STI – Technical Working group

Date : 9th May 2011

Venue: IDSA, New Delhi

NACO had organized the TWG meeting for STI for NACP IV planning on the 9th & 10th of May 2011 at New Delhi. The issues discussed and preliminary recommendations given by members as well as some issues flagged for further discussion during the two day meeting are summarized in this document.

Process:

The division described the current status of the program implementation at the outset. Each group member discussed each point in the TOR. Current implementation plan on the topic was reviewed and some issues related to the programme were also flagged. The group provided inputs in identifying any other left over issues and provided input/s on finding possible solutions and discussed the implementation plan for NACP IV. Group also provided input on how to monitor and supervise and suggested any other innovation or suggestion for the programme.

Discussion Point 1:

Review current status of STI services and suggest strategies for extending STI services through public sector health care delivery system up to sub-district level.

Public Health Facilities supported by NACO

The NACP III has adapted syndromic case management as a policy for implementing the program. RTI has been included with STI, to reach MDG goals in an effective manner. NACO supports 1033 designated STI/RTI clinics (DSRC) across the country, ensuring every district has minimum one DSRC, which are located at Medical College hospitals, District Hospitals and select sub district level hospitals involving both Gynae and STI depts. Each facility is supported by one STI counsellor in the programme and doctors, staff nurses and lab technicians are available from the pool of human resource. Standardized training, recording and reporting systems are developed. Colour coded STI/RTI drug kits are used to treat at first contact. Syphilis screening clubbed with HIV screening through single prick method at ICTC and syphilis

screening of ANC attendees is supported ONLY at hospitals where DSRC located. Referral linkages developed with ICTC/PPTCT/ART/TI/RNTCP/CCC projects. NACO has a standardized system of capturing STI data every month through prescribed format. Sero prevalence of syphilis among DSRC is about 3%, among ANC less than 1% and among HRG about 7%. As per utilization of services eight states showing utilization of services by more than 14 clients per each working day. Six states showing less than 6 clients per working day. The rest of the states showing utilization of services by 6 to 14 clients per working day. The division has achieved 100% target from 25% in the beginning of NACP III.

Recommendations:

- Continue with SCM with minimal Lab support wherever available (ESCM)
- Continue with the existing support for counsellor in the programme.
- Programme should ensure strengthening of existing OPD for quality STI/RTI service delivery instead of positioning additional system, which is not always feasible due to lack of dedicated space and manpower.
- STI/RTI service delivery should be through involvement of all possible service providers of the designated facilities irrespective of specialilties, not limiting to gynae and STI specialists. GDMOs also should be involved to enable uninterrupted service delivery.
- NACO should provide handholding support to provide standardized service delivery across all facilities.

Issues for further discussion:

- How to provide supportive supervision and build the capacity of the service providers especially at PHC and CHCs on a dynamic mode.

Discussion points 2

Develop mechanisms for convergence with ARSH, family planning, sexual and reproductive health services under RCH II of NRHM

Convergence with family planning, ARSH and SRH-

The existing DSRCs are part of general health system and also cater to youth and adolescents. As per CMIS reports about 20% of attendees are adolescents. DSRCs are not formally linked with Family Planning and reproductive health services, though informal referral services happening between departments. All DSRC staff including counselors are oriented on ARSH services as

part of their training curriculum. DSRCs branding "Suraksha" is brand name for "Sexual and Reproductive health services" and there is scope for extending the brand to related services.

Recommendations:

- ARSH services should be comprehensive in nature and there should be functional linkages of gynae, STI, ANC family welfare and post partum facilities in the given hospital for meaningful ARSH services.
- "Suraksha" brand name for "Sexual and Reproductive health services" should be extended to brand all related services as mentioned above.

- Special package for communication to this population needs to be designed
- NACO and NRHM should visit and explore possibilities of replication of innovations like helplines in implementing ARSH services by organizations such as Tarshi, Mamta, etc

Discussion points 17

Explore the possibilities of integration activities with NRHM

Integration with NRHM

According to joint working group recommendation, NACO STI Division has spearheaded the convergence process. The STI/RTI services are delivered at NRHM sub district health facilities through the existing staff of health facility. NACO ensures uniform service delivery through a standardized training plan and development of a cadre of master trainers in every state and district, who in turn are training doctors, staff nurse and laboratory technicians from every PHC/CHC/MMU/Dispensary etc varieties of sub district health facilities. Colour coded STI/RTI drug kits have been made available at all these facilities. NRHM currently reports STI /RTI data in absolute numbers through HMIS without any syndromic bifurcation. The other key indicators pertaining to STI/RTI have been proposed for inclusion in HMIS. Syphilis screening of ANC is being focussed and referral linkages with DSRC and TI projects through Link workers and ASHA/ AWW/ MPHW is envisaged.

Program implementation at state level is overseen by STI focal person at SACS in close coordination with the state and district RCH officers and PMU, but there are issues of ownership of programme at state and district level.

Recommendation:

- The overarching goal would be to provide universal, comprehensive quality standardized service to all citizens through convergence and integration mechanisms.
- NACO should provide handholding support to provide standardized service delivery through the NRHM facilities in close coordination with maternal health division at national level. Positioning of structured monitoring system at national, state and district level for facilities under NRHM in convergence with NACO would be finalized in consultation with maternal health division. NRHM should ensure regular reporting from all NRHM facilities in the HMIS with respect to the agreed STI/RTI monitoring indicators.
- Syphilis screening of pregnant women should be scaled up across all ICTC/PPTCT and F-ICTC located in the facilities supported by NRHM. NRHM should budget to procure the requisite numbers of syphilis screening test kits.
- The programme should involve Urban Health facilities (Urban health facilities, health posts, corporation hospitals and to cater to populations living in urban and peri-urban slums. NACO/SACS should provide training of service providers and syndromic colour coded drug kits to treat STI/RTI. Syphilis screening should be ensured in these centres for both STI/RTI attendees and pregnant women through state support.
- Positioning of STI programme with state health system would also be helpful to reach maximum number of people. Responsibility for treatment and monitoring needs to be fixed with NACO/NRHM. In this regard clear role clarity of NACO/NRHM needs to be defined.
- Mobile medical units under NRHM should be linked with difficult to reach HRG population and linkages to be established between MMU and link workers, Asha and AWW. NRHM should train the staff of MMU in syndromic case management and provide colour coded drug kits. The facility may also be used to screen pregnant women for syphilis and HIV who are not accessing health facilities at PHC/ subcentre have not been utilized properly.
- NACO and NRHM to involve rural private providers already seeing STI/RTI cases in the programme as an option to overcome staff shortage at NRHM facilities.

Issues for further discussion:

- Modalities for monitoring systems at national, state and district level along with role clarity of NACO/NRHM needs to be discussed in detail.

Discussion points 3

Suggest measures for enhanced involvement of private sector for providing quality STI services.

PPP scheme

In the current program, private sector was involved through third party agencies across the country to provide services to clients of sex workers, primarily. About 8000 providers in private sector were identified through structured process and trained and franchised for service delivery. Drug kits were provided under social marketing concept. Due to poor performance, drug marketing related issues, the scheme was discontinued and modified as a model to cater HRG population using the existing TI projects. Presently, 4036 community preferred providers have been involved to provide services to HRG across states. NACO colour coded STI/RTI drug kits have been given for free distribution to the HRG through TI projects. Providers are paid a maximum of Rs 50/- per consultation limiting to symptomatic visit or RMC visits. There is no cost reimbursement for follow up or partner treatment. The PPP scheme has scaled up the access to services and utilization by HRG has gone up from less than 5% to more than 60%.

Recommendations:

- The group agreed on the relevance and importance of partnering with the private sector and suggested that it should not be limited only to provide STI/RTI services to HRGs, but to cover larger population.
- The group further suggested training of members of the professional associations across rural and urban areas without an obligation of an agreement and provide basic job aids to them with an expectation that they adhere and follow standardized treatment protocols for treating various STI/RTI among the patients accessing their services. The group felt that this kind of a strategy will cater service needs of larger populations in a standardized manner.
- Recording and reporting is one of the bigger challenges, hence minimal indicators should be introduced from the data retrieving from the private sector. Similarly, the monitoring should be very minimal and may be institutionalized using the governing bodies of associations at district, state and national levels.
- The group expressed their appreciation on the efforts made by the programme for partnering with other central government health systems such as Railways, ESI and Armed forces and paramilitary forces and further suggested to scale up of linkages with other organized public sector undertakings such as SAIL, Coal India, etc and nationally accredited corporate hospitals like Apollo, Fortis etc. The group suggested to the programme to structure the linkages for enabling staff of the partnering organizations to

be trained as per national guidelines and position simple data capturing systems. The same mechanisms can be replicated at state and regional level by respective SACS. An action plan in this regard may be developed in this programme to establish and sustain convergence with the above mentioned organizations during the current financial year itself.

- Programme should consider conducting minimum two evaluations of PPP models through agencies and organizations.

Issues for further discussion:

- Feasibility and effectiveness of saturated training of private providers for STI/RTI
- View on whether NACO should negotiate, as a National policy with Medical Council of India to consider trainings as part of CME activity and link the same with periodic renewal of licences.
- Issues, need for continuation and strategies to overcome obstacles related to involvement of RMP and AYUSH and non qualified traditional practitioners into the programme.
- Use of Just Dial services/ local networks/ cable TV etc to provide information on STI treatment. Subscription could be paid by NACO on behalf of the PPP and the service could provide linkage to the doctor for STI treatment.

Discussion points 4

Review methods of providing STI services to HRG and suggest innovative methods to reduce STI prevalence among HRG substantially

Targetted intervention projects –

The essential STI service package for FSW,MSM, TS/TG comprising quarterly regular medical check up, twice a year syphilis screening, PT for first asymptomatic visit and repeated if she/he misses clinic services consecutively for more than six months and symptomatic treatment syndromically any time they suffer from an STI episode is supported by NACO. Simple user friendly guidelines have been disseminated for implementing STI services to HRG population. Different modalities of service delivery are encouraged (Static ,Preferred provider, health camps, linking with government health facilities, and hybrid models) to scale up the number of HRG accessing the services. The service utilization has scaled from less than 5% to over 60% across various subpopulations and states. 4036 practioners in private practice (both MBBS and Non MBBS qualified) have been identified as community preferred providers and trained to provide services to HRGs. All the TI projects are registered in CMIS for reporting STI data. All

the key staff (PM/Staff Nurse/Counselor, M&E Assistant/Accountant) from each of the TI projects in country has been oriented on STI program.

Program implementation at state level is overseen by TI focal person at SACS, in close coordination with the STI focal person. In some states there is support from PO-STI in technical support unit. The numbers of facilities to be monitored have increased from 1500 TI to 4036 preferred private providers enrolled for TI STI service delivery.

Recommendations

- The group recommended that TI and STI division NACO provide flexibility to SACS for using the best possible modality/ies for STI service delivery based on the population spread and number of HRG
- The group suggested reworking the honorarium to preferred private providers in accordance to the tier of city and improving the monitoring systems to maintain quality. At the same time, it must be ensured that the privacy of the private practitioner is not to be interfered.
- Group also suggested to the programme to consider and introduce service delivery for HRG through qualified ANM/ nurses to counter the non availability of qualified providers which is being done in some north eastern states.
- The group suggested linking all the service outlets both in urban and rural areas both in government and private sector for service delivery to HRG and general populations as the group felt that some of the HRG is accessing providers who are not in a programme and paying for the services. Hence payment aspects of the providers is not the key issue but ensuring all the providers in a given area are trained and aware of the guidelines assumes greater importance.
- All trainings should have a person from HRG communities and PLHIV networks to sensitize the service providers to bring in attitudinal change among service providers and to induce empathy towards MARPs among providers.
- SACS should ensure and monitor the linkages between TI projects and State and Regional STI centres for laboratory screening of STI/RTI, understand etiologies of repeat and recurrent STI and monitor drug sensitivity pattern of gonococci and impact of presumptive treatment among the core groups.
- Community monitoring systems to be introduced across TI projects as a policy to monitor the quality of service delivery by the community.

Issues for further discussion

- Programme also to consider and introduce service delivery through qualified ANM to counter the non availability of qualified providers which is being done in some north eastern states.
- Provision of free services to the bridge populations (Free colour coded STI/RIT drug kits)

- Scope of service should not be limited to STI/RTI, but it should be comprehensive health service.
- Differential honorarium to the providers according to the tier of city.
- Exploring the possibility of using existing and introducing new mobile services as a strategy to reach difficult to reach HRG
- Further discussion needs to be carried out on whether simple syndromic case management is a good enough option or services like minimal laboratory tests or PAP etc. could be added to the treatment.

Subcommittee comprised of the following members met on 11th May 2011 at IDSA.

1. **Epidemiologist: Dr. Gangakhedkar/Dr. DCS Reddy**
2. **Microbiologist: Dr. Majubala Dr. Usha Baweja and Dr. Sameer Kumta**
3. **Clinician: Dr. Anjana Das**
4. **NACO: Dr Shobini, Dr TLN Prasad**

Dr Arvind Pandey and Dr Sheela Godbole could not attend the meeting due to prior commitments. The terms of reference no 5, 6, 7, 9 were discussed in the group.

Discussion points 5, 6 and 7

Provide recommendations to strengthen the syndromic approach, rapid testing and etiological management of STI services at appropriate level of service delivery.

Suggest measures for strengthening laboratory support for etiological management of STIs and set up of a laboratory based STI surveillance system .

Suggest measures for strengthening Regional Laboratories for conducting Anti Microbial Drug Resistance studies.

Enhanced Syndromic Case management:

ESCM is the cornerstone of the STI/RTI programme during NACP III. Enhancement is in terms of simple to perform laboratory tests as per technical guidelines 2007. The providers were recommended to perform these investigations wherever available and feasible. The investigations are not mandatory for treatment. CMIS reporting also captures laboratory investigations which are reported by few centres regularly. Etiologic management of STI is not the programme policy. There were no rapid test kits to diagnose STI/RTI in current programme.

Regional STI Centres and State Reference Centres:

There are 7 regional STI centres supported under the programme located at Delhi (SJH, MAMC), Chennai (IOV MMC), Nagpur (GMC), Hyderabad (OGH), Kolkata (IOS KMC) and Vadodara (GMC). In consultation with states, 45 state reference centres have been identified who are already working in the HIV programme under HIV EQAS. Each regional centre is allotted certain states and the state reference centres located within them. They are also linked to 25 – 30 Designated STI/ RTI clinics and TI projects. Regional centres have conducted capacity building training of the staff of these centres. SACS have allotted certain districts to each state reference centres to conduct lab assessment of samples or patients referred by the DSRC or TI located in these districts. The centres perform under the close supervison of SACS in coordination with four basic departments (Microbiology, Skin VD, PSM and Gynaecology)

The laboratory surveillance is currently limited to existing 7 regional STI centres. Most of the samples they screen are among attendees of DSRC. After 2002- 03 community based study, there is no cross country study conducted. Tamil Nadu has done laboratory based screening of about 45000 HRG. The results are yet to be disseminated. Avahan has conducted an Operations Research in Maharashtra and Andhra Pradesh, apart from an IBBA light. The major finding of these studies is widely prevalent asymptomatic STI. There is wide variation of STI/RTI prevalence across the country.

Recommendation*:*

- The group recommended introducing minimal laboratory investigations as part of the programme as a parallel activity without linking to treatment at DSRC located in Medical College hospitals.
- The group recommended to introduce newer Point of care diagnostic test kits after regional STI centres validating their feasibility and suitability for the programme.
- The regional STI centres should develop the capacity to evaluate the syphilis test kits and newer diagnostic tests and help the programme to introduce them as add ons.
- The group also recommended scaling up regional STI centre concept to other premier laboratory based institutes under ICMR and develop linkages with them.
- The existing network of sentinel sites should be used in assessment of samples of patients accessing private sector and NRHM facilities also.
- The group also recommended to strengthen the sentinel sites with need based human resource, equipment and consumable support.
- The group recommended linking of 45 state reference centres and 7 regional centres with GASP programme of WHO
- The group recommended NABL accreditation of all the 52 laboratories.

Points for further discussion:

- The feasibility of introducing etiologic management of STI by medical colleges and accordingly modifying the syndromic protocols is an issue flagged for STI TRG.
- The sub-group to revisit terms of reference of the Regional and State Reference Centres and the implementation plan of laboratory based STI surveillance and give their recommendations for consideration.
- Feasibility and cost effectiveness of linking with huge network of private corporate status laboratories which are NABL accredited such as Thyrocare, RPG, SRL, Metrocare etc to capture data from private and affluent sector of the community.
- Whether to introduce minimal laboratory investigations in TI site to begin with for core groups and projects having static clinics under the directions of Regional or State reference centres: programme implications, feasibility and .
- To look into the possibility of strengthening mobile medical units who can undertake minimal laboratory tests as part of the package of tests to be delivered.
- Feasibility of inclusion of national level surveillance for STI as part of national HIV sentinel surveillance

Discussion Point 9

Revisit the appropriateness of the estimates of STI/RTI burden on the basis of available data in the country.

Burden of disease, estimates –

2002/03 CSTI study suggested a prevalence of 5% to 6% of STI/RTI among sexually active population. This results into about 30 million episodes every year. Of this, 10 million was considered as target both for NACO and NRHM including TI. The remaining 20 million, supposedly seeking care from private sector including organized public sector undertakings such as ESI/Railways/Defence etc. Program is achieving 100% of its target during the 4th year of NACP III. MTR team suggested a repeat study to understand the disease burden. BSS (2009), NFHS (2009), RAS conducted by ICMR (2005) have shown considerable sexual and reproductive morbidity in the country. MTR team conducted desk review of literature, filed visits to certain select states and analysed the passively collected CMIS data and concluded that the program targets were appropriate and may be revisited for revision if any new findings emerge for planning NACP IV. A study was suggested, which was not taken up due to high costs. The team also observed that there is no single scenario and there is wide variation across states and mostly concentrated among HRGs.

Recommendation/ Points for further discussion:

- The sub group reviewed midterm review findings which states that the programme targets were in accordance to the available evidence. The group also felt that there is no evidence to state that the 2002 – 3 was inappropriate for programme planning.
- Since the available evidence and observed that there was no uniformity of methodology across studies. Hence it is suggested to develop a forest plot analysis of all studies.
- Majority of the studies are laboratory based while the programme is syndromic based. Hence the group suggested revisiting the raw data of 2002 – 3 study, match the prevalence rates of individual STI with the metaanalysis findings of the desk review and observe points of deviation and correlation.
- The group also recommended to have syndromic estimates using 2010 – 11 CMIS data.
- The group has created a small working committee consisting of epidemiologist, clinician and researcher. The group will conduct the above mentioned steps and submit their report to the larger group during second meeting.

Discussion point 8

Identify programmatic thrust areas for taking up as OR activities under the programme

OR conducted in STI/RTI programme

As per the terms of reference of Regional STI centres developed during a consultative meeting in April 2009, the regional STI centres are expected to undertake one OR activity per year on programme related issues. Six of the seven centres have undertaken OR activity as per thrust areas identified during a subsequent consultative meeting held by NACO.

Recommendation

- The group recommended creating a small core committee to monitor and mentor Regional and State Centres' performance.
    - The core committee will act as an external quality assurance system, whose TOR will be defined by the programme division.
    - The core committee should consist of clinician, laboratory, programme and research/ epidemiology person.
    - The committee should be linked to the research activity with other organizations and agencies working with department of health research for optimization of resources and effective utilization.
    - The core group will look at the proposals submitted by regional centre, prioritize them, and select the study to be given to the regional centre after vetting.

- The group recommended supporting the activities of young residents in undertaking OR activities in close coordination of the four departments of Regional STI centre within the existing budgetary sanctions.
- Some of the suggested topics for conduction of Operational Research include

1. Sensitivity and Specificity of current national syndromic protocols among various population sub groups.
2. Different strategies for partner management
3. Re infection rate among index patients
4. Task shifting for STI/RTI management by nurses
5. Cost effective clinical service model for MSM, Migrants
6. Private sector involvement / Public private partnership to understand different needs of Ayush, Allopaths and RMPs.
7. Acceptance of HRGs to enhance health seeking behaviour
8. Different screening for HPV related morbidity for different population subtypes
9. Determine different issues raised due to convergence like condom use for HIV prevention vs. permanent family control methods
10. KAP of health care workers in Railways, ESIS, PSU etc. pertaining to STI to be done by concerned ministry
11. Pilot screening for Point of care testing for syphilis for ANM mothers who deliver at home
12. To understand the sexual and other health care needs of adolescents and their parents
13. Placing of package for Adolescents to be done in such a way that their needs and their parents' needs of sexual health/other relevant message are addressed. An OR to address these needs can be carried out.
14. Conduct OR on the sexual behaviour and sexual health needs of Intravenous drug users across four regions of the country, as there is no available data.

Discussion point 10

Develop strategies to scale up the programme achievements of reducing syphilis prevalence into elimination of congenital syphilis

Syphilis screening -

The programme recommends syphilis screening of all the STI/RTI clinic attendees as well as pregnant women attending antenatal clinics. The data suggests very low prevalence of syphilis among pregnant women and the next logical step could be the possibility of introducing

elimination of congenital syphilis. Syphilis is easily diagnosable , treatable and curable bacterial STI and at the same time, is easily missed due to screening not being done. There are many simple screening test are available which will help to screen ANC attendees even in remote and rural field areas. Simple training is all that is needed to empower grass root worker to use these tests. Currently, screening of ANC attendees is largely limited to hospitals where DSRCs are, located. The screening can be scaled up to all ICTCs including F-ICTCs to cover larger number of ANC.

Recommendation

- Reaching the goal of congenital syphilis elimination entails a strong focus on institutional delivery and scaling up of syphilis screening and should be an RCH priority. Hence there is need for a focussed convergence between NACO and MH division to achieve the same. NACO with its expertise in programme implementation should share their technical experts with MH division to design, implement and monitor systems for screening, treatment, follow up to ensure cure of infected pregnant woman, her spouse and the newborn.
- Both the divisions should consider introduction of point of care testing of syphilis as a strategy to reach larger numbers of pregnant women across the country, especially pregnant women residing in difficult to reach rural, desert, high altitude and tribal areas. All sera found reactive with POC must be subjected for further testing with RPR/VDRL test to understand infectiousness and to enable follow up of the individuals for cure.
- NRHM should incorporate sufficient funds to procure syphilis screening kits to begin with these kits can be introduced across all those facilities where currently pregnant women are screened for HIV. is not for screening syphilis some states are mandatorily screening for syphilis. Universal screening of all pregnant women is essential for elimination of congenital syphilis. But for this we need to have that many labs.
- All ANMs/ sub-centre level functionaries should be trained to use Point of Care testing in convergence with NRHM.

Points for further discussion:

- Need to conduct OR to understand whether a linkage with the private sector, Janani Suraksha Yojana or other programmes could be established to reach all the deliveries
- Role of Public private partnership to cover the deliveries in private sector

Discussion Points 11

Suggest channels (IEC/BCC) for communications on STI management services for increasing demand

Demand Generation

STI division in consultation with IEC division has developed and disseminated program specific job aids and IEC material for patient education. Simultaneously mass media campaign through radio and TV has been undertaken. DSRCs have been branded as ***Suraksha clinics*** across country. The same material is also used across TI projects.

Recommendations:

- BCC tools explaining RMC, speculum examination, proctoscopy, presumptive treatment, syphilis screening etc should be developed and used in TI to reduce myths and misconceptions; fears and phobias related to these among HRG.
- IEC materials should be developed to address gaps like partner treatment, and also perceive risk and benefit in undergoing treatment.
- All IEC material must be undergo prior pretesting.
- There should be specific material for specific populations.
- The group emphasized the need for proper packaging of IEC material and adding messages on issues such as infertility, cancer care, substance abuse, etc so as to destigmatise SRH.
- The entire IEC BCC material should link and articulate existing implementing grass root level workers such as link workers, ASHA, AWW, SHG, VHND committees etc as a primary source of further information to community.
- Transgender group requested for specific referral directory providing specific information related to silicone implantation, hormone replacement therapy, sex reconstructive surgeries as well as poster on drug interactions between the STI/RTI medicines, ART, hormones and general medicines. and inclusion of the same in training curriculum of the providers.

Discussion point 12

Recommend effective cross-linkages of RTI/STI with other HIV prevention and care and support programmes

Referrals and Linkages –

Till 2nd phase of NACP the STI clinics operated as standalone structures. In3rd phase, the program has linked STI with RTI, thus both Gynae and STI departments function together for a comprehensive service delivery. Apart from this, DSRCs have been linked with ICTC, PPTCT, ART and TI projects. The referrals to ICTC helped the program to detect unidentified PLHIV among the DSRC attendees. The Counselor at DSRC is also encouraged to conduct weekly outreach with TI staff at hot spots and motivate the community to seek services from DSRC both STI consultation and Syphilis and HIV screening. The DSRCs are also linked with regional STI centres for lab assessment of patients and samples. All clients found sero reactive for HIV are linked with ART centre and responsibility jointly taken by ICTC and DSRC counselor.

Recommendations

- Referral linkages and outputs should be a part of dash board indicators for monitoring the programme at district, state and national level. The implementing unit should be provided with feedback based on observation.
- The primary responsibility of making the cross-referrals effective is with the counselors of the respective facilities, however the same should be regularly reviewed by the medical officer incharge, TI and the programme managers at SACS.
- NACO should take a policy decision and instruct all counselors at ICTC, PPTCT and ART to refer all clients with history of un-safe sexual behavior and all clients found reactive for HIV to STI/RTI clinic for a detailed history and examination.
- It was also recommended to introduce single prick Syphilis and HIV screening through single window at all HIV testing facilities in the country.
- The option of providing an exclusive counselor for Gynecology department based on the case load should be considered to improve the service delivery and cross referrals.

Points for further discussion:

- Discuss the feasibility/ effectiveness of providing STI/ gynae/ family welfare/ ARSH/ ICTC/ PPTCT/ post partum services through a common or closely linked platform as a strategy to enhance the reach and acceptability of services

Discussion point 13

Develop benchmarks for a quality assurance system for STI services in public and private sector.

Quality assurance -

The Operational Guidelines describes minimum standards of STI/RTI service delivery across all levels of service provision including DSRC, NRHM facilities and TI projects. To assess the quality of service delivery, a standardized supervisory checklist is used to assess STI service delivery. Regular review of CMIS data is done regularly and key observations and gaps identified are shared with SACS for correction. Twice a year review of program officers is conducted at national level to assure quality of program implementation. Similar review is also conducted twice yearly for STI counselors and medical officers at state level. STI division has developed a scoring system to differentiate and grade various SACS based upon their performance and regularly uses the same to evaluate their performance. In addition, a standard operating protocol has been developed for all the laboratory tests for diagnosis of STI/RTI and the Apex centre has developed benchmarks for Syphilis EQAS and Gonococcal antimicrobial sensitivity patterns as per GASP protocols along with supervisory tool for state reference centres. A system of supportive supervision has been developed wherein all service delivery sites are regularly visited and mentored and feedback provided for improvement.

Recommendations

- The group recommends that the simple standardized supervisory check list may be adapted for NRHM facilities in consultation with MH division. NRHM facilities are to be monitored twice a year. Instead of all facilities, a fraction of them may be visited. Priority should be given to hard to reach facilities, facilities lacking adequate space and staff.
- MH division has to circulate the minimum standards prescribed under the programme jointly with NACO to all NRHM facilities through their existing systems for adherence.
- A structured action plan needs to be developed for taking forward convergence between NACO and NRHM at central, state and district levels.
- NACO and MH division should have joint structured field visit plan and conduct review of implementation at state and district level, which hastens and sustains convergence activities.
- Follow up is difficult because the STI focal person is not in a power to negotiate with the supervisors and counter parts in SACS. JD STI would be a more appropriate person to talk to their counter parts.
- Quality assurance means to set right the mechanisms that are not working.
- Once in a quarter 25% of facilities once in 6 months 100% NRHM facilities visited by mentors are mandated to be visited by mentors who are faculty of Medical Colleges.

Every medical college has 4 mentors. However this one of the weakest activity. Other than community medicine people no one else is willing to take up field visits. To address this guidelines were made more flexible to include any agency or person interested and capacitated to mentor.

- The group recommended mandatory monitoring of coordination between the four departments (Gynecology, Microbiology, Skin/VD and PSM) on a monthly basis by SACS and atleast two times in the year by NACO in a regional manner.
- NRHM has to develop a strategy of monitoring STI/RTI service delivery in consultation with NACO, maybe as a part of existing quality control committees or it may be entrusted to a dedicated person at block/ district level. The technical experts of NACO to extend handholding support to MH division to set up this monitoring system.
- Quality Assurance of laboratories performing STI/RTI diagnostics is the whole and sole responsibility of State and Regional STI centres. They should have a structured key activity covering the laboratories upto district level.
- The group also suggested creating a small core committee of external experts from programme, clinical and laboratory, which will act as an external quality assurance system of laboratory diagnostics. NACO has to ensure that all the laboratories in the programme are adhering to the lab SOPs developed.

Points for further discussion:

- Linking of 45 state reference centres and 7 regional centres with GASP programme of WHO: Feasibility and cost effectiveness
- NABL accreditation of the 52 laboratories: Need and relevance
- Strengthening of laboratories: additional manpower, budget and equipment: Need and relevance

Discussion point 14

Assess technical support needs and recommend measures for capacity building and supportive supervision for both public and private sector

Technical support -

STI division in NACO has been strengthened during NACP III since it was a weak area identified under NACP II. The division comprises of Deputy Director General who heads the division and is supported by one Deputy Director, one Assistant Director. The division is receiving able technical assistance through two Technical Experts of National Technical Support Unit and work in close coordination with the division as a team. There are one or two STI focal persons in SACS (totaling to 60 sanctioned posts at the level of Deputy Director and/or Assistant Director), of which 33 posts are filled. They are supported by Programme officer STI in Technical Support Units in 12 states. These national and state teams are supported by national, state and regional mentors and resource faculty, who are mostly from medical colleges and organizations, who are trained and focused on STI/RTI programme. The present system is enough only to cater to the monitoring and support needs of the NACO supported facilities (DSRC and TI).

Recommendations

- In view of recommendation that NACO should provide Technical support to NRHM to ensure effective implementation of programme upto sub-district level, technical Technical support from NACO needed and the modalities need to be worked out
- There is a need to rationalize and optimize available resources
- There should be an increase in the level of seniority of the STI focal person at state and also the person assigned the task of monitoring the programme under NRHM should also be of sufficient seniority to be able to effectively liaise with both the departments.
- The training curriculum, plan and calendar under the STI programme should involve identified training institutes in the government under heatlh programmes such as HFWTC, District training centres, ANMTC etc for optimal utilization of available resources. The capacity of staff of these institutes should be built as trainers in addition to existing pool.
- The programme implementers at district level like the medical officer incharge of DSRC, District RCH officers person in the clinic should be trained as resource person at the district.

Points for further discussion:

- The programme has invested on two technical experts at the national level and on similar support of 19 positions at state level. Currently the programme needs are greater and cannot be met with the existing team. In convergence with NRHM, the number of facilities to be monitored and requiring technical assistance has increased enormously from 1000+ DSRCs , 1500 + TI Projects , 4000 PPP to nearly 26000 additional facilities under NRHM. In the light of the above, modalities to provide the monitoring, technical

and mentoring needs of the scaled up programme require to be proportionately scaled up. Hence, the group should deliberate and suggest strategies.

- Feasibility and cost effectiveness of involving additional institutions and organizations with the capacity for capacity building, monitoring and mentoring due to shortage of human Resources at the Medical Colleges to provide technical/ mentoring support to the facilities.

Discussion point 16

Suggest innovations in implementation

Recommendations

Note: Innovation being a cross cutting issue across all discussion points of the TOR, the recommendations made under the various discussion points are summarized below.

- Programme should consider moving towards "Elimination of CONGENITAL SYPHILIS" in view of consistently reported low positive rates among pregnant women.
- The group recommended to introduce Point of care testing for syphilis to cover hard to reach pregnant women, HRG and bridge population to upscale the uptake of syphilic screening.
- The group recommends to conduct a baseline (2011-12) and endline (2016 – 17) community based study across the country to provide the insight into the epidemiologic situation of various STI/RTI among various population sub-groups.
- Introduction of Community monitoring mechanisms for both NACO and NRHM.
- The group recommended linking with disaster management teams at all levels to address the issues pertaining to sexual health needs of the displaced populations.
- The group recommends to conduct OR on the sexual behaviour and sexual health needs of Intravenous drug users across four regions of the country, as there is no available data.
- The group recommended to link the STI programme with cancer screening programme to detect early HPV induced malignancies.
- The group recommends to link the STI programme with UIP for HBV vaccination for HRG and DSRC attendees.

- The group recommended short term epidemiological orientation for programme division in consultation with ICMR at institutes such as NARI, NIE, etc

Issues for further discussion:

- Scope and feasibility and cost effective modalities of screening HPV related morbidity among HRG and DSRC attendees
- Scope and cost effectiveness of introducing HBV screening and vaccination at HRG and DSRC attendees.