TAI - VHS - Avahan

GOOD PRACTICE DOCUMENTATION

Providing Quality STI Care for the Marginalized

TAI-VHS
Chennai

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INDIA AIDS INITIATIVE

PROVIDING QUALITY STI CARE FOR THE MARGINALIZED

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Project Background

Tamil Nadu AIDS Initiative (TAI) administered by Voluntary Health Services (VHS) with support from Avahan – Bill and Melinda Gates Foundation (BMGF), has been implementing HIV prevention programs in the State of Tamil Nadu since 2004. TAI project has worked with Female Sex Workers (FSW), Transgender(TG) and Kothis in Tiruvallur, Vellore, Krishnagiri, Dharmapuri, Salem, Namakkal, Erode, Madurai, Theni, Coimbatore, Thanjavur, Dindigul and Tiruppur districts.

The community expressed the need for accessing STI services in a non-stigmatized environment with empathetic healthcare providers free of cost. Based on the community's need TAI established Static clinics at all intervention locations with an attached drop-in-center (DIC).

Over a period of nine years TAI has been addressing the HIV epidemic with various approaches and has best practices and challenges to share with other stakeholders.

Objective of TAI Program:

The main objective of TAI was to reduce the Sexually Transmitted Infection (STI) among sex workers from 25% (estimated baseline APAC: a community prevalence study 2003) to 12% in three years (and 6% in five years). The main scope of the STI Program was

- To increase the accessibility of STI services to the community
- To detect cases early, diagnose and provide complete treatment
- To render quality STI care

Rationale for static STI clinics and referral services:

The STI care for the marginalized in Tamil Nadu was through referrals to the government STI clinics. The community members feared accessing government clinics, due to stigma & discrimination. The hospital timings were also not suitable to the community members.

The TAI program envisaged clinic services which will be accessible, acceptable and available to the community in a community friendly space. The community expressed that they needed medical professionals who could spend time with them, hear their concerns, counsel them and provide options to resolve their problems. Hence, TAI set up exclusive clinics for the Female and Male Sex Workers to provide quality clinical care in strategic locations.

Standardization of Quality Care:

TAI standardized all components of STI clinics to ensure that the same quality of services was provided at all the locations. Standardization was done in the area of branding clinics, infrastructure, patient flow procedure, display materials, counseling, treatment protocol, side labs, drug inventory management, documentation and coordination between outreach and clinic teams. In standardizing the clinic procedures, TAI followed 'Clinic Operational Guidelines (COGS)' developed by Family Health International (FHI) in line with the National AIDS Control Program (NACP) guidelines.

Branding of Clinics:

TAI Static clinics were branded to help community members relate to them easily. The clinic for FSWs was called "TAI Clinic" and that for MSMs was "SESA Clinic".The names of the clinics were chosen by the community members. The word 'SESA' in MSM lingo means excellent. Identical name boards were displayed at all clinics.

1. Infrastructure:

The clinic space included a waiting area, Drop-in-Centre (DIC), Counseling area, nurses' station,doctor's examination room and laboratory. The minimum clinic equipment was made available in all clinics. A uniform system was followed in clinical procedures like counseling, examination, lab test and drug dispensing.

2. Display material

Materials containing awareness and prevention messages were displayed for the benefit of the community while they waited at the clinics.These materials were aimed at increasing health seeking behavior. Some materials were also made available at the clinics to address guilt and improve self-esteem and quality of life. As encouraged by TAI, community members developed a code of conduct and ethics which were prepared in a participatory manner and displayed in DIC. Charts on management of anaphylaxis, Post Exposure Prophylaxis (PEP) and referral directory were displayed.

Standardization of STI Care:

It was felt that standardization of STI care can enhance the quality of services across all clinics. Hence, standardization was followed with respect to infrastructure and supplies, counseling services, treatment protocol, lab procedures, documentation.

1. Counseling

Counseling services were provided at clinics and DIC to community members under emotional stress. The counseling skills, types of counseling, messages to be communicated and records and registers were standardized across all clinics. The counselors and nurses were trained on basic counseling skills. They provided preventive, risk reduction, emotional and pre and post-test counseling. The counseling sessions were documented and followed up. Community members appreciated the interactive counseling sessions as they provided options for them to resolve their issues.

2. Treatment protocol:

TAI and SESA clinics provided treatment for common STIs as per the NACO guidelines. The COGS was followed in presumptive treatment, treatment of STIs, sterilization and disinfection procedures, waste segregation and disposal and PEP.

3.Side labs:

The nurses of the TAI clinic were trained to perform basic laboratory procedures like screening for syphilis, using the Rapid Plasma Regain (RPR)and ICST methods, vaginal and cervical smear examination & staining procedure. External Quality Assurance System (EQUAS) was in place to assess the standard of lab test. The records and registers for data collection in laboratories were standardized.

4. Drug inventory management:

There was a uniform drug re-order policy and a minimum re-order level for each static, expanded and private healthcare provider clinic. This was to ensure that there was no shortage of essential STI drugs at any point of time. All clinics maintained the drug supply and updated utilization registers on a daily basis, physically verified documents and drug stocks periodically.

5. Documentation:

Documentation in clinics was standardized using uniform case cards, master registers, referral & cluster tracking registers, counseling registers and laboratory registers. The staff responsible for maintaining documents were given training and monitored periodically.

6. Coordination between clinic and outreach team

Weekly and monthly reviews were conducted to identify gaps and address them, for effective utilization of clinical services. Clusters performing poorly due to distance factor were identified and community members from those areas were directed to newly identified service providers at proximal locations. The STI Committee participated in the reviews to expressthe views, opinions and suggestions of the community members which were documented and given attention immediately.

Mentoring and capacity building:

TAI contracted two management agencies with expertise in the field of clinic management. These agencies assisted in establishing the clinics and provided monitoring and mentoring support to the staff. They undertook activities such as selection and appointment of doctors and other clinic staff, supply of equipment and drugs, data collection and management, organizing trainings at the central and zonal level and sharing of best practices.

Capacity building organizations, FHI and World Health Organization (WHO) visited TAI clinics periodically and provided technical inputs to improve the quality of clinic services and ensure standardized functioning in all locations. The feedback from FHI and WHO helped in validating the quality of services provided at TAI / SESA clinics.

Community ownership in TAI/SESA clinic:

The community ownership in the STI program ensured community sensitization to access the clinics for STI care. The DIC attached to the clinic was a space for the community to discuss their health issues, fears, myths and misconceptions. Frequent sharing of testimonials by community members about the empathetic approach of the doctors, nurses and about the painless internal examination andtreatment resulted in building the confidence of their peers to access clinic services. Short films on internal examination, RMC & syphilis screening were used to provide the necessary information. Some of the KPs who were under emotional stress were able to discuss their problems and find solutions by interacting with nurses and counselors. The members of the STI committee provided feedback about the clinic services to outreach and clinic team. This feedback helped in making the necessary changes to make the clinic truly ‘community friendly’.

TAI created the post of a Community Liaison Officer (CLO) to help the community access clinic services and motivate them for the first visit/RMC/Follow up. The CLO worked closely with the clinic and the outreach team and participated in the review meetings to understand the outreach dynamics. This concept was a novel one and was appreciated by the capacity building team of FHI/WHO, who in their report mentioned that the ‘community liaison officer is a good model of community involvement and coordination between the clinic and the outreach team’.

The Community Advisors from TAI were deputed periodically to ascertain the gaps in the functioning of the clinic. They interacted with the community to get feedback on the comfort levels that the community

experienced with the clinic team. They also monitored the clinic flow in a given period. The capacity building team appreciated the periodic inputs from the community advisors on the community perception of STI services.

Results

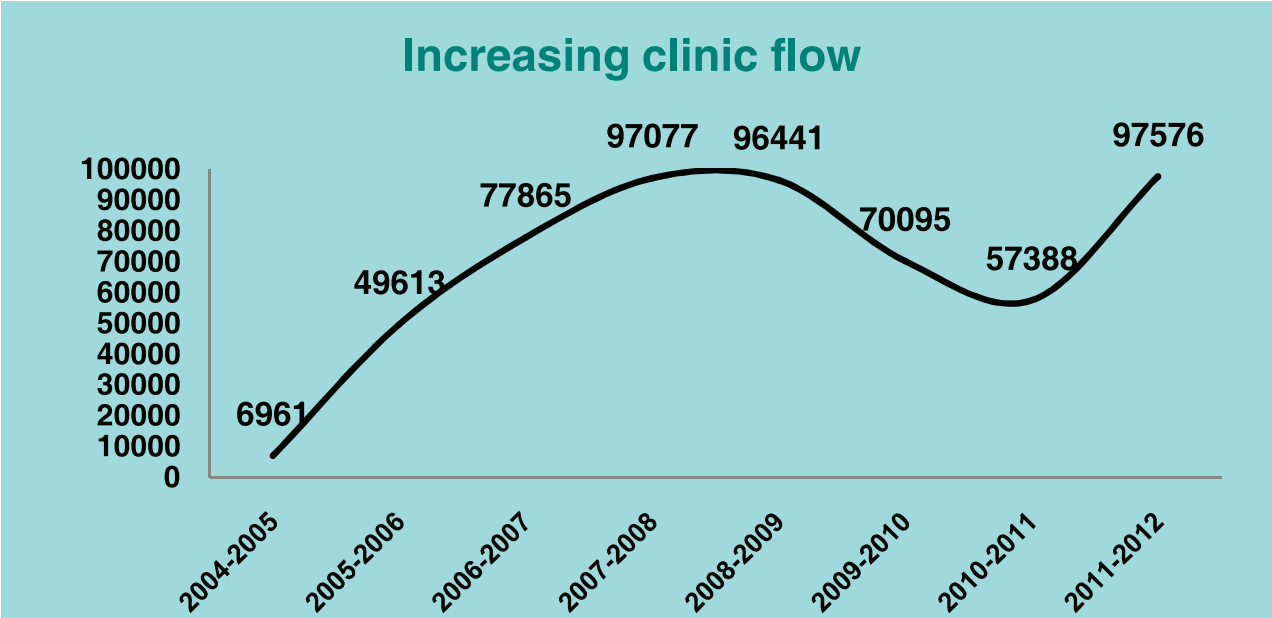

Figure 1: Increasing clinic visits 2004-12

The number of HRGs accessing the clinic showed an increasing trend from 2004 to 2009.
The dip in numbers during 2010 to 2011 is attributed to the phased transition of the program.

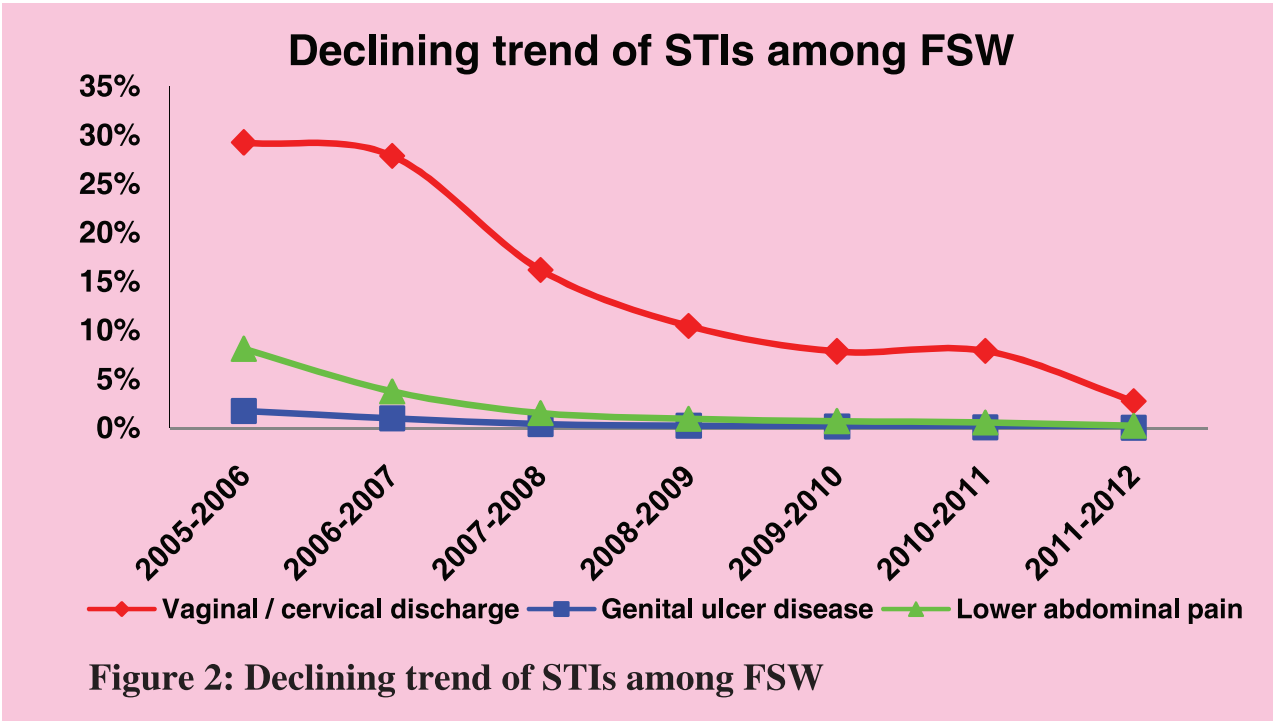

Figure 2: Declining trend of STIs among FSW

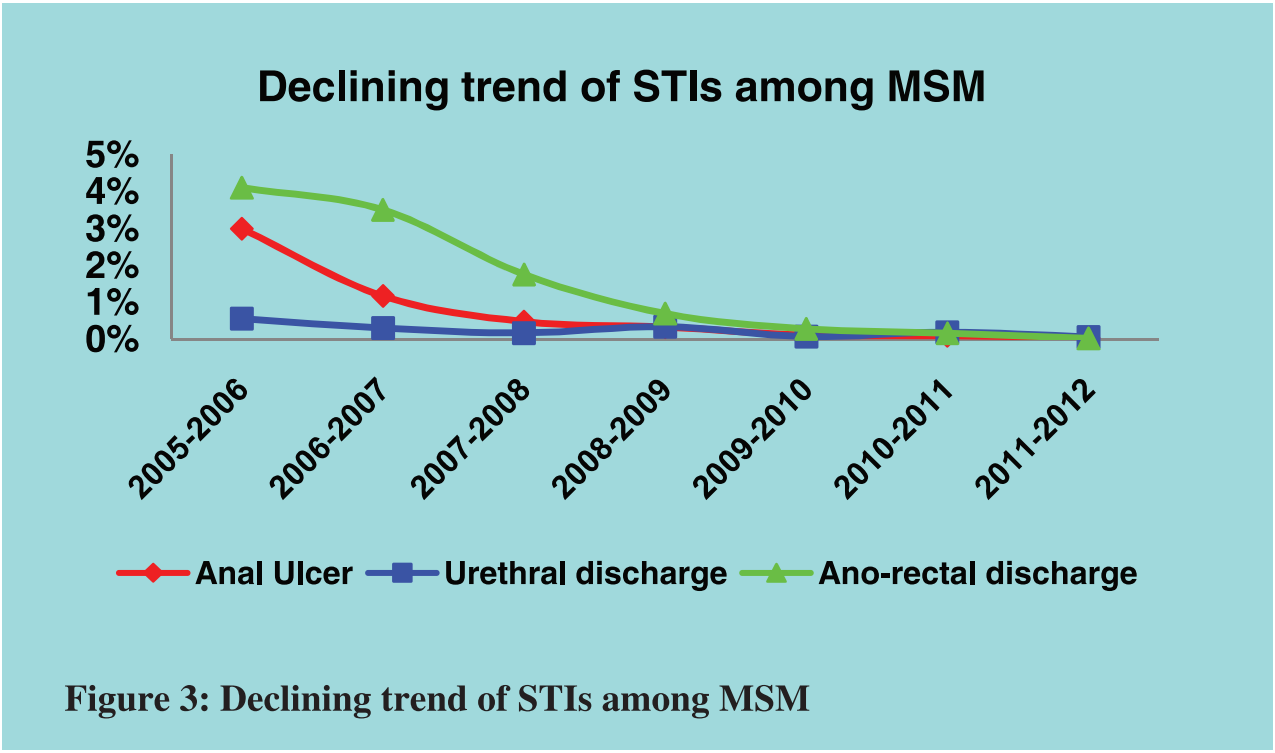

Figure 3: Declining trend of STIs among MSM

Figure 2 and 3 show a declining trend of common STIs among FSWs and MSM clinic attendees. This could be attributed to early diagnosis and standardized treatment of STIs.

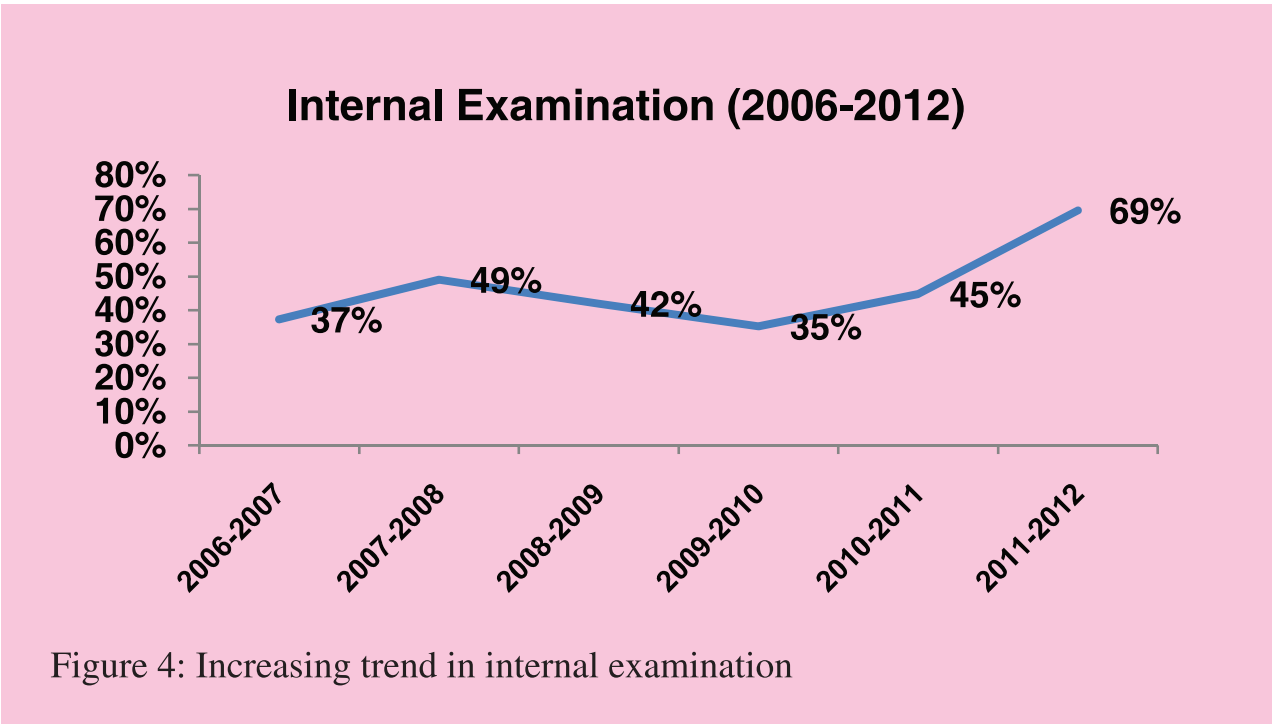

Figure 4: Increasing trend in internal examination

The fear of community towards internal examination was addressed through effective counseling and guidance provided by the community committees, through IPC materials and videos. This resulted in increase in the number of internal examinations.

Discussion:

Early diagnosis and treatment of STIs is a proven strategy for reducing the HIV burden.

The efforts of TAI in involving the community members as key players in the clinic activities and creating an ownership of the clinic program helped in increasing the number of clinic attendees over a period of time. The regular feedback from the community to the clinic team also helped in identifying the areas for strengthening clinical services and addressing the felt need of the community.

The STI committee and community members were involved in the routine clinical activities. They helped allay the fear of internal examination and made them realize the importance of this procedure. Frequent testimonial sharing motivated the community members to come forward for internal examinations and syphilis screening. Since most STIs are asymptomatic, volunteering for these procedures helped in diagnosing STIs.

Standardization of all procedures including diagnosis and treatment of common STIs using the NACO treatment protocol was followed in all clinics. All doctors posted in TAI/SESA clinics underwent regular periodic trainings and on the job monitoring and mentoring support to ensure correct diagnosis and treatment. The standardized drug procurement and supply across all clinics ensuring minimum re-order level helped in essential STI drugs being available at all times. This helped in complete treatment at the first point of contact and resulted in the decreasing trend of common STIs reported and documented across all clinics.

The community came forward voluntarily to access clinical services because they were assured of confidentiality and treatment in a stigma free environment by 'community friendly health care professionals'. Importance and due respect was given for the sentiments expressed by the community. No coercion was used to undergo any clinical procedure and sound ethical practice was followed across all clinics.

TAI inculcated a health seeking behavior among the community and the importance of symptom recognition for seeking treatment. This played an important role in bringing down the burden of STIs/HIV among the high risk community. This behavior change when in place helped in achieving a sustainable prevention model in HIV care.

Conclusion:

TAI provided quality STI care to the marginalised in a community friendly, non-stigmatised space which they considered their own. The community members received not only STI care but also counselling services which guided them to adopt safe sexual practices. The outreach efforts in reaching the unreached and reluctant community in remote locations helped in mobilizing them to access clinical care. The health seeking behaviour brought about through outreach & counselling sessions, use of community friendly IPC material and experience sharing increased the clinic flow over a period of time. The attitude of the healthcare professionals, quality STI care and enabling environment helped sustain the behaviour change and resulted in reducing the STI/HIV disease burden. TAI clinic model is a cost effective, community friendly one which can be replicated to provide quality STI care to the marginalized.

Abbreviations

AIDS	:	Acquired Immunodeficiency Syndrome
APAC	:	AIDS Prevention & Control Project
BMGF	:	Bill & Melinda Gates Foundation
CBO	:	Community Based Organisation
CLO	:	Community Liaison Officer
COGS	:	Clinic Operational Guidelines
DIC	:	Drop in Center
EQUAS	:	External Quality Assurance System
FHI	:	Family Health International
FSW	:	Female Sex Worker
HIV	:	Human immunodeficiency virus
HRG	:	High Risk Group
ICST	:	Immunochromatic strip test
MSM	:	Men having sex with men
MSW	:	Male Sex Worker
NACP	:	National AIDS Control Program
NACO	:	National AIDS Control Organisation
NGO	:	Non- Governmental Organisation
PEP	:	Post Exposure Prophylaxis
RMC	:	Regular Medical Check up
RPR	:	Rapid Plasma Regain
STI	:	Sexually transmitted Infection
TAI	:	Tamilnadu AIDS Initiative
TG	:	Transgender
VHS	:	Voluntary Health Services
WHO	:	World Health Organisation

Name of the Book	**:**	**Good Practice Documentation – Community Ownership in STI / HIV / AIDS Prevention program in Tamilnadu**
Documented by	**:**	**Nafeesa John, Dr.Radha, Mr. Simpson Cornelius Dr.Joseph D Williams**
Published by	**:**	**TAI-VHS**
Year of Publication	**:**	**2013**
Designed & Printed by	**:**	**Flame Advertising**

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