

PROVIDING COMMUNITY-BASED SERVICES FOR SEXUALLY TRANSMITTED INFECTIONS

# *Setting up and Managing* **Sexual Health Clinical Services in Resource-Poor Settings**

*A Comprehensive Programmatic  
Guide for NGOs*

**Volume I**

Published in 2004

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- ➔ Sengupta, S. 2001. *Minimum Standards for STD Service Delivery.* The International Congress of Sexually Transmitted Infections (ICSTI); Berlin, June 24-27, 2001. Monduzzi Editore (publisher).

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# ABBREVIATIONS

AIAP	Alliance India Andhra Pradesh (office)
AIDS	Acquired immuno-deficiency syndrome
APSACS	Andhra Pradesh State AIDS Control Society
ARV	Antiretroviral therapy
CAA	Children affected by AIDS
CBO	Community-based organisation
FPP	Frontiers Prevention Programme
HIV	Human immunodeficiency virus
IAI	India AIDS Initiative
IDU	Injecting drug users
IEC	Information, education and communication
KP	Key population
MSM	Men who have sex with men
NACO	National AIDS Control Organisation
NGO	Non-governmental organisation
OI	Opportunistic infection
PIN	Personal identity number
PLHA	People living with HIV/AIDS
RMP	Registered medical practitioner
STI	Sexually transmitted infection
TSS	Technical support staff
VCT	Voluntary counselling and testing
VDRL	Venereal disease reference laboratory test
WHO	World Health Organization



# 1 INTRODUCTION

## 1.1 Overview

HIV/AIDS is an unprecedented global development challenge that has caused unrivalled levels of ill health, death, and emotional, social and economic hardships. This pandemic not only impacts individuals, but also devastates households and communities, and threatens the stability of nations.

The behaviours that spread HIV are fuelled by social, cultural, economic and legal factors, increasing the inability of people to protect themselves and exacerbating the epidemic's consequences. HIV starts and spreads in different manners in different places, but the epidemic is consistently accompanied by fear, blame and prejudice. In almost all cases, poor and marginalised people are disproportionately vulnerable to HIV/AIDS. This is particularly true for girls and women because of their low status and limited access to knowledge and resources, which ultimately affect their ability to protect themselves to negotiate safe sex.

The most successful responses to HIV/AIDS are built upon local leadership, commitment and responsibility, and are supported by strong knowledge base. Local non-governmental organisations (NGOs) and community-based organisations (CBOs) are particularly well placed to facilitate community responses as well as to effectively bridge the needs and capacities of poor people and communities with broader health and development efforts.

No single organisation can respond to HIV/AIDS in isolation. The pandemic demands mobilisation and collaboration at community, national and international levels. Government, civil society and private enterprise all have vital roles to play. Through collaborative efforts, all stakeholders must strive to complement each other's strategies, while respecting each other's independence and acknowledging differences. Transparency, critical thinking, learning and sharing are essential elements of successful partnerships and of successful responses to AIDS.

## 1.2 The Andhra Pradesh Programme

The **International HIV/AIDS Alliance** (Alliance) is an international NGO established in 1993 by a consortium of international donors. Headquartered in Brighton, United Kingdom, the Alliance's mission is to support communities in developing countries play a full and effective role in the global response to AIDS through implementing care, prevention, and impact-mitigation projects around the world. To promote the sustainability and scaling-up of effective community AIDS efforts, the Alliance builds the capacity of CBOs, NGOs and NGO support programmes. The Alliance also works in partnership with national governments, private and public donors, and the UN system.

**The India HIV/AIDS Alliance** (Alliance India) was established as a country office in New Delhi in 1999 and is part of the International HIV/AIDS Alliance. Its strategic goal is to increase community action for, and access to, prevention, care and impact mitigation efforts in India. This is achieved through improving coverage of effective community focused AIDS efforts; strengthening leadership and capacity of civil society to respond to AIDS; and, improving institutional, organisational and policy environments for community AIDS responses. Strategic priorities include home and community-based care and support, children affected by AIDS (CAA), positive and meaningful involvement of people living with HIV/AIDS (PLHA), focused prevention with key populations groups, and community mobilisation to facilitate ownership and sustainability of HIV/AIDS efforts.

The rapid expansion of Alliances' focused prevention efforts in India is being spearheaded by the Alliance India office in Hyderabad, Andhra Pradesh (AIAP). The Andhra Pradesh team is providing strategic and programmatic leadership for the implementation of the Frontiers Prevention Programme (FPP) in 14 sites and the India AIDS Initiative-Avahan (IAI-Avahan) programme in 24 sites across the Rayalseema and Telengana regions of Andhra Pradesh. These two programmes are supported by the Bill and Melinda Gates Foundation and are being implemented by partner NGOs. The objectives of these programmes are to:

- Reduce STI prevalence among key populations (KPs) of sex workers, men who have sex with men (MSM), injecting drug users (IDUs), people living with HIV/AIDS (PLHA)
- Increase condom use among key populations in these sites
- Increase condom usage and reduce STI prevalence among clients of sex workers



- Empower and mobilise KPs to support the creation of an enabling environment
- Strengthen the capacities of NGOs and CBOs supported by Alliance India to implement effective prevention and care programmes
- Expand the evidence base through rigorous impact monitoring and evaluation

Across three groups of sites in the Rayalseema and Telangana regions, the programmes are expected to reach 460,000 clients of sex workers and 80% of approximately 22,000 female sex workers and 10,000 MSM. In the 14 FPP sites, the KPs include sex workers and their clients, MSM, IDUs and PLHA. The basic package of STI/HIV services provided to the KPs will be complemented by community-led interventions aimed at social capital building, leadership training, empowerment, voluntary counselling and testing (VCT), and care and support services. In the 24 IAI-Avahan sites, sex workers will be provided with STI/HIV services, behaviour change communications (BCC) and access to condoms, all aimed at creating an enabling environment through processes led by local NGOs.



### A Snapshot of Technical Strategies

It is expected that by 2008, the FPP and IAI-Avahan programmes will result in the reduction of curable STIs to 15% among sex workers and their clients; consistent condom use by 80% of sex workers; and, the effective implementation and sustainable management of HIV/STI prevention and care programmes by the supported NGOs and CBOs in the designated sites. To meet these objectives, combinations of the following technical strategies, provided as a part of the STI/HIV service package, will be delivered:

#### *Management of Sexually Transmitted Infections (STI)*

- Syndromic management of STIs coupled with counselling services
- Project-owned mobile and static community clinics
- Referral networks with STI service providers in the private and public sectors, including accompanied referrals
- Comprehensive training to strengthen clinical capacities and the quality of services
- Integration with a STI franchising programme to ensure minimum standards and quality control

### *Condom Programming*

- ➔ Free distribution of condoms available from government sources
- ➔ Social marketing of other preferred condoms

### *Behaviour Change Communication (BCC)*

- ➔ Context-specific information, education and communication (IEC) materials that are culture- and gender-sensitive will be used to respond to the needs of each KP group
- ➔ Delivery through peer education, outreach activities and other enabling strategies using multiple and innovative channels that include folk art and folk media
- ➔ Identification and capacity building of peer educators for outreach work
- ➔ Promotion and skills building for negotiating safer sex and using condoms and lubricants

### *Mobilisation and Social Capital Building*

- ➔ Intensive community mobilisation through participatory site assessments (PSAs)
- ➔ Collectivisation, promoting mutual support, networks and solidarity (social capital) among KPs
- ➔ Leadership training and capacity building for KPs to address structural determinants of inequality, marginalisation, and vulnerability (including violence reduction) risks and impacts
- ➔ KP-led enabling environment activities based on respect, recognition and reliance
- ➔ KP-led activities and linkages with community gatekeepers to build support and reduce risk among KPs
- ➔ Collective mobilisation of KPs to influence and inform policy through multi-tier advocacy efforts
- ➔ Provision of “safe spaces” for KPs to come together, bond, work and discuss issues affecting them
- ➔ Strengthen NGO capacity to integrate KPs into organisational and governance structures

### 1.3 Purpose of the Manual

Medical interventions have a crucial role to play in STI/HIV control. The provision of correct, timely and inexpensive services and treatment are essential for STI control. NGOs supported by AIAP are required to provide STI diagnostic and curative services; programmes that reduce risk-taking behaviours such as BCC and condom promotion; mobilise and empower individuals, groups and communities; and, to support the creation of enabling environments for risk reduction through individual and organisational capacity building.

Experience has shown that the success of any STI control programme rests (in addition to quality clinical services) on three critical pillars of

1. Enhanced health seeking behaviours and early diagnosis (including self examination and early reporting of symptoms to reduce period of STI infectivity)
2. Community-based follow-up for ensuring compliance and
3. Partner management. Since these three pillars are essentially entrenched within the community, it is important to move away from a purely medical approach to STI service delivery to a more socio-medical approach that will put the community at the centre of the STI services, build on and rely on their capacities and support them, over a period of time, to take over the management of STI services. (Please refer to section 2.6.1 of this volume)

**Volume I** of this manual describes methods in which NGOs may design, deliver and manage services for STIs. Its purpose is to assist the AIAP partner NGOs to design and implement strategies and workplans for STI service delivery as part of a focused and comprehensive package of prevention interventions.

**Volume II** is primarily intended as a manual for clinical staff who will oversee and manage a variety of interventions, including the diagnosis and treatment of STIs, within the specialised NGO clinics (**Mythri Centres**).

# DESIGNING NGO-MANAGED STI SERVICES

The following section examines the steps involved in designing NGO-managed STI services and offers specific steps to take to assess the organisational capacity to implement such services.

## 2.1 STEP I - Assessing the Situation

Before implementing a programme for STI control services, it is important to understand the actual situation to determine if there is a genuine need for STI services. Due to social marginalisation and occupational/sexual behaviours, KPs are comparatively more vulnerable to STIs and HIV/AIDS. To assess whether STIs pose a significant problem for KPs it is important to consider their acknowledgment of vulnerability and their recognised need for health services.

The collection of information from local hospitals, clinic records, epidemiological information from the government, interviews with local medical practitioners (including quacks), personal interviews with KP members, and anecdotal evidence will provide a clear picture of the prevalence and trends of STIs within KP groups and available services. At each site level, this STI assessment should provide an understanding of (Refer to Matrix 1 and 2):

### *Key Population Dynamics*

- ➞ The main key population groups in each site
- ➞ Their location
- ➞ The estimated size of the identified key populations



### *Existing Services*

- The range of STI services (qualified private medical practitioners, quacks, government hospitals, etc.) presently available within 5-10 kilometres of the site
- The range of basic HIV services (qualified private medical practitioners, quacks, government hospitals, etc.) presently available within 5-10 kilometres of the site and if they include antiretroviral therapy, treatment for opportunistic infections and psychosocial care

### *Identification of Preferred Providers*

To obtain information on this, a series of focus group discussions and in-depth interviews with representatives of KPs should be organised to gather information on:

- Existing sexual health services actually being used and accessed by KPs
- The kind of health services preferred by KPs and why
- The constraints and barriers that affect KP access to sexual health services (e.g. clinic hours, distance and quality, attitude and gender of service provider, costs, and social restrictions)

- ➡ How these constraints differ for men and women
- ➡ The constraints to accessing HIV care locally
- ➡ Identification of preferred site for STI clinic
- ➡ Identification of KP-friendly service providers who can be appointed in the project clinics

### Matrix 1: Service Provision

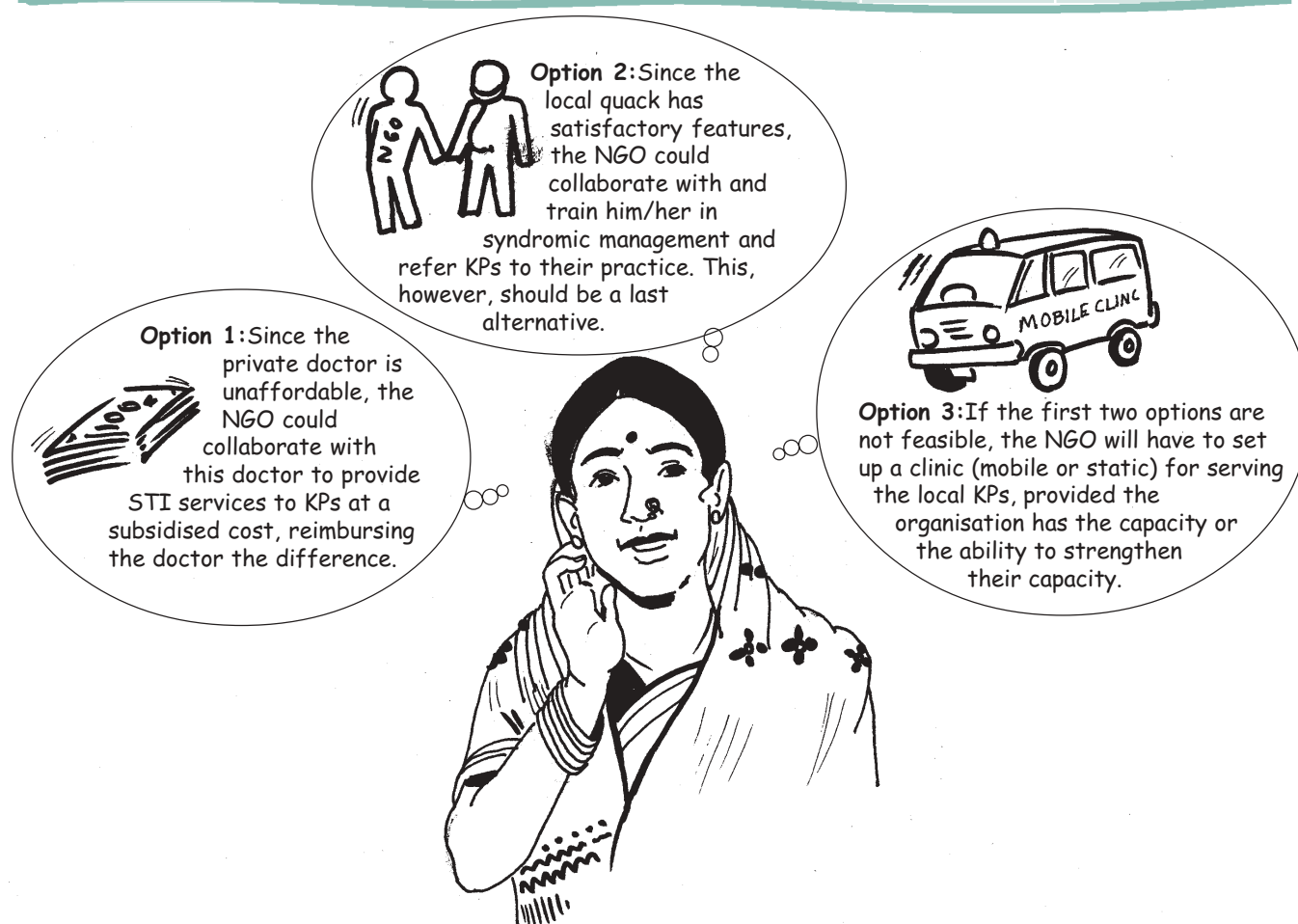
To determine where individuals go for treatment, the following matrix can be used to map the service providers (top) against the services provided (left).

	Government Hospital	Private Doctor	Compounder	Quack/RMP	Any Other	Any Other
STIs						
Lab facilities for STI diagnosis						
HIV ARV OI Basic Care						
Abortions						
General Problem						
Option 1:						
Option 2:						
Option 3:						

## Matrix 2: A Hypothetical Example

This matrix can be used to determine the status of existing health service providers for specific target groups such as female sex workers, MSM, and IDUs by plotting service availability (top) against service providers (left).

	Available (yes/no)	Accessible (yes/no)	Affordable (yes/no)	Community Confidence (high/low)	Options for Intervention
Government Hospital	No	Not Applicable	Not Applicable	Not Applicable	
Private Doctor	Yes	Yes	No	High	
Compounder	Yes	No	Yes	Low	
Quack/RMP	Yes	Yes	Yes	High	
Any Other					



## 2.2 STEP II - Assessing Organisational Strengths and Weaknesses

Using an internal consultative process and taking into account the information gathered on KP priorities and the existing local situation from STEP I, the NGO will have to assess its own experiences and resources to determine what the organisation is best qualified to do.

***The NGO will have to decide whether it will provide STI services directly or it will establish referral linkages with existing service providers.***

If the NGO has significant experience in running general health or reproductive health clinics, it may be possible to incorporate a STI component. However, if the NGO does not have any experience in community health and clinic management, it would be advantageous to explore what linkages and collaborations can be constructed with other health providers including local medical practitioners and government clinics, providing they are accessible and friendly to KP members.

**In the analysis of the NGO's strengths, the following should be kept in mind:**

- ➔ It will be easier to start an STI clinic if the organisation already has a foundation in community health activities and has provided some clinical services.
- ➔ Existing relationships with local doctors, chemists and nearby government hospital will facilitate the development of referral systems.
- ➔ If the NGO doesn't have the necessary trained medical and paramedical staff, it is essential to recruit professionals who have proper medical training.
- ➔ An important component of the clinic is to offer counselling services by trained counsellors trained.
- ➔ Newly recruited staff will need to be trained in the STI syndromic management and case management prior to service delivery.

**Following this analysis, the NGO should be able to answer the following questions:**

Is the organisation capable of providing quality STI diagnosis and treatment services independently? (Refer to STEP III, Option 1)

If yes:

- ➔ What additional staff is needed and what training is required?



- Are there any KP members who can be trained and appointed in the project?
- What are the associated costs?
- Where would the clinic be located?
- How will the clinic be managed?

If no, but there are there are preferred service providers in the area it is important to consider whether the NGO can collaborate with other individuals and/or institutions to provide quality STI diagnosis and treatment services through a system of referrals (Refer to STEP III, Options 2, 3 and 4).

- Who are these service providers?
- Are they KP-friendly?
- What are the views of the KPs regarding these service providers?
- Where are they located?
- Are they willing to collaborate with the NGO?
- What kind of formal and/or informal agreements need to be reached?
- What kind of MIS and monitoring system needs to be agreed upon and put in place?
- Is it feasible to appoint and locate a counsellor?
- What coordination will be required for making the arrangement successful?
- What are the training needs of the NGO to get up and running and to whom should they be provided?

Referrals should only be done after consultations with the KP members are undertaken and they express their confidence/satisfaction with the service providers.

**Service Provision:** Armed with the above information and analysis, a final decision can be made by the NGO on the service options and actual service provision. Such consideration must focus on the extent to which the minimum standards for service provision can be achieved. These key standards include ensuring that the premises are designed to respect the privacy of patients; ensuring the services are non-judgmental, non-coercive and non-stigmatising;

and, ensuring that the syndromic management protocols are properly followed and all clinic attendees receive counselling services (Refer to Section 3.10 for more detail).

## 2.3 STEP III – Deciding the Service Options

In the delivery of STI services, there are numerous options to consider. It is recommended to apply the following model(s), in accordance with the existing NGO capacity, in order to provide effective STI services and delivery of those services.

### 2.3.1 Option 1 - Providing community-based and outreach-oriented STI services through NGO-managed static or mobile clinics

The main component of this option typically involves setting up a dedicated clinic and/or space in areas where sex workers, MSM and other key populations solicit sex or provide sexual services (including red-light areas and cruising sites). The STI service facility will provide syndromic treatment, with or without lab support, and has the option to operate throughout the week or for a few days. The services in these clinics could be free or user charges could be levied based on an assessment of the ability and willingness of the KPs to pay for the services received.

Locating dedicated services in the heart of the target community has proved to be one of the most successful methods of gaining the confidence of hard-to-reach groups. Such groups often feel uncomfortable using conventional services and respond well to those provided specifically for them within their own community. For such community-based outreach STI services to succeed, it is important to closely involve the target groups in the choice of location and the outward appearance of the building, including how it is identified and how the services are provided. Prior experience has shown that signs carrying the words “AIDS” or “STI” may deter clients and antagonise the local community. The use of discreet wording or branding works to diminish these hurdles. After a detailed consultation with KPs and NGOs, AIAP has decided to brand all clinics and drop-in centres in the Rayalseema and Telengana regions as **Mythri Centres** (meaning friendship and goodwill in Telegu/Sanskrit) and uses a local yellow flower, the “*chamanthi*”, as their logo.



In addition to appropriate branding, the following key issues must be considered when providing community based STI services:

**The need for a holistic approach:** It is important to remember that STIs and HIV/AIDS may be a relatively low priority for individuals struggling with day-

to-day survival. As such, they have many other needs, and in particular, other pressing health needs such as malnutrition. An outreach service that does not offer assistance with general medical ailments as a complement to STI services is unlikely to be accepted by the target group. Projects can be strengthened by offering literacy programmes, alternative income generation opportunities, services for building social capital, and activities that meet the other practical and strategic needs of KP members.

***Demand generation for STI services through the integration with other outreach services:*** For the clinic to attract patients, it will require the support of outreach workers and peer educators who can contact target group members, making them aware of the available services. Experience has shown that the most effective outreach workers have an interest in outreach work, tend to possess a high status within their associated peer groups, have good communication skills and are reliable.

***Referral linkages to secondary and tertiary care levels for complicated cases:*** The minimum desirable clinical capacity for the NGO-run clinic is an ability to deal with uncomplicated STIs exhibiting commonly associated symptoms such as genital discharge, ulcers, inguinal bubo, or lower abdominal pain in women. When patients display more complicated problems or fail to respond to treatment, referral to secondary or tertiary care levels may be necessary.

***Additional referrals:*** A substantial number of KP members may continue to seek additional healthcare services from other local health providers. While carrying out the NGO-operated STI services, efforts should be made to establish contacts and linkages with the other providers (often quacks and RMPs) to sensitise them on project activities and to disseminate useful information on recommended treatments for STIs.

***Static and mobile services:*** The use of mobile clinics has proved successful in many outreach programmes. These mobile clinics are particularly useful when permanent sites are difficult to acquire or maintain, when target groups are dispersed over a large area, or if the target group can only attend during a limited timeframe. Mobile services typically are provided either as clinical services in travelling vans or services which transport doctors to



Flat-based sex workers in central Calcutta revealed that although qualified doctors were present in their locality, they were reluctant to visit the local offices because of long waiting hours, crowded waiting rooms, and the fear that their identity will be revealed. The sex workers wanted prompt services, while protecting their identity and privacy.

In Mahishadal (a site in West Bengal), sex workers were going to local quacks for STI treatment, but the quality was perceived as poor by the sex workers because they experienced a high relapse rates. Furthermore, a supporting policy of this programme specified that official association with quacks was prohibited. In Mahishadal, however, the sex workers were left with little choice as the nearest government health centre was 7 kilometres away, making it difficult for them to travel back-and-forth for treatment.

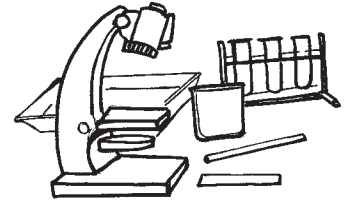
The local NGOs, in both cases, decided to open their own community-based clinics to provide free STI treatment to sex workers and their clients. The NGO in Calcutta negotiated with the flat owner, guaranteeing that the clinic would not be branded a STI clinic, but a women's health clinic. In Mahishadal, the NGO decided to open a clinic in local youth clubs. The club members were assured that the project would repair and maintain the building. In return, the club members agreed the NGO could run the clinic four days per week.

To ensure the privacy of their patients, both of NGOs refurnished their clinic areas so that there were separate waiting, consultation and counselling areas. The NGOs appointed MBBS doctors who were subsequently trained in syndromic management of STIs. The NGOs also appointed trained counsellors to provide information and support to patients on safer sex practices, partner notification, treatment seeking, and treatment compliance.

sites. Although large vans often provide greater privacy than static sites, there is a risk of drawing unnecessary attention when such large, fully equipped mobile clinics are parked within the communities. Mobile clinics also incur high initial investments costs and attendance rates are sometimes low. In such cases of low attendance, dissemination of information about the availability of services will help to increase their utilisation. In general, mobile services should be added where existing and well-established static programmes are in place and should be based on a careful needs assessment.

**Laboratory services:** One of the essential features of the syndromic approach to the management of STIs is that it is not dependent on laboratory testing. The syndromic approach can achieve high curative rates and patient satisfaction without the use of a laboratory. Most projects should aim to provide services without laboratory testing, except in the following circumstances:

- There is a demand for the screening of asymptomatic infections from the target group. Syphilis, gonorrhoea and chlamydia are often asymptomatic and difficult to detect. Screening for these infections with tests such as the rapid plasma regain (RPR) test or the venereal disease reference laboratory (VDRL) test is cheap and simple.
- There is a need to refine syndromic treatment algorithms through the inclusion of simple laboratory tests.



When a laboratory is used, it is crucial that an inspection is made to ensure that the laboratory meets certain standards and a determined level of quality control is operational. Specifically, it is important to verify that internal and external checks are completed at regular intervals to ensure results are replicable; the laboratory has a properly trained staff using accepted and up-to-date technology; and, the laboratories are subjected to an independent screening by an expert before any contractual arrangements are made as many laboratories are substandard and report unreliable results.

### 2.3.2 Option 2 - Exclusive referrals to government clinics

In instances where there are accessible (within 5-10 kilometres) government STI and healthcare services, it is important to assess the quality and the perceptions of KPs regarding these services. To the extent possible, the following should be assessed:

In Chennai, the Ali community (comprising transgenders/hijras) was terrified of approaching the STI department at the public hospital. *"Everytime we go there, the doctors would call all the students, ask us to strip and exhibit ourselves. They would take pictures of our private parts, so we were willing to suffer the pain of not getting treated rather than face humiliation."*

Based on discussions with and the sensitisation of the hospital administrator, an advocacy and training programme was organised with the hospital staff in which some of the Ali peer educators participated. A commitment was given by the doctors that they would treat the Ali's with dignity and provide them with friendly services.

Three Ali community health workers were identified to escort Ali members in need of STI treatment to the hospital. A project counsellor was also assigned to provide support services. The health workers established a good rapport with the doctors and other departmental staff, which facilitated the improvement in the quality of care provided to the Alis for STIs and other health concerns. This service also played a major role in promoting trust between the project staff and the Ali community.

CAN, Chennai 1997.

In Surat, negotiations were held between an NGO and a state-run mother and child health clinic to make it friendly towards sex workers and to incorporate STI services into the clinical operations. Peer educators were encouraged to refer sex workers with STIs to this clinic as the medical officer was a woman trained on the syndromic management of STIs. Following this intervention, the MCH clinic started to provide basic counseling services for the sex workers. At the initiative of the project staff, STI medication was also provided to the patients and eventually, the clinic services were extended to cover clients of sex workers with STIs.

*SMA, Gujarat 1997.*

- How could these services be made more accessible and KP-friendly?
- What are the specific barriers facing KPs in accessing services and how might these barriers be reduced?
- How can STI services be incorporated into the existing general healthcare services?

Following the above assessment, extensive advocacy and negotiations with the administrators of government healthcare services may be necessary in order to make existing services more KP-friendly. If the barriers are irredeemable, alternate options will have to be explored.

### 2.3.3 Option 3 - Exclusive referrals to private local doctors

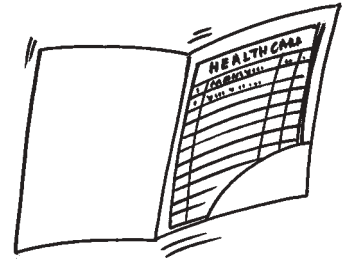


This model utilises the existing private sector healthcare providers for providing STI services for the KPs.

In providing STI services, it is logical to begin by assessing where the majority of STI patients are obtaining treatment. The next step entails determining what action is necessary to improve the quality of existing STI service providers. The difficulty, however, is that most patients currently use the informal sector (mainly quacks/RMPs) and there is strong opposition from the medical profession in India for their empowerment. Despite this, a number of programmes in India are looking to deliver services through healthcare workers other than qualified doctors. Experience from other countries has shown that it is not always difficult to train these “informal” healthcare workers in the management of uncomplicated STIs and that their contribution to the prevention of STIs and HIV/AIDS can be significant. In the instance where



medical care is to be contracted out, it is important to ensure that the doctor selected can provide services that reach reasonably close to the minimum standards (Refer to Section 3.9) and that they are willing to participate in periodic monitoring.



As an incentive to maintain quality services for STI treatment, offering reimbursable vouchers to cooperating doctors for other common ailments may be an option. This model focuses on training private local doctors on the syndromic management of STIs, referring cases from the community (through peer educators and from NGO drop-in centres) to the doctor and reimbursing him/her for the cases handled and/or treated. As a prerequisite, the doctor has to be KP-friendly and may have to be specifically sensitised for this purpose. In return, the doctor should refer all patients directly visiting him/her to visit the drop-in centre to receive counselling and to participate in community-building and recreation facilities.

Under this model, a coupon can also be given by the doctor to STI patients wherein the patient upon the production of the coupon, could obtain free STI medication from the NGO or local pharmacy. In case the drugs are being dispensed by a local pharmacy (on production of a note/coupon by the doctor), in addition to a formal agreement with the pharmacy, a management information system will have to be developed by the NGO to record and track drugs being dispensed and reimburse the pharmacy accordingly.

It is important to emphasise that the referral process and the recruitment of private doctors to provide services increases the difficulty for the NGO to measure, monitor and influence the quality of care provided. Experience has shown that the quality of care has to be carefully monitored (along with

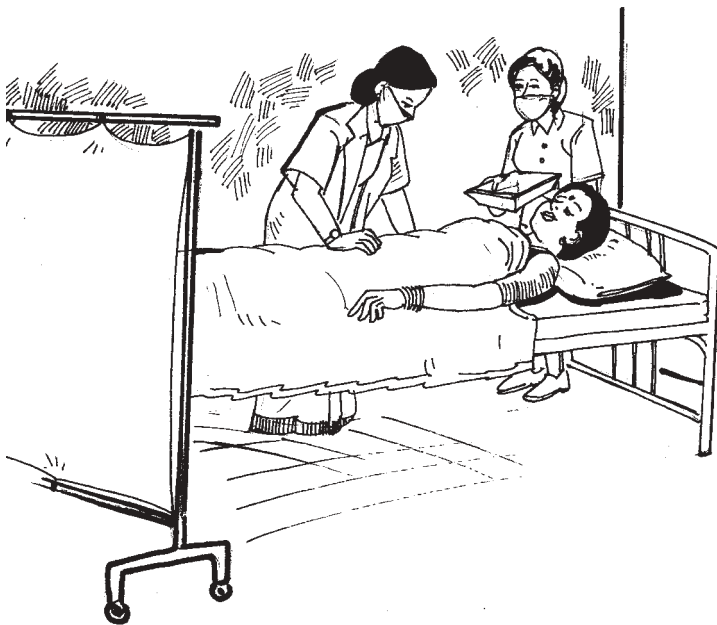
The Technical Support Staff (TSS) appointed by LEPR under the Frontiers Prevention Programme (FPP) have identified KP-friendly doctors for referral. The TSS conduct regular outreach work and refer KPs with STI symptoms to these doctors. The KPs are currently using a referral card system, however, it is unknown how many referrals are resulting in the correct STI diagnosis and complete treatment. A training strategy directed towards private doctors for properly recording STI cases from KP members must be developed and implemented. Also, to improve the quality of care through monitoring, a formal agreement with the private doctors needs to be explored and improved, if necessary, through training.

Many MSM in Calcutta were resistant towards seeking treatment for STIs, particularly anal STIs, because it exposed them as people who had sex with other men. While a minority of the doctors were friendly to the MSM and encouraged them to return for any health problems, most doctors, sneered at the MSM.

The MSM community, with the help of an advocacy officer from a local NGO, mapped both the private and public doctors as part of a referral system. The advocacy officer, with the assistance of some articulate MSM, contacted these doctors and sensitised them towards MSM issues and motivated them to provide MSM friendly services. Mock clients were sent to the doctors to assess their attitude towards MSM and if any had a bad experience, the doctor was removed from the referral list. The NGO also conducted regular follow-up advocacy activities with the network of doctors and invited them to discussions and trainings on sensitisation and the syndromic management of STIs. The NGO also impressed upon these doctors that they were making a major contribution in controlling the spread of the HIV epidemic in the region and were therefore doing a social service.

community representatives) if STI treatment services are to be implemented effectively. One way to address this issue is to ensure that the participating doctors attend periodic project management discussions where they can put forward practical suggestions about monitoring. It is also important to stress that such referrals are likely to incur costs in time, travel and treatment for the

patients. Therefore, it is essential that the referral arrangements are made with individuals and institutions that are known to have a sufficient capability in dealing with these issues and that the costs to patients are not prohibitive. It is important to constantly seek feedback from both the patients (community) and health centres to monitor the effectiveness of the referral arrangements.



#### 2.3.4 Option 4 – A managed network of private and public sector doctors

This model utilises a combination of the preceding two models pertaining to the use



### 2.3.5 A comparative analysis of the four models

Type of STI Service	Strengths	Weaknesses
NGO-Run Clinic/ Community Based Clinic	<ul style="list-style-type: none"> <li>• Well targeted and focused</li> <li>• Quality of care</li> <li>• Less marginalisation</li> <li>• Ability to conduct follow-up with patients</li> <li>• Greater opportunity to provide training and quality monitoring</li> <li>• Greater opportunity to keep records and monitor service delivery</li> <li>• Easier to ensure issues like privacy, confidentiality, and convenience of timings</li> <li>• Availability of counselling services</li> </ul>	<ul style="list-style-type: none"> <li>• High start-up and recurring costs, may not be cost-effective or sustainable</li> <li>• Need to create adequate new demand</li> <li>• Unhealthy competition with local STI doctors, especially quacks</li> <li>• Lack of confidentiality, particularly if the clinics are not branded as general health clinics</li> </ul>
Government Clinic/Doctor	<ul style="list-style-type: none"> <li>• Free services</li> <li>• Facilities for laboratory services may be available on occasion</li> </ul>	<ul style="list-style-type: none"> <li>• Free drugs may not be available</li> <li>• Lack of confidentiality</li> <li>• Quality of services not predictable</li> <li>• May be unfriendly and stigmatising</li> <li>• May require considerable travel for patient</li> </ul>
Private Clinic/Doctor	<ul style="list-style-type: none"> <li>• Confidentiality is generally maintained</li> <li>• Sustainable</li> <li>• No need to create new demand if KPs are already accessing services</li> <li>• Tends to be more friendly than government clinics/doctors</li> </ul>	<ul style="list-style-type: none"> <li>• May or may not be well targeted and focused</li> <li>• Quality of care may not be assured</li> <li>• Limited ability to do patient follow-up</li> <li>• Limited opportunity to provide training and monitor quality</li> <li>• Limited opportunity to keep records and monitor service delivery</li> <li>• Timings may not be accessible for KPs</li> <li>• Unwilling to get associated with the project</li> </ul>

Managed Network of Private & Government Doctors	<ul style="list-style-type: none"> <li>• Utilises existing services and resources</li> <li>• Specialised care can be given if proper training is provided</li> <li>• Cost-effective and sustainable</li> </ul>	<ul style="list-style-type: none"> <li>• Free drugs may not be available</li> <li>• Quality of services not predictable</li> <li>• May be unfriendly and stigmatising</li> <li>• May require considerable travel for patient</li> <li>• May or may not be well targeted and focused</li> <li>• Quality of care may not be assured</li> <li>• Limited ability to do patient follow-up, particularly if they are KPs</li> <li>• Limited opportunity to provide training and monitor quality</li> <li>• Limited opportunity to keep records and monitor service delivery</li> <li>• Timings may not be accessible for KPs</li> <li>• May not be willing to get associated with the project</li> </ul>
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of public and private sector doctors. The effective application of this model ensures the long-term sustainability of services and the optimum utilisation of human and financial resources. When designed properly, it can also minimise the marginalisation of KPs with respect to accessing STI care services. This system requires the proper training of healthcare providers; developing a system of referrals and reimbursements (particularly for the private doctors); a system of coupons to provide free STI medicines; and adequate monitoring and supervision structures in place.

## 2.4 STEP IV – Defining STI Service Objectives, Activities, Tasks and Targets

After assessing the community's needs and priorities, the existing service providers and the ability of the NGO to deal with these issues, the next step is to specifically define what STI services will be delivered and how this will be achieved. For achieving these objectives, specific activities and tasks must then be determined and planned accordingly.

### 2.4.1 Setting the service objective

If the STI service objective is to provide community-based STI services to sex workers and their clients, then the activities could include setting up a clinic, recruiting and training doctors, STI counsellors and paramedical staff, and treating patients. Each activity should then be divided into various tasks. For example, when setting up a clinic the tasks would include:

- Identifying a clinic space in consultation with the community
- Renting the space (working within budget constraints)
- Furnishing the clinic and ensuring water and electrical supply
- Purchasing equipment, supplies, medicines and condoms
- Developing a record-keeping system
- Identifying the human resources needed for manning the clinic



When recruiting and training service providers, the tasks should include:

- Developing job descriptions
- Identifying and recruiting doctors, counsellors and paramedics
- Developing a training schedule
- Conducting training for all staff, general and specific to their duties
- Conducting follow-up trainings

### 2.4.2 Setting targets

Once the objectives have been determined, targets must be set that reflect what can be achieved during the established project period. It is important that the targets are quantifiable, realistic and achievable. For example, if you have 300 sex workers in a designated site:

- It can be assumed that during the first year 180-200 sex workers and 800 clients will be reached.

- Assuming that each sex worker has two STI episodes per year, the NGO will be treating 300-400 STIs episodes among sex workers and approximately 100-200 STIs among their clients.
- The total number of STIs to be treated in the first year would be 400–600.
- Approximately 600–1,000 counselling sessions on STIs and high-risk behaviours will be provided to sex workers and their clients in one year.

Once arriving at the tentative annual targets, quarterly targets should then be determined using the following table:

	Q 1		Q 2		Q 3		Q 4		Annual		
Indicator	T	A	T	A	T	A	T	A	T	A	%
No. STIs Treated	50		100		200		150		500		
No. Counselling Sessions	75		125		225		175		800		
T: Target (set at the beginning) A: Achievement (made at the end of the quarter) Q: Quarter											

## 2.5 STEP V – Defining a Work Plan and Budget

### 2.5.1 Devising a work plan

Now that the overall programme and strategy for STI services has been planned, the next step is to design a detailed work plan (a week-to-week outline is suggested) that specifies a schedule for the monthly implementation of activities. To develop the work plan, make a detailed list of all the activities and tasks that need to be accomplished to achieve the STI programme objectives. Against each activity and task indicate which month and week it will begin and the month and week it will end. The following table can be used to present your work plan.

		Month/Week											
		Jan				Feb				March			
No.	Activity/Task	1	2	3	4	1	2	3	4	1	2	3	4

### 2.5.2 Determining the budget

Once the strategy and the workplan for the delivery STI services have been established, a budget must be developed. A good way to do this is to take each activity and break it down into separate tasks to determine the associated costs. Before the total cost associated with a task can be determined, the unit costs of items such as STI drugs, general drugs, supplies and equipment, and the salaries of clinical staff will need to be determined. Once these figures have been calculated, they can then be incorporated into the project budget. In planning the budget it is also important to consider the running costs associated with:



- ➔ Rent of clinic
- ➔ STI and general drugs
- ➔ Salaries of staff
- ➔ Training of clinic staff
- ➔ Equipment
- ➔ Salaries of clinic and support staff
- ➔ Clinic supplies

### 2.5.3 Determining the indicators

In order to measure the progress of achieving the STI service objectives, indicators must be developed. Remember that when selecting an indicator, you are specifying the information that will need to be collected during the project. For example, an indicator for STI treatment would be the number of STI patients treated as per the records maintained in the clinic.

### Example: Proposed output indicators on STI management\*

Intent to Measure	Indicators (both quantitative and qualitative)	Means of Verification	Tools/Instruments
1. Accessibility of services (including trend)	Total number of genital ulcer cases treated in the clinic (self reported and clinically diagnosed cases)	Clinic data sheet compiled on monthly basis	Standardised patient treatment card
2. Quality of services/ Efficacy	The time lag between onset of symptoms and seeking treatment	Quarterly report of the NGOs (compiled from monthly clinic data sheet)	Patient History Sheet
3. Compliance	Percentage of cases completed full course of treatment out of total cases treated	Monthly report produced by the clinic-based data using a standardised format	Peer Educator's follow up records/ patient history sheets/counselling records
4. Partners' treatment	Number of partners out of total referral cases who sought treatment from the clinic	Exit interview of patients	
5. Clients* satisfaction *(clinic attendees)	Level of clients' satisfaction could be assessed using a qualitative indicator focusing on conduct, communication, counselling, comfort, and condom promotion at the clinic		Standardised tools developed to measure level of satisfaction

\* AVAHAN (IAI)

## 2.6 STEP VI - Implementing the STI Diagnosis and Treatment Programme

Now that an STI management strategy is in place, it is time to implement the STI diagnosis and treatment programme. An important thing to remember during this implementation phase is that the programme for STI diagnosis and treatment must integrate counselling services and programmes focusing on BCC, health education, condom promotion and structural interventions. The combination of these interventions will ultimately create an enabling environment for KPs and enhance their health seeking behaviour.

During the implementation of STI services, and after, it is crucial to ensure that the services are free of stigma and discrimination and are non-coercive and gender sensitive. Again, it is advisable not to name the clinic as a “STI clinic” because this may deter KPs from accessing the services and may lead to the stigmatisation of KPs within the community. To increase the gender sensitivity of services, the organisation will have to consider the problems women face in accessing STI services and make special efforts to remove any barriers that hamper their access. Such action may include planning clinic timings to suit the women in the target audience and involving more women as staff members, particularly within clinic. Finally, ensure that there is enough privacy in the STI clinic for the consultation, examination and counselling of patients in order to ensure strict confidentiality of the patients.



### 2.6.1 Community-led STI service management and monitoring

In addition to the provision of high quality clinical services and ensuring easy access, the success of a STI control programme depends on:

- Early diagnosis and treatment of STIs so as to reduce the duration of infectivity.
- Community-based follow-up to ensure compliance and follow-up clinic visits.
- Contact tracing and management of partners.
- Individual and community satisfaction with the services.

### 1. Early diagnosis

This can happen only when:

- a. The community is sensitised and informed on the symptoms of STIs, taught how to do self examination (many ulcers – particularly the syphilitic ones being painless and difficult to detect unless one does a proper self examination) and a culture of self-examination and health-seeking behavior is built within the community.
- b. There is constant community-based follow-up to ensure that individuals go to the clinic to seek treatment as soon as there is an onset of symptom, such that the time lag between the onset of symptoms and treatment is minimised.
- c. The clinical service is so designed that it is easily accessible, affordable, user-friendly and gender and key-population sensitive.

### 2. Compliance

While the focus of STI treatment is on single dose, directly observed therapy (please refer to Volume II), there are treatment options that require completion of a course of medicine over a period of time. In general, there is a propensity to discontinue the treatment, as soon as the symptoms disappear. Community- and peer-based follow-up is therefore extremely critical to ensure compliance and that the entire course of medicines are taken.

Further some drugs like Metronidazole may cause a metallic taste in the mouth and few others lead to nausea and gastro-intestinal symptoms like indigestion, cramps and loose stools. Some drugs may be contraindicated with alcohol, as a result of which the patient may not complete the course. Therefore there is a strong case for community-based follow up to provide necessary support to the patients to ensure that they do not discontinue the course mid-way for any of the above reasons.

### 3. Partner management

Partner management plays an important role in preventing the spread of STIs. Unless one can treat the most likely source of a patient's infection (source contact) and also, any people to whom the patient may have passed on infection (secondary contacts) any effort to treat just the current and single contact, will have limited impact.

Information about sexual contacts may be disclosed by patients through sensitive questioning, but many may prefer not to give any details unless they enjoy the confidence of the project staff and outreach workers. Partner



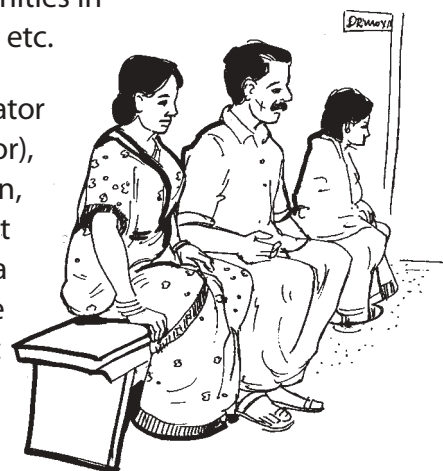
management can therefore only be facilitated through community-based and community sensitive outreach services, on which the individual (patient) has a high degree of confidence.

It is amply clear that the success of any STI control programme rests (in addition to quality clinical services) on three additional and very critical pillars that are entrenched within the community. Therefore it is important to move away from a purely medical approach to STI service delivery to a more socio-medical approach that will put the community at the centre of the STI services and enable them, over a period to time, to take over the management of STI services.

### *Making STI services community-centric*

There are some basic and simple steps that can ensure that to start with, the NGO run STI services are made community-centric and over a period of time, the services are managed by the community themselves. Some of the steps are:

- Ensure that community (through their representatives) is involved in the selection of services option (mobile clinics / static clinics / referral services) as well as the location of the clinics and drop-in centres.
- For selecting the doctors, seek suggestions from the community and encourage them to identify local KP-friendly doctors who may be appointed by the project.
- Ensure that the service providers are KP- and gender-sensitive and seek periodic feedback from the community on their satisfaction with the service providers as well as the services.
- Based on the periodic feedback from the communities, ensure that the clinic is operational as per the needs and priorities of the communities in terms of timings, physical infrastructure, comfort, confidentiality, etc.
- Appoint a community representative as the paid clinic administrator (just below or even equal in organisational rank to the clinic doctor), after providing necessary training to this person on supervision, record keeping, minimum standards and quality control. The post of clinic administrator can rotate within the community if, over a period of time, more that one community representative can be trained to do the job. Between the doctor and the clinic administrator, they would ensure that the minimum standards of STI service delivery (mentioned in the annex) are maintained and that the services are sensitive and responsive to community needs.



- To the maximum extent possible, select paramedical staff from the community and if this is not possible right at the beginning, identify potential KP representatives and build their capacity to take on these roles.
- Similarly, identify and build capacities of potential KP representatives to be trained as counsellors and over a period of time, hand over counseling services entirely to the trained community members. To begin with, it is important to appoint professional/ trained counsellors, who would, over a period of time, transfer knowledge and skills to the community members to take things forward.
- Ensure that there is a strong and organic linkage between the clinic staff and the peer outreach staff to promote
  1. Self-examination and early reporting of STI cases,
  2. Community-based follow-up for compliance and
  3. Community-based follow-up for partner notification and management.
- Ensure that KP representatives are involved as members of any research / review / study teams and such reviews address issues of KP satisfaction.
- Finally, at the organizational level, constitute a 8-12 member STI Services Review Committee headed by the NGO Executive-head and that will have clinic doctors, counsellors, project coordinator, the NGO executive-head and an equal number of KP representatives. This committee will take the lead in monitoring STI services, meet every three months to review the STI services, bring community perceptions and feedback on the table and advise the project on improving services.

The strategies and steps suggested above are by no means exhaustive. Experience has shown that provided with the right opportunity, necessary back-up and the space to execute their ideas, the KPs will, over a period of time, come out with their own strategies to ensure that the STI services are entrenched within that the community and that the community starts taking the lead in managing the services.

Based on the above ideas and through further consultation with the KPs, Alliance's NGO partners need to then come out with a clear road-map for transfer of STI service management to the KPs.

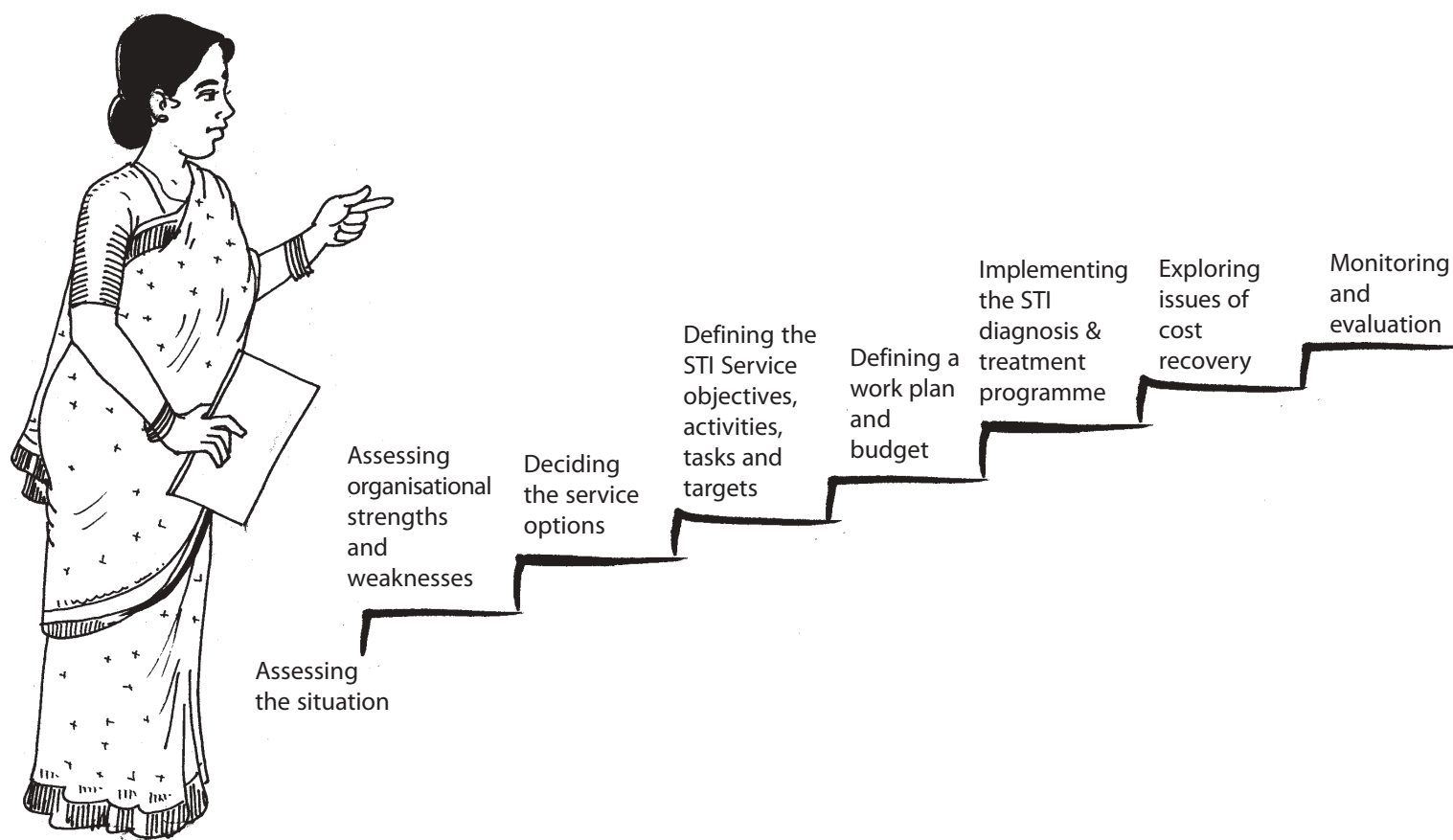
## 2.7 STEP VII - Exploring Issues of Cost Recovery

Ideally, STI treatment should be offered without charge in order to remove the barrier of cost to patients. This strategy is followed in many countries in the interests of controlling the spread of STIs and HIV/AIDS more effectively.

Others argue that this approach is not sustainable in resource-poor settings; that many patients are able and willing to make payments; and, that their respect for paid services is higher than those free of cost. A clear relationship between the scale of charges and attendance levels indicates that high costs tend to drive patients to cheaper sources of care. At present, many NGOs are charging a small fee for treatment and are prepared to show flexibility about cost recovery. This approach is endorsed by the Alliance.

## 2.8 STEP VIII - Monitoring and Evaluation

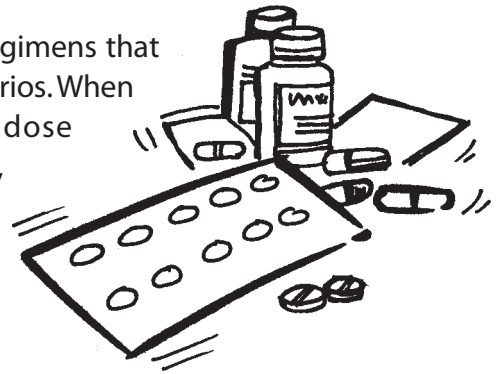
Monitoring means keeping regular track of the progress of activities in order to ascertain whether they are going as planned. For monitoring purposes, periodical reviews (weekly/monthly/quarterly) of what has been achieved (e.g. the number of patients examined and treated for STIs, the number of patients counselled, etc.) and analysis of these achievements should be conducted. For monitoring the achievements in STI services, a process monitoring tool form has been developed by the Alliance which all partners are required to submit quarterly to the Alliance. In addition to this, research on STI services and other information may assist in the analysis of the success and/or failure of the STI programme. At the end of the project period, the STI programme will be evaluated through a knowledge, attitude, behaviour & practice (KABP) study.



### 3.1 The Syndromic Management of STIs and Treatment Regimens

The syndromic approach to the management of STIs is one of the cornerstones of effective STI control. The syndromic approach was devised to ensure that patients are given effective treatment for a STI on their first clinical visit, regardless of the availability of laboratory tests. In practice, this means that a patient attending a clinic with a particular symptom (e.g. genital discharge or genital ulcer) will be given a combination treatment of usually two drugs instead of carrying out tests or prescribing a single treatment. This approach to STI management typically increases the probability of cure to nearly 100%. The syndromic approach has been endorsed by the World Health Organization (WHO), the National AIDS Control Organisation (NACO) and the Alliance. The Alliance expects that all NGOs implementing their programmes will employ doctors trained in the syndromic case management of STIs.

There are certain principles about treatment regimens that are worth stressing and applying in clinical scenarios. When choices exist between treatments, single dose therapies are preferred to multi-dose therapies, as it is possible to administer the full treatment under supervision and ensure drug compliance. The practice of single dose therapies should be utilised whenever possible.



The doctor of the clinic should ensure that the NGO staff members and peer outreach workers are well acquainted with the common side-effects of some of the STI drugs.

Further information on drugs and their side effects can be found in Volume II.

## 3.2 Diagnostic Procedures

Diagnosing STIs is based on taking a patient's sexual history followed by a clinical examination, which all patients should undergo. When laboratory tests are to be used, the appropriate specimens are to be collected at the time of examination.

The main purpose of laboratory tests is not to confirm a clinical diagnosis, but rather to screen the attendees for asymptomatic STIs that cannot be identified using other methods, increasing the total number of STI cases identified and treated. Examples of tests that may be useful include:

- ➔ A VDRL or RPR test to screen for syphilis
- ➔ The wet prep examination of vaginal discharge in women undergoing a speculum examination
- ➔ Gram staining

HIV testing should only be done when counsellors, fully trained in pre- and post-testing HIV counselling services, are available and arrangements can be made with a laboratory providing high testing standards. The project staff should be aware of locally available VCT services and proper referrals should be made accordingly. HIV testing should never be carried out without the knowledge or consent of the individuals concerned.

Further information is provided in Volume II.

## 3.3 The Integration of Medical and Health Promotion Services

Health education and condom promotion are two elements of STI service delivery that are commonly neglected. These tasks may be carried out either by a single member of staff such as the doctor, or can be shared between the medical service provider and the counsellor. To ensure these practices are enforced, clinics should have a clear understanding about the responsibility each task involves.

Listed below are the areas that should be addressed to ensure a quality and holistic approach to service provision.

- ➔ The patient should be given a thorough explanation of their illness.
- ➔ The medication should be explained and proper counselling should be given.



- Patients should be informed that they may remain infectious until the full course of medication has been completed.
- Partner notification must be discussed with all patients (Refer to Section 3.7).
- A discussion on safer sexual behaviour and the prevention of future STIs and HIV/AIDS.
- All patients, male and female, must be asked if they are familiar with condoms. If not, a condom demonstration should be done.

**Remember that interactions with STI patients provide an invaluable opportunity to share behaviour change communications**

Current policies of the partner NGOs working with the Alliance incorporate holistic service provisions that attempt to provide for all the basic health needs of their patients. Holistic services do not have to entail stocking an extensive array of medicines, but should provide simple and useful everyday medications such as analgesics, vitamins, iron supplements, antacids, and antibiotics for common infections.

### 3.4 Case Holding

Clinics need to ensure the use of thorough case records for STI patients that gather and track the following information from a client's initial visit:

- |  |                        |
|--|------------------------|
| ➤ Registration details                 | ➤ Drug allergies       |
| ➤ Main symptoms                        | ➤ Examination findings |
| ➤ Previous STIs                        | ➤ Syndromic diagnosis  |
| ➤ Sexual history, including condom use | ➤ Other diagnosis      |
| ➤ Treatment history                    | ➤ Treatment prescribed |
|  | ➤ Partner notification |

Further details on case holding can be found in Volume II.

### 3.5 Follow-up

The follow-up visit provides a useful opportunity to check the compliance and to monitor the effectiveness of the treatments the patients is taking. It



also provides an opportunity for the doctor to check if the symptoms have eased and/or stopped; if the treatment is completed; if the patient has avoided re-exposure to infection; and, if their sexual partners have been notified. This may improve compliance, especially if field workers can visit patients in their homes. Follow-up visits, however, may be difficult for patients who travel long distances to the clinic or are mobile.

### 3.6 Referral to Second Line Services

In case a patient's symptoms do not subside within a week's time, it is advisable to refer the patients to a specialist or a higher facility. Doctors working with NGOs should be aware of such referral services.

### 3.7 Partner Notification

Partner notification, also referred to as contact tracing or partner management, plays an important role in preventing the spread of STIs. It aims to identify and treat the most likely source of a patient's infection (source contact) and any individuals the patient may have passed the infection onto (secondary contacts).

Information about sexual contacts may be disclosed by patients through sensitive questioning, but some may prefer not to provide any details. Partner notification must be voluntary and it is the responsibility of the health provider to explain the potential health consequences of not disclosing such information. Partner notification cannot occur unless patients are willing to relinquish some degree of confidentiality about their illness. Health workers must stress that any information provided by the patient is confidential and will not be disclosed to anyone without the patient's full consent.



The common method of notification is to ask patients to advise their partners to seek treatment. It is beneficial to reinforce this advice by asking the patient to give their partner a confidential contact card to be handed in when they seek medical attention (Refer to Appendix 4.5). The card requests that the health provider prescribe the appropriate medication to the partner, and if the original patient agrees, state the diagnosis.

### 3.8 Minimum Qualification of Service Providers

Experiences have shown that the syndromic approach can be delivered successfully by paramedical staff and that a doctor is not required to diagnose

and treat uncomplicated STI cases. The syndromic approach should not be delivered by untrained staff, but if training is provided, it can be delivered by doctors and/or paramedical staff under adequate super-vision. It is expected that NGOs will work with all types of practitioners who treat STIs in order to sensitise and inform them on the syndromic approach to STI management.

For Alliance supported NGOs (for referrals or for appointment in project run clinics):

- ➔ To the maximum extent possible, only qualified MBBS doctors should be used.
- ➔ In remote areas where qualified MBBS doctors are not available, NGOs may work with other types of non MBBS practitioners, but those who are popular with and are being accessed / preferred by KP members, provided these providers can be trained properly and supervised regularly.
- ➔ Under no circumstances should STI services be provided by paramedical staff.

### 3.9 Required Infrastructure

The provision of STI services requires a building that can provide a waiting space, a room for a doctor and/or health worker to examine patients, and a room for counselling. It is important to provide adequate privacy for the patients seeing the doctor and counsellor, so that discussions cannot be overheard and their confidentiality can be maintained. This typically requires separate rooms for the doctor and counsellor with partition walls that extend from the floor to the ceiling and doors that shut. The doctor's room requires space for an examination couch and the clinic should be free from excessive external noise and have the basic amenities such as water, electricity and cooling fans.

The following are items required by all clinics:

#### *Syndromic management resources*

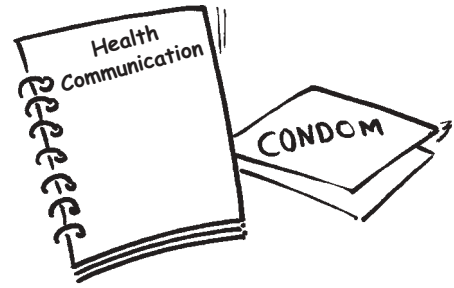
- ➔ Syndromic case management flowcharts
- ➔ Specula with light source
- ➔ Steriliser
- ➔ Alternative drugs for the management of genital ulcer or genital discharge (as specified in NACO Guidelines) may be provided



A detailed list of STI drugs is given in Volume II

### **BCC resources**

- Health education materials
- Condom demonstrator
- Condoms



### **Recorder keeping resources (Refer to Appendix 4)**

- Attendance record
- Clinical records completed by the doctor (clinic held)
- Clinical records completed by paramedical staff (clinic held)
- Counselling records
- Outreach worker records
- Reporting forms
- Partner notification slips

### **Other medicines**

- |   |               |
|---|---------------|
| ➤ Medicines for minor ailments                | ➤ Analgesics  |
| ➤ Adrenaline for the treatment of anaphylaxis | ➤ Antacids    |
| ➤ Vitamins and iron supplements               | ➤ Antibiotics |

### **Furniture and equipment**

- |                            |                            |
|----------------------------|----------------------------|
| ➤ Examination couch        | ➤ Steriliser (for specula) |
| ➤ Chairs, desks, cupboards | ➤ Safe waste disposal      |
| ➤ Filing cabinets          | ➤ Disposable gloves        |
| ➤ Seating for patients     | ➤ Syringes                 |
| ➤ Examination lights       | ➤ Disinfectants            |
| ➤ Specula                  |                            |



## **3.10 Minimum Standards for STI Service Delivery**

In obtaining clinical services, staff should endeavour to ensure the following minimum standards are met.

## Checklist for STD minimum standards

No	Minimum standard	Fully met	Partially met and reasons	Not possible to meet and reasons
1.	Premise located close to the target community (accessible)			
2.	People in the immediate vicinity cannot overhear doctor-patient discussions or see what transpires between the two (privacy)			
3.	People in the immediate vicinity cannot overhear counsellor-patient discussions or see what transpires between the two (privacy)			
4.	There is a separate waiting space and seating for patients			
5.	The clinic is open on days and timings when most people can access it			
6.	The clinic has all the equipment for syndromic management as per list			
7.	The clinic has BCC resources/condoms and condom demonstration is done for individuals with STIs			
8.	Clinic records (patient registers, patient cards, patient history, condom registers, counselling registers, counselling cards, drugs registers) are present and regularly maintained			
9.	Medicines for STI treatment available as per attached list			
10.	Furniture, equipment and other clinic supplies are available as per attached list			
11.	The doctor is trained in syndromic management of STDs			
12.	Medicines for common general ailments available			
13.	Support of trained counsellors available, with counselling on treatment compliance, reduction of high risk behaviour and partner notification			
14.	Clinical records are kept confidential			

## 4

#### 4.1 Patient Card Number Register

To be completed by the Clinic Assistant

[illegible]

*Note: Please refer to the client's personal identification number, Volume II, Appendix 1.*

## 4.2 Total Patient Register

To be completed the Clinic Assistant and/or Social Worker

[illegible]

*\* To be completed by the clinic assistant and/or social worker from the health card, provided by the doctor after he/she fills it.*

### 4.3 Follow-up Register

Date	Client PIN (6-field number)	Follow- Up date	Actual Visiting Date	Next Follow-up Date	Actual Visiting Date	Remarks* (if any)

\* To be completed by the doctor or counsellor. The follow-up date needs to be obtained from the patient card.

### 4.4 Daily Patient Report of the Clinic

To be completed by the Doctor

Date:


1. Name of the doctor:
2. Total number of patients treated during the day:
3. Total number of new patients examined for STIs:
4. Number of new STI cases treated:
  - Males:
  - Females:
5. Symptom wise break-up of new STI cases:
  - Urethral Discharge (males) :
  - Vaginal Discharge (females) :
  - Genital Ulcers (males) :
  - Genital Ulcers (females) :
  - Pelvic Inflammatory Disease :
  - Ophthalmia Neonatorum (child) :
  - Others \_\_\_\_\_ :
6. Number of follow-up STI cases
7. Number of cases referred:
8. Number of condoms distributed free:

Signature of the Doctor


\_\_\_\_\_

## 4.5 Specimen Partner Notification Card

Side 1

	<b>CONTACT CARD</b>
<p>Please go to a doctor, hospital or clinic (preferably to a Mythri Clinic) as soon as possible.</p> <p><b>Please take this card with you and show it to the doctor.</b></p>	

Side 2

	<b>CONTACT CARD</b>														
<table> <tr> <td>This person's contact was treated for:</td> <td>Treatment given:</td> </tr> <tr> <td>Genital Ulcer:</td> <td>Benzathine penicillin:</td> </tr> <tr> <td>Vaginal Discharge:</td> <td>Doxycycline:</td> </tr> <tr> <td>Urethral Discharge:</td> <td>Norfloxacin/Ciprofloxacin</td> </tr> <tr> <td>Pelvic Inflammatory Disease:</td> <td>Metronidazole:</td> </tr> <tr> <td>VDRL/RPR Positive:</td> <td>Other:</td> </tr> <tr> <td>Other:</td> <td></td> </tr> </table> <p>Please provide appropriate syndromic treatment</p>		This person's contact was treated for:	Treatment given:	Genital Ulcer:	Benzathine penicillin:	Vaginal Discharge:	Doxycycline:	Urethral Discharge:	Norfloxacin/Ciprofloxacin	Pelvic Inflammatory Disease:	Metronidazole:	VDRL/RPR Positive:	Other:	Other:	
This person's contact was treated for:	Treatment given:														
Genital Ulcer:	Benzathine penicillin:														
Vaginal Discharge:	Doxycycline:														
Urethral Discharge:	Norfloxacin/Ciprofloxacin														
Pelvic Inflammatory Disease:	Metronidazole:														
VDRL/RPR Positive:	Other:														
Other:															
<table> <tr> <td>Signed:</td> <td>Date:</td> </tr> <tr> <td colspan="2">Hospital/Clinic/Doctor:</td> </tr> </table>		Signed:	Date:	Hospital/Clinic/Doctor:											
Signed:	Date:														
Hospital/Clinic/Doctor:															

## 4.6 Counselling Format

Name:

Address:

Sex:

Occupation:

Card No.:

Education:

Date:

Session Number:

Number of hours spent counselling:

Remarks:

Sl. No.	Date	Case History/ Problem	Family History	Social History	Sexual History	Previous Medical History	Issues Discussed	Progress on Objective	Impediment	Areas to be Addressed in Future	Next Follow-up Date

*Note : The number of condoms distributed and whether condom demonstration has been completed can be listed in the column "Issues Discussed." From here the counsellor can fill in the condom distribution figures while completing the daily performance report on counselling.*

## Guidelines: Counselling Format

**Case History/Problem:** The counsellor has to question the client and document the history of his/her present problem or illness.

**Family History:** Questions could include:

- Type of family
- Family composition
- Their ages`
- Sex
- Education
- Occupation
- Income
- Relationship of the family members with the client
- Marital status
- Education of wife
- Relationship with wife
- Information on children
- Any major illness in the family

**Social history:** Questions could include:

- Close friends
- Peers
- Relationship with friends
- Relationship with peers
- Member of any club/association/ institution

**Sexual History:** Questions could include:

- Client's sexual behaviour
- Type of partners
- Type of sex
- Condom use
- In case the patient is currently having one or more STI symptoms, after how many days of the onset of symptom did the patient come to the clinic?

**Previous Medical History:** Determine what type of illness the client has previously suffered from.

**Issues Discussed:** Discussion could focus on:

- STIs
- HIV/AIDS
- Condom use
- Barriers to condom use including availability
- Accessibility to health services
- Barriers to accessibility
- Symptoms of STI
- The importance of self examination and how to do self examination
- The importance of coming to the clinic as soon as there is a symptom of STI



**Progress on Goal:** Examine how the client is progressing towards achieving his/her goal and how receptive the client is towards the options given by the counsellor. For example, when the client is an STI patient, a goal could be for the client to either reduce the number of partners and/or use condoms during future sexual activities. The counsellor has to thus explore how receptive the client is at this stage of counselling to reducing the number of partners and/or to using condoms during future sexual activities.

**Impediment:** Explore what factors and/or issues are present that may deter the client from reaching his/her goal. Factors could include client's mindset, misconceptions, apathy, recreational drug use, etc.

**Areas to be Addressed in the Future:** These are the areas that the counsellor has to focus upon in future sessions with the client. For example, if the client is an alcoholic, the counsellor will have to keep this in mind in later sessions.

**Follow-up Date:** The scheduled future date of the client's next visit.

#### 4.7 Daily Performance Report on Counselling

To be completed by the counsellor and submitted to the project coordinator

Date:

1. Total number of sessions:
2. Number of new sessions (both STI & non-STI):
3. Total number of follow-up sessions:
4. Total number of new cases counselled for STIs:
5. Number of STI follow-up cases:
6. Total number of new non-STI cases:
7. Number of cases referred to another counsellor:
8. Number of condoms distributed free:
9. Number of condoms sold:
10. Money recovered from sale of condoms:
11. Problems faced by the counsellor (if any):

## 4.8 Monthly Performance Report on Counselling

To completed by the counsellor and submitted to the project coordinator.

Date:

1. Total number of sessions:
2. Number of new sessions (STI & non-STI):
3. Number of follow-up sessions:
4. Total number of new cases counselled for STIs:
5. Number of follow-up cases for STIs:
6. Total number of new non-STI cases:
7. Number of condoms distributed:
8. Number of condoms sold:

## 4.9 Daily STI Tally Sheet

Clinic : \_\_\_\_\_

Officer Reporting: \_\_\_\_\_

Designation: \_\_\_\_\_

Qualification: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Number Of Patients Treated \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

																	All Cases		
	10 -14		15-19		20-24		25-29		30-34		35-39		40 -44		45 -49		Male	Female	Total
Diagnosis	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female			
Urethral Discharge (Males)	o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o
Vaginal Discharge (Females)		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o	
Genitalulcers (Males & Females)	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o
Pelvic Inflammatory Disease		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o		o o o o o o o o o	
Total	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o	o o o o o o o o o

Daily Tally Sheet of Children Treated for Ophthalmia Neonatorum

Ophthalmia Neonatorum	o o o o o o o o o o o o	o o o o o o o o o o o o	o o o o o o o o o o o o
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## 4.10 Medicine and STI Kit Requisition Form

**Date:**

Clinic:

**Name of the medicine:      Quantity required:      Quantity supplied:**

Name (Colour) of the STI Kit:

Upon issue of medicines:

\_\_\_\_\_  
Signature of the responsible party for      Co-signature of doctor

clinical operations

Upon receipt of medicines:

\_\_\_\_\_  
Signature of Project Coordinator      Signature of Recipient

### **Please Note:**

The requisitions shall be filed in a systematic manner.

The requisitions will have a duplicate copy; one copy will be maintained at the central store and the other at the requesting clinic.

The issue figures of the central stock register should be posted from the requisition forms.

The receipt figures should be posted from the original bills as soon as the material is received.

The medicine stock registers should be maintained on a first-in, first-out (FIFO) basis, meaning that the batch of medicine received earlier must be issued earlier. This is essential to guard against the expiration of medicines and is the reason why the "*rate*" and the "*expiry date*" columns have been provided. These columns must be meticulously maintained.

Alliance has developed a 8 colour coded STI kit for easy administration. All NGOs are expected to use these kits (refer to Vol. II)

#### 4.11 Condom Requisition Form

Clinic:

Date:

Brand	Quantity requested	Quantity supplied

Upon request for condoms

\_\_\_\_\_  
Signature of person responsible for clinical operations

Upon receipt of condoms

\_\_\_\_\_  
Signature of project coordinator

\_\_\_\_\_  
Signature of recipient

#### **Please Note:**

The central condom stock register will be maintained by the accountant or the person designated for maintaining condom stocks at the central level.

This register will have a receipt and issue side with the usual columns for date, quantity and balance.

The receipts will be entered from the requisition notes.

Issuing condoms to peer educators, supervisors or any other person in charge of distributing condoms to beneficiaries will be noted in this register and their signature will be obtained in the appropriate column.

Balances will be drawn regularly and checked regularly by the appropriate authority. The recipients of condoms from the clinic will maintain appropriate records for their distribution and stocks.

## 4.12 Guidelines for Stock Registers and Records

The medicine and STI kit stock registers are maintained in three parts:

1. The **Central Stock Register**
2. The **Patient-Wise Medicine Stock Register**
3. The **Clinic Medicine and STI Kit Stock Register**

The **central stock register** is to be maintained at the site where the medicine and STI kits are centrally purchased or stored. This is necessary because partner NGOs may run more than one clinic and central purchasing and storage allows for the stock to be adequately maintained.

Medicines and STI kits shall be issued to the clinics on the basis of requisitions made by the staff member responsible for the respective clinical operations. The requisitions must be numbered and if possible, co-signed by the doctor of the respective clinic (Refer to Appendix 4.10).

When the medicine is issued, the coordinator will sign the requisition and if there are any deviations in amount of any medicine requested and actual amount supplied, this shall be noted in the appropriate column.

On receipt of the medicines, the recipient shall sign in the appropriate column in the central stock register.

### The Patient-Wise Stock Register

This register records the issue of medicines to patients on a daily basis and will be maintained at individual clinics.

The names of all the medicines and STI kits available will be written horizontally with each medicine having a separate column. Columns will also be provided for the "Date" and "Card Number."

The entries to this register will be made from the patient cards which will record the medicines prescribed and the actual number of medicines distributed.

Daily totals will be calculated, which will give the total number of medicines distributed.

This register can be maintained by the Clinic Assistant or any other person responsible for dispensing medicines. This register should be ideally be updated at the time of dispensing medicines or the end of the clinic day. It must be updated daily.

### *Utilities of the Patient-Wise Stock Register*

- ➡ The daily totals of each type of medicine issued can be readily obtained
- ➡ The medicines given to any particular patient on any particular day can be easily obtained

### **The Clinic Medicine and STI Kit Stock Register**

This is the final step of the stock maintenance for medicines. The Clinic Medicine Stock Register is maintained by the Clinic Assistant or by the person responsible for maintaining the medicine stocks in each clinic. In the form of an attendance register, the names of all the available medicines available are to be written down on the left-hand side of the register. The right-hand side will have 4 columns: "*Opening Balance*," "*Receipt*," "*Issue*," and "*Closing Balance*." A separate page will be used for each day.

The "*Opening Balance*" of all medicines will be entered each day.

The "*Receipt*" figures will be entered from the duplicate copy of the Requisition Form.

The "*Issue*" figures will be taken from the daily total on the Patient-Wise Medicine Stock Register on the corresponding day.

The "*Closing Balance*" will be drawn and carried forward as "*Opening Balance*" for the following day.

### *Utilities of the Clinic Medicine Stock Register*

- ➡ The stock of all medicines on any particular day can obtained
- ➡ The recording of all medicines is easily maintained
- ➡ Facilitates the valuation of the medicine stock when considered in conjunction with the Central Stock Register

## While maintaining the Medicine Stock the following must be noted

The number of medicines stocked must be kept within manageable limits. It has been observed that a stock of more than 25 medicines becomes unmanageable. Also, the stock of general drugs should be kept to a minimum when possible. It is also advisable that the medicines are purchased and stocked using their generic names rather than their brand names. This procedure avoids stocking the same medicines under different brand names and unnecessarily increasing the number of drugs stocked. To simplify this process, the NGO may also consider developing a coding system for stocking medicines.

The stock registers must be maintained accurately and regularly. They should be regularly monitored and checked by appropriate authority.

## Condom Stock Registers

The Condom Stock Registers are also maintained in two parts: The Central Condom Stock Register and the Clinic Condom Stock Register.

### Central Condom Stock Register

This register is to be maintained in the central office where the stocks are held and purchases made. The "*Receipt*" column will be completed using the information from the original bills on the actual receipt of the materials. The "*Rate*" column records the number of condoms requested by the individual clinics and facilitates valuation.

Condoms will be issued to the clinics on the basis of requisitions made by the person responsible for the respective clinic operations. The requisitions will be numbered and signed by the person responsible for the respective clinic operations.

The Project Coordinator will sign the Requisition Form once the condoms have been supplied. If the number of condoms supplied and the number of condoms requested for are different, this will be recorded in the appropriate column of the form.



### 4.13 Guidelines for Purchasing Drugs

#### *Factors to consider while identifying drugs to purchase*

1. Using guidelines from WHO and NACO
2. The availability of drugs in the market
3. Based on the syndromic approach
4. Doctor's and STI control officer's recommendation
5. Consultations with other organisations about the drugs used by them
6. The type of STI cases that the clinic deals with
7. Discussions with the drug wholesalers about STI drugs

#### *Factors to consider while purchasing drugs*

1. Past history
2. The type of STI cases that the clinic deals with
3. Present stock availability and last quarter's usage
4. Shelf life
5. Quality
6. Cost
7. Effectiveness

#### *Factors to consider in identifying the supplier*

1. Credibility of the supplier to supply drugs within the specified timeframe
2. Cost effectiveness of the drugs supplied
3. Quality of drugs supplied

4. Supplier should meet all necessary formalities as per the rules and regulations of the GOAP and the GOI
5. Must be local, reliable and known
6. Must be able to supply large quantities, if necessary
7. Past performance
8. Availability of supplier
9. Reputation of the supplier

### *Selecting the supplier*

The selection of the supplier has to be done through a competitive tendering procedure. It is up to the organisation to decide if it will invite tenders through an advertisement in the newspaper or whether it will obtain quotations through directly approaching the suppliers. All partner organisations must obtain at least 3 quotations, make a comparative analysis based on the factors provided above. The organisation should maintain the details about quotations received, which supplier(s) is selected and why. It is also suggested that drugs are purchased by their generic names as there is a high degree of cost effectiveness. However, it is up to the organisations to decide.

### *Monitoring drugs and suppliers*

Monitoring the supply of drugs as well as the suppliers is very important as it helps to decide on future strategies for purchasing drugs and deciding the supplier. The following factors should be closely monitored:

1. Cost
2. Cost versus quality of the drugs supplied
3. Effectiveness of the drugs
4. Drug resistance, changing drugs accordingly
5. Drug side-effects

6. The reliability of the supplier
7. Cross-checking stock registers with physical stocks

### *Expired medicines*

Proper control should be exercised over medicines purchased and issued so that there are no expired medicines. In cases where particular medicines are not used and expire, the medicines should be properly destroyed with the permission of the head of the organisation and reflected in the stock books. This, however, should not become a regular phenomenon and the reasons for expired medicine stocks should be analysed and the information utilised to that such occurrences can be avoided in future.



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