Assessment of Health Care Services Availing from Multiple ART Centre Dealing PL-HIV (People living with HIV) under STD-AIDS program

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Abstract

Background:
More than lacs of people in Bangladesh are living with HIV-AIDS and more people are vulnerable to develop it for their unhealthy life style, social stigma and poor health coverage and planning. Monitoring and Evaluation is essential for improving program performance. The availability of complete and accurate data contributes to the development of program policy and planning and facilitates corrective actions for improvement. It also guides the ART staff to strengthen clinical management of PL-HIV and helps attain long term goals of improving patient survival and reducing morbidity.

Methods:
Six centers of ART for HIV treatment from Cumilla, Chittagong, Sylhet, Dhaka and Cox's Bazar were selected for data collection and 240 PL-HIV (40 From each center) registered in these centers were interviewed during a period of January 2023 to May 2023.This a cross sectional study. The data collection tools to assess the center were designed by a core team using the questionnaire as the standard for comparison. Standard questionnaire against which the existing infrastructure, human resources and other services actually available at the center, primarily for onsite data validation and to record information about technical service delivery was compared.

Result:
Among 240 subjects most were male 150(62.5%) and female are 90(37.5%). Male to female ratio was 1.67:1. Male were affected more as they are the most working force of the country visits different countries and have different sexual behaviors. Age group distribution revealed <20 years were 20(8.3%), 21- 30 years were 72(30%), 31-40 years were 74(30.8%) 41- 50 years were 40(16.7%) and >51 years were 34(14.2%). Regarding acquiring the HIV-AIDS 64(26.7%) got it from the spouse, 97(40.4%) got from the sex workers, 8(3.3%) got from injection workers 70(29.2%) got it from others and 1(0.4%) got it unknowingly. Here maximum infection transmitted from sex workers and from the spouse among all 177(73.8%) got the information of ART center from hospital facilities, 52(21.7%) got it from PL-HIV and 11(4.6%) from the media. Among all maximum 238(99.2%) receiving treatment. Among the six facilities all had 40(16.7%) patients. 238(99.2%) got medicine and advice and all have not spent money for it. For 203(84.6%) PL-HIV, ART center is >10km away and they have to spent average 352 Taka per visit. Among all 95(36.9%) were symptomatic, 38(99.2%) had pretest counseling and 297(98.8%) had post test counseling. 216(90.0%) answered that confidentiality was maintained. 184(76.7%) come for regular follow up, 168(70%) answered that they had a regular meeting with the physician of ART center and 115(47.9%) noted some suggestions to improve further. PL-HIV were collected from six ART centers of Cumilla, Sylhet, Cox's bazar 250 bedded, Ukhiya UHC of Cox's Bazar, Chittagong and Dhaka. Data taken from the in charges of those six centers. They are posted for the job and as project of government. Some has physicians, SSN, MT lab and community peer counselor and others had none. ART services are provided through outdoor or OPD, they communicate with land phone or cell phone, and their service hour is 8 hours. Few center had MLSS and guard, freezer, store room and waste management systems. Resources are available in all centers but not up to the mark. Most of the centers screened >100 per month, some had reception rooms and waiting room, toilet facilities, educational materials, general outpatient consultation room and private room for consultations. Regarding scoring of the different centers for operational activities, score of Cumilla was low (43.24%) but others were above 50%. In short, it is a good work to have a snapshot of ART centers and the PL-HIV status in our country.

Conclusion:

Findings and the interviews from the ART centers and PL-HIV indicate that ART centres have a positive attitude towards the patients and provide good levels of satisfaction to clients from the different centers. Majority of the beneficiaries reported being satisfied with the counseling services.

Keywords: AIDS, ART, PL-HIV.

Introduction:

The first case of HIV in Bangladesh was detected in 1989. Bangladesh initiated an early response to the HIV epidemic starting in the mid-1980s. The National AIDS/STD Programme (NASP), within the Directorate General of Health Services (DGHS) of the Ministry of Health and Family Welfare (MOHFW), acts as a nodal body responsible for programming to address HIV issues in the country. It was established to provide a high-level leadership from the Government and to facilitate program implementation and coordination. The major roles of the NASP comprise policy, information, coordination and regulation, and implementation where necessary.

The government of Bangladesh developed and approved a comprehensive policy on issues relating to HIV and AIDS and sexually transmitted infections (STIs) in 1997. The first National Strategic Plan (NSP, 1997–2002) and the second National Strategic Plan (2004–2010) have been developed and approved. The NSP provides the framework to guide response to the HIV epidemic. The priority areas are identified under five broad program objectives, which include: provision of support and services for priority groups; prevention of vulnerability to HIV infection in Bangladesh society; promotion of safe practices in healthcare system; provision of care and support services for people living with HIV and AIDS; and minimizing the impact of the HIV and AIDS epidemic. The NASP also has been developing guidelines on antiretroviral treatment, harm-reduction strategy for drug-users, national STI management, national universal precaution protocol, voluntary counselling and testing (VCT), and training on safer sex strategy promotion. Current 4thNSP2018-2022 is developed in alignment with the 4thHealth, Nutrition and Population Sector Program, 2017-2022 as well as other national, regional and global commitments, namely the 2016 Political Declaration to End AIDS by 2030.

With about 9,708 HIV infected people, Bangladesh is estimated to have the significant number (14,513) of people living with HIV (PLHIV). At present Bangladesh estimated adult (15-49 age group) HIV prevalence less than 0.01% among the general population. HIV prevalence remains about 4.1% among the PWID as per latest IBBS. In 2022 maximum number of new cases identified HIV positive came from age group(25-49) 66.74% and some of HIV positive getting from (19-24) 16% years age populations. The national response to HIV epidemic has been swift and remarkably comprehensive since the time it was recognized as an important public health problem by the government of Bangladesh during its early years. While the absolute numbers are significant, Bangladesh has demonstrated an overall reduction of the annual new HIV infections among adult population, largely due to intense and sustained efforts by the National AIDS/STD program of the Government of Bangladesh. National AIDS Control Programme (NACP) launched in 1992 is now in its fourth phase, which aims to accelerate the process of epidemic reversal and further strengthen the epidemic response in India through consolidating gains, focusing on high risk groups (HRGs), scaling up services, providing comprehensive care support and treatment services to all and accelerating quality assurance.

The country is committed to achieving the SDG of ending AIDS as a public health threat by 2030 and is signatory to the UN strategy of 95-95-95 which aims at ending AIDS epidemic by achieving that-95% of the estimated PLHIV know their status, of which 95% PLHIV are on ART, of which 95% PLHIV have viral suppression.

Methodology:

The areas for assessment were divided into four "domains" – Operational, Technical, Monitoring and Evaluation (M&E) and Logistics. Each of these domains had two or more sub elements, which termed as "attributes". These attributes are presented in the below table. Each domain was accorded different maximum possible scores which was weighted based on the perceived importance of that domain in the optimum functioning of an ART center. In addition to the score, the centers were also graded 1 or 0 based on the percentage of score attained. These grades calculated were not only for the overall score, but also for each domain. Each positive response was graded 1 and negative response were graded as zero. Percentages were calculated with relation with total score.

Data collection tools: The data collection tools to assess the center were designed by a core team using the questionnaire as the standard for comparison. Standard questionnaire against which the existing infrastructure, human resources and other services actually available at the center, primarily for onsite data validation and to record information about technical service delivery was compared.

Sampling: Currently 11 ART centers are functioning. Of these, 6 ART centers & 240 PL-HIV (40 from each center) were selected randomly. Sample was constructed using a stratified random sampling process.

Data collection, analysis and reporting: The review was conducted in two phases: i. Desk Review; ii. Onsite assessment of facility. Following the onsite review, the assessors shared their findings with the in-charge of the parent institutions well as the Focal Person of the ART center. Plans for improvement will also developed based on these discussions. The data was analyzed with basic frequency tables and charts. Scores and grades across each domain were generated.

Results:

Reports for the patients:

Demographic data of the subjects: Among 240 subjects most were male 150(62.5%) and female are 90(37.5%). Male to female ratio was 1.67:1. Male were affected more as they are the most working force of the country visits different countries and have different sexual behaviors. Age group distribution revealed <20 years were 20(8.3%), 21- 30 years were 72(30%), 31-40 years were 74(30.8%) 41- 50 years were 40(16.7%) and >51 years were 34(14.2%). More working groups are affected found in age group distributions. PL-HIV data were collected from different areas of Bangladesh as Chittagong, Dhaka, Cumilla, Sylhet and Cox's bazar are the main cities of Bangladesh and most of the people of Bangladesh gather here for job opportunities. Among all 222(92.5%) were Muslims and 15(6.3%) were Hindu rest 3(1.3%) were Buddist. Religion ratio represents the national religion ratios. Among all 181(75.4%) were found married, 50(20.8%) were unmarried, 3(1.3%) were divorced, 6(2.5%) were separated. Among all most 73(20.4%) were illiterate, 74(30.8%) passed the primary and 61(25.4%) completed the secondary education. It represents the national scenario of Bangladesh. Like the population behaviors of Bangladesh most of the study patients were from rural setting. In average they earned 13710 taka per month last and earning were from business, service and family income.

Knowledge on HIV-AIDS (PL-HIV): Regarding acquiring the HIV-AIDS 64(26.7%) got it from the spouse, 97(40.4%) got from the sex workers, 8(3.3%) got from injection workers 70(29.2%) got it from others and 1(0.4%) got it unknowingly. Here maximum infection transmitted from sex workers and from the spouse. So it is important to prevent the transmission from person to person. Among all 95(39.6%) used condoms and 21(8.8%) answered nothing. Significant number of patients had not used condoms during their sexual behaviors which was related with the transmission of AIDS among them. Among the 202(84.2%) had not even heard of female condom use. Among the condom users 78(32.5%) had not used new condoms

before their sex works. Regarding the cause of not using condoms 31(12.9%) not used that due to shy to procure, 10(4.2%) not used due to much cost and did not want to carry.

Knowledge on ART of the participants (PL-HIV). Among all 177(73.8%) got the information of ART center from hospital facilities, 52(21.7%) got it from PL-HIV and 11(4.6%) from the media. Among all maximum 238(99.2%) took treatment. Among the six facilities all had 40(16.7%) patients. 238(99.2%) got medicine and advice and all have not spent money for it. 203(84.6%) had ART center >10km and they have to spent average 352 Taka per day. Among all 110(45.8%) were satisfied and 124(51.7%) had good experience with the ART center and 6(99.6%) were not satisfied. 239(99.6%) answered that ART center provided treatment when needed and also 88(36.7%) answered that they were provided financial/nutritional support when needed. 149(62.1%) had regular contact with ART center and contact was done by phone or physical or both. 236(98.3%) answered that ART center respond in need and 174(72.5%) had regular communication. 48(20.%) answered that the attend regular meeting with ART center. 230(95.8%) responded that they did baseline investigations done before ART and money was not demanded for that in 238(99.2%) patients . Test of TB was done in 190(79.2%), test for viral load was done in 181(75.4%) and it was several times for maximum patients and among them 146 (60.8%) were virally suppressed and test was done in the same center (81.3%). No charge was demanded for the service in 212(88.2%) patients. 180(75%) answered that they had sitting or toilet facilities at ART center and 226(94.2%)were happy with the environment of the ART center.

Conditions of overall ART center and HIV(PL-HIV): Among all 95(36.9%) were symptomatic, 238(99.2%) had pretest counseling and 297(98.8%) had post-test counseling 216(90.0%) answered that confidentiality was maintained 184(76.7%) come for regular follow-up, 168(70%) answered that they had a regular meeting with the physician of ART center and 115(47.9%) noted some suggestions to improve further.

Results of the ART centers

Data taken from the in charges of those six centers. They are posted for the job and as project of government employee. Some has physicians, SSN, MT lab and community peer counselor and others had none. ART services are provided through outdoor or OPD, they communicate with land phone or cell phone, and their service hour is 8 hours. Few of all had MLSS and guard, freezer, store room or waste management systems. Most of the centers screened >100 per month, some had reception rooms and waiting room, toilet facilities, educational materials, general outpatient consultation room and private room for consultations. Regarding scoring of the different centers for operational activities score of Cumilla was low (43.24%) but others were above 50%. Regarding resources, maximum resources are available at different ART centers. All center had all equipped data reporting systems and data are prepared by expert administrators. Monitoring & Evaluation: Positivity rate is very high in Cox's Bazar Sadar ART center (13-15%)and low Ukhiya UHC(0.13%). All have screened more than 100-400 patients in the year 2022 except Chittagong (89) but they had some drop out patients also the reason which was non adherence. 131 cases died in the Cox'sbazar ART center and it was 0 in Sylhet ART center. Cause of death was related to HIV-AIDS and other diseases conditions.

Discussion:

The provision of high quality care has been our focus at all stages of service delivery. The STD-AIDS program aims to provide "Universal access to comprehensive, equitable, stigma free, quality care, support and treatment services to all PLHIV using an integrated approach". This assessment reviewed four domains namely Operational, Technical, M & E and Logistics comprising of attributes necessary for the smooth delivery of ART services as well maintenance of quality care at the ART centers.

The overall performance of the ART centers was satisfactory under this domain. Most of the facilities were

found to be clean and well-maintained. The ART centers will need to strengthen their efforts to create adequate space, storage facilities and shelving. There were no Separate rooms available for the ART staff, nursing stations and counseling rooms with audiovisual privacy, were the key components of concern in almost half of the centers. Some center did not have adequate infrastructure across all the ART centers which was in line with the overall health infrastructure. The centers with insufficient infrastructure will require major infrastructural improvements to meet the guidelines, enhance quality of service delivery and create a congenial environment for the PLHIV.

Conclusion:

Findings and the interviews from the ART centers and PL-HIV indicate that ART centers have a positive attitude towards the patients and provide good levels of satisfaction to clients from the different centers. Majority of the beneficiaries reported being satisfied with the counseling services.

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