Abstract

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Systematic review of 66 service delivery models for female sex workers (FSWs) in Africa and India

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Background: Several biological, behavioural, and structural risk factors place FSWs at heightened risk of HIV and other sexually-transmitted infections (STI) transmission. Interventions targeting these factors can reduce HIV incidence among FSWs and, consequently, the general population. However, the optimum scale, intensity and delivery model of these interventions needs to be determined. This systematic review of projects in Africa and India evaluated service delivery settings, intervention packages provided and extent of government involvement in these services.

Methods: We searched Web of Science, MEDLINE and reference lists for studies of FSWs in low- and middle-income countries published from January 2000 to November 2012. Articles in key non-indexed journals and on websites of international organizations were also identified. All studies describing a set of clinical or non-clinical services for FSWs in India and Africa were included. A single reviewer screened articles and extracted data into predefined fields.

Results: A total of 181 articles were included, with 58 service delivery models in Africa and 8 in India. In Africa, most models were localised and small-scale; distinct from other services; and centred around research activities or demonstration projects. Conversely, Indian models covered large geographical areas and often extended beyond state lines. However, there were few instances of services in Africa beginning as single clinical sites and later expanding to other areas. Also, two initiatives to provide regional coordination of projects in Africa were located, especially around services along major transport routes. Although models in both settings were generally funded by international donors, the Indian government recently took over its programme. In Africa and India, almost all models provided integrated HIV and STI interventions. Most services distributed male condoms, but only about 10% provided female condoms. While most HIV services encompassed HIV counselling and testing, including mobile and peer outreach testing, few offered antiretroviral therapy (ART) or CD4 testing. STI services were more comprehensive and included screening and syndromic management, although periodic presumptive treatment was only provided by 11 services and acyclovir treatment was rare. By contrast, few projects in Africa or India included reproductive health services such as family planning and cervical cancer screening. Unlike models in Africa, those in India placed much emphasis on gender-based violence services and community engagement.

Conclusions and recommendations: We found marked weaknesses in delivery models in Africa, compared with those in India. The coordinated large-scale programmes in India, and their consequent economies of scale, contrast strongly with the multiple small projects in Africa with low coverage. The India project was recently subsumed within government services. A large-scale project in Africa, initially donor-led, could do likewise. While HIV prevention remains the mainstay of services, access to ART should be enhanced both for FSWs health and for reducing onward HIV transmission. Moreover, service delivery models are needed which integrate reproductive health services and address structural risk factors, such as gender-based violence. Much could be learnt from the India experience. By raising the quality and scale of services for FSWs, Africa can reduce the considerable transmission of HIV and STIs in these settings.

Key words: female sex workers, intervention packages, service delivery settings, government involvement