STI CLINIC SUPERVISORY HANDBOOK

Comprehensive STI services for Sex Workers
in Avahan-Supported Clinics in India

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List of Abbreviations

BX	Biopsy
CT	*Chlamydia trachomatis*
CMIS	Computerized Management Information System
COGS	Clinic Operational Guidelines and Standards
CXR	Chest X-ray
DMC	Designated Microscopy Center
DOTS	Direct Observed Therapy Short Course
FNAC	Fine needle aspiration biopsy
GC	*Neisseria gonorrhoeae*
ICST	Immunochromatography Strip test
ICTC	Integrated Counseling and Testing Center
IEC	Information, Education and Communication
INP+	Indian Network of Positive People
HIV	Human Immuno-deficiency Virus
KP	Key population
NGO	Non-government organization
ORW	Outreach worker
RPR	Rapid Plasma Reagin
SCM	Syndromic case management
SLP	State Lead Partner
SOP	Standard Operating Procedure
STC	STI Technical Coordinator
STI	Sexually Transmitted Infections
RNTCP	Revised National Tuberculosis Control Program
TB	Tuberculosis
TU	Tuberculosis Unit
WBC	White blood cells

Introduction

Supervision is the process of directing and supporting staff so that they may perform their duties more effectively. There are many functions of supervision, including motivating and training staff; sharing data and guidelines; monitoring and evaluating staff performance; managing day-to-day challenges; and facilitating organizational support.

This handbook provides a quick reference to the principles and processes of effective supervision. It is intended to help supervisors work together with the clinic staff to provide the best possible services for the key population.

Section One

PRINCIPLES OF SUPERVISION

Chapter One: Principles of Supervision

1. Supportive approach to supervision

In supportive supervision, supervisors focus on the needs of the staff they oversee which leads to improvement in staff performance than the traditional inspection and control approach. They enable staff to improve the quality of services, to meet the needs of the community they serve and to implement project goals.

Table A : Supervision styles

Traditional	Supportive
• Superficial • Punitive, fault-finding and critical • Focuses on individual, not process • Emphasizes past, not future • Not continuous	• Mentoring • Two-way communication • Focuses on process • Joint problem-solving • Ongoing

The supportive approach to Supervision includes:

1.1 Mentoring

Mentoring is an approach to supervision that seeks to achieve continuous improvement in staff performance through:

- **Motivation:** Believe in the person being mentored and praise his/her good work when it is deserved;
- **Modeling:** Serve as a role model in caring about quality of services and respect for staff and community members;
- **Practice:** Allow the staff you are mentoring to practice job and communication skills with your immediate feedback;

- **Constructive feedback:** Learn how to provide constructive feedback (see Chapter 3); and
- **Skills transfer:** Try to teach a new skill at every visit.

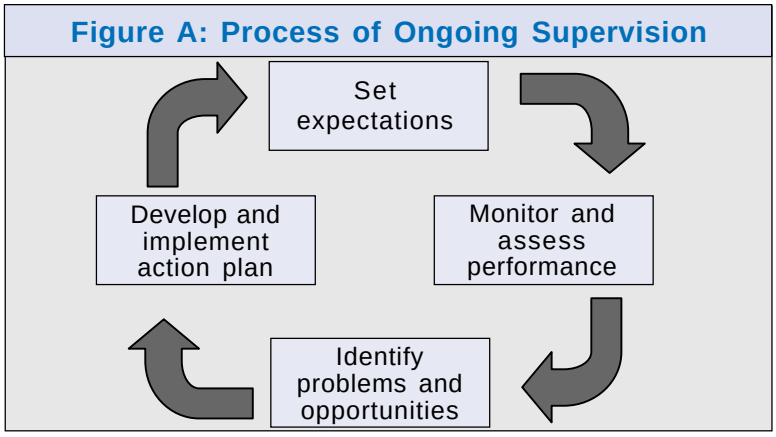
1.2 Ongoing supervision

Supervision is an ongoing action loop with four steps:

- **Set expectations-** Expectations for performance of Avahan STI clinics are clearly spelt out in the *Clinic Operational Guidelines and Standards (COGS)* and the *STI Clinic Handbook*;
- **Monitor and assess performance** through clinic visits, ongoing monitoring, analysis of reported data and feedback from the community;
- **Identify problems and opportunities** using a participatory approach to examine the potential causes and possible solutions; and
- **Develop an action plan** by motivating and supporting staff to implement interventions and activities to address performance gaps.

The actions agreed upon in step four then function as new expectations, and the process starts all over again.

Figure A: Process of Ongoing Supervision



Between supervisory visits, the staff should monitor their own performance and work to address the issues raised during the previous visit. They can continue with the supervision process through:

- Recording actions and decisions; and
- Ongoing monitoring of weak areas and improvements.

1.3 Supportive supervision beliefs

You, as a supervisor, are part of the clinic team. Each member of the team brings a different perspective. Being aware of this dynamic and respecting all the team members will enhance your working relationship with the clinic staff and naturally foster a participatory approach to supervision.

When taking a participatory approach to supervision, the supervisor believes that:

- Staff want to do a good job and will improve with encouragement;
- Supervisors can improve staff performance by giving them:
  - Responsibility;
  - Involvement in decision-making (not dictating); and
  - Opportunities to improve on mistakes.
- Staff become committed when they
  - Understand their roles and why they are important;
  - Receive positive feedback; and
  - Have the skills, knowledge and resources to perform their jobs.

1.4 Benefits of supportive approach

Supervisors who follow the principles of supportive supervision will find that:

- As staff learns to solve their own problems, you will have fewer routine, low-level problems to manage;
- Staff will be more motivated to follow through on agreed actions when they participate in decision making;
- You will be more welcome at clinics because you help solve problems, rather than criticize;
- Your job will be more fulfilling as your staff is motivated and committed; and
- You will gain a reputation as a leader, an effective supervisor and an enabler.

Chapter Two: Role of the Supervisor

The supervisor may be called upon to function in some or all of the following roles during a supervision visit:

- **Planner/Problem solver:** Working together with the clinic team, the supervisor facilitates the planning of activities and estimation of resources needed to solve the problems that arise;
- **Trainer:** The supervisor reinforces previous training attended by staff through on-the-job training, providing updated information and guidelines, and identifying further training needs;
- **Communicator/Coordinator:** The supervisor is in a unique position to facilitate communication and coordination between staff members; staff and community; and staff and SLPs. By listening to all problems that arise, the supervisor can give feedback and facilitate better understanding;
- **Motivator:** The supervisor can motivate clinic staff to perform better through recommending them for development or advancement and by praising them and recognizing their accomplishments;
- **Counselor:** Provide advice to staff when social, personal or job-related problems interfere with performance at work. The role of the supervisor is to first listen and then advise, guide and encourage the staff member to solve his/her own problems; and
- **Monitor/evaluator:** Assess the status of the clinic's performance in relation to the guidelines and standards, using direct observation of staff performance, records review, interviews, group meetings and inspection of supplies, materials and equipment.

Chapter Three: Communication Skills

Effective communication is a key skill for supportive supervisors. Two-way communication will facilitate problem-solving and help improve the quality of services at clinics.

Table B - Communication Styles

Supervision style	Tone	Communications	Role of supervisor
Traditional	Critical	One way	Police-like, inspector, critic
Supportive	Supportive	Two way	Facilitator, consultant, colleague, team member

3.1 Giving feedback

Feedback communicates to the clinic staff what they are doing well, where they need improvement and how they can improve. In reality, feedback takes place almost continuously during a supervisory visit.

✦ Supportive supervisors use:

- Positive feedback, when performance is good; and
- Constructive feedback, when performance needs improvement.

When a problem arises with a staff performance, start by determining the root causes of the performance gap.

- Does the staff member understand what's expected of him/her?
- Does the staff member have everything he/she needs to carry out the work?

- Does he/she receive clear and immediate performance feedback?
- Is he/she motivated to perform as expected?
- Does the staff member have the skills and the knowledge required for the job?

In consultation with the staff member (and other clinic staff, if appropriate), select interventions to address the causes. Make an action plan with clear steps and assign persons responsible for carrying out each task.

Follow up on your next visit and congratulate the employee on the improved performance, if appropriate. If there's no improvement, reassess the situation.

Table C : Six steps of constructive feedback

- **Choose appropriate timing.**
  - Choose a private moment – do not give feedback in public.
- **Convey your positive intent.**
  - Begin with a neutral statement about the topic.
    "Let's take a look at…." or "I'd like to discuss…."
  - Point to a common goal. e.g
    "Lakshmi, we need to get our statistical reports on time so we can use them to assess how well we're serving the community."
- **Describe specifically what you have observed.**
  - Focus on the behavior or action, not on the person. (e.g. "You are lazy.")
  - Avoid "you" statements.
    (e.g. "You were late with your reports.")
    Say it like this: "The reports were not submitted on time."
- **State the impact of the behavior or action.**
  - Link the behavior to program goals.
    "If we don't get the clinic reports on time, the MIS reports will be out of date by the time we get them back. Then we won't be able to use the information to improve our community coverage."
- **Ask the other person to respond.**
  - "What do you think?" "What is your view of the situation?"
  - Listen attentively, with encouragement.
- **Focus the discussion on solutions (the constructive part)**
  - Explore solutions jointly - try to avoid imposing the solution. However, you should be able to suggest a solution if the person cannot.

3.2 Managing group discussions

As a supportive supervisor, your goal is to help the NGO clinic staff learn to solve their quality-related problems by themselves. In order to do that, the staff will need to work as a team to address the problems as they arise.

Most staff have little experience of working effectively in groups. Working within the Avahan project may be the first time they've been asked to participate in groups with different levels of staff as well as key population (KP) members.

To work effectively with groups, you need to;

✦ Foster a non-threatening environment.

- Practice respect. Use good communication skills with everyone to show that all opinions are valued. Set ground rules (e.g. no interrupting, no accusing people instead of giving ideas, no sarcasm, etc.). Deflect or neutralize aggressive behavior.
- Establish confidentiality. This does not necessarily apply to all of the group's discussions, but may pertain to certain topics or types of interactions. An individual member may request that his/her comments should not be repeated outside the group.
- Meet in a comfortable physical environment, if possible. Pay attention to temperature, lighting, noise, seating and ventilation.
- Arrange the seating so that it fosters equality. Avoid creating positions of dominance (e.g. at the head of the table). Be sure everyone can see and hear each other.

✦ Encourage different levels of staff to work together.

- Providing quality services is everyone's responsibility. All levels of staff have a role in ensuring quality and have valuable insights and suggestions for how to do so. This is especially important in Avahan, where sometimes the sex workers' or KP's input is more valuable than the doctors'.

This is a new way of relating for many of the staff.

Higher level staff must learn to:

- Empower others in decision making and problem solving;
- Encourage discussion rather than give orders;
- Ask questions rather than presume to know;
- Listen to others' opinions with an open mind; and
- Believe that everyone has good ideas.

Lower level staff must learn to:

- Share their opinions in group settings;
- Take responsibility for their opinions;
- Express their feelings and be open to others';
- Ask for what they need;
- Negotiate support for their opinions;

Remember :

We are all in this together, and everyone has a valuable role to play.

To help the clinic staff break out of their hierarchical communication habits, you can lead the way in discarding traditional roles. You can model new behaviors. For example, you can offer to write brainstorming ideas on a flipchart, taking on the secretary's role. Or set up the chairs for the meeting, paying attention to the seating arrangement.

Model a respectful attitude toward all staff and use positive feedback. Encourage lower level staff to participate fully. Engage them, make eye contact if appropriate and encourage them with a nod and a smile while they are speaking.

✦ Encourage different types of people and personalities to work together and manage conflict.

Failure to manage personality differences and resolve conflict can have a negative impact on the group and interfere with its productivity.

Table D : Tips for managing different attitudes in group settings

If **interruptions** are frequent, disrespectful or disruptive:

- « Give the floor back to the first speaker
- « Rely on ground rules
- « Organize speakers in the order in which they asked to speak

To help shy **people participate:**

- « Give ample opportunity for everyone to speak.
- « Direct questions to introvert people from time to time.
- « Have everyone speak in turns.
- « Pay special attention and praise them when they speak.

To deal with **insulting comments:**

- « Confront the person and shift the discussion from the attacked person to the problem or idea.
- « Take the question to the group.
- « Ask the person to explain by giving specific information, not judgmental statements.
- « Take a break if two people are trading insults.

To deal with negative **comments and complaints:**

- « Ask the group whether they agree there's a problem.
- « Ask the complainer to give specific information about the criticism or complaint.
- « Ask the critic to offer a solution.
- « Focus the group on solutions, not complaints.

To manage domineering, extrovert and over talkative **personalities:**

- « Intervene.
- « Use body language.
- « Use the ground rules.
- « Interrupt and redirect the discussion.

Section Two

THE SUPERVISION VISIT

Chapter One: General considerations

✦ Supervision visits should be scheduled:

- Monthly at each clinic;
- In advance, at a time agreed upon with the clinic staff; and
- When the project coordinator/ director is available to attend the wrap-up meeting.

Prior to the visit, it is important to review the previous visit's report with particular attention to the action plan that was developed and other issues that were raised at that time.

✦ During the visit, the supervisor will:

- Gather information (using Clinic quality monitoring tool, clinic records and registers, CMIS generated reports);
- Follow up on problem areas and action steps identified during previous visit;
- Update staff on new guidelines or information;
- Give on-the-job training at every opportunity;
- Provide corrective and supportive feedback on performance; and
- Delegate responsibility to individuals to undertake the specific activities identified during the visit for proper clinic functioning.

Chapter Two: Tracking Quality of Clinic Services

Regular supervisory and technical support to the clinics staff is necessary to ensure the delivery of quality STI services consistent with the Avahan common minimum program and COGS. The clinic quality monitoring tool (see Annex 1) will be used to track the quality of STI services in the clinics against the COGS benchmark. This tool will give a snapshot of the quality of clinical services and will be used to strengthen STI services and identify capacity building needs.

The Clinic quality monitoring tool is designed to serve as a quick check in all areas of clinic and staff performance. If a problem is identified in a particular area, more in-depth observation and discussion of that area is required.

For more detailed information on guidelines and standards in each area, refer to the Clinic Operating Guidelines and Standards (COGS) and the STI Clinic Handbook.

In order to complete the clinic quality monitoring tool, the supervisor will:

- **Review**
  - Clinic reporting forms; and patient records; and
  - Minutes of coordination meetings between clinic and outreach staff.
- **Observe**
  - Clinic operations and compare to standard;
  - Infection control measures as carried out by staff; and
  - Doctor-patient interactions.
- **Inspect** physical premises and stocks

- **Interview**
  - Doctor and other clinic staff;
  - Outreach workers/peer educators;
  - Clinic manager; and
  - Patients and community members.
- **Record** findings on the clinic quality monitoring tool.

A detailed description of how to fill the clinic quality monitoring tool is provided in Annex 2. When the checklist is completed, the supervisor makes an assessment of the clinic performance and records his/her summary on the last page of the form.

Remember:
During observation, inspection and interviews, the supervisor should take every opportunity to mentor staff by transferring skills; modeling behaviors and communication skills; motivating staff; and providing constructive feedback.
It is essential that before clinic observations are done, the purpose of the observation is explained and the staff, key population (KP) and patients' agreements are sought.

Clinic Quality Monitoring Tool will monitor the following STI standards:

- Clinic performance indicators
- Community involvement and coordination with outreach
- STI clinical management
- Records and Reports
- Referral system and network
- Clinic operation
- Technical Support

The clinic performance indicators (A) are defined as follows:

A.1 Clinic Uptake = (Total number of KPs who visited the clinic at least once in past 6 months) / (Total number of KPs contacted through at least one service in past 6 months) x 100.

Numerator includes the total number of KPs (individuals) who visited the clinic at least once in past six months. This is irrespective of the reason for visit (e.g. general or STI consultation). Individual is counted only once.

Denominator includes all the KPs (individuals) who have come in contact with the program at least once in the past six months. The contact could be with either in the outreach or in the clinic or both. Individual is counted only once.

A.2 Clinic orientation to key population = (Total number of clinic visits by KPs in the previous month) / (Total number of clinic visits in the previous month) x 100.

This indicator only measures the orientation of Avahan clinic services towards the KPs.

Numerator includes the total number of clinic visits by KPs (not the number of individuals), irrespective of the reason for clinic visit.

Denominator includes the total number of clinic visits by KPs and non KPs (not the number of individuals), irrespective of the reason for clinic visit.

A.3 Clinic orientation to STI = (Total number of STI visits by KPs in the previous month) / (Total number of clinic visits by KPs in the previous month) x 100.

This indicator measures the orientation of the clinic services towards STIs.

Numerator includes the number of STI visits by KPs (not the number of individuals). STI visits include the following:

a) STI symptoms visits : The KP complained of symptoms of STI and was treated accordingly.

b) STI checkups : The KP does not complain of STI symptoms but receives genital examination which may include speculum or proctoscope examination and/or STI asymptomatic or symptomatic treatment. The KP came to the clinic for general health complaints or non STI reasons and received genital examination which may include speculum or proctoscope examination. This will also include those KPs who came for serologic test for syphilis.

c) STI follow-ups : The individual returned to the clinic within two weeks of last treatment for a review by the doctor for the previous STI episode.

   This may happen for many reasons such as symptoms not cleared, allergic to medicines, a review by the doctor, etc. If the individual visits the clinic more than two weeks after the last visit to the clinic, it is not a follow-up visit.

A.4 Clinic performance on monthly STI checkups = (Total number of KPs provided with Regular Monthly Checkup (RMC) in the previous **three** months ÷ **3**) / (Total number of KPs contacted by at least one service in last 6 months) x 100.

Regular Monthly STI checkup is also termed as regular health checkup or regular medical checkup by various SLPs.

RMCs are clinic visits by KPs for their routine STI screening, in the absence of STI complaints. KPs are provided with

genital examination which may include speculum or proctoscope examination and/or STI treatment.

The denominator includes all the KPs contacted by any service in the last six months.

A.5 Clinic performance on asymptomatic GC/CT treatment = (Total number of **new** KPs or KPs returning after six months provided with GC/CT treatment in the previous month) / (Total number of new KPs or KPs returning after six months contacted in the previous month) x 100.

Numerator includes the number of newly contacted (by any service) KPs or KPs returning after six months provided with GC/CT treatment in the previous month, irrespective of the reason for treatment.

Denominator includes the total number of new KPs or KPs returning after six months contacted by any service in the previous month.

A.6 Clinic performance on syphilis screening = (Total number of KPs who underwent syphilis screening (RPR/ICST) in previous 6 months) / (Total number of KPs contacted through at least one service in last 6 months) x 100.

Numerator should include the individuals (if a KP has undergone the RPR test more than once, she is to be counted only once) who underwent syphilis screening (RPR/ICST) in the previous six months.

The denominator includes the total number of KPs contacted by the program through at least one service in the last six months.

A.7 RPR/ICST positive KPs started on treatment = (Number of RPR/ICST positive KPs started on treatment

in last 3 months) / (Total number of KPs newly diagnosed as RPR/ ICST positive in last 3 months) x 100.

Numerator includes all those KPs who were started on Syphilis treatment in the last 3 months.

Denominator includes all those KPs who were newly diagnosed to be RPR/ICST positive. Do not include those who received a follow up RPR and had a lower or same RPR titre. However, include those who had a higher or rising RPR titre at follow up.

The following process will be carried out to document the findings:

- STI Coordinators (STCs) will fill up the clinic quality monitoring form. Scores will be calculated for each indicator (e.g. A1, 2, 3…..B1, 2 …) under all components (A to F) based on the formula. This score would range from 0-5, 0 being poor and 5 indicating an outstanding performance.
- STCs will transfer the score to the summary sheet, complete summary sheet and file it.
- The clinic scores will be calculated under three main headings. They are :
  - **I. Clinic performance**: It includes score of category **A** in the clinic quality monitoring tool.
  - **II. STI clinical management**: This includes score of category **C** in the clinic quality monitoring tool.
  - **III. STI clinic system management**: This includes the scores of variables **B, D, E and F** from clinic quality monitoring tool.
- STCs will transfer the information to the quarterly tracking sheet and submit to the SLPs for collation.

Chapter Three: Laboratory supervision

In clinics with on-site laboratory services, supervision visits will include a check of laboratory functioning. A laboratory checklist is provided in Annex 3.

N.B. The monthly supervision visits conducted by the STI technical officer do not substitute for internal quality control and external quality assurance systems required at all Avahan Project laboratories. This applies to both referral laboratories and on-site clinic laboratories.

Chapter Four: Wrap-up meeting

At the conclusion of the visit, the supervisor will conduct a meeting with the NGO project coordinator, clinic staff, outreach team and selected peer educators to:

- Review his/her assessment of clinic operations;
- Reinforce guidelines;
- Mentor staff; and
- Facilitate joint problem-solving using a participatory approach.

The wrap-up meeting will ensure that the entire team is involved in the quality assurance of the clinic and actively follows up between supervisory visits.

- **During wrap-up meeting:**

- Share new information, such as guidelines, and training opportunities;
- Discuss progress on action steps agreed upon at the last visit;
- Review the monthly data report for the clinic and how it compares to expectations;
- Discuss findings of the assessment carried out at the current visit;
- Agree upon a list of current problem areas;
- Agree upon action plan to address problem areas using a joint problem solving approach;
- Identify persons responsible to solve the identified problem; and

- Schedule next visit.

A form for recording the outcomes of the wrap-up meeting is included in Annex 4. If possible, leave a copy of the wrap-up meeting report with the clinic staff and keep the original for your records.

The wrap-up meeting report in combination with the completed clinic quality monitoring tool will serve as a report of the visit.

Section Three

MONITORING AND REPORTING DATA

Chapter One: How to use monitoring and reporting data?

When used effectively, the Computerized Management Information System (CMIS) can be a valuable tool for guiding decisions on clinic policies and procedures, identifying staff training needs and designing strategies to improve service utilization by the sex worker community.

Regular review of the computer-generated monthly report for each clinic will provide information on how well the clinic is reaching the key population and serving their STI prevention and treatment needs.

To ensure that statistics are relevant to the current situation, the clinic report should be reviewed monthly. It is also required that an efficient reporting system should be in place and the following steps are carried out in a timely fashion:

- Submission of clinic data to state-lead partner;
- Data entry;
- Analysis; and
- Distribution of reports to technical staff and clinic-based staff.

Chapter Two: Interpretation of selected clinic performance statistics

Data from the daily STI registry (see Annex 5) will be analyzed by deriving the indicators listed below. These will provide information on the clinic performance. They should be discussed with the clinic team at the time of the supervisory visit.

NOTE: Indicator values depend on multiple factors. Before making assumptions about the reasons for low indicator values, it may be necessary to go back to the monthly CMIS to check other data or to discuss the determining factors with the NGO and clinic staff. Some of the possible causes for low indicator values are discussed in the individual sections below.

Consider all possible explanations and problems when trying to understand the meaning of the indicator value. Then, using a participatory approach with clinic staff and community members, develop a joint action plan to address the identified issues.

✦ Are KPs coming to the clinic?

● Indicators

- ▲ *Monthly clinic uptake* measures the number of individuals receiving STI services for the first time during the past month.
- ▲ *Cumulative clinic uptake* measures the proportion of the contacted sex worker population attending the clinic at least once since the beginning of the project. It is calculated as the percentage of the contacted population that has ever received STI services through the project.

- *Trends in monthly and cumulative uptake* over the past six months.

- **What to look for**
  - Ultimately, the pr oject goal is high coverage rates in all clinic intervention areas. To reach this target, high *monthly uptake rates* (enrolling new attendees in the clinic) are needed each month. This will result in steadily increasing *cumulative clinic uptake*.
  - However, as the cumulative uptake approaches its maximum level, (approximately 80% and above), the *monthly uptake rate* will plateau and then decrease since there are fewer KPs who have not yet received STI services at the clinic. At that point, the outreach focus should shift to increasing regular monthly checkups.

- **What to do if results do not meet expectations**
  - If the trend graph shows a slower than expected rise or is leveling off at a low level of *cumulative clinic uptake*, raise the issue in the wrap-up meeting during your supervisory visit.
  - There are many possible reasons for low uptake that are specific to the situation of the individual clinic. Explore community perceptions of the clinic, patient satisfaction, community involvement and effectiveness of outreach and education in the community, etc. The problem may be within the clinic, in the outreach approach, or barriers to accessing the clinic.

- Another possible explanation for low uptake may be a rapidly increasing denominator. If large numbers of new KPs are being contacted early in the project, or if there is a rapid turnover in the sex worker population in the intervention area of the clinic, the large number of contacted KPs may cause the calculated percentage of KPs attending the clinic to be temporarily low, even when the clinic is showing good attendance.

How busy is the clinic?

Indicators

- *Total number of STI consultations* done over the past month.
- *Total number of general health consultations* over the past month.
- *Overall total number of consultations*.

What to look for

- Early in the life of the clinic, the numbers should increase each month. Later, they should stay the same or increase slightly.
- Use the number of consultations to assess adequacy of staffing, logistic support, working hours and space available in the clinic.

What to do if results do not meet expectation

- If the clinic fails to become busy or if attendance drops, the possible reasons could be similar to those for low clinic uptake.

✦ Are the clinic services appropriately oriented?

- **Indicators**
  - *Percentage of patients who are KPs* (N.B. This will not appear on the CMIS report. You must obtain the number from the clinic records directly.)
  - *Percentage of STI related clinic visits by KPs.*
- **What to look for**
  - Almost all patients should be KPs and the vast majority of visits should be STI consultations.
  - While non-sex worker visits and general health consultations may be necessary until the clinic establishes a reputation within the key population, the monthly statistics should show a trend toward more STI visits for KPs. Keep in mind that the overall goal of the Avahan project is to provide STI services to KPs.
- **What to do if results do not meet the expectations**
  - Discuss the issue in the wrap-up meeting. The issues affecting the orientation of services are similar to those already discussed for uptake.
  - If KPs are not attending for STI services it may be due to negative community perceptions about the clinic services, poor knowledge of STI symptoms, or inadequate health-seeking behavior for STIs.
  - Some of the responsibility may lie with clinic staff - are they taking every opportunity to carry out a STI check-up? Even if a sex worker comes with

a non-STI complaint, he/she should be asked about STI symptoms. A regular STI checkup can be done at that visit, with or without symptoms present.

✦ Are KPs regular checkup visits increasing? Record the following:

- **Indicators**
  - ▲ *Proportion of recent clinic attendees who received STI clinic services monthly and at least once every three months*.

    NOTE:

    1) The percentage attending at least once every three months includes those attending monthly.
    2) The monthly attendance is calculated for the preceding three months and the quarterly attendance is calculated for the preceding six months.
  - ▲ Check the *trend over time for both proportions*.
- **What to look for**

  Increasing proportion of the recent clinic attendees who return for clinic STI services regularly.
- **What to do if results do not meet expectations**
  - ▲ Raise the issue at the wrap-up meeting to explore the reasons behind the low number of regular checkup visits. Since the concept of attending the clinic for monthly checkups in the absence of symptoms is new to the key population, changing

their health seeking behavior will depend on education, by both clinic and outreach staff, as well as on community perceptions of the clinic.

- Once the issues are identified, develop an action plan to address them using a participatory approach.

✦ Are new KPs or KPs returning after six months receiving treatment for gonorrhea and chlamydia during the first visit?

● Indicators

This indicator is calculated for the previous month.

- *The proportion of individuals attending the clinic for the first time or returning to the clinic after six months and received treatment for gonorrhea and chlamydia.*
- *Trend over the past six months.*

● What to look for

This statistic measures the number of KPs attending the clinic for the first time or those who returned to the clinic after six months and received STI treatment 1 or 5, for whatever reason (asymptomatic or symptomatic treatment). Clinics should approach 100% on this indicator. If the proportion of KPs receiving treatment for gonorrhea and chlamydia during the period is low (<95%), explore the reasons.

● What to do if results do not meet expectations

- Raise the issue at the wrap-up meeting. Possible problems could include inaccurate recording, drugs

stockouts and resistance of staff to give asymptomatic treatment. If the reason for not giving treatment is patient refusal, explore the community perceptions of the treatment and its reported side effects.

- Once the issues are identified, develop an action plan to address them using a participatory approach.

✦ Is syphilis screening being done? Record the following:

- **Indicators**
  - *Number of individuals screened for syphilis with ICST/ RPR test over the past 6 months.*
  - *Proportion of KPs that attended the clinic at least once in the past 6 months that received an ICST/RPR test at least once.*

  This measures routine six-monthly syphilis screening.
- **What to look for:**
  - The *number of ICST/ RPR tests* should remain steady or increase each month, depending on changes in the number of clinic visits.
  - The *proportion of regular attendees receiving six monthly RPR tests* should approach 100%. However, a few KPs may not be due for an RPR test if they attended only once in that period and it has been less than six months since their last test.

- **What to do if results do not meet expectations**
  - If the *number of tests* is lower than the previous month or low overall in relation to the number of STI visits and/or less than 95% of clinic attendees were not tested for syphilis in the past six months, you will need to explore the reasons why.
  - Possible factors include the number of KPs attending the clinic regularly, the consent of the patients, laboratory capability (staff and reagents, or referral laboratory arrangements), and doctor's recommendation for testing. In addition, community resistance to blood tests or fear of being tested for HIV without their knowledge may contribute to a low rate of syphilis testing.

✦ Is the duration of symptoms decreasing?

- **Indicators**
  - *Proportion of symptomatic STI visits for repeat attendees with more than seven days duration of symptoms on repeat visits.* (This indicator is limited to repeat visits to allow for the effect of peer education and education by clinic staff on the first visit.)
  - *Trend over the past six months*
- **What to look for**
  - Duration of symptoms prior to consultation decreasing over time.

- **What to do if results do not meet expectations:**
  - The duration of symptoms is a marker of treatment seeking behavior. If the *proportion of KPs presenting to the clinics with symptoms of longer than 7 days duration* is increasing or not decreasing over time, raise the issue at the wrap-up meeting.
  - Areas to consider are content and delivery of health education messages, community perception of the clinic, self-treatment, visits to unqualified health care providers, quality of STI services and other barriers to access, such as lack of time-off from the brothel, inconvenient clinic opening hours, etc.

✦ Are STI patients receiving correct treatment?

- **Indicators**
  - *Percentage of patients treated correctly for each syndrome*
- **What to look for**
  - The *percentage of correct treatment for each syndrome* should be high, but may not reach 100% due to extenuating circumstances.
- **What to do if results do not meet expectations**
  - If low percentages are seen, explore the issue further. Check whether the problem is incorrect recording, drugs out of stock, patient refusal, side-effect profiles, doctor's knowledge, etc. and address the problem directly. If the problem is doctor's knowledge, on-the-job training may suffice, or possibly a training update for the doctor may be required.

Annexes

Annex 1: STI Clinic Quality Monitoring Tool

Standards for Monitoring Quality of STI services

A. CLINIC PERFORMANCE

Clinic Performance (See explanatory notes for guidance on calculating standards A.1 to A.7 below)		
1	**Clinic Uptake** = (Total number of KPs who visited the clinic at least once in the past six months) / (Total number of KPs contacted through at least one service in the past six months) x 100.	
2	**Clinic orientation to KPs** = (Total number of clinic visits by KPs in the previous month) / (Total clinic visits in the previous month) x 100.	
3	**Clinic orientation to STI** = (Total number of STI visits by KPs in the previous month) / (Total clinic visits by KPs in the previous month) x 100	
4	**Clinic performance on monthly STI checkups** = (Total number of KPs provided with STI checkup in the previous **three** months ÷ 3) / (Total number of KPs contacted by at least one service in past 6 months) x 100.	
5	**Clinic performance on asymptomatic GC/CT treatment** = (Total number of **new** KPs or KPs returning to the clinic after six months provided with GC/CT treatment in the previous month) / (Total number of new KPs or KPs returning after six months contacted in the previous month) x 100.	
6	**Clinic performance on syphilis screening** = (Total number of KPs who underwent syphilis screening (RPR/ICST) in the previous 6 months) / (Total number of KPs contacted through at least one service in last 6 months) x 100.	
7	**RPR/ICST positive KPs started on treatment** = (Number of RPR/ICST positive KPs started on treatment in last 3 months) / (Total number of RPR/ICST positive KPs diagnosed in last 3 months) x 100.	

Calculate score using formula: Score = indicator percentage/20

B. COMMUNITY INVOLVEMENT & COORDINATION WITH OUTREACH

Score	N/A	0	1	2	3	4	5

Method: Interview of program/clinic staff & review of records

	Yes	No	Notes
Peer/ORW follow-up KPs for STI services			
KP involved in clinic operations - infection control, registration			
DIC functional - scheduled activities managed by community			
Weekly meetings/ forum for clinic and outreach staff to interact and documented			
Community clinic monitoring system exists / clinic advisory committee provides recommendations and these are acted upon			
Score = Total no. of Yes			

C. STI CLINICAL MANAGEMENT

Score	N/A	0	1	2	3	4	5
1. Clinic Staffing and Training							

Method: Interview of clinic staff and program staff

	Yes	No	Notes
Qualified (MBBS) doctor in position			
Doctor trained on SCM and COGS > 2 days (16 hrs)			
Nurse in position			
Nurse trained on job responsibility > 1 day (8 hrs.)			
Counselor in position			
Counselor trained on counseling and COGS > 2 days			
Score = (Total Yes x 5) / 6			

Score	N/A	0	1	2	3	4	5
2. Physician Clinical Performance							

Method: Observation and interview of physician

	Yes	No	Notes
Approachable, friendly and non judgmental			
Adequate history taking (present history, sexual history).			
Proper physical examination (Including Speculum & Proctoscopic exams).			
Administer Syndromic Treatment (first line treatment - including Benzathine Penicillin injection.)			
Explain compliance, condoms, contact tracing and follow-up			
Score = Total no. of Yes			

Score	N/A	0	1	2	3	4	5
3. Nurse Performance							

Method: Review of records and interview of nurse

	Yes	No	Notes
System to track monthly medical check-up and follow-up available			
Able to tell or show speculum decontamination			
Supervised treatment is provided			
Explain drug compliance and promote condoms after STI consultation			
Score = Total no. of (Yes x 5) / 4			

Score	N/A	0	1	2	3	4	5
4. Counselor Performance							

Method: Interview of counselor

	Yes	No	Notes
Maintains confidentiality and proper documentation of counseling			
Promote the essential service package for sex workers			
Explain 4'Cs (compliance, condoms, contact tracing, counseling)			
Explain risk reduction counseling (assess risk and barriers, provide options, risk reduction plan, condoms)			
Define informed choice for HIV testing (explain benefit and risk of HIV testing)			
Score = Total no. of Yes			

Score	N/A	0	1	2	3	4	5
5. Correct STI Case Treatment (SCM & PT)							

Method: Randomly select 10 patient records of present quarter and verify

Circle correct treatment and cross (X) incorrect treatments	1	2	3	4	5
	6	7	8	9	10
Score = Total correct treatments / 2					

Score	N/A	0	1	2	3	4	5
6. Completeness of Patient Record							

Method: Randomly select 10 patient record and review

Circle on complete and accurate records and cross (X) inaccurate or incomplete record	1	2	3	4	5
	6	7	8	9	10
Score = Total complete and accurate records / 2					

Score	N/A	0	1	2	3	4	5
7. Laboratory Systems for Syphilis Screening							

Method: Observation and interview of lab person. This is applicable to both clinic based and referral laboratories

	Yes	No	Notes
Laboratory personnel trained on issues related to syphilis screening (RPR, ICST)			
Laboratory SOPs available			
Laboratory internal quality assurance system in place			
Laboratory external quality assurance system in place			
Proper handling, storage and disposal of specimens and reagents			
Score= Total no. of Yes			

D. REFERRAL NETWORK

Score	N/A	0	1	2	3	4	5
1. Referral System & Networks							

Method: Review of records and interview of clinic and program staff

	Yes	No	Notes
Referral directory available and up-to-date			
Referrals documented (register available and up-to-date)			
Formal linkages with HIV testing			
Formal linkages with HIV care and support (including INP+)			
Referral outcomes are followed up			
Score= Total no. of Yes			

Score	N/A	0	1	2	3	4	5
2. RNTCP linkage							

Method: Review of records and interview of clinic and program staff

	Yes	No	Notes
Clinic staff trained on RNTCP			
Clinic staff / NGO attend district/TU level RNTCP meeting regularly			
Clinic has formal linkage with designated microscopy center and other diagnostic center (FNAC/BX/CXR) in the district			
Clinic staff has follow-up mechanisms to ensure that the KPs who are TB suspects complete the diagnostic procedures for TB (3 sputum test and additional tests if required for sputum negative cases)			
Clinic staff ensure that all the KPs diagnosed with tuberculosis are started on TB treatment			
Avahan TB record is filled correctly and submitted to STI CB monthly			
Score= Total no. of (Yes x 5) / 6			

E. CLINIC OPERATION

Score	N/A	0	1	2	3	4	5
1. Clinic Set-up							

Method: Observation and interview of clinic staff

	Yes	No	Notes
Visual and auditory privacy			
Clean and tidy			
Well equipped (speculum, proctoscope, condoms, IEC, exam table and light)			
Clinic signage with appropriate messages and posters in appropriate location			
Score= Total no. of (Yes x 5) / 4			

Score	N/A	0	1	2	3	4	5
2. Infection Control & Waste Management							

Method: Observation and interview of clinic staff

	Yes	No	Notes
Hand washing facility at the site of exam, gloves used in speculum exam			
Proper disposal of sharps (puncture proof containers, needle cutter)			
Proper sterilization of speculums & proctoscopes			
Segregation of waste and proper decontamination before disposal			
Available biohazard waste disposal system			
Score = Total no. of Yes			

Score	N/A	0	1	2	3	4	5
3. Drug and Condom Supply Management							

Method: Review of records and observations

	Yes	No	Notes
Essential STI drugs/kits and condoms available - not expiring, no stock-outs in past 3 months			
Anaphylaxis kit available (drugs within expiry dates) and properly located			
Drug inventory list available, up-to-date and tallies with stock			
Drug re-order level guidelines available in the clinic			
Drugs arranged systematically by expiry dates			
Score = Total no. of Yes			

Score	N/A	0	1	2	3	4	5
4. Documentation and Reporting							

Method: Review of records

	Yes	No	Notes
Individual patient' s records filed systematically and retrievable			
Clinic registers are complete and up-to-date			
Variables in clinic registry filled based on COGS/Avahan definition			
Reports are submitted timely			
Clinic data analyzed and utilized			
Score = Total no. of Yes			

Score	N/A	0	1	2	3	4	5
5. Ethical Standards and Confidentiality							

Method: Observations

	Yes	No	Notes
Confidentiality maintained at all stations (eg. HIV status etc.)			
Confidentiality agreement signed by staff			
Confidentiality policy and patient's rights displayed in the clinic			
Clinic records and reports are kept in lock and key			
Score = Total no. of (Yes x 5) / 4			

F. TECHNICAL SUPPORT

Score	N/A	0	1	2	3	4	5
1. Technical Support							

Method: To be filled by the STC' Supervisor

	Yes	No	Notes
Number of supportive visits conducted by STC in last 90 days. (write exact number of visits under Yes category)			
STC maintains clinic wise quality monitoring tool			
Score = Total no. of (Yes x 5) / 4			

Annex 2: Methods of collecting information for the Clinic Quality Monitoring Tool

Component	Standards	How to document
Use standard classification for type of clinic		See below for details
A. Clinic Performance	1. Proportion of KPs who visited the clinic at least once in last 6 months	Review clinic registry and calculate based on formula given. **Note:** A3. STI visits include a) STI symptoms visits b) STI check-ups c) STI follow-ups. For details refer to COGS and the CEF guide.
	2. Clinic services orientation towards KPs	
	3. Clinic orientation to provision of STI services	
	4. Proportion of KPs provided monthly STI check-up.	
	5. Proportion of new KPs provided asymptomatic treatment for Gonorrhea and Chlamydia in last one month	
	6. Proportion of KPs who have undergone RPR test in the past 6 months	
	7. Proportion of RPR +ve KPs started on treatment	
B. Community Involvement	1. Peer/ORW follow up KPs for STI services	Interview of program and clinic staff.
	2. KP involved in clinic operations - infection control, registration	Review of records and interview with clinic and outreach staff.
	3. DIC functional-scheduled activities managed by community	Observation, review of records
	4. Weekly meetings/forum for clinic and outreach staff to interact and documented	Review of records
	5. Community clinic monitoring system exists/clinic advisory committee provides recommendations and these are acted upon	Review of records
C. STI Clinical Management	1. Clinic adequately staffed and staff trained on their job responsibility. Clinic staffed with physician, nurse and counselor[1].	Interview of clinic staff and program staff
	2. MBBS Physician manages STIs based on the COGS guidelines	Observation, interview of physician, review of records

[1] Counselors qualifications: A postgraduate in social work, psychology or counseling. In certain circumstances a KP may be also taken as counselor if he or she has the aptitude and the right attitude to be a counselor.

Component	Standards	How to document
C. STI Clinical Management contd ..	3. Nurse maintains clinic records, is able to follow-up cases and referrals, properly implements infection control including sterilization of instruments, maintains drug register, supervises treatment, explains drug compliance and promotes condoms after STI consultation.	Observation of records and interview of nurse
	4. Counselor provides STI (4'Cs) and risk reduction counseling including advantages and disadvantages of HIV testing and ensures proper referral for VCT, HIV care and support and other services.	Interview of counselor, review of referral register
	5. STI treatment provided based on the COGS (SCM and asymptomatic treatment)	Randomly select 10 patient records of present quarter and verify
	6. Records and reports are accurate, complete and consistent with COGS reporting guidelines.	Randomly select 10 patient records of present quarter and review
	7. Laboratory system for syphilis screening is in place with internal and external quality assurance systems[2].	Observations, interview of laboratory person
D. Referral Network	1. Referral network established with: a) available referral directory on site; b) referrals are documented and up-to date; c) formal linkages with HIV testing, care and support including feedback and follow-up mechanisms are established; d) formal linkages with HIV care and support available; and e) Referral outcomes are followed up.	Review of records and interview of clinic and program staff
	2. Linkage with RNTCP is established a) Clinic staff trained on RNTCP; b) Clinic staff / NGO attend district/ TU level RNTCP meeting regularly; c) Clinic with formal linkage with designated microscopy center and other diagnostic center (FNAC/ BX/CXR) in the district;	Review of records and interview of clinic and program staff

[2] Laboratory system indicators are applicable wherever samples are collected and testing is done (including referral center for testing).

Component	Standards	How to document
D. Referral Network contd ..	d) Clinic staff with follow-up mechanism to ensure that the KPs who are TB suspects complete the diagnostic procedures for TB (3 sputum test and additional tests if required for sputum negative cases); e) Clinic staff ensure that all the KPs diagnosed with tuberculosis are started on TB treatment and f) TB register is filled correctly and submitted to Avahan monthly.	Review of records and interview of clinic and program staff
E. Clinic Operations	1. Clinic is tidy, with visual and auditory privacy, well equipped with adequate signage with reasonable waiting time	Observation
	2. Universal precaution, infection control, waste segregation and bio-waste disposal system is praticed in the clinic at all times.	Observation and interview of clinic staff
	3. Condoms and essential STI drugs are available in the clinic at all times and no stock-outs.	Review of records and observations
	4. Records & reports are maintained and utilized for data analysis	Review of records and observations
	5. Ethical standards and confidentiality are observed in the clinic (All treatments, procedures, testing & counseling are performed to the highest professional & ethical standards & basic human rights are respected).	Review of all clinic records Observations
F. Technical Suport	1. Monthly technical support provided by SLP to the clinic staff and is documented	Self reported by STC, CB team to verify records

Annex 3: Laboratory Checklist

Name of Clinic **Location of the Clinic**	**Date** **Conducted by**
Is all equipment present and in working order? (refrigerator, rotator, centrifuge)	**Yes No** Comments:
Is the equipment clean and properly maintained?	**Yes No** Comments:
Have there been stock-outs of supplies or reagents in the past month?	**Yes No** Comments:
Are any reagents expired? (check stock)	**Yes No** Comments:
Is temperature monitoring chart for refrigerator up-to-date and within recommended range?	**Yes No** Comments:
Are SOPs available in the laboratory for all tests being conducted?	**Yes No** Comments:
Centrifuge and rotator properly timed?	**Yes No** Comments:
Are RPR controls run regularly? Check internal quality control register for RPR - is it up-to-date and legible?	**Yes No** Comments:
Check external Quality Assurance register	Was last laboratory supervision visit done on time? **Yes No** Comments: Concurrence with panel samples for RPR: Reactivity ___% Correct titer___% Concurrence with panel samples for Gram stain: WBC/s ___% Presence of gonococcus ___%
Is RPR register up-to-date and legible?	**Yes No** Comments:
Were all RPR-reactive patients requiring treatment in the past month provided with initial treatment?	No. of reactive RPR tests__ No. treated ___ Comments:

Annex 4: Supervision visit/ Wrap-up meeting report

Site: _____

Date: _____

Persons present:

Follow-up on last meeting's action plan:

Previous action plan/ planned activities	Steps taken to achieve action plan/ planned activities	Outcome

Strengths identified:

Priority issues identified:

New action plan / planned activities	Person(s) responsible	Time frame

Annex 5: STI Daily Registry

Demographics (complete all)				Referred by				Reason for Visit		Type of Visit							Syndromes								Treatment								Referrals					Laboratory tests done			Education/ Counseling					
S.No	Date (dd/mm/yyyy)	ID No.	Peer Educator (Y/N)	PE/ORW	Self	Partner	Other	STI related	Non STI related	STI Symptoms	STI Checkup	STI Follow-up	TB Screening	Primary HIV/OI Mgt.	General Visit	1st STI Visit (Y/N)	Duration of symptoms in days	Condom use (Y/N)	Internal Examination (Y/N)	VCD	GUD	LAP	UD	ARD	Other	Asymptomatic only	None	Rx1	Rx2	Rx3	Rx4	Rx5	Rx6	Other	None	Syphilis Screening	ICTC	HIV Care	RNTCP	Other	RPR/VDRL/ICST	HIV	Other	HIV/STI Counseling	Condom Demo	# Condom Provided	Partner Treatment	IDU Harm Reduction	Date of Next visit

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Family Health International
India Country Office :
16, Sunder Nagar,
New Delhi - 110003, INDIA.
Tel: 91 -[011] 4150 7444, 4150 7555,
Fax : 91 -[011] 2435 8366
www.fhi.org

World Health Organization
Regional Office for South-East Asia,
World Health House,
Mahatma Gandhi Marg,
Indhraprastha Estate,
New Delhi 110 002, INDIA.
Tel. 91-(011) 23370804,
Fax:91-(011) 23378412
www.searo.who.int

Bill & Melinda Gates Foundation
Avahan India AIDS Initiative
Sanskrit Bhawan A-10,
Qutab Institutional Area,
Aruna Asaf Ali Marg,
New Delhi - 110067, INDIA.
Tel: 91-(011) 41003100
Fax: 91(011) 41003101
www.gatesfoundation.org

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