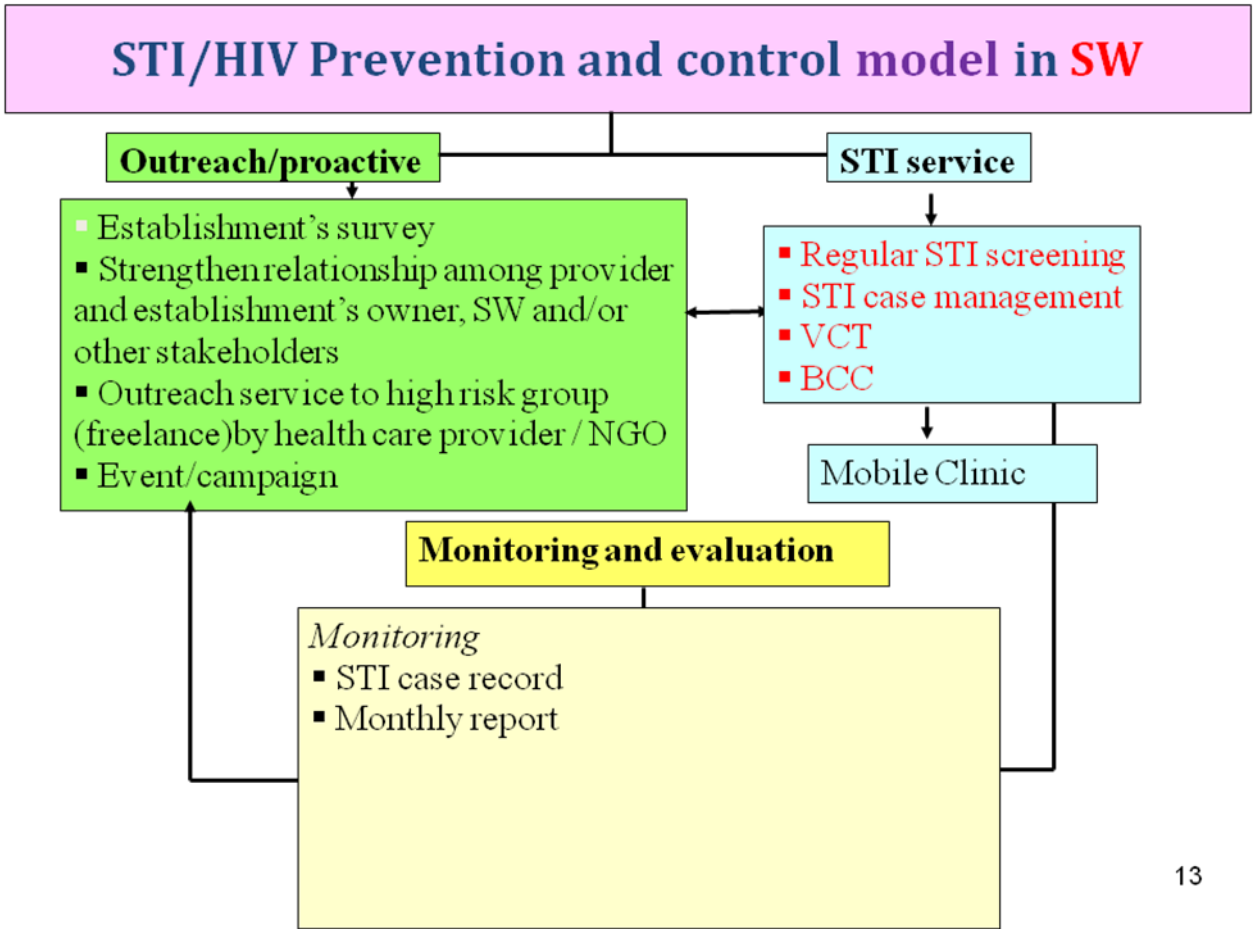
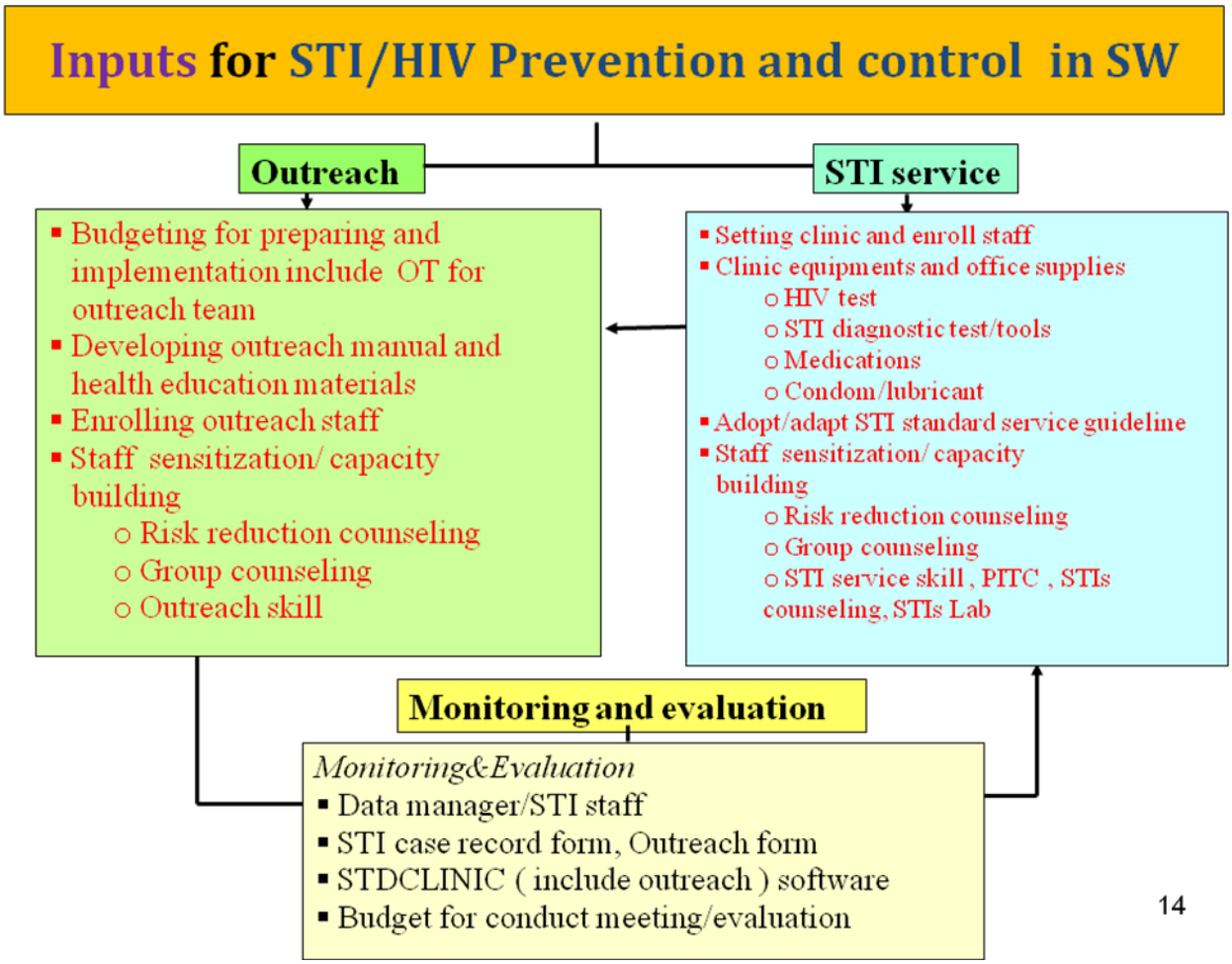
STI/HIV Prevention and control model in SW




Inputs for STI/HIV Prevention and control in SW
Outreach
STI service
Budgeting for preparing and implementation include OT for outreach team
Developing outreach manual and health education materials
Enrolling outreach staff
Staff sensitization/ capacity building
Risk reduction counseling
Group counseling
Outreach skill
Setting clinic and enroll staff
Clinic equipments and office supplies
HIV test
STI diagnostic test/tools
Medications
Condom/lubricant
Adopt/adapt STI standard service guideline
Staff sensitization/ capacity building
Risk reduction counseling
Group counseling
STI service skill , PITC , STIs counseling, STIs Lab
Monitoring and evaluation
Monitoring&Evaluation
Data manager/STI staff
STI case record form, Outreach form
STDCLINIC (include outreach) software
Budget for conduct meeting/evaluation
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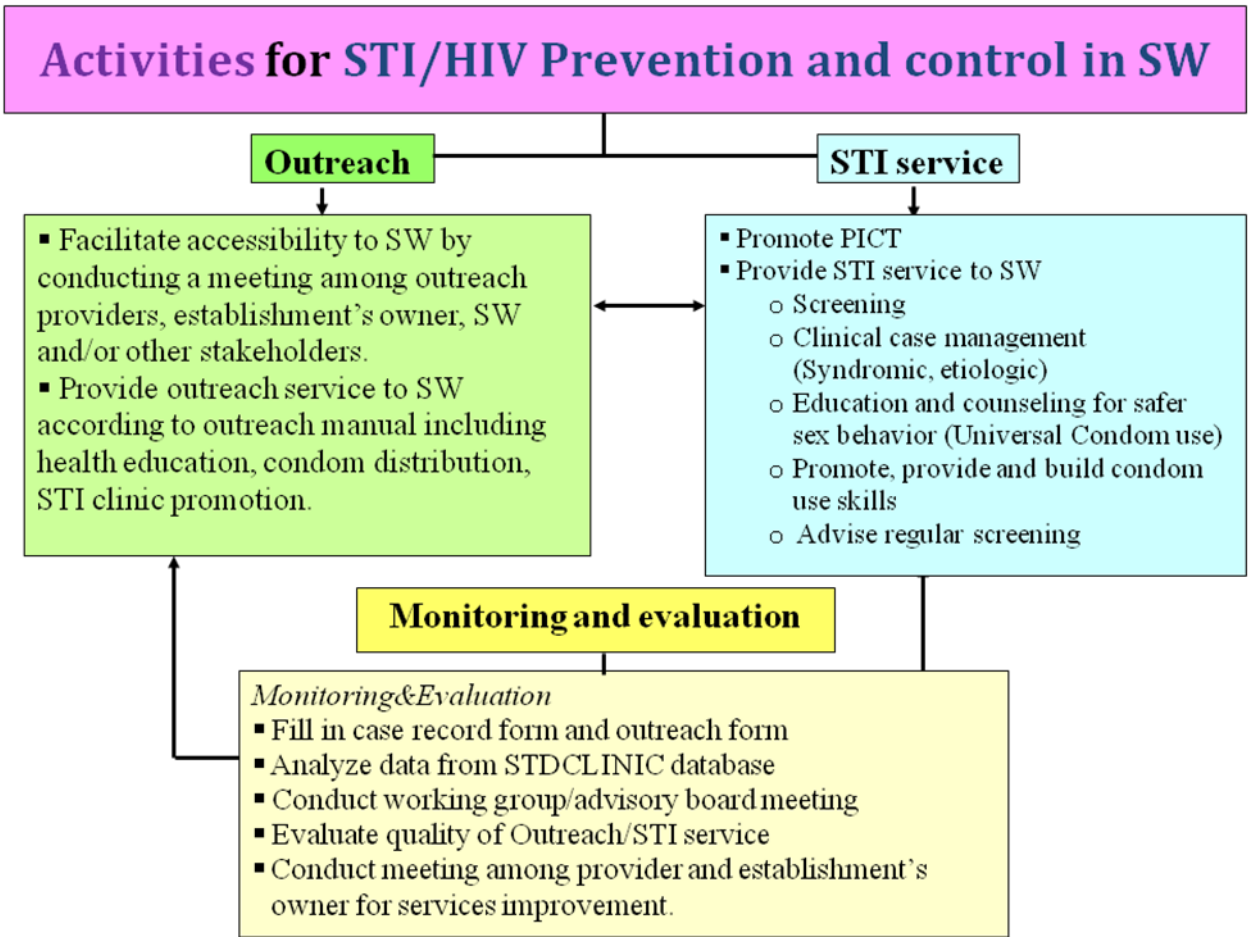
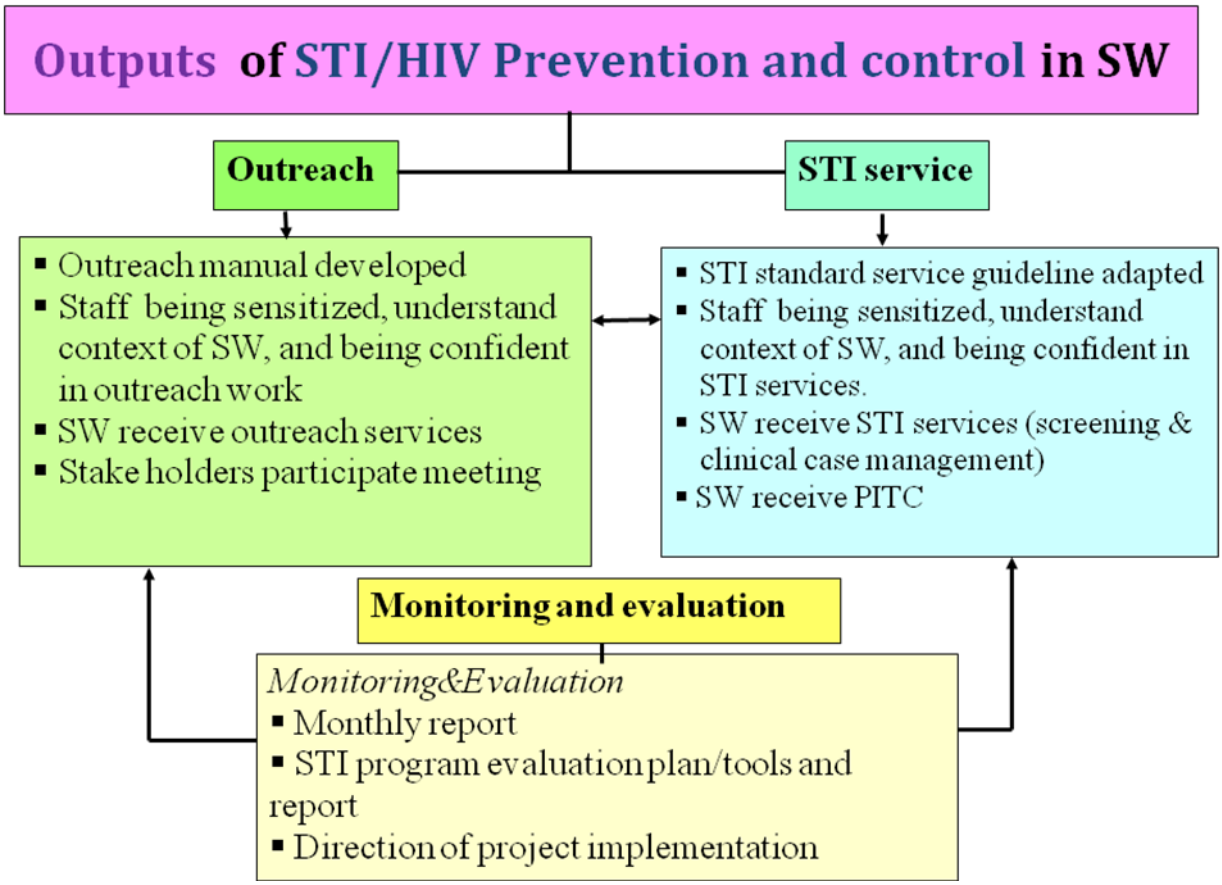
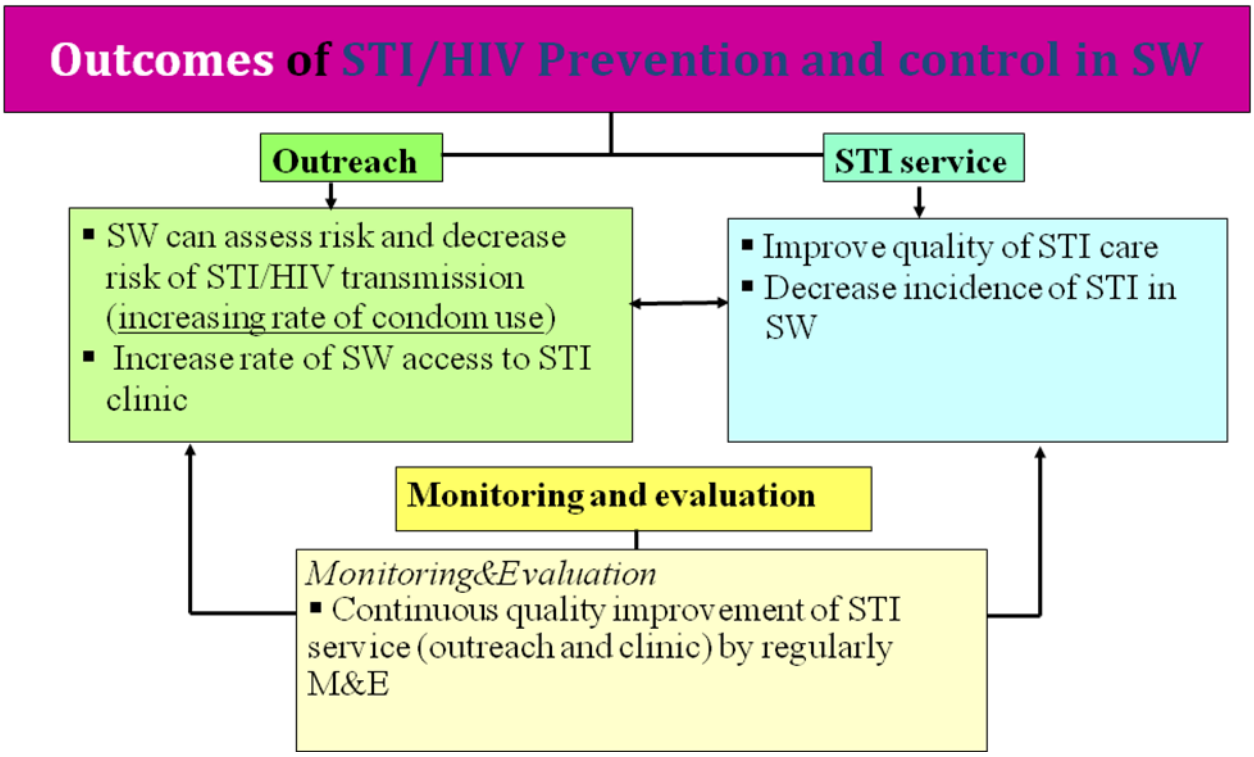

Activities for STI/HIV Prevention and control in SW
Outreach
STI service
▪ Facilitate accessibility to SW by conducting a meeting among outreach providers, establishment's owner, SW and/or other stakeholders.
▪ Provide outreach service to SW according to outreach manual including health education, condom distribution, STI clinic promotion.
▪ Promote PICT
▪ Provide STI service to SW
o Screening
o Clinical case management (Syndromic, etiologic)
o Education and counseling for safer sex behavior (Universal Condom use)
o Promote, provide and build condom use skills
o Advise regular screening
Monitoring and evaluation
Monitoring&Evaluation
▪ Fill in case record form and outreach form
▪ Analyze data from STDCLINIC database
▪ Conduct working group/advisory board meeting
▪ Evaluate quality of Outreach/STI service
▪ Conduct meeting among provider and establishment's owner for services improvement.


Outputs of STI/HIV Prevention and control in SW
Outreach
STI service
Outreach manual developed
Staff being sensitized, understand context of SW, and being confident in outreach work
SW receive outreach services
Stake holders participate meeting
STI standard service guideline adapted
Staff being sensitized, understand context of SW, and being confident in STI services.
SW receive STI services (screening & clinical case management)
SW receive PITC
Monitoring and evaluation
Monitoring&Evaluation
Monthly report
STI program evaluation plan/tools and report
Direction of project implementation


Outcomes of STI/HIV Prevention and control in SW
Outreach
STI service
SW can assess risk and decrease risk of STI/HIV transmission (increasing rate of condom use)
Increase rate of SW access to STI clinic
Improve quality of STI care
Decrease incidence of STI in SW
Monitoring and evaluation
Monitoring&Evaluation
Continuous quality improvement of STI service (outreach and clinic) by regularly M&E

STI screening and STI case management in FSW

History taking

For each visit, the following contents should be asked;

1. Chief complain and additional symptoms
2. sexual risk behavior assessment (Privacy and confidentiality)
    - Consistence of condom use
    - Condom breakage and slippage route of sexual intercourse and condom use
    - Condom use with regular clients, non client partner(s) and husband
3. Previous treatment and antibiotic use
4. Drug allergy*
5. Blood donation and Anti-natal Care*
6. Previous STIs**
7. Other sexual health history-taking including last menstrual period (LMP) and contraception use other than condom

NOTE: * First visit only

** Inconsistent visit only

Physical examination and laboratory investigation

Details for physical examination and laboratory investigation can be seen in module 2. For female sex workers**,** clinician should pay attention to the following information.

1. Adequate and appropriate physical examination must be performed including a speculum and bimanual examination of all female patients.
2. Rectal examination must be performed including anoscopy for patients practicing receptive anal sex.
3. The following tests are recommended where laboratory services are available:

    Basic microscopy (Gram stain for vaginal, cervical and urethral specimens and wet-mount slide preparation for vaginal specimens)

    Vaginal pH testing (One of indicators of bacterial vaginosis)

    Syphilis serology (on-site quantitative RPR/VDRL or rapid test and confirm with TPHA for positive case).

    Pretest and HIV testing (rapid test if possible)

Effective prevention and control of STIs among female sex workers

Details of STIs management can be seen in related modules. Two strategies are suggested to effectively prevent and control STI among female sex worker.

1. Requires attention to both symptomatic and asymptomatic infections.
2. Have the following two components:

Treatment of symptomatic infections:

Using syndromic management flowcharts and laboratory diagnosis where available. If the symptom occurs before the next appointment, please visit STI clinic/OBGYN OPD as soon as possible.

Screening and treatment of asymptomatic infections:

- Monthly history taking and physical examination and simple laboratory tests (when available)
- Provide treatment for asymptomatic gonococcal and chlamydial infections at the first visit if clinical sign are suspected or the tests are positive or female sex worker had practiced unsafe sex (in case that there is no specific lab)
- Serologic screening for syphilis every 3 months
- PITC and HIV testing every 3 months
- Screening for hepatitis B for the first visit and provide vaccination if non-immuned.

STI screening schedule for FSW attending Bangrak hospital

General physical examination and pelvic examination every ½ - 1 mo.

Tests	Frequency
Wet smear	every ½ - 1 month (every visit)
Gram stain *(vagina,endocervix,urethra)*	every ½ - 1 month (every visit)
Culture GC *(endocervix,urethra)* *pharynx only if practice unsafe sex)*	every ½ - 1 month (every visit)
Chlamydia test *(endocervix,urethra)*	every 3 months
VDRL / RPR	every 3 months
Hepatitis B	first visit
HIV	every 3 months

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Non STIs

For those who are non STIs, it's necessary to promote, provide and build condom use skills so that they can maintain their non STIs conditions. The following health education topics are recommended;

1. Condom use practice using a penis model
2. Providing information on STI/AIDS related symptoms, contraception methods other than using condoms and sexual health hygiene
3. Providing information on signs and symptoms that require immediate medical visit before the next visit
4. Providing information what to do when condom is broken
5. Correct misbelieve about killing germs by douching vagina with disinfectant.
6. Teaching correct technique to wash vagina

NOTE: For STIs please follow the flowchart and suggest for sick leave. Make an appointment for a follow up**.**

Symptoms that require medical attention

1. Abnormal vaginal discharge, discharge present in partner's urethra
2. Bleeding after sexual activities (pos coital bleeding)
3. Ulcer, pimple, and lump present at self genitalia or partner's genitalia.
4. Inguinal bubo present
5. Dysuria
6. Lower abdominal pain
7. No symptom but risk assessment is positive

Condom breakage management

1. Stop sexual activities immediately and washing genital area of both female sex worker and clients using soap.
2. See specialist on the next day
3. Find causes of breakage and learn to prevent from those causes
4. Be careful for next condom use by
    - *Using lubricant correctly and properly*
    - *Use condom correctly. Makes sure that there is no air at the tip of condom every time.*

Misbelieve about douching vagina with disinfectant.

Female sex worker douches their vagina for some reasons as follow;

1. To eliminate condom's smell/odor.
2. To kill germs by douching vagina with disinfectant
3. To make their vagina tight to satisfy their client.

These misbelieves put FSW at higher risks for STIs.

1. Don't douche the vagina because;
    - ➢ It increases risk of other infections when normal flora in vagina is destroyed/killed.
    - ➢ Tightened vagina due to its dryness (no mucous) may cause condom breakage
2. Do not clean vagina by inserting finger inside. This will cause cervicitis/abrasion and increase higher risk of acquiring STIs and HIV.

Proper ways for vaginal cleansing

1. Normal cleansing with tap water after each urination.
2. Cleaning vulva first, then cleaning anus in order to prevent infection from anus to vulva
3. Daily soap cleansing
4. Change underwear daily and wash it properly
5. Do not douche the vagina
6. If abnormal discharge present, go to see clinician. Do not use over the counter medication.

Characteristics of STI screening services for SW

STI screening services for SW can be provided in several approaches such as:

1. **STI special clinic**. This type of STI special clinic can be arranged in 2 ways

   1.1 Facility based service

   a. STI special clinic for general population. The service can be arranged by gender, male and female STI special clinics.
   b. STI special clinic for SW. The service can be arranged by gender, male and female STI special clinics for SW.

   In case of transgender, before having sexual reassignment they can receive the service in a gender-specific STI clinic according to their biological sex.

   1.2 Outreach service

   c. STI mobile clinic. To improve STI screening service accessibility among SW, outreach STI screening service is the option. STI mobile clinic is very convenient for both venue and non-venue SWs and increase the coverage of STI screening. However, full option STI mobile clinic with enough space for pelvic examination and side-room laboratory is necessary for non-venue SWs.

2. **Integrated in general clinic.** STI screening services can be provided in OBGYN clinic for female SW and in urology/internal medicine/surgery clinic/department for male SWs. However, the possibility for them to come to general clinics for STI screening is very challenging due to several reasons as indicated in the following table.

   There are weaknesses and strengths of providing STI services as a special clinic and as a general clinic, details can be seen in the following table.

STI Special Clinic		Challenges to weakness	General clinic		Challenges to weakness
Strengths	**Weaknesses**		**Strengths**	**Weaknesses**	
1. Health care providers' competency - Professional - Skillful - More experienced 2. Health care providers willingness and understanding to work with SWs 3. Trust from SW and sex establishment owners • Relationship with SW and sex establishment owner has been formed for more than 30 years by local government officers working in provincial health office. • This relationship has been transfers from senior to young staffs.	1. SW self stigma 2. Using separated STI medical record may result in uncompleted health information for other sickness 3. Stand alone STI clinic may face a problem of timely referral for other sickness	1. Private location of STI clinic 2. Hospital Information System (HIS) 3. Effective referral system	1. Referral system for other sickness may be more efficient 2. Be able to share human resources and facilities with general clinic/department	1. Health care providers' competency - Less professional - Less skillful - Less experienced 2. Health care providers less willing to work with SW due to negative attitude (Stigma) toward their promiscuous behavior 3. Staff's works are overloaded due to - Health security scheme (30 Baht) - Taking care of other diseased patients 4. Weak relationship with SW and sex establishment owner	1. Training - Curriculum training - On the job training 2. Sensitization 3. Very Challenging 4. Regular outreach activity to enhance trust relationship by clinic and outreach staff