

BORDER|NET *work*

2010-2012
CROSSING BORDERS,
BUILDING BRIDGES

**Improving access to early HIV/STI
diagnostics for vulnerable groups.**

**Learning from practice: a practical
recommendation guide.**

Bordnet Work Package 6



Funded by
the Health Programme
of the European Union



Bundesministerium
für Gesundheit

 SPI FORSCHUNG



Tervise Arengu Instituut
National Institute for Health Development

Improving access to early HIV/STI diagnostics for vulnerable groups.

Learning from practice: a practical recommendation guide.

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BORDERNET*work* 2010–2012

Highly active prevention: scale up HIV/AIDS/STI prevention, diagnostic and therapy across sectors and borders in CEE and SEE

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Publisher: National Institute for Health Development, Estonia

This publication arises from the project BORDERNETwork which has received funding from the European Union, in the framework of the Health Programme

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Acknowledgments

The authors would like to thank all the participating service staff for their contributions. Special thanks to Tzvetina Arsova Netzelmann and Elfriede Steffan from SPI Forschung gGmbH (SPI Research) for their contributions in planning and implementation of the pilot projects as well as for guidance in drafting the current report.

Abbreviations and acronyms

| | |
|--------|--|
| ACC | AIDS Counselling Centre |
| AHP | AIDS Hilfe Potsdam |
| AHW | AIDS Hilfe Wien |
| AIDS | acquired immunodeficiency syndrome |
| AISC | AIDS Information and Support Centre |
| ARAS | Romanian Association against AIDS |
| BBSS | Bio-behavioural surveillance survey |
| CBVCT | community-based voluntary counselling and testing |
| ECDC | European Centre for Disease Prevention and Control |
| EMCDDA | European Monitoring Centre for Drugs and Drug Addiction |
| EMIS | European MSM Internet Survey |
| EU | European Union |
| FSW | female sex worker |
| HAV | hepatitis A virus |
| HCT | HIV counselling and testing |
| HBV | hepatitis B virus |
| HCV | hepatitis C virus |
| HESED | Health and Social Development Foundation |
| HIV | human immunodeficiency virus |
| HSC | Health and Social Centre of HESED in the “Fakulteta” Roma Community in Sofia |
| IDU | injecting drug user |
| LIC | Infectology Centre of Latvia |
| LLC | limited liability company |

| | |
|------|---|
| LTC | low threshold centre |
| MMU | Mobile Medical Unit |
| MSM | men who have sex with men |
| NGO | non-governmental organization |
| NIHD | National Institute for Health Development |
| PCR | polymerase chain reaction |
| PWID | people who inject drugs |
| SP | sexual partner |
| STI | sexually transmitted infection |
| SW | SW |
| TKEL | <i>Tervisekeskus Elulootus</i> medical centre |
| VCT | voluntary counselling and testing |
| WHO | World Health Organization |
| WP | work package |

Introduction

Sexually transmitted infections (STIs) and HIV are a major public health problem in Europe. Even though the rates of HIV and STIs in many European countries have somewhat decreased in recent years, some vulnerable groups are still highly affected. For example, in 2008, almost three quarters of syphilis cases were diagnosed among men and this may be influenced by the ongoing epidemic among men who have sex with men (MSM) (ECDC 2010a). Infectious diseases such as HIV and viral hepatitis are among the most serious health consequences of injecting drug use (IDU) and can lead to significant healthcare costs (EMCDDA 2010). Furthermore, SWs (SW) are at increased risk for HIV, STIs and other sexual and reproductive health and rights problems (Lafort 2010).

WHO policy stresses that HIV testing and counselling (HTC) must meet the needs of most-at-risk and vulnerable populations and expand beyond clinical settings to involve civil society and community-based organizations in providing the HCT services (WHO 2010). Community-based testing (CBT) models are implemented in many countries to increase the updating of HIV testing. There are various healthcare provider models offering HIV testing. Some are heavily based on the primary care sector, some are primarily based on the secondary care sector and others operate through dedicated AIDS centres or with the support of NGOs. However, each of these models sits within a complex health system environment and few have been subjected to rigorous research to examine their effectiveness or efficiency or the equity of their services. Facilitating access to testing for at-risk populations also needs to be addressed in light of an increase in new HIV diagnoses both in migrants and in MSM populations in Europe. Service models have already proved effective for IDUs and SWs and they enable hard-to-reach groups to access testing, which could be extended to other at-risk groups (Mounier-Jack 2008).

There are significant differences between countries and vulnerable groups, creating the need for tailored responses in the provision of HIV and STI services that take into account the specific barriers in access to health care for each case. Most common barriers to the early diagnostics of HIV and STIs include:

- 1) Geographical barriers (distance from services, rural and inner-city health professional shortage areas);
- 2) Sociocultural barriers (client's health beliefs and behaviours, practitioner's beliefs and behaviours);
- 3) Socioeconomic barriers (lack of health insurance, inability to pay out of pocket, poor education, lack of knowledge and information);
- 4) Organizational barriers (lack of interpreters, long appointment waiting times, opening hours, etc.);
- 5) Combinations of the previous factors – many disparities are likely due to a mixture of these factors.

Different models and methods exist to provide targeted HIV/STI services for most-at-risk populations. Oftentimes, models of target group specific services are implemented. One of the most important features of the services provided to vulnerable groups is flexibility. Offering flexible services that respond to the needs of the service users including operating outreach services, listening to feedback, offering flexible

opening hours and providing service users with the kinds of services they want were all key facilitators cited by the respondents (Flanagan 2010).

BORDERNETwork is an EU funded (Public Health Programme) networking project with 13 participating organizations from 8 EU countries, and over 20 collaborating partners, 5 of them from non EU countries. The main goal of the project is to improve the prevention, diagnostics and treatment of HIV/AIDS (including co-infections) and STIs through bridging gaps in practice, policies and cross-country cooperation as well as enhancing capacity in interdisciplinary response (medical, prevention, research). Work package 6 (WP6) focuses on early diagnostics and its main aim is to intensify efforts in the early diagnosis of HIV and STIs for most at risk groups based on human rights and gender equity and to decrease the number of those who are unaware of their infection status. It involves nine organizations from eight countries (see the list of WP6 partners in Annex 1).

In the first phases of the BORDERNETwork project WP6, all the partners conducted a desk review of the existing situation regarding the HIV/STI epidemiology and services for vulnerable groups, and they assessed the good practice level of their HIV counselling and testing services. The main aim of these two assessments was to identify possible gaps in service provision as well as to collect the information necessary to improve access to the services. For the assessment of HIV counselling and testing services, the “Self-Assessment Checklist for Voluntary Counselling and Testing” developed by International Planned Parenthood Federation was used. The assessment revealed that the majority of participating organizations had adequately trained staff, systems and regulations in place, and they have sufficient resources to ensure the provision of good quality and confidential HCT services. The primary recommendations for improving access to HCT services were to increase client-friendliness even more (appropriate opening hours and locations, etc.), implement more active out-reach work, provide appropriate partner notification and counselling as well as increase the scope of the provided services (to provide not only HIV testing, but also other blood borne and sexually transmitted infection screening).

The next task in the framework of WP6 was to pilot different HIV/STI service provision models for vulnerable groups. It was a possibility for the participating organizations to introduce new and innovative strategies for HIV/STI diagnosis and to bridge existing gaps in the services they had identified in the earlier phases of the project. To describe the plans for piloting WP6, partners developed a common protocol template (see Annex 2) and data collection template (see Annex 3), and for presenting and analysing results, a common report template was developed (see Annex 4). Templates included general guidance for describing the process of piloting and presenting the results. Several previous initiatives in the field were used as examples to design the pilot projects, namely the TAMPEP project (European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers, funded from European Union, in the framework of the Public Health Programme) and others (see also references).

The current report summarizes the results of the piloting projects in partner countries and provides guidance for future actions. The report consists of descriptions of the country-by-country piloting projects followed by a general discussion and conclusions.

Piloting HIV/STI service provision models for key vulnerable groups: local reports

Austria, AIDS Hilfe Wien

HIV/STI community-based VCT for MSM in Vienna

Rationale for the piloting project

Aids Hilfe Wien has traditionally worked in HIV prevention among MSM and also provided free and anonymous HIV testing. However, studies (such as EMIS 2010) have shown that 25% of the MSM population are still unaware of their HIV status. The main objective of the pilot project was to decrease this proportion. The needs addressed were:

- Including information about the VCT offers in the prevention messages and linking prevention and diagnostics
- A campaign on knowing one's status
- Diversifying the MSM population into different subgroups
- Finding alternative methods to the existing prevention methods to reach the different subgroups

General target group description

The total number of MSM living in Vienna can only be estimated. We assume that it is between 50,000 and 60,000, with one-third active in the gay scene. As not all MSM are at the same risk, we chose some subgroups for our project. We wanted to focus on:

- MSM active in the gay scene: either Austrians, German or second or third generation migrants. They are very well informed but condom use in dark rooms and saunas is not consistent.
- MSM who mainly use the Internet for social contacts: they are hard to find in the gay scene. They prefer anonymous sex in cinemas, dark rooms or cruising areas. They use Internet platforms like Gayromeo or Facebook to look for partners. They might also be reachable through organizations like gay professionals and gay cops.
- MSM with migration background: they are also highly affected by new infections and late diagnosis. Because of their culture and faith, homosexuality and HIV are often taboos and highly stigmatized.

Language and general access to the health system is also a barrier.

- MSM at high risk: these are MSM
 - with more than ten sex partners per year,
 - who go on holiday to big gay metropolises,
 - who are or have been co-infected with another STI,
 - who prefer risky sex practices (e.g. fisting, anal sex without a condom)
- Young MSM (<25 years old): according to medical experts, they are especially affected by new HIV and STI infections. Ignorance, trivialization and thoughtlessness can also be observed in this target group. They can quite easily be reached over the Internet, Telecommunication and Clubbings.

Methodology

A project team in the Aids Hilfe Wien was formed to bridge the gap between prevention and VCT. This team developed a concept to reach the different target sub groups, which included a campaign in the gay scene and on the Internet, a peer project to reach those under 25 years old and migrants. The team also had to find a suitable community-based VCT (CBVCT) location and determine the suitable tests to use.

Steps of Intervention

The prevention department worked very closely with the VCT department and were in charge of promoting the new services. The start of the project took place on Christopher Street Day, which is always celebrated with a big parade in Vienna. For four days in the forefront of this event, a tent town with bars and entertainment (Pride Village) was erected on a car park in the gay scene. Aids Hilfe Wien offered VCT in the nearby HardON, a gay club opened only on the weekends. The services were promoted in the gay village by the prevention team. Handouts were used to distribute information in the gay scene, in cruising areas and at the event. In addition, there was also an advertisement in the magazine produced exclusively for the parade. The initiative was promoted over Internet platforms, MSM groups in Facebook, in gay magazines and through newsletters. 8 peers were selected and trained to reach and inform the subgroup young MSM.

Counselling & testing was offered from Tuesday 14 June 2011 to Friday 17 June 2011 from 3 p.m. to 8 p.m. The following tests were offered: HIV antibody test, HIV rapid test, syphilis screening, hepatitis screening. A team of two counsellors, one doctor and one administrator were present during operating hours. The standards for counselling & testing established by Aids Hilfe Wien were also maintained during the outreach project. The results of the HIV antibody tests were either available after four days at Aids Hilfe Wien or at the test site (HardOn, Kaiserbründel). The test results were communicated at HardON on Wednesday 22 June 2011 and on Monday 27 June 2011 or during the regular counselling & testing opening times at Aids Hilfe Wien.

After the Vienna Pride, the VCT outreach services were continued once a week in HardON over the summer. In addition, there were also VCT services offered on all weekdays including a weekend in a gay sauna (Kaiserbründl).

After counselling, participants received a questionnaire concerning: gay identity, source of information of the outreach project, satisfaction with the counselling & testing service and risk behaviours. The response rate was almost 74%.

42 clients were tested during the Vienna Pride, 103 in HardOn, and 72 in the Kaiserbründel gay sauna. More detailed information about the clients is presented in table 1.

Table 1. Results of CBVCT in Vienna

| Criterion | No | % |
|---|-----------|----------|
| Number of days | 33 | |
| Number of clients | 217 | 100 |
| Number of questionnaires | 199 | 92 |
| Migrants of Turkish descent and from the former Yugoslavia* | 4 | 2 |
| Austrians* | 139 | 64 |
| Younger than 25 | 37 | 17 |
| Risky sex practices | 38 | 18 |
| Not into gay scene** | 35 | 16 |
| First test ever | 29 | 13 |
| Last test more than 3 years ago | 39 | 18 |
| Number of HIV-AB-Laboratory tests | 61 | |
| Number of HIV-AB-rapid tests | 147 | |
| Number of syphilis tests | 187 | |
| Number of HBV tests | 59 | |
| Number of HCV tests | 76 | |
| HIV test positive | 1 | |
| Syphilis test positive (registered new infections) | 4 | |
| How did clients hear about VCT services in Aids Hilfe Wien | | |
| Campaign or activities in the gay scene | 99 | 46 |
| Campaign or activities in the internet | 39 | 18 |
| Advertisement or articles in print media | 25 | 12 |
| Friends or acquaintances | 32 | 15 |
| Volunteers or co-workers from Aids Hilfe Wien | 7 | 3 |
| Bar or sauna personnel, barkeepers or sale clerks | 11 | 5 |
| MSM-Organizations | 4 | 2 |
| Events where Aids Hilfe Wien was present | 18 | 8 |

* born in Austria

** search for (exclusive) sexual contacts on the Internet

Cost assessment

The costs of the piloting project were higher than those related to regular services, as we distributed vouchers for free HIV rapid tests, syphilis tests, and HBV and HCV tests, which clients have to purchase during regular services. Additional transport costs also had to be paid. The extra costs related to the pilot project amounted to 4,036.83 EUR.

Lessons learned and recommendations for the future

- One major lesson that we have learned is that the promotion of VCT services in connection with prevention activities and campaigns is extremely important. Specially tailored services reach out to new less visible members of well known “reached” target groups (for example, 20% of the MSM clients of the AHW piloting campaign were tested for HIV for the first time).
- Outreach and community-based VCT are able to reach key populations but they also have their limits. For example, we were unable to reach MSM with a migration background.
- The outcomes of the project encourage the on-going collection of further data on the target groups.
- In the future, we will also extend the project to other target groups (migrants) and we want to provide testing in other settings, such as cruising areas.

Conclusions

Beside existing offers for free and anonymous testing, the efforts undertaken proved effective. 20% were tested for HIV for the first time and the service was very well received. The further activities of CBVCT will be undertaken by Aids Hilfe Wien in cooperation with the gay community.

Bulgaria, HESED

STI testing for Roma male SWs in Sofia

Rationale for the piloting project

The aim of this pilot campaign was to increase the number of male SWs receiving testing for Gonorrhoea and Chlamydia in a particular part of the biggest Roma neighbourhood in Sofia – Glaveva mahala – that is located on the border with the West Park area of Sofia. These male SWs can receive testing for HIV, HBV, HCV and syphilis as a regular service. As Gonorrhoea and Chlamydia are two highly relevant STIs for SWs, we deemed it essential to complement that service with the Gonorrhoea and Chlamydia pilot campaign. The results from the bio-behavioural surveillance survey (BBSS) implemented by HESED in Sofia found a considerable number of positive cases for Gonorrhoea and Chlamydia. The aim of this pilot campaign was to increase the number of Roma male SWs receiving testing for Gonorrhoea and Chlamydia as well as the treatment of all positive cases.

General target group description

Mobile STI testing and treatment services were provided to 58 current male SWs. Within WP 8 of BORDERNETwork, HESED provides outreach for high risk Roma young men, training for leaders of friendship circles, and testing and treatment for four STIs (syphilis, HIV, Gonorrhoea and Chlamydia) for these leaders and their friends. Through this regular work, male SWs were identified and were used as a starting point for a snowball sample of a Roma MSM sample of BBSS within WP5. As a result of both activities (outreach work in WP8 and BBSS in WP5), we discovered a group of about 50 young Roma male SWs, who work in the West Park of Sofia, have very low education and are highly isolated from the rest of the Roma community in the Fakulteta neighbourhood. This precise group was accessed with this pilot campaign.

Methodology

The pilot project was conducted by HESED's team with the use of the Mobile Medical Unit (MMU), the community-based Health and Social Centre (HSC) in the Roma Community in Sofia and the help of a gatekeeper from the Roma neighbourhood. A gatekeeper is a person of Roma origin living in the Roma neighbourhood and working as part of the HESED team. This is a key person who establishes the link between the team and the Roma community. The campaign started on 15 November 2011 and ended on 31 January 2012

Steps of the intervention

- The group was visited by the MMU to offer the regular service of counselling and blood testing for HIV, syphilis, HBV and HCV. During these regular visits, the new piloting campaign with two additional tests for Gonorrhoea and Chlamydia was promoted and people interested in this were referred to HSC where they had to give a urine sample for the new tests.
- All interested male SWs visited HSC in the Roma neighbourhood and gave the urine samples there.
- The urine samples were forwarded to a laboratory for testing with the PCR method as the most reliable method.
- The results were given back to HESED and the SWs were informed. Post-test counselling was provided to them by the experts of HESED.
- Treatment was offered to all positive cases and all interested persons were treated free of charge by a medical doctor in HSC.

Results

In the framework of the pilot campaign, 58 male SWs of Roma origin aged between 16 and 33 years were reached. No one was an injecting drug user. However, all participants presented high-risk behaviours being male SWs and practicing mainly anal sex with other men, as well as originating from the Roma community. Roma origin should not be considered as a risk factor in itself but as a precondition for risky behaviour. Traditionally, Roma people are of low educational level, lack good social skills and/or skills for negotiating condoms, for example. On the other hand, the Roma community in Bulgaria is a closed group where most of the people communicate between themselves very intensive and different risky, unsafe practices and folk beliefs come into circulation rapidly.

Data analysis shows the alarming trend of a very low age for starting sex work – more than 41% of the group said they had started offering sexual services for money, presents or other things at an age under 16 years (some cases even as young as 8–10–11 years).

In the framework of the pilot campaign, the following positive cases were diagnosed:

- Gonorrhoea – 5 cases (9% of all tested persons)
- Chlamydia – 3 cases (5% of all tested persons)

All positive cases were treated by a medical doctor of HESED. The medicines were provided by another project of HESED.

During the pre-test counselling, all of the people were informed that the possible treatment in case the test was positive would be free and that their regular partners could also be treated by HESED free of charge. This was highly appreciated as a care not only for themselves but also for their family.

The whole HESED team is pleased when it is able to reach as many people as possible and to enrich the proposed services.

Cost-assessment

The regular testing for HIV, syphilis, HBV and HCV with the MMU of HESED costs about 14 EUR per person, as the charge for laboratory testing is not included in this.

The additional service for Gonorrhoea and Chlamydia costs the sum of the regular service plus the laboratory testing of about 20 EUR, which makes a total of 34 EUR. If the case is positive, we pay an additional 15 EUR for the doctor's service but this price does not include the cost of medicine.

Lessons learned, recommendations for the future

Every successful campaign needs to provide low-threshold services as close to the target group as possible. Care for hard-to-reach populations could be given in line with the principles of accessibility and flexibility. In terms of great invisibility of the SWs in Bulgaria, it is essential to develop and offer them different services according to their needs. A key factor in the effective approach to vulnerable groups remains outreach work and the availability of mobile services. The outreach work should be developed further. The success of improved access is guaranteed by the integration of different services, taking up the various needs of the vulnerable groups: complementation and saturation (continuity in time, quantity and quality of services provided) of outreach, counselling, diagnostics, referral, treatment and behaviour change (communication and skills building, health care and help seeking behaviour trainings within a community setting: *Roma community*).

An effective, recommended practice is the organisation of training groups in which the awareness of the participants can be focused on topics like:

- realisation of the risk they are exposed to
- ways to reduce risky behaviour
- change of attitudes and social norms
- health care and health seeking behaviour
- communication skills for the negotiation of safer practices

Conclusions

The effective models of service provision for hard-to-reach groups should follow the principles of accessibility and flexibility, which is especially valid for marginalised hidden, vulnerable population groups. The availability of an equipped mobile medical service for prevention, diagnostics and medical check-ups is essential to ensure coverage and a high quality of STI diagnostic offers in non-medical settings. The success of improved access is guaranteed by the integration of different services that address the various needs of the vulnerable groups.

Estonia, AISC

STI testing for female SWs and their regular partners in Tallinn

Rationale for the piloting project

The aim of the pilot project was to organize the first medical screening for SWs and their respective regular partners. To increase the access of regular partners of SWs to HIV/STI services by giving vouchers to the SWs for the testing of their regular partners; to increase awareness among the regular partners of SWs and SWs themselves of their HIV/STI status on an anonymous and confidential basis by outreach and health workers. The aim was to begin providing medical HIV/STIs services for the first 30 regular partners of SWs who use medical HIV/STIs services at the AIDS Information and Support Centre (AISC) from 30–40 persons during piloting in September–November 2011 to 70 persons in 2012.

Methodology

The target group for this piloting project included regular sexual partners of SWs (spouses, life partners, regular clients, pimps, etc.). The project was implemented in the premises of AISC in Kopli 32, Tallinn, Estonia. The entire project period from start to preparation, organization, implementation and evaluation lasted about 6 months from August 2011 to February 2012. It took more time than expected in practice due to several circumstances. From August to October, we organized a reception on every Friday from 12 to 18, but from 1 November until the end of pilot it was possible to come during our general reception hours 5 days a week.

Equipment, logistics (rooms for interviewing, incentives, participation cards, condoms and lubricants), interviewing, database (monitoring evaluation templates, statistics), and refreshments for participants were organized by AISC and BORDERNETwork project personnel.

Setting. Medical procedures – medical nurse, rapid tests for HIV and HCV, syphilis and Chlamydia as well as counselling and prescription of treatment in the case of positive tests results from dermatovenerologist, psychiatrist, or narcologist – were provided at *Tervisekeskus Elulootus* medical centre (TKEL).

Description of the personnel (who will do the recruitment, who will provide the services, etc.). The initial recruitment of SWs was performed by the outreach worker/medical nurse. Additional recruitment was conducted by the programme assistant and the coordinator of the BORDERNETwork project. All piloting project personnel (including counsellors, nurse, interviewer and technical assistant) received training before the piloting, including information on the goals and methods of the piloting project, recruitment, questionnaire, etc.

Incentives. Each SW regular partner who participated in the services received a food store voucher (to the value of 5 EUR) and a pack of free condoms/lubricants after participation in the services and filling in the questionnaire. SWs, who invited the regular partner for participation, also received a food store voucher (to the value of 5 EUR) and a pack of free condoms/lubricants on their first visit and an additional 5 EUR voucher in case the invited partner came for reception.

Steps of the intervention

We invited approximately 80 SWs who have regular partners and used HIV/STI services in the clinic more or less regularly during September-November 2011 to participate in the pilot (considering that not all partners would agree to come). After additional selection (additional recruiting was done using SWs telephone numbers and emails available in our database), we finally selected 40 SWs, who were ready to participate and promised to convince their regular partners to join the pilot.

All SWs and their regular partners participated anonymously; no personal data was collected (names, personal identifiers, detailed birth dates, etc.).

All participants (SWs and their regular partners) were numbered sequentially to keep track of who was coming back for services. The same unique code was used on the voucher (which was needed for the participation of regular partners in the services), questionnaire for SW and on the questionnaire filled in by outreach and health workers during testing for regular partners (this helped to link data from different questionnaires).

The pilot project site was open 3 hours a week on Fridays in the same location as the TKEL medical service for SW. Regular partners could attend services together with SW or at a suitable time with prior registration by phone or email. Test results were immediately delivered for participants (all tests used were rapid). In case there was a need for further diagnosis/counselling/treatment, they were referred to a dermatovenerologist of TKEL or other service providers (Hepatitis specialist, therapist, psychiatrist or psychologist in TKEL, infectious diseases specialist in West-Tallinn Central Hospital in the case of HIV (this is the largest clinic in country working with people with HIV).

Medical services provided for SW and their regular partners were the following: rapid tests for HIV, syphilis, HBV, HCV, and Chlamydia

Results

Altogether, 40 SWs were invited to participate in the pilot project with the aim of convincing and bringing their regular partners to the pilot. From those, 40 SWs and 31 regular partners of SWs visited the pilot project site, received medical services and were interviewed. For comparison, the data of only those 31 SWs who had been successful in bringing their regular partners to the site for interviewing and testing were analysed.

Sociodemographic and risk profile of SWs who participated in the pilot project:

84% of participating SWs were females, 13% male SWs and 3% were transgender (1 person).

The majority of SWs were 25–35 years old – 74%, little bit less than one quarter were less than 25 years old. No adolescent SWs participated; the youngest SW was a 22 year old male and the oldest was 48 years old FSW.

Only 16% of SWs had health insurance. The majority of SWs provided services at rented apartment, and only 13% at their own home. Only a few of them (13%) work on the streets.

The majority of SWs had a life partnership relation with their regular partners (68%) instead of official marriage (13%). One person indicated having a regular partner and a long term sexual relationship with a pimp, and three SWs had long term regular clients.

30% of the participating SWs had had sex with same sex partner. 13% had injected drugs (four persons with different periods of use – 1, 4, 5 and 7 years).

52% of SWs admitted that they used condoms in sexual intercourse with their regular partner. From questionnaires, we found that those are spouses or regular partners with whom the SWs live. As an explanation for not using a condom, SWs mostly marked “trust” towards their partners (44%) and the “high cost” of quality condoms and lubricants (31%). One SW (HIV-infected) said that she did not need to use condoms because her partner was also HIV-infected. 19% explained that they avoid condom use because they regularly test themselves for HIV and STIs.

Only five SW (16%) have not been previously tested for HIV. The majority of those who have been tested have done so within a period of less than one year – 65%. From 26 SWs who had been tested for HIV previously, two persons were HIV-infected (8%). Both of them have a history of drug use.

One quarter of the SWs had not been tested for STIs in the past year. Another quarter have visited family doctors (in our case, those who had health insurance) or private doctors (those who have not). Slightly less than half of the participants had tested at TKEL. From those who had been tested in the past year at different sites, one was diagnosed with syphilis, two with Trichomoniasis, two with Candida, two with Chlamydia, one with Mycoplasmosis and one with genital Herpes.

Outcomes of SWs testing during the pilot project:

During the testing of the 31 SWs, the following infections were diagnosed: two HIV-infected (however, after counselling, the doctor discovered that these were not new diagnoses). Both persons were previously diagnosed with HIV; one person has a background of 5 years of drug use and had not been prescribed ARV treatment. However, she is being monitored in the hospital (at present, she doesn't require treatment; HIV was diagnosed 2 years ago). The other person has a background of 7 years of drug use, receives ARV treatment and regular health monitoring at the hospital; HIV was diagnosed 5 years ago. For both SWs, HCV was also diagnosed and they were referred to the therapist, counsellor on Hepatitis C.

Sociodemographic and risk profile of SW regular partners who participated in the pilot project:

94% of the SW regular partners who participated were male and 6% female. The majority of the regular partners were 25–35 years old (71%); only 13% were less than 25 years old and 16% were older than 45 years old. The youngest SW regular partner was 23 years old, the oldest 51.

Only 38% of SWs regular partners had health insurance. A significant proportion of regular partners do not have regular work (42%).

32% of respondents had up to a one-year long relation with a sex worker, (34%) from 1 to 3 years long and (32%) longer than 3 years.

29% of regular partners admit that they have other sexual partners at the moment who are not sex workers. 23% of regular partners admit that they have experienced same sex intercourse, 10% (3 persons) injected drugs for different periods (2, 5 and 8 years).

52% of SW regular partners admitted that they use condoms in sexual intercourse with SW. As an explanation for not using condoms, they mostly marked "trust" towards their partners (53%), which is higher than among SWs, and 27% explained that they avoid using condoms because they regularly visit service providers and test themselves for HIV and STIs. Only 13% marked the "high cost" quality condoms and lubricants as a reason. One regular partner (HIV-infected) said that he does not need to use condoms because his partner is also HIV-infected.

Significant part – 13 regular partners of SW (42%) had not been previously tested for HIV. The majority of those tested (18 persons) had done it in period less than 1 year – 61%.

From 18 regular partners previously tested for HIV, one person was HIV-infected (6%) and had a drug use background.

Nearly half of regular partners have not been tested for STIs in the past year. 16% have visited family doctors (in our case, those who have health insurance) or private doctors (23%; those who have not). Only 4 persons have been tested at TKEL previously.

From those who have been tested at different sites in the past year, one was diagnosed with Gonorrhoea, two with Trichomoniasis, one with Candida, three with Chlamydia, one with Mycoplasmosis, one with Ureaplasmosis and three with genital Herpes.

Testing outcomes of SW regular partners:

One person was found to be HIV-infected (partner of HIV-positive SW with drug use background) but during consultation the dermatovenerologist discovered that he had previously been diagnosed at an ACC, had had regular medical monitoring and had received ARV treatment. Also, this person had a history of drug use, was diagnosed with Hepatitis C and referred to the therapist and counsellor. Another regular partner of the second HIV-infected SW with a history of drug use was also diagnosed with HCV, but was not infected with HIV.

Five cases of Chlamydia were diagnosed and treated. Also, one case of syphilis was diagnosed, but it had been previously diagnosed and required additional check-ups, counselling and treatment.

Monitoring and evaluation

Instruments (questionnaires and forms to document the participants, services received, and outcomes):

- Each SW who participated in the pilot completed a small questionnaire (15 questions) including questions on sociodemographics, sexual risk behaviour, STI, HIV and IDU history, and previous interactions with HIV and STI services.
- Each regular partner of SW who participated in the pilot completed a small questionnaire (15 questions) including questions on sociodemographics, sexual risk behaviour, STI, HIV and IDU history, and previous interactions with HIV and STI services.

The outreach worker/nurse administering the testing added the results of the tests to the respective questionnaires. Daily monitoring of the process (keeping record of the vouchers, clients, etc., supervision of the process) was done by a technical assistant and coordinator of the project.

Pilot project personnel (in recruitment site) kept the record of the following:

- How many vouchers were given out to SWs face to face (by study personnel) (record the number of voucher, code, age and gender of the SW to whom the voucher was given)
- Number of SW and number of voucher was connected in way that it is possible to have a record of which partner came from which SW
- How many regular partners of SW received the services during the pilot site reception in period from September 2011 to January 2012.

Cost-assessment

The cost of one client (SW or regular partner) was not different from the usual cost of general out-patient care, only by the amount of incentives that were given to them.

The full cost of one participant depended on the range of tests and the amount of incentives. The average price of a HIV/HBV+HCV/syphilis/Chlamydia test for one SW + medical service of nurse + incentives was about 35 EUR. The average price of a HIV/HBV+HCV/syphilis/Chlamydia test for one regular partner of SW + medical service of nurse + incentives was about 30 EUR.

The actual cost of services for a pilot project participant was a little higher due to the final costs. We should also add the cost of additional consultations with specialists and treatment costs in positive cases.

Lessons learned, recommendations for the future

This was, in fact, the first complex intervention (medical tests + data collection + safer sex education + condoms/lubricants) for regular partners (spouses, life-partners, regular clients, etc.) of sex workers. In previous projects, some HIV prevention and safer sex promotion interventions for clients of SWs have been undertaken (truck drivers on the highway near the border with Russian Federation).

The following alarming information about regular partners was obtained and should be taken into consideration:

- A large number of regular partners do not have health insurance (38%). 42% do not have regular work
- 29% of regular partners admit that they have other sexual partners at present, who are not sex workers.
- 48% of SW regular partners admit that they do not use condoms in sexual intercourse with partner-SW, more than half marked "trust towards their partner" as the reason for not using condoms while only 27% cited regular medical control as a reason.
- A significant portion of regular partners (42%) have not been previously tested for HIV.
- Nearly half of regular partners have not been tested for STIs in the past year.

The following measures should be undertaken:

- From January 2012 to December 2012, an individual risk assessment of every visitor to the anonymous HIV/STI testing and counselling site should be conducted, and one of the risks addressed should be sex with SWs. If the visitor has had such contacts, additional questions about the type and continuation of the relationship should be asked and answers collected.
- During 2012, at least 80 regular partners of SWs should be counselled by a dermatovenerologist and tested for HIV and STIs.
- To organize an informational materials (leaflet or sticker) campaign for regular partners of SWs with the aim of improving their condom use.

- Every visitor who has had relationships with SWs should receive short safe sex education and receive free condoms and lubricants
- During 2012, we plan to provide free of charge HIV test opportunities for the regular partners of SWs.
- At the end of the year, we can analyze how big a proportion of the general public who visited the anonymous HIV/STI testing and counselling site has had regular or occasional sex with SWs.

Conclusions

Offering specially tailored low threshold testing and counselling services reaches client groups with increased vulnerability, such as those exposed to various unfavourable health consequences due to a lack of health insurance.

Estonia, NIHD

Intensified partner notification in an STI clinic for vulnerable groups in Jõhvi

Rationale for the piloting project

Blood borne and sexually transmitted infections are common among people who inject drugs (PWID). Their non-injecting sexual partners are at a higher risk of contracting these infections because of repeated contacts. There are no special services or interventions for them to reduce the spread of HIV/STIs in Estonia. To fill this gap, intensified partner notification and counselling was implemented in an STI clinic working with vulnerable groups.

The main aim of the pilot project was to increase the access of people who inject drugs and their sexual partners to HIV and STI diagnostic services, thereby reducing the proportion of those unaware of their infections. For these purposes, active referral and partner notification approaches were implemented.

Methodology

The target group included people who inject drugs and their sexual partners who attend a special STI clinic for vulnerable groups. Piloting was conducted in Jõhvi, North-Eastern Estonia, by LLC Corrigo (which run the STI clinic) and the National Institute for Health Development (NIHD) (supervision). Recruitment and testing took place during from 7 September 2011 to 31 March 2012.

Steps of the intervention

1. All patients (either PWID or their partners) diagnosed with HIV, HCV, HBV or any STI were invited to participate in the project. They were introduced to the procedures and aims of the project. Upon agreement, all participants (so-called index case) filled in a semi-structured questionnaire (including socio-demographic data, HIV, STI, and IDU history, recent sexual behaviour). Participation was anonymous and everybody received a unique code.
2. All of the participants were counselled regarding the need to invite their sexual or injecting partners to testing. The sexual partner could either be a regular or casual partner, and must have had sex with the index case in the last 6 months in regard to STI diagnosis or 12 months in case of HIV diagnosis. The injecting partner could be somebody with whom syringes or other injecting paraphernalia had been shared within the last 3 years. Partners could be invited either by:
 - a. Index case – they were asked to inform their partner(s) about the need to test and they were given vouchers for inviting (which STI clinic contact details and the unique code of the index case); or

- b. Study nurse – the index case was asked the phone number and first name of the partner(s) and the nurse had to call the partner(s) and invite them to testing (a unique code was given to the partner).
 - c. The index case could choose themselves which invitation method they preferred (and they had a right to refuse). Each index case could invite up to three partners.
3. Partners attending the services were offered STI screening and counselling and had to fill in the same questionnaire as the index case. Upon attendance to the services, the partners had to present the voucher they had received from the index case.
4. The index case received a small food package (approximately 3 EUR) for every partner attending the STI services (for up to a maximum of three partners).
5. A study nurse documented all the steps of the intervention.

Results and outcomes

- Index cases. During the study period, the number of STI clinic patients who were invited to participate was 210. 158 people (index cases) consented to participate (participation rate 75%). Out of the 52 who refused, 30 were female (58%). The average age of those who refused was 29 years. 12 people who initially agreed to participate refused to fill in the questionnaire and therefore were not eligible. The analysis includes data of 146 index cases.
- Besides the initial index cases, four attending partners also invited their own partners.
- The number of partners invited was 279. Of them, 276 were invited by index cases (by personal invitation) and 3 by the study nurse (by calling them). 64 people invited one partner, 75 invited 2 partners and 23 invited 3 partners.
- The number of partners who attended the services was 177:
 - 2 out of 3 (return rate 67%) invited by the study nurse and
 - 175 out of 276 invited personally by the index case (return rate 63%).

145 partners were included in the analysis (who met the inclusion criteria). 32 partners refused to fill in the questionnaire and, therefore, were not eligible.

In the following analysis, the data of 146 index cases and 145 partners are used. 58% of the index cases and 88% of the partners were females. The average age of the index cases was 29 years and that of partners was 31 years. More than 90% of both index cases and their partners were Russian speaking, 88% of all participants had secondary education or less, 68% were unemployed, and more than 86% had a tone stage injected drugs (out of them, 78% had injected for three or more years). Table 2 includes data on how many tests were performed and the results.

Table 2. Number of tested people and number of diagnosed infections among index cases and their partners.

| | Index cases (n=146) | | Partners (n=145) | | Total (n=291) | |
|----------------|---------------------|----------|------------------|----------|---------------|----------|
| | Tested | Positive | Tested | Positive | Tested | Positive |
| HIV | 43 | 3 | 55 | 5 | 98 | 8 |
| HCV | 48 | 32 | 42 | 26 | 90 | 58 |
| HBV | 52 | 32 | 51 | 12 | 103 | 44 |
| Syphilis | 69 | 2 | 90 | 2 | 159 | 4 |
| Gonorrhoea | 61 | 6 | 92 | 1 | 153 | 7 |
| Trichomoniasis | 46 | 26 | 58 | 7 | 104 | 33 |
| Chlamydia | 69 | 21 | 92 | 4 | 161 | 25 |
| Candidiasis | 18 | 16 | 15 | 6 | 33 | 22 |

Evaluation

During the piloting, two cases of gonorrhoea, eight cases of trichomoniasis and four cases of Chlamydia were diagnosed, which most likely were related (both index case and partner were infected). The total number of these infections diagnosed among partners was higher, but the rest were most likely not related to the index cases.

Furthermore, five new cases of HIV, 40 new cases of HCV and 39 new cases of HBV were diagnosed among the invited partners (for blood borne viruses, infection source identification is not so easy).

The project succeeded in reaching people who had not been in contact with the STI services previously. For example, among the index cases 1%, and among the partners 18%, had never been tested for HIV ($p < 0.001$).

Of index cases, 87% had visited the clinic before – of their invited partners, this was only 6% ($p < 0.001$). Considering the number of previously undiagnosed infections among partners (especially HIV, HCV and HBV – see Table 1), the project was successful in reaching vulnerable populations.

The extra costs (nurse's salary and patients' bonuses) related to the project totalled 2,240 EUR. The price of tests and the regular salary of the doctor is not included here because this not an extra cost related to inviting the partners.

Lessons learned, recommendations for the future

In general, clients of the STI services had a positive attitude towards the programme. Most participants wanted to invite their partners themselves and only very few were willing to share phone numbers and have the nurse of the STI clinic call their partners.

The study personnel felt that one of the factors strongly encouraging participation was the study incentive for inviting partners. In the future, in everyday practice, incentives will not be used, which may have a negative effect on the partner attendance rates for the STI services. However, the experiences gained during the pilot project can be implemented in the future in everyday practice. In tracing contacts and inviting partners, medical nurses can play a major role, thereby reducing the work burden of the doctors and the costs of the services.

With relatively little additional costs, we were able to increase the number of people who received STI services. Moreover, these people, being partners of people with STI or a blood borne infection, had a higher probability of being infected themselves. Considering the relatively small sample size, we cannot make any definitive conclusions about the effect of the project on reducing the STI burden in this community; nevertheless, the project was successful in contact tracing and providing testing to partners of people with STI.

Conclusions

Partners of STI clients and sexual partners of PWID are often an overshadowed vulnerable group, which can be effectively addressed with specially tailored pilot diagnostic measures. An early STI diagnostics service provision model using respondent-driven recruitment of clients proves effective in intensified partner notification. The provision of incentives plays a considerable role for the persons recruiting their regular partners.

Germany, AIDS Hilfe Potsdam

STI testing for SWs in the Brandenburg region and the border region between Germany and Poland

Rationale for the piloting project

During Streetwork (a project started in November 2010), our organisation was evaluating the needs of sex workers working in the Brandenburg region and the border region between Germany and Poland. The results of this research showed that the women who work on the street are mostly Bulgarian and Polish citizens and have neither health insurance nor do they have regular access to medical services. What is important to be mentioned is that there are no opportunities for testing for other STIs except HIV in the Brandenburg region. The pilot campaign was used as a probation phase to see whether medical services are being used by the target group when offered. Furthermore, if the medical services are being used, then we have data to apply for financing for a long term service.

General target group description

The targeted group consists of female sex workers working on the streets. We focused on this group because the need was there along with the possibility to address this need. During winter, there are between 10 and 20 women. Not all are there at the same time because they partially work here and partially go back to their home countries. In summer, there are between 20 and 30 women working in this region.

In Germany, sex work has been legal since 2002. If the police conduct controls, they check the women for registration with the city council and the finance office. Where Poland is concerned, sex work is illegal but tolerated. The women say they don't have trouble from the police.

Methodology

The pilot campaign was conducted in the border region between Germany and Poland, namely between Schwedt/Oder and Chojna. In the Brandenburg region, it was conducted on the national road between Fürstenwalde and Hangelsberg. The campaign was planned to take place during the month of February 2012. During this month, we were present on the street twice a week – Tuesdays and Thursdays. The notification of medical tests and results were done over 8 days. The pilot campaign was planned and organized by BORDERNETwork (AIDS-Hilfe Potsdam). The campaign was conducted by IN VIA together with a doctor and a Bulgarian translator. IN VIA is a catholic organisation that has been working in the field of HIV and STI prevention for sex workers in the Brandenburg region and the border region between Germany and Poland since November 2010.

Steps of the intervention

The pilot campaign had the target of offering anonymous and free testing for HIV, HBV, HCV, HAV, syphilis, Chlamydia and pregnancy tests to the FSWs who work on the streets. As previous attempts have shown that the will or possibility of going to the medical centres in Berlin were not an option, the idea of providing the tests on the spot emerged. Several attempts to find a medical bus failed. Therefore, we decided to conduct the medical tests in our IN VIA car – a Citroen Berlingo. Not having the option of gynaecological counselling, the conducted tests were only those based on urine or blood samples. Testing for Gonorrhoea was not possible without gynaecological counselling.

Results

Of the 10 participants, 4 tests for Chlamydia came out positive. At that time, there were 13 women working in this area currently and all were invited. During the summer, there are more, but this was during the winter. They used a nickname or their first name (their choice) for the medical file. The results for the other tests – HIV, HBV, HCV, HAV, syphilis were all negative. The participants that were tested positive for Chlamydia immediately received their medication for free and a test was conducted after about 10 days to check if the disease had been treated successfully. 2 of them came back.

Evaluation

The feedback from the participants was very positive. Most of them did not have the information or financial means to see a doctor and have regular medical check-ups. They were grateful to have the chance to have a check-up on the spot and for free. It was also very important that we had a Bulgarian translator and a Polish IN VIA staff member who could communicate to the women in their native language.

Cost assessment

Doctor – 150 EUR/day + Translator – 100 EUR/day Tests for HIV, syphilis, HBV, HCV, HAV, Chlamydia – 60 EUR/person for all the tests. The tests cost less than a regular service because a special price for the campaign was negotiated with a laboratory. Often, the women have no opportunity to make use of regular services because of administrative regulations, e.g. health insurance. Medical utensils – about 700 EUR.

Lessons learned, recommendations for the future

The pilot campaign has proven that the FSW working in the streets are lacking the opportunity to see a doctor and are willing to have medical check-ups if they are offered them for free and nearby the region where they work. The need is there and we would like to address it. We would like to offer regular medical check-ups to FSWs in Schwedt/Oder-Chojna region and the surroundings. As the number of women is not that high, we plan to offer the medical check-ups once a month and after one week the results. As not only the blood and urine samples are important, but also a proper gynaecological counselling, we

have already started looking for partners to support our “plans”. The hospital in Schwedt/Oder is willing to support us with a gynaecological counselling room. We have applied for financial support to the Health Ministry of the Brandenburg region to be able to maintain the offer of the anonymous and free check-ups for FSWs. The targeted are not only those working on the street but also those working in brothels and apartments.

Conclusions

Mobile services are important in rural remote border areas. The pilot project revealed the needs in the community and resulted in better cooperation with state health care structures. The results and experiences from this pilot project can be rolled out and extended to other target groups.

Latvia, PĀPARDES ZIEDS

STI testing for the regular partners of SWs in Riga

Rationale for the piloting project

The pilot project 'Involving men and women whose partners are SWs in HIV and STI diagnostic services' was created to involve sexual partners (SP) of female SWs (FSW) into utilizing HIV and STI testing services

Considering that the regular sexual partners of FSW are at high risk of STIs and target oriented activities to involve the mentioned risk group in the diagnostic services have not been organized, we decided to reach those people with the help of FSWs involved in the BBSS study conducted in the framework of WP5 of the BORDERNETwork project and by using some incentives (such as free of charge counselling by medical specialists, condoms and express diagnostic of several STIs) to increase their motivation to utilize the testing services.

Methodology

Activity was piloted together with WP5 activity (from 4 July to 1 November) and in the same venue – the low threshold AIDS Counselling Centre (ACC) of Infectology Centre of Latvia in Riga (LIC). There was a plan to involve the sexual partners of about 20 to 25 FSW, which is about 10% of FSW planned to be reached by the WP5 survey. Actually, the SPs of 18.8% FSWs (n=22) were involved since the number of FSW recruited for the survey was lower than initially planned (n=117).

During the counselling, the medical worker of ACC informed the FSWs about the issue of STI prevention and motivated them to invite their SPs to free counselling by receiving a bonus in the form of the option to have HIV, HBV, HCV and syphilis diagnostics, as well as a set of 12 condoms. In case the SP arrived for counselling, the FSW received bonuses, too – pregnancy express test (for home use when necessary) and a set of 12 condoms.

Special invitation coupons in Latvian and Russian (figure 1) were created for inviting SPs and as many as needed were given to each FSW (one FSW could get several coupons if she wanted to invite more than one SP).

The medical worker consulted SPs who came with appropriate coupons during the working hours of the ACC, informed him about HIV and STI prevention measures and offered to have a test on HIV, HBV, HCV and syphilis using rapid tests. SPs were also informed about the other services of ACC and offered to use them in the future. By stressing the risk of getting infected due to the fact that the person is a FSW's sexual partner, they were motivated to repeat testing after 3-6 months.

Information about the services provided to the SP was recorded in the ACC's client database and the person was informed that this does not contain any personal identification data.

If the SP agreed to be tested for HIV, HBV, HCV and syphilis, express diagnostic tests were provided with appropriate pre-test and post-test counselling. The medical worker explained that this free testing was one of the bonuses upon his arrival to the counselling. Each FSW whose partner/s arrived for counselling received bonuses – pregnancy express test (for home use when necessary) and a set of 12 condoms.

Results

In this way, 22 persons – male partners of FSW were reached. According to the information in the ACC database, 10 of them were new clients but the other 12 had already been registered in the database; this means that these persons had been clients of ACC before. 12 persons had been recorded as IDUs but 10 asserted that they had never injected drugs. Four new HIV cases were found among the SPs. All of these persons reported that they had been tested for HIV before. One person rejected the HIV test because he already knew that he was HIV positive. A total of 17 persons had been tested for HIV before, but five had not.

Also, other express diagnostics (HBV, HCV and syphilis) were offered. 12 tests were done for HBV and 0 reactive results were found, 16 tests were done for HCV (4 reactive results) and 14 tests for syphilis (0 reactive results).

Cost assessment

All the express tests for HIV, HBV, HCV and syphilis, as well as the condoms necessary for providing the activity were available in ACC, as those materials had been purchased through the government procurement for the running of LTC services. The pregnancy tests used for motivating FSWs to involve their SPs were available in the required amounts from other sources.

A special purchase was not performed, as there were no finances for this activity in the project's budget. Our main challenge was to stress the attention of FSWs and their sexual partners that they are at very high risk of getting STIs and to involve them regularly in free of charge low threshold services to keep their health and to be referred to medical treatment in good time if there is a need.

Evaluation

Medical staff involved in the activity acknowledged the satisfaction of the target audience about the offered service. Despite the fact that there were no special bonuses (as mentioned above, free testing and condoms are available daily for all visitors to the ACC who are at risk), people were happy with the information and special attention, and they remarked that free of charge testing is most important for them. Both medical workers motivated SPs with reactive test results to visit LIC for confirming diagnosis and treatment if necessary, and there is feedback that all four clients with reactive HIV test results have visited LIC and confirmed the HIV diagnosis.

Lessons learned, recommendations for the future

It's early to prejudge whether the SPs involved in the activity who were not clients of ACC before will become regular visitors to the low threshold service centre. Also, another problem is that in the middle of November 2011 ACC was unexpectedly moved to another place, which immediately resulted in a decrease in the number of visitors.

We consider that involving FSW sexual partners in utilizing testing services was successful and should remark that such an activity does not need special resources – just goodwill and a creative approach – as free of charge rapid testing is attractive for persons at risk, and we just have to find the right channel of information to meet them.

Conclusions

Addressing new client groups with the usual services does not necessarily involve special resources, but a creative approach and commitment as well as the right recruitment channel play the most important roles.

Poland, POMOST

Community-based HIV testing (CBVCT) for inmates in Podkarpackie Region

Rationale for the pilot project

We decided that prisoners staying in prisons in the Carpathian (Podkarpackie) are the group of people who are largely marginalized and vulnerable to HIV/STI. Therefore, we have taken steps to start the cooperation with the director of one of the prisons in the Podkarpackie Region to carry out a campaign for information, education and promotion of HIV testing. POMOST is the only non-governmental organization in the Podkarpackie Region, which deals with this subject and the first NGO in whole Poland to have signed an agreement with prison's administration for introduction of HIV prevention in the penitentiary setting.

We conducted interviews with 5 directors of prisons in the Podkarpackie Region and convinced them of the benefits of carrying out this diagnostic campaign in their prisons. The result of the discussions was the signing of a cooperation agreement between the president of the organization POMOST and the director of the Prison in Łupkow: maj. M. Grabek. It was jointly decided that the aim will be HIV prevention and the campaign will start with an assessment survey among the prisoners on their risky behavior associated with using psychoactive substances, HIV / AIDS and others.

The prison in Łupkow (262 inmates), located in the border area between Poland, Slovak republic and Ukraine is a half-open prison for repeat offenders convicted of penitentiary. This prison can accommodate up to 579 inmates (including the branch in Moszczaniec – 317 inmates).

At the end of 2010 we conducted an anonymous survey among residents in the Prison in Łupkow using a self-complete questionnaire. 50 inmates filled-in the questionnaire on voluntary basis. Knowledge misbeliefs and risky behavior in general and related to HIV/drug use in particular were studied as well as risks with regard to social exclusion. The results were analysed by the prison psychologist. Based on the assessment findings the education campaign and the CBVCT pilot diagnostic were planned in 2011.

Steps of the intervention

Since the beginning of 2011 an education campaign was conducted among convicted inmates in the Correctional Facility in Łupkow aiming at raising awareness of HIV/AIDS, transmission modes, risk behavior, ways of preventing infection, places in which diagnostic services are offered, treatment, care and support opportunities. The education campaign in cooperation with the prison staff conducted the following activities designed for prisoners to familiarize the subject of HIV/AIDS and to encourage them to take up the VCT offer within the prison:

- Information sessions broadcasted through the local prison radio station each week to convicts with the aim to expand their knowledge on HIV/AIDS and to emphasize the seriousness of the problem of infections. There were presented specific examples of infections, how they occur and what precautions take to keep in contact with an infected person. This action was conducted to all inmates.

- Distribution of leaflets, which were inserted into public places for prisoners such as: library, common room, the Hall of therapy, the psychologist's office and the medical service office. Total number of distributed leaflets was 500.
- Contests (quizzes) on knowledge about HIV/AIDS conducted every three months. Each winner received a prize as an important factor motivating them to expand their knowledge in this field. The contests involved 170 prisoners.
- Information on HIV/STI testing and diagnostic services posted on the information boards located in the prison cell provided. This action was conducted to all inmates.
- Prison's medical centre (outpatient medical ambulatory) hosted posters with information about HIV/AIDS. This action was conducted among all inmates.
- Education and psychological counselling sessions on the subject of HIV/AIDS and interaction on the topics within the group rehabilitation sessions. A psychologist in the course of their educational and therapeutic program for drug addiction devoted to this topic workshop and the entire thematic block. 80 inmates participated in that course.

As an outcome of the information and awareness raising campaign lead by members of the POMOST and the prison staff, 14 prisoners from the prison in Łupkow and the branch in Moszczaniec were tested for HIV. The testing was conducted according to the VCT standards, accompanied by pre- and post-test counseling talk, conducted by the prison nurse, who also took the blood on the spot. The blood samples were brought to a private lab in the nearest town (40 km distance). The results were handed-over personally, 14 days after the testing took place. None of the inmates was infected with HIV.

Lessons learned, recommendations for the future

It is worth to emphasize that the information/education campaign and the piloting CBVCT action are unique for the prison setting in the whole country and not only in the Region of Podkarpackie. We hope that our efforts will pay dividends in the future. It takes long time and intensive efforts to change structures in some known as rigid state institutions as the penitentiary ones. It takes though even longer time to change the mentality and attitudes of the administration as a first step, as this is the prerequisite to open the gates in the whole prison setting for HIV prevention. This year we plan the continuation of the education activities (the whole package as the year before) in the Łupkow prison. During these actions we will disseminate information to all directors of the other prisons in the Podkarpackie Region in order to increase their interest in the subject of HIV and AIDS and to gain their support.

Conclusions

Prisons are a very important setting for prevention and testing, often "given up" in advance due to various structural barriers (lack of allowing regulations for harm reduction and VCT etc.). Ensuring supporting environment in the prison institution (commitment of the administration) is a decisive gate opener for information/prevention diagnostic interventions. Testing should be embedded in awareness raising and education campaign, so that VCT services can reach this client's group and hope for good uptake.

Poland, SPWSZ

Rapid testing of HIV and STI for vulnerable groups

Rationale for the piloting project

The geographical situation of Szczecin and touristic character of the region are supporting migration of the population which in turn affects the incidence of HIV and other sexually transmitting infections (STI). An anonymous and free-of-charge HIV testing is available in Counseling and diagnostic point open on Mondays, Wednesdays between 15:15 and 19:15; Fridays between 15:15 and 17:15. The testing possibilities are therefore limited. The project was targeted to female and male sex workers, clients of the sex workers as well as their families. One of the cooperation partners was Association DADU which is the only organization in Zachodniopomorskie working with female sex workers, through HIV/STI prevention carried out in housing agencies and on a street.

General target group description

The target groups for this pilot project were:

1. Female and male sex workers working in housing agencies and on a street;
2. Clients (men and women) of female sex workers working on a street and in housing agencies;
3. Families and close ones on sex workers.

Steps of intervention

1. First step involved information distribution about the possibility of HIV, HCV and syphilis testing. Repeated visits to 15 housing agencies, including one for male sex workers, were conducted 2–3 times a month. Outreach work with SWs working by the highways was conducted 2 times a month. During the visits information materials were distributed (HIV/STI epidemiology, modes of infection transmission, prevention, etc.). The information was also given about the possibility of free-of-charge testing for HIV, and HCV antibodies, and for syphilis as well as possibility of counselling of infectious diseases specialist.
2. Testing was conducted in Testing Point in Outpatient Clinic of Acquired Immunologic Deficiencies in Szczecin, pursuant to applicable standards, meaning that the pre- and post-test counseling were carried out by certified counselors. The laboratory tests were conducted in Bacteriological Laboratory of SPWSZ in Szczecin. The anti-HIV +antigen 24 (Combo) screening tests were used and positive results were confirmed with Western Blot test in Laboratory in Wrocław.

3. We also advertized the testing possibilities on a vintage tram. The following information was announced during the ride through the sound system: *“If you ever used the service of sex worker you should come to examination in the Clinic on Broniewskiego St.”* Thanks to a long way of the ride through the main streets of Szczecin the information reached large group of people.

Results

Overall, within August 2010 to August 2011, 300 visits were conducted to the housing agencies and 72 meetings were organized with FSWs working on the streets.

Between 2 October 2010 and 31 August 2011 548 persons went testing. 59% of them were women and 41% were men. The vast majority were Polish, two people were Norwegian. Only 4 persons pointed the countryside as a place of residence. 93% were heterosexuals, 3.7% were homosexuals, and 3.3% bisexuals. 102 persons reported never using condoms, 26 reported using them rarely, 16 – frequently, 38 – always, and 26 persons did not answer this question.

HIV infection was identified among 3% of the tested people, HCV among 4 % and syphilis among 1.25 % of the tested people (see test results in Table 1). Total number of consultations carried out by infectious diseases specialist was 150.

Table 3. Test results

| | Anti-HIV antibodies | Anti-HCV antibodies | Syphilis testing |
|----------------------------|---------------------|---------------------|------------------|
| Number of positive results | 12 | 19 | 4 |
| Number of negative results | 398 | 475 | 320 |
| Total number of tests | 410 | 494 | 324 |

Lessons learned, recommendation for the future

The multidirectional activities such as visits in housing agencies, on a street, and information distribution in the “Prevention Tram” were effective. The actions carried out together with DADU Association that have experience in the matter had brought measurable benefits. It is important that such actions are not only one-time but systematic.

An awareness of the responsibility for health was increased among SWs and their clients. Detection of new infections (HIV 12 persons, HCV – 19 persons, syphilis – 4 persons) will enable the infected persons to undertake early treatment, as well as will save other persons from getting infected. Reaching such a large group of people working in the sex business and their clients was a great challenge but we were able to meet it. Only actions directed to specific groups enable to achieve prevention goals effectively.

Romania, ARAS

STI testing for female SWs who inject drugs and their partners in Bucharest

Rationale for the piloting project

To increase the access of partners, clients and families of those that are both a SW and IDU in Bucharest to counselling and testing services by ensuring friendly, client specific and client oriented services through the ARAS “Social Service” mobile units by implementing peer-to-peer counselling and vouchers for testing.

This piloting gives information about and encourages people in different kinds of relationships (client, sexual partner, husband, other family members living together or not) with women that are both SWs and IDUs, and it increase the number of those who utilize the mobile clinic counselling and testing services by 10% per year.

Methods

We provided HIV and STI counselling and testing services in the mobile clinic and drop-in centre for 63 SWs/IDU and we distributed 63 vouchers.

- All the beneficiaries participated anonymously, and no personal data were collected (names, personal identifiers, birth dates etc.). All participants provided oral informed consent.
- All participants were numbered sequentially to keep track of who was coming back for services. The same unique code was used on the voucher (which is needed to participate in the services).

Participants were recruited in the outreach settings, in the drop-in centre for counselling and through peer-to-peer information distribution.

1) Description of the intervention (how participants will be put in touch with services)

- The counsellors informed their clients of the opportunity for additional STI testing in the mobile clinic or drop-in centre. Each person received a voucher for these services. Counsellors also gave additional vouchers to SWs, which they could give to the people they are in contact with.
- The mobile clinic was opened 8 hours a week in specific locations in Bucharest (Gara de Nord, Piata Unirii, Ferentari, Piata Matache, Bdul Pache).
- The beneficiaries had the opportunity to attend services without prior registration. Test results were received in 20–30 minutes. In case further diagnosis/counselling/treatment was needed, they were referred to Matei Bals Institute for HIV and Hepatitis tests and to Colentina Hospital for syphilis counselling/tests.

2) Description of the services provided (rapid HIV testing, STI screening, etc.)

Services provided in the mobile clinic included HIV and STI testing and counselling and referrals to specialized services. We used rapid testing for HIV, HBV, HCV and syphilis.

3) Description of the personnel (who did the recruitment, who provided the services, etc.)

- The initial recruitment of SWs was done by the counsellors/social workers, etc. in the drop-in centre or outreach. Additional recruitment was done by SWs themselves who were invited to distribute the service vouchers to other SWs or partners/members of their family.

- HIV and STI services in the mobile clinic were provided by trained doctors/nurses and social workers.
- All study personnel (including counsellors, nurses and doctors) received training before the piloting, including information on the goals and methods of the piloting project, recruitment, questionnaire etc.

4) No incentives were provided for participation and for inviting the contacts.

Monitoring and evaluation

- Instruments (questionnaires and forms to document the participants, services they receive, and outcomes):
- Every client who received services in the mobile clinic filled in a small questionnaire including questions on socio-demographics, type and history of sex work, sexual risk behaviours, STI, HIV and IDU history, and previous interactions with HIV and STI services.
- The counsellor in the mobile clinic filled in a short questionnaire including the SWs basic data (unique code, gender, age) and the results of the tests
- Daily monitoring of the process (who keeps record of the vouchers, clients, who supervises the process) Study personnel kept the following records:
 - 63 SW/IDU received services face to face (by study personnel)
 - 63 vouchers were given to SWs to distribute to their peers or partners/members of their family
 - 18 peers or partners/members of their family returned for services including HIV/STI testing and counselling; HIV/STI results:
 - HIV – 1 positive test
 - HBV – no positive results
 - HCV – 2 positive tests
 - Syphilis – 1 positive test

Cost-assessment

The costs were quite high but did not differ very much from the usual costs for these type of activities. Outreach work and testing – mapping, appointments, meetings, information, pre and post test counselling, testing with rapid tests, accompanying to specialized laboratory if the rapid test is positive

1. Total social costs (including all taxes and fees) for 3 persons x 12 weeks – 6,000 EUR
2. Costs of the tests – 18 HIV + 18 HCV + 18 HBV + 18 Syphilis + needles + consumables = 125 EUR
3. Petrol costs for the mobile unit – 20 trips x 30 km x 15 l/100km oil x 1.2 euro/l = 100 EUR

TOTAL – 6,225 EUR

Lessons learned, recommendations for the future

As expected, these activities proved that hard to reach populations are unaccustomed and unwilling to come to fixed centres and services, and the only way to provide testing to them is to go into their environment and then provide transportation to other services.

Conclusions

CBVCT remains the only bridge to the groups that are unfamiliar/unaccustomed with the state services. Since only NGOs offer outreach testing in Romania, there is a need to develop more outreach testing services for hard to reach populations and advocate that the authorities build bridges between these and other types of services.

Slovakia, PRIMA

STI testing for homeless and socially marginalized persons in Bratislava

Rationale for the piloting project

In Slovakia, probably based on stereotypes, STI testing has been highly focused on IDUs and street SWs. The aim of the field social work is to test IDUs and sex workers as well as other target groups with risk behaviours. We contacted the partner NGOs working with homeless people (mainly street alcoholics) and other socially disabled people involved in reintegration programmes, who often provide sexual services in exchange for money or items.

Methodology

The piloting project was conducted from May 2011 to January 2012 in Bratislava together with the institutions working directly with clients – CA Prima with cooperation partners NGOs-UNICEF, CA Upstream, CA Gateway to Life, CA Lighthouse, CA Crossroads, CA Vagus, CA Fortuna, CA Mea Culpa.

Steps of the intervention

Through the organization CA Marginal Bratislava-local partnership of social inclusion, the following steps were taken:

- 29 April 2011 Initial meeting focused on cooperation in the project, where we presented a project to test other target groups with risk behaviours
- Our colleagues from CA PRIMA, who worked in the partner organizations, have piloted testing their clients. The project included testing and counselling.
- From 10 June 2011 to 31 January 2012, the testing itself was carried out. Social workers approached their clients and offered testing. If the client agreed, then a meeting was organized with Mgr. Lívia Miklianová by our staff, who tested the client.
- From 1 February 2012 to 29 February 2012, we conducted evaluation of the project.

Results

Rapid testing was provided to 179 clients of the social projects. Of them, 122 were women and 57 were men (32%). Clients were aged 18 to 56 years. The average age was 32.7 years. 80% were unemployed. 65% were homeless. 48% had primary education. 29% had high school education and 19% had graduated from secondary school. 79% were inhabitants of Bratislava.

All tested people were HIV negative and all syphilis tests were negative. 29% of the tests were positive for HCV. 15 people came for retesting and 8 of them went to receive treatment.

Evaluation

All participants positively evaluated the project, in particular that it was free of charge. The problem now, however, is that the project is not stable and sustainable.

Cost-assessment

Tests were received from a sponsor; therefore, the costs included salaries for the coordinator and street worker, transportation, and phone communication. Costs included:

- coordinator 15 hours – 450 EUR
- street worker 200 hours – 1,000 EUR
- transport – 200 EUR
- phone communication – 25 EUR

For comparison, one day in a hospital costs 466 EUR, and annual HIV treatment costs amount to 33,000 EUR.

Lessons learned, recommendations for the future

Our experience shows that outreach and community-based VCT are important in order to reach the most vulnerable groups. Our goal is to provide stable funding to test these groups in the future.

Conclusions

Support from state authorities is essential for ensuring the sustainability of the services and for creating the bridges between non-governmental and state health care service providers.

Discussion and conclusions

The aim of the WP6 was to pilot different HIV/STI service provision models for vulnerable groups in order to bridge existing gaps in the services and meet the needs of target groups. Partners implemented a range of projects, including community-based VCT, the active involvement of sexual partners of members of vulnerable groups and testing in a prison setting.

There are some common lessons learned from the projects and areas that need addressing (presented not necessarily in the order of importance):

- Specially tailored services facilitate reaching out to new less visible members of well-known and generally well-reached target groups as well as regular/casual sexual partners of the members of vulnerable groups.
- Effective models of service provision for hard-to-reach groups should follow the principles of accessibility and flexibility, including appropriate opening hours, service provision locations, etc.
- Availability of equipped mobile medical services for prevention and testing are essential to coverage and the high quality of HIV/STI diagnostic offers in non-medical settings. Mobile services are especially important in rural and remote border areas, where stationary services provision is not feasible.
- The success of improved access and the attractiveness of services is guaranteed by integration of different services, taking up various needs of the vulnerable groups (for example, the provision of STI, not only HIV screening). For women, the provision of complete gynecological check-ups is needed.
- The sexual partners of SWs and PWIDs are an especially hidden and over-looked group, which can be effectively addressed with specially tailored pilot diagnostic measures. For example, early STI diagnostic service provision model implementing the respondent-driven recruitment of clients can be effective in intensified partner notification.
- Addressing new client groups with the usual services does not necessarily require special resources, but a creative approach and commitment and the right recruitment channel (as in the case of testing the regular partners of SWs in Riga, Latvia).
- Testing and counselling can be a successful part of awareness raising and education campaigns.
- Ensuring the support of local authorities (including prison administration) is a decisive gate opener for collaboration between organizations (NGOs and health care service providers) and essential to ensure the sustainability of the services.

Our experience also confirms that a pilot project can also play the role of needs assessment – checking the uptake of a new service, evaluating the satisfaction of the target group with the services, and the appropriateness of the mode of service delivery. The protocol and report templates developed in the framework of the BORDERNETwork project can be used for similar exercises in the future.

Even though we used convenience samples, our sample sizes for testing the new service provision approaches were small, and we did not involve any control groups, we can conclude that the projects were successful in reaching people in need. With further modifications based on gained experiences, the developed models can be implemented on a regular basis in the future in the respective organizations and countries.

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Annexes

Annex 1. List of WP6 partners

List of associated partners and contact persons

| <u>Organisation</u> | <u>Contact Persons</u> | <u>Contact Details</u> |
|--|-------------------------------|-------------------------------|
| AHW, Vienna (Austria) | Isabell Eibl | eibl@aids.at |
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ENP country partner, involved in the assessment survey

| | | |
|------------------------------|-----------------------|--------------------|
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|------------------------------|-----------------------|--------------------|

Collaborating partners: LRAC (Ukraine), THBB (Germany), LIC (Latvia), HUMANITARIAN ACTION (Russian Federation), CORRELATION II (Netherlands).

Annex 2. Protocol template

Protocol template for piloting services for HIV and STI diagnostics for vulnerable groups

General objective of the WP6 in BORDERNETwork project: To intensify efforts for two years in the early diagnosis of HIV and STIs for the most at-risk group based on human rights and gender equity and to decrease the number of those unaware of their infection status.

Outcome Indicator for WP6 is: 10% increase in rates of HIV/STIs diagnostic service utilization by clients from the most at-risk groups among the participating services in WP6 in M32.

Protocol should include the following basic information:

1. Aim of the pilot project:

Example: To increase the access of ... to ... services by ... (To increase the access of sex workers to STI services by introducing a mobile clinic; to increase HIV testing among IDUs by implementing peer-to-peer counselling and vouchers for testing; to increase the number of PLHIV aware of their status by implementing partner notification of newly diagnosed cases; etc)

Materials and methods section uses an example, in which Clinic X where sex-workers (SW) go for STI and HIV testing wants to increase the number of SWs tested by using a mobile clinic that provides its services in the city regions where SWs mostly work. Clinic X will use the help of a SW drop-in centre to recruit sex workers and provide information on the mobile services. The aim is to increase the number of SWs who utilize the services of Clinic X by 10% per year (for example, if last year 3,000 visits by sex workers were made to clinic X, then this piloting should increase the number of visits by 300 cases).

2. Materials and methods:

- 1) Target group definition (including the approx. number)
 - For example: We plan to provide STI services in the mobile clinic for 300 current sex workers, and for this we will distribute 400 vouchers (considering that not all may come).
 - All SWs will participate anonymously; no personal data will be collected (names, personal identifiers, birth dates, etc.). All participants will provide oral informed consent.
 - All participants will be numbered sequentially to keep track of who is coming back for services. The same unique code will be used on the voucher (which is needed to participate in the services), questionnaire the SW fills in and on the questionnaire filled in by the doctor/nurse administering testing in the mobile clinic (this will help to link data from different questionnaires).

- 2) Recruitment (how, where, by whom they will be contacted and recruited)
 - For example: Sex workers will be recruited in the drop-in centre for counselling and through peer-to-peer information distribution.
- 3) Description of the intervention (how participants will be put in touch with services)
 - For example: In the drop-in centre, the counsellors will inform SWs of the opportunity for additional STI testing in the mobile clinic. Each SW will receive a voucher for these services. Counsellors will also give additional vouchers to SWs, which they can give to other SWs they know.
 - The mobile clinic will be opened ... hours a week in specific locations (please specify). SWs can attend services without prior registration/with registering? Test results can be received.... In case there is a need for further diagnosis/counselling/treatment, they will be referred to... (please specify where for which infections).
- 4) Description of the services provided (rapid HIV testing, STI screening, etc.)
 - Services provided in the mobile clinic will include STI testing, treatment, counselling, etc. The tests that will be used include: rapid testing for HIV and syphilis, blood tests to diagnose chlamydia and gonorrhoea, etc.
- 5) Description of the personnel (who will do the recruitment, who will provide the services, etc.)
 - For example: Initial recruitment of SWs will be done by the counsellors/social workers, etc. in the drop-in centre. Additional recruitment will be done by SWs themselves who will be invited to distribute the service vouchers to other SWs. HIV and STI services in the mobile clinic will be provided by trained doctors/nurses. All study personnel (including counsellors, nurses and doctors) will receive training before the piloting, including information on the goals and methods of the piloting project, recruitment, questionnaire, etc.
- 6) Incentives (if applicable): Each SW who participates in the services will receive a food voucher (with the value of ... EUR)/free condoms (or something else) after participating in the services and filling in the questionnaire.
- 7) Ethical committee's approval. The study was approved by the ...
- 8) Data input from the monitoring forms and questionnaires filled in by SWs and study personnel and initial analysis will be done in MS Excel.

3. Monitoring and evaluation

- 1) Instruments (questionnaires and forms to documents the participants, services they receive, and outcomes):
 - Every SW who receives services in the mobile clinic will complete a short questionnaire including questions on sociodemographics, type and history of sex work, sexual risk behaviours, STI, HIV and IDU history, and previous interactions with HIV and STI services.
 - The doctor/nurse administering testing in the mobile clinic will fill in a short questionnaire including SWs basic data (unique code, gender, age) and the results of the tests
- 2) Daily monitoring of the process (who keeps record of the vouchers, clients, etc. who supervises the process)

For example:

- Study personnel (in recruitment site) will keep the record of the following:
 - How many vouchers were given out to SWs face to face (by study personnel) (record the number of voucher, age and gender of the SW to whom the voucher was given)
 - How many vouchers were given to SWs to distribute to their peers (may have to be limited, how many can be given out to one SW)
- Study personnel (in the mobile clinic) will keep a record of the following:
 - How many people received the services in the mobile clinic

Annex 3. Data collection template

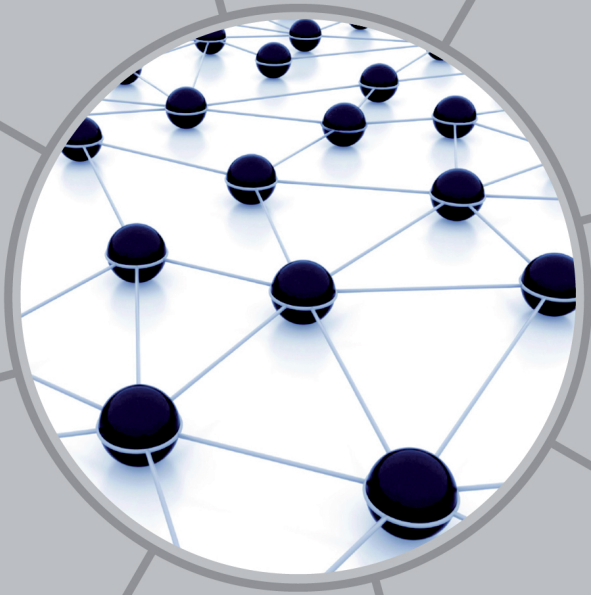
| Participant number | Gender | Age | Ever had sex with the same-sex partner? (YES or NO) | Ever injected drugs? (YES or NO) | How many years has injected drugs? | Ever had sex for money or other things? (YES or NO) | How many years has been involved in sex work? | Previous HIV-testing (YES or NO) | Result of the last HIV test (POS, NEG, inconclusive) | Tests done during the piloting and results |
|--------------------|--------|-----|---|----------------------------------|------------------------------------|---|---|----------------------------------|--|--|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
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Annex 4. Report template

Report template for piloting services for HIV and STI diagnostics for vulnerable groups

Suggested topics and format for reporting pilot project results:

- Rationale – why was this piloting project organized – what kind of needs/problems were planned to address; why was this target group selected?
- General target group description
- Where
- When
- Who performed the task (organization(s))?
- Steps of the intervention in more detail (what exactly was done)
- Results – description of participants (how many people were reached, their sociodemographic and risk profile) and outcomes (how many cases of infections were diagnosed/treated, how many were successfully referred to further care/counselling/treatment)
- Evaluation of the piloting, including provider feedback (what did the participants and personnel think about the piloting project, services provided?)
- Cost-assessment – covering the costs related to the piloting, including incentives offered to the participants. How much did the detection of one case of STI/HIV cost? Was the cost higher or lower than in the case of regular services?
- Lessons learned, recommendations for the future. How can this piloting exercise help to build bridges between services and hard to reach key populations? Can it be implemented (wholly or partially) on a regular basis in the future?



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