Training of

Doctors to deliver STI/RTI Services

Resource Material for Trainers

May 2011

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
2005 - 2012

सत्यमेव जयते

NACO
National AIDS Control Organisation
India's voice against AIDS
Department of AIDS Control
Ministry of Health & Family Welfare, Government of India
www.nacoonline.org

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सत्यमेव जयते

Sayan Chatterjee
Secretary & Director General

Department of AIDS Control, NACO, Ministry of Health and Family Welfare, Government of India

MESSAGE

The prevention, control and management of STI/RTI is a well recognized cost effective strategy for controlling the spread of HIV/AIDS in the country as well as to reduce reproductive morbidity among sexually active population. Individuals with STI/RTI have a significantly higher chance of acquiring and transmitting HIV. Moreover STI/RTI are also known ti cause use infertility and reproductive morbidity. Controlling STI/RTI helps decrease HIV infection rates and provides a window of opportunity for counselling about HIV prevention and reproductive health.

An operational framework for convergence between National AIDS Control Programme Phase III and Reproductive and Child health Programme Phase II under National Rural Health Mission has been developed. This will bring about uniformity in implementation os STI/RTI prevention and control through the public health are delivery system Through this, the availability and reach of standardized STI/RTI care at all levels of health facilities will be ensured.

The NACP III Strategy and Implementation Plan (2007-2012) makes a strong reference to expanding access to a package of STI management services both in the general population as well as for high risk behavior groups.

For nation-wide training of health functionaries on STI/RTI management standardized training modules and training aids/job-aids for various functionaries involved in provision of STI/RTI care have been developed to train doctors ANMs/Nurses, and to technicians on Syndromic Case Management of STI/RTI.

I am sure that these comprehensive operational guidelines will help towards ensuring the provision of quality STI/RTI services across the country.

(Sayan Chatterjee)

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PREFACE

Sexually transmitted infections and reproductive tract infections (STIs/RTIs) are important public health problems in India. Studies suggest that 6% of the adult population in India is infected with one or more STIs/RTIs. Individuals with STIs/RTIs have a significantly higher chance of acquiring and transmitting HIV. Moreover, STIs/RTIs are also known to cause infertility and reproductive morbidity. Controlling STI/RTIs helps decrease HIV infection rates and provides a window of opportunity for counseling about HIV prevention and reproductive health.

The implementation framework of National Rural Health Mission (NRHM) provided the directions for synergizing the strategies for prevention, control and management for STI/RTI services under Phase II of Reproductive and Child Health Programme (RCH II) and Phase III of National AIDS Control Programme (NACP III). While the RCH programme advocates a strong reference "to include STI/RTI and HIV/AIDS preventions, screening and management in maternal and child health services", the NACP includes services for management of STIs as a major programme strategy for prevention of HIV.

These modules are intended as a resource document for the programme managers and service providers in RCH II and NACP III and would enable the RCH service providers and NACO service provider in organizing effective case management services for STI/RTI through the public health care system.

(P.K. Pradhan)

सत्यमेव जयते

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FOREWORD

Community based surveys have shown that about 6% of adult Indian population suffers from sexually transmitted infections and reproductive tract infections. The prevalence of these infections is considerably higher among high risk groups ranging from 20-30%. Considering that the HIV epidemic in India is still largely concentrated in the core groups, prevention and control of sexually transmitted infections can be an effective intervention to reverse the HIV epidemic progress.

Syndromic Case Management (SCM) is the cornerstone of STI/RTI management, being a comprehensive approach for STI/RTI control endorsed by the World Health Organization (WHO). This approach classifies STI/RTI into syndromes, which are easily identifiable group of symptoms and signs and provides treatment for the most common organisms causing the syndrome. Treatment has been standardized through the use of pre-packaged colour coded STI/RTI drug kits. SCM achieves high cure rates because it provides immediate treatment on the first visit at little or no laboratory cost. However, it goes hand in hand with other important components like counseling, partner treatment, condom promotion and referral for HIV testing.

As per the convergence framework of NACO-NRHM for STI/RTI service delivery, uniform service delivery protocols, operational guidelines, training packages & resources, jointly developed by NRHM & NACO are to be followed for provision of STI/RTI services at all public health facilities including CHC and PHC. As per joint implementation plan, NACO/SACS would provide training, quality supervision and monitoring of STI/RTI services at all health facilities, thus overseeing the implementation. For tracking access, quality, progress and bottlenecks in STI/RTI program implementation, common information and monitoring system jointly developed by NACO and NRHM would be followed.

As a step to take convergence forward, it is envisaged that a resource pool of trainers is created at state and district level so as to enable roll out trainings for service providers in the public health care delivery system using the jointly developed training material and through the cascade models of trainings. The ultimate aim is to ensure high quality STI/RTI service delivery at all facilities with best utilization of resources available with both NACP III and RCH II/NRHM.

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ACKNOWLEDGMENT

Reproductive tract infections (RTIs) including sexually transmitted infections (STIs) present a huge burden of disease and adversely impacts the reproductive health of people. The emergence of HIV and identification of STIs as a co-factor have further lent a sense of urgency for formulating a programmatic response to address this important public health problem.

The comprehensive training modules on the Prevention and Management of STI/RTI have come through with the coordinated and concerted efforts of various organizations, individuals and professional bodies, who have put in months of devoted inputs towards it.

The vision and constant encouragement of Ms K Sujatha Rao, IAS, Secretary Health and Family welfare, Shri K Chandramouli, IAS, Secretary and Director General NACO, Ms Aradhana Johri, IAS, Additional Secretary NACO and Shri Amit Mohan Prasad, IAS, Joint Secretary RCH, Ministry of Health and Family Welfare is sincerely acknowledged, under whose able leadership these modules have been developed.

The technical content has been jointly developed by STI division, Department of AIDS Control (National AIDS Control Organization) and Maternal Health Division of MoHFW. The National Institute for Research in Reproductive Health (NIRRH), Mumbai under ICMR initiated and lead the process of reviewing the existing training material and developing updated training modules through the organization of a number of meetings and workshops. The preparation and design of material also involved the technical assistance, funding support and other related support provided by WHO, UNFPA, FHI and many other experts in the field.

Thanks are due to Dr. Anjana Saxena, Deputy Commissioner, Maternal Health Division, Dr. Himanshu Bhushan, Dr. Manisha Malhotra, and Dr. Dinesh Baswal, Assistant Commissioners Maternal Health Division for their constant technical inputs, unstinted support and guidance throughout the process of developing these guidelines. The hard work and contributions of Dr. Ajay Khera, then Assistant Director-General, and NACO STI team comprising of Dr. Shobini Rajan, Deputy Director, Dr. Bhrigu Kapuria, Technical Officer, Dr. TLN Prasad, and Dr. Aman Kumar Singh, Technical Experts and Dr. Naveen Chharang, Assistant Director at NACO have been invaluable in shaping the document.

Sincere appreciation is due to Dr. Sanjay Chauhan, Deputy Director, NIRRH who coordinated the whole process along with his team comprising Dr. Ragini Kulkarni, Research Officer and Dr. Beena Joshi, Senior Research Officer at NIRRH. Special mention is made of contribution of Dr. Deoki Nandan, Director, NIHFW, Delhi and for all those who coordinated the piloting of the module through State Health Directorates and State AIDS Control Societies of Uttar Pradesh, Madhya Pradesh, Assam, Kerala, West Bengal and Gujarat. I also thank to Public Health Foundation of India (PHFI) for providing assistance to print these modules.

(Dr. Sunil D. Khaparde)

Contents

Instructions for Facilitators

1. This Training Workshop is intended for doctors responsible for delivering STI/RTI services in medical colleges, district hospitals and targeted intervention sites.
2. The content of the training modules is based on the "National Guidelines on Prevention, Management and Control of Reproductive Tract Infections including Sexually Transmitted Infections", August 2007, issued by NACO, medical officer handout, similar publications of the World Health rganization (WHO).
3. The scope of the discussions is limited to the job responsibilities of doctors (Medical Officers) as described in the "Operational Guidelines for Programme Managers and Service Providers for Strengthening STI/RTI Services", NACO, May 2011.
4. The facilitator is expected to be well acquainted with adult learning principles and learning techniques such as interactive presentation, case-study, role play and demonstration.
5. It is absolutely essential that the facilitator has complete conviction in the syndromic management approach to STIs/RTIs and actively practices it.
6. It is mandatory for the facilitator to read through and understand the entire content of this Facilitator's Manual, including the PowerPoint slides for each module, thoroughly. This will help the facilitator to prepare and become familiar with the content well in advance so that the module/session runs smoothly. It will also help her/him to discuss the topic/s competently and refer to other modules/sessions as and when relevant.
7. The facilitator is advised to arrange a dry run or a practice run of the entire Workshop before conducting the modules/sessions for the Workshop participants (trainees).

Using Workshop Materials

The Workshop materials are:

1. "National Guidelines on Prevention, Management and Control of Reproductive Tract Infections including Sexually Transmitted Infections", NACO, August 2007, on which the content of this training Workshop is based. This document will hitherto be referred to as the "National Technical Guidelines" for the sake of brevity.
2. "Operational Guidelines for Programme Managers and Service Providers for Strengthening STI/RTI Services", NACO, May 2011, which provides the parameters for discussions consistent with the job responsibilities of the trainees (Doctors/Medical Officers). This document will hitherto be referred to as the "Operational Guidelines" for the sake of brevity.
3. A set of PowerPoint slides.
4. Medical Officer Handout and Facilitator's Manual for "Training of Doctors to Deliver Quality STI/RTI Services".

PowerPoint Slides

1. PowerPoint slides have been created for each training module to assist the facilitator to conduct the module/session systematically and effectively.
2. The slides are meant for reference and recall of key points for discussion
3. The slides are numbered according to the module they belong to and their chronological

number within that module. For example, Slide M-8/15 is Module No. 8, Slide No. 15 or Slide No. 15 in Module No. 8.

4. We strongly recommend that the facilitator should not read out the slides. S/he should pick up a point or an issue on the slide and discuss it by supplementing it with relevant content from the Participant Handout of Medical Officer, "National Technical Guidelines" and "Operational Guidelines". Guidance for the talking points is provided in the Facilitator's Manual.
5. All the slides have animation to help the facilitator to display the key points on the slides sequentially, step-by-step.
6. The Facilitator's Manual contains clear instructions on when and how to use each slide. We recommend that these instructions be followed carefully, without deviating from them.
7. We recommend that the facilitator self-operate the computer and change the slides in order to better coordinate between what s/he says and what s/he shows on the slide. The facilitator should not rely on others for changing slides as it invariably results in poor coordination.
8. The facilitator should go through the entire set of slides required for a module/session before using them to ensure a smooth and efficient presentation.

Facilitator's Manual

1. We strongly recommend that the facilitator reads the Facilitator's Manual, Medical Officer Participant Handout and Operational Guidelines very carefully.
2. The Facilitator's Manual provides detailed instructions for facilitating each session of the modules.
3. Each module contains the following components:
   - **i. Module Number:** denotes the module number.
   - **ii. Module caption:** is the topic covered by the module.
   - **iii. Learning objectives:** are the objectives to be achieved by the participants on completion of a module.
   - **iv. Materials required:** provides a list of the materials required for conducting the module. These comprise essential supplies such as blank flip charts, marker pens etc, common to all modules, as well as specific requirements for a certain session/sessions of a module. The facilitator must review the list of materials required for a module while preparing her/his presentation and ensure that s/he has all the necessary materials. The 'Materials required' and the following component – "Preparation by facilitator' [see (v) below] – are given in grey shaded boxes at the beginning of each module.
   - **v. Preparation by facilitator:** contains instructions for the facilitator to prepare herself/himself for conducting the sessions of a given module competently.
   - **vi. Module outline:** shows the number of sessions in a particular module along with the recommended training technique or methodology.

vii. **Sessions:** The content of each module is distributed across two or more sessions, each with its own objective/s. It is recommended that not more than two facilitators conduct any one session (preferably one facilitator, unless the session is too extensive, such as those in the modules on flowcharts and client education and counseling).

viii. **Instructions for facilitator/s:** Instructions for facilitating sessions are presented in grey shaded areas in boxes. The instructions are in the "active voice". The facilitator is expected to conduct the module/session by following these stepwise instructions. The instructions include the actual statements, given in "inverted commas", which the facilitator is expected to speak out, as well as instructions which s/he is expected to read and follow step by step as s/he conducts the module/session.

ix. **Exercises and group work** instructions are also provided in the shaded boxes.

x. The facilitator should go through the content of the shaded boxes very carefully and understand the discussion points and how to use them.

xi. In addition to the shaded boxes, many sessions contain text which is not shaded. This text provides details of discussion points/issues that are relevant to the session. Some of this text namely, introductory statements for certain modules, and tips and reminders for the facilitator are boxed. We strongly recommend that the facilitator uses this information to make the presentation more informative and helpful.

4. PowerPoint slides are incorporated in the instructions by their individual slide numbers for easy identification and to enable the facilitator to follow the slide sequence in a systematic and stepwise manner.

Module 1

Introducing the Workshop

Module 1

Introducing the Workshop

Learning Objectives:

At the end of this module, the participants will be able to:

1. Introduce themselves to the group
2. State and describe the objectives of the Workshop
3. Set behavioral norms for effective learning
4. Provide an overview of the Workshop

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Blank flip charts
- A flip chart with Workshop objectives written on it (Session 3)
- A flip chart showing a Satisfaction Meter (Session 3)
- Small cards (at least 34) with a pairing word written on each card (for an introduction game; Session 2)
- Marker pens

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1.	Introduction to Module 1	Presentation
2.	Getting to know each other	Group exercise
3.	Workshop objectives and norms	Interactive presentation
4.	Pre-workshop assessment	Pre-training assessment

SESSION 1

Introduction to Module 1

Objective:

At the end of this session, the participants will be able to:

- Provide an overview of this module

Show Slide 1 and welcome the participants.

Say: "We are very happy to have you here for this Workshop on "Training of Doctors to Deliver Quality STI/RTI Services".

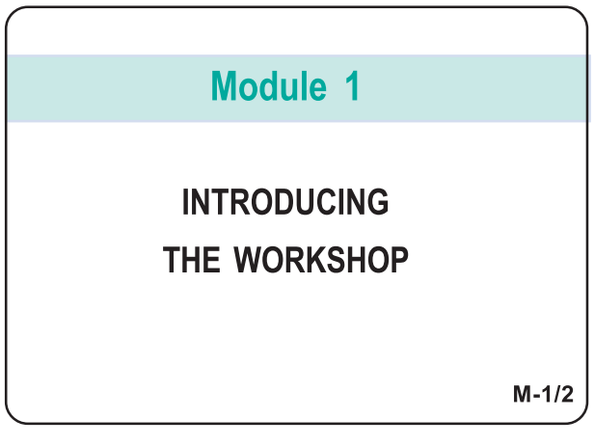
Slide 1

Now, show Slide 2 and say : "The content of this Workshop is based on the job responsibilities of doctors (Medical Officers) as stated in the "Operational Guidelines" issued by NACO (see Annexure-3 page 56).

"We will begin the next session of this module with a game to help us get to know each other. We will then move on to discuss the objectives of the Workshop. We will also set down some ground rules or norms to help us to work comfortably and make the fullest use of our time here. We will conclude the module with a Pre-Workshop Assessment, an exercise which will help us, your facilitators, to appraise your knowledge of STIs/RTIs and their management so that we can suitably emphasize content areas which indicate information gaps.

"Let us try to ensure that we work together as a great team and generate a stimulating learning atmosphere so as to achieve the objectives of this Workshop."

Slide 2



SESSION 2

Getting to know each other

Objectives:

At the end of this session, the participants and facilitators will be able to:

- Identify each other in the group
- Establish rapport with other participants in the group

Welcome the participants once again to this first session of the Workshop and the first module

Introduce the session by saying: "The purpose of this session is to introduce ourselves to each other because, as you are aware, we have participants who have come from different locations. This activity is important in order to ensure that we have an open and participatory atmosphere throughout the Workshop. The next session of this Module will cover the objectives and agenda of the Workshop."

Now, say: "Now, let us get introduced to each other through a small exercise on introductions. Each participant will be given a card with a word of a well-known word-pair written on it. HIV-AIDS, Husband-Wife, Laila-Majnoo, and Romeo-Juliet are some examples of well-known word-pairs."

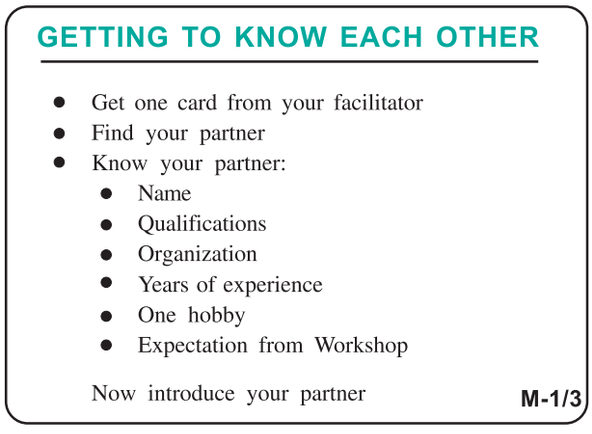
Keep at least 17 word-pairs (that is, 34 cards) ready, assuming that at any given workshop there would be, on average, at least 30 participants and 3-4 facilitators. However, use only as many word-pair cards as the number of participants present.

Now, show Slide 3.

Hand out the word-pair cards; one card to each participant, and say: "You have to find your partner with the help of your card. That is, find the person who has a card with the word which pairs with the word on your card."

When all the participants have found their 'word-pair' partners, ask each pair of partners to get to know each other by talking to each other for 3 minutes, using the points written on Slide 3 under "Know your partner".

Slide 3



When the participants are ready, ask them to introduce their partners. Tell the participant who is being introduced to stand up.

The facilitator/s must also participate in this introduction activity.

Now, move on to Session 3.

SESSION 3

Workshop objectives and norms

Objectives:

At the end of this session, the participants will be able to:

- List their expectations of the Workshop
- Describe the objectives and norms of the Workshop

Begin the session by saying: "Looking at the title of this Workshop, what would you expect from it?"

Put up a blank flip chart with the caption: "Participant expectations".

Let each participant share one major expectation.

Write the participants' expectations on the flip chart. Do not stop or interrupt them even if an expectation is beyond the scope of the Workshop.

When the expectations of all the participants have been listed, show Slide 4 and share the objectives of the Workshop.

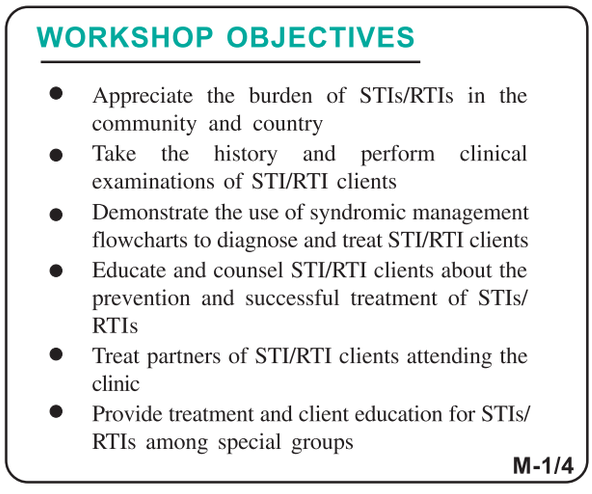
Clarify the objectives by saying: In this workshop, we are going to discuss the major components of STI/RTI case management which include:

- Extent of the problem
- Classification of STIs/RTIs
- Epidemiology of STIs/RTIs
- Clinical management of STIs/RTIs using the enhanced syndromic approach
- Client education and counseling
- Management of STIs/RTIs in special groups such as adolescents, sex workers, and victims of sexual violence
- A brief discussion of laboratory tests for STIs/RTIs

Explain that the entire discussion will be based on"what a doctor can do in a typical clinic setting'.

State that other supporting clinic staff such as nurses and laboratory technicians will also be trained at similar workshops so that they can effectively assist the doctor in managing STI/RTI patients.

Slide 4



Now, compare the participants' expectations on the flip chart with the Workshop objectives on Slide 4.

If a participant expectation is related to STIs/RTIs but is not directly addressed by the Workshop, explain that it will not be possible to take it up during Workshop sessions; however, facilitators will be available to discuss it during breaks.

If an expectation is not pertinent to the Workshop agenda, mention politely that it will not be possible to meet it at this Workshop.

Put up the previously prepared flip chart with the Workshop objectives written on it, in a prominent place on the wall of the classroom. Let it remain there throughout the Workshop.

Next, hand out a copy each of the "Medical Officer Handout" and "Operational Guidelines" to each participant.

Inform them that the Workshop is of 2-3 days' duration – the first two days will be devoted to classroom discussion and skills practice, and the last day to clinical practicum.

Explain that the Workshop programme is tightly structured, requiring everyone's presence and active participation.

Show Slide 5 and clarify that the Workshop is based on the learning principles shown on the slide. Therefore, all the participants are expected to participate actively in the discussions and practice sessions.

Slide 5

LEARNING PRINCIPLES

What I hear, I forget

What I see, I remember

What I do, I understand

M-1/5

Say: "The purpose of this Workshop is to make the best use of our time and resources to learn the essentials of STI/RTI management within its 2-3-day duration. Therefore, we need to have some norms to ensure that this learning happens in a congenial atmosphere. Let us try to set some norms for making this happen."

Ask the participants to name some norms or rules that they would like to follow during the Workshop.

List the norms on a blank flip chart.

Finally, show Slide 6 and add the norms not mentioned by the participants, to the flip chart.

Emphasize that participation by everyone is essential for good learning. Tell them that they are welcome to share their experiences of STI/RTI case management during the discussion sessions.

Slide 6

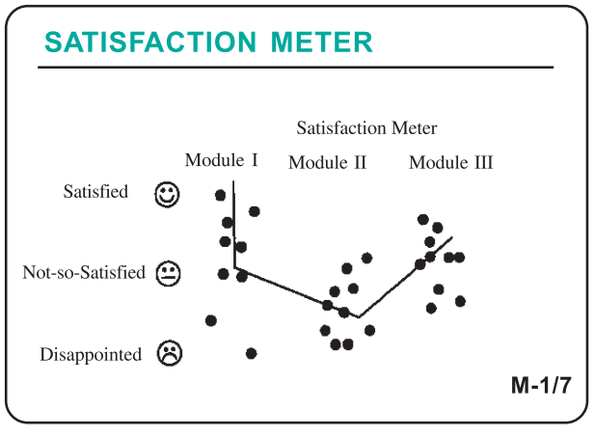
WORKSHOP NORMS

- Treat everyone with respect
- Respect timelines
- Speak one at a time
- Provide feedback, respecting the feelings of others
- Keep mobile phones in silent mode

M-1/6

Now, show Slide 7 and say: "Everyone will get an opportunity to express her/his views on the quality of the discussions held on each module covered on each day of the Workshop. You can do so by recording your opinion on a 'Satisfaction Meter' provided on a flip chart in this room."

Slide 7



Place a *'Mailbox'* in a corner of the classroom and explain that it will remain there at all times, throughout the Workshop, so that the participants can write down question/s related to the topics covered each day and drop them in it. Encourage them to use the Mailbox; tell them that they need not write their names to their questions.

Also tell them that the facilitator will answer their questions on the following day.

Remember ...

Put up the ***Satisfaction-Meter*** every day, one for each module covered on that day.

The "***Mailbox***" serves as a vehicle for the participants to convey any questions/matters arising during the Workshop to the facilitator/s so that they can be addressed promptly. Place the ***Mailbox*** in an easily accessible place. Check it every evening and answer the questions in it, the next morning.

SESSION 4

Pre-Workshop Assessment

Objective:

At the end of this session, the facilitators will be able to:

- Assess the participants' current level of knowledge of STI/RTI prevention and management

Show Slide 8 and explain that the purpose of this test is to make a pre-workshop evaluation of the knowledge of the participants.

Slide 8

PRE-WORKSHOP ASSESSMENT

- To assess our current level of knowledge and skills
- To plan for improving specific knowledge and skills areas
- Time 30 minutes

M-1/8

Dispel the apprehensions of the participants by telling them that it does not matter if they do not know the answers to some of the questions.

Overall, their answers will help the facilitator/s to assess their existing knowledge of STI/RTI prevention and management and other issues related to reproductive health. Clarify that this will enable the facilitator to lay more emphasis on topics which show gaps in information when s/he discusses these topics during the course of the Workshop.

- Give each participant a Pre-Workshop Assessment Form.
- Tell them that it has 3 Sections – A, B and C – which they have to complete within 30 minutes.
- Ask them to answer the questions on their own and not discuss them with their co-participants.
- Collect the Pre-Workshop Assessment Forms after 30 minutes.
- Thank the participants for filling up the Pre-Workshop Assessment Forms.

Remember ...

The Pre-Workshop Assessment Forms must be evaluated before the first session following the tea-break on Day 1 of the Workshop. This is essential as it will help the facilitator/s to identify areas in which the participants are relatively well-informed and areas which need emphasis.

The Answer Key of the Pre-Workshop Assessment Form is given at the end of this session for your reference. One of the facilitators should use the Answer Key to correct and score the completed Forms.

Score 1 mark for each correct answer to a question in Sections A and C, and 2 marks for each correct answer to a question in Section B. After correcting each Pre-Workshop Assessment Form, add the total marks obtained and calculate the percentage score.

Training of Doctors to Deliver Quality STI/RTI Services

PRE-WORKSHOP ASSESSMENT FORM

Name of State: _____ Name of District: _____

Name of Block/Taluka : _____

Name of Designated STI Clinic: _____

Sr. No.: _____

Designation of Participant: _____

Dates of Workshop: _____ Date of Test: _____

Instructions

- Answer all the questions in Sections A, B, and C.
- Read each question and the multiple choices carefully, and tick the correct answer.
- Follow the specific directions for each Section.

SECTION A

Tick (✓) the circle 'True' or 'False'.

1. STIs are passed from person to person mainly through sexual contact**.**
   ○ True | ○ False
2. *Safer sex* refers to practices that allow partners to reduce their sexual health risks**.**
   ○ True | ○ False
3. It is possible to have a STI/RTI without having any signs or symptoms of infection**.**
   ○ True | ○ False
4. STIs/RTIs can be classified according to syndromes and type of infectious agent.
   ○ True | ○ False
5. An experienced clinician can accurately diagnose STIs/RTIs based solely on her/his past experience, the client's symptoms and the clinical signs observed during a physical examination.
   ○ True | ○ False
6. Clinical management is the most accurate of the three approaches (clinical, etiological and syndromic) to STI/RTI management.
   ○ True | ○ False
7. All STIs/RTIs are easily curable with antibiotics.
   ○ True | ○ False
8. If left untreated, STIs/RTIs can cause serious complications.
   ○ True | ○ False

9. Gonorrhoea is one of the causes of vaginal discharge in women.
   ○ True | ○ False
10. Asymptomatic infections cannot be passed to a partner during sexual contact.
   ○ True | ○ False
11. Partners need not be referred for STI/RTI diagnosis and treatment unless they have signs and symptoms of infection.
   ○ True | ○ False
12. Single-dose therapy is preferable to multiple-dose therapy for STIs/RTIs.
   ○ True | ○ False
13. STI treatment and prevention can be important tools for limiting the spread of HIV.
   ○ True | ○ False
14. Biologically, both men and women are equally vulnerable to a STI from a sexual partner.
   ○ True | ○ False
15. Using spermicides can prevent STI/RTI transmission.
   ○ True | ○ False
16. Condoms are the only barrier method proven to be highly effective against STI/RTI transmission and pregnancy prevention.
   ○ True | ○ False
17. Cervical cancer can be prevented by screening women for herpes.
   ○ True | ○ False
18. In order to communicate effectively with clients, providers should use only medical terminology when discussing sexual anatomy.
   ○ True | ○ False

SECTION B

Select two correct answers to each question. Place a tick mark (✓) in the left margin, next to the correct answers.

1. Why are STIs/RTIs, excluding HIV, regarded as a public health priority?
   a) Because all STIs/RTIs are incurable even if they are treated promptly.
   b) Because they have severe health consequences.
   c) Because treating them promptly can help prevent the spread of HIV.
   d) Because STIs/RTIs are the Number One cause of death in our country.
2. Women are more vulnerable to STIs/RTIs than men are because:
   a) Pregnancy and breastfeeding lower a woman's resistance to STIs/RTIs.
   b) Women are often anemic.
   c) Semen stays in contact with the vaginal wall for a long time.
   d) Women have less power to negotiate safer sex.

3. Which of the following consequences may result if STIs/RTIs are not treated?
   a) Women may develop breast cancer.
   b) Women may become infertile.
   c) Men may become infertile.
   d) Men may develop brain tumor.
4. Which are the most common signs of STIs/RTIs?
   a) Genital ulcers.
   b) Genital discharge.
   c) Generalized swelling of the lymph nodes.
   d) Loss of weight.
5. The two main elements of STI/RTI control are:
   a) Case management.
   b) Legalizing prostitution.
   c) Prevention.
   d) Providing laboratory diagnosis at all clinics.
6. The disadvantages of syndromic management include which of the following?
   a) The potential over-use of antibiotics.
   b) Patients must wait for treatment.
   c) It avoids wrong treatment since all possible RTIs causing signs and symptoms are treated at once.
   d) It does not work well for vaginal discharge.
7. A young woman who has come to you with vaginal discharge is at a high risk for STIs. Before prescribing medication for her, what is most important for you to know from her?
   a) If she has multiple partners.
   b) Whether she can afford the medication.
   c) Whether she is pregnant or breastfeeding.
   d) When was her last menstrual period?
8. Education about sexual health for girls and boys:
   a) Helps in preventing unwanted pregnancy.
   b) Delays the age of onset of sexual activity.
   c) Encourages early sexual activity.
   d) Increases unsafe abortion.
9. Which of the following are open-ended questions?
   a) Tell me about your symptoms.
   b) Is the discharge milky or clear?
   c) Did you use a condom the last time you had sex?
   d) What does the pain feel like?

SECTION C

Select only one answer. Place a tick mark (✓) in the left margin, next to the correct answer.

1. Which of the following contributes to the rapid spread of STIs/RTIs?
   a) Lack of sufficient laboratory facilities for diagnosis.
   b) Poor hygiene.
   c) Lack of effective drugs.
   d) High-risk sexual behavior.
2. In women, the signs and symptoms of STIs/RTIs are often:
   a) More easily recognized than in men.
   b) Less reliable indicators of disease than in men.
   c) Less likely to become serious than they are in men.
   d) More likely to affect older women.
3. When a patient complains of symptoms of STIs/RTIs, the following examination is ideal:
   a) A general physical examination.
   b) A genital examination.
   c) Both general physical and genital examinations.
   d) Neither is necessary when using a syndromic approach to STI/RTI management.
4. Examination for urethral discharge in men should be done:
   a) Without retracting the foreskin in uncircumcised men.
   b) By asking the patient to urinate before the examination.
   c) By milking the penis if you do not see any discharge.
   d) By asking the patient to wipe off his penis before you examine him.
5. The main causes of urethral discharge are:
   a) Syphilis and gonorrhoea.
   b) Herpes simplex and chancroid.
   c) Gonorrhoea and chlamydia.
   d) Chlamydia and syphilis.
6. A woman has cervical mucopurulent discharge and lower abdominal pain with no rebound tenderness or guarding. Which of the following is correct?
   a) She should be referred immediately to a surgeon.
   b) She should be treated for PID.
   c) Trichomonas vaginalis is probably the causative organism.
   d) She is unlikely to have complications unless she is pregnant.

7. Genital ulcer disease is important because:
   a) It is a major cause of infertility.
   b) It may facilitate the spread of HIV.
   c) It often causes impotence in men.
   d) It is usually associated with another RTI.
8. Which of the following laboratory tests is most useful for STI/RTI control in developing countries?
   a) Screening tests for syphilis such as RPR or VDRL test.
   b) Gram stain for gonorrhoea.
   c) Urine LED (leukocyte esterase dipstick) for white blood cells.
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9. A person infected with chancroid will often have:
   a) Genital ulcers which come and go spontaneously over many months.
   b) Genital ulcers that progress, causing extensive tissue damage if not treated.
   c) A genital ulcer that lasts one or two weeks and then resolves completely on its own.
   d) Multiple, painful vesicles filled with clear fluid.
10. A young female sex worker comes to you with vaginal discharge. She says she has had various STIs/RTIs several times in the past. Which of the following is the most appropriate action to take?
   a) Find out what she knows about STIs/RTIs.
   b) Tell her to find other work.
   c) Warn her that she might have a STI/RTI.
   d) Avoid topics that might embarrass her.
11. Using the enhanced syndromic approach to STI/RTI management, providers diagnose and treat infections based on:
   a) The results of laboratory tests.
   b) Classifications that have been developed on the basis of the client's symptoms and clinical signs.
   c) Only clinical signs found upon physical examination.
   d) All of the above.
12. Syndromic management is of limited utility in clients who present with the following syndrome:
   a) Vaginal discharge.
   b) Genital ulcers.
   c) Scrotal swelling.
   d) Urethral discharge.
13. In men, urethral discharge can be a sign of:
   a) Chlamydia.
   b) Gonorrhoea.
   c) Trichomoniasis.
   d) All of the above.

14. Swelling or pain in the scrotum can be caused by:
    a) Chlamydia.
    b) Hepatitis C.
    c) Yeast infection.
    d) All of the above.
15. Which of the following questions may help you assess a person's risk of getting or giving a STI/RTI?
    a) Does your partner live away from home?
    b) Are you over 30 years old?
    c) Do you know anyone with AIDS?
    d) Have you had a new sexual partner in the past three months?
    e) Have you ever had a STI?
    f) b, c and e.
    g) a, d, and e.
16. Hepatitis B, hepatitis C and HIV infection can be transmitted:
    a) Through unprotected sexual intercourse.
    b) Through shared needles, razors, toothbrushes, skin-cutting tools, or tattooing instruments.
    c) From mother to child during pregnancy and delivery.
    d) All of the above.
17. The following are all good ways of preventing STIs/RTIs in married women having a monogamous relationship except:
    a) Making sure that STI/RTI services are available to their husbands.
    b) Outlawing prostitution.
    c) Promoting widespread condom use.
    d) Giving women the skills to negotiate safer sex.
18. Which of the following is a critical component of STI/RTI management?
    a) Condom promotion.
    b) Partner notification.
    c) Counseling and education.
    d) All of the above.

ANSWER KEY

SECTION A:

Tick (✓) the circle 'True' or 'False'.

1. STIs are passed from person to person mainly through sexual contact.
   ○ True | ○ False
   Answer: True
2. *Safer sex* refers to practices that allow partners to reduce their sexual health risks.
   ○ True | ○ False
   Answer: True
3. It is possible to have a STI/RTI without having any signs or symptoms of infection.
   ○ True | ○ False
   Answer: True
4. STIs/RTIs can be classified according to syndromes and type of infectious agent.
   ○ True | ○ False
   Answer: True
5. An experienced clinician can accurately diagnose STIs/RTIs based solely on her/his past experience, the client's symptoms, and the clinical signs observed during a physical examination.
   ○ True | ○ False
   Answer: False
6. Clinical management is the most accurate of the three approaches (clinical, etiological and syndromic) to STI/RTI management.
   ○ True | ○ False
   Answer: False
7. All STIs/RTIs are easily curable with antibiotics.
   ○ True | ○ False
   Answer: False
8. If left untreated, STIs/RTIs can cause serious complications.
   ○ True | ○ False
   Answer: True
9. Gonorrhoea is one of the causes of vaginal discharge in women.
   ○ True | ○ False
   Answer: True
10. Asymptomatic infections cannot be passed to a partner during sexual contact.
    ○ True | ○ False
    Answer: False
11. Partners need not be referred for STI/RTI diagnosis and treatment unless they have signs and symptoms of infection.
    ○ True | ○ False
    Answer: False
12. Single-dose therapy is preferable to multiple-dose therapy for STIs/RTIs.
    ○ True | ○ False
    Answer: True

13. STI treatment and prevention can be important tools for limiting the spread of HIV.
    ○ True | ○ False
    Answer: True
14. Biologically, both men and women are equally vulnerable to contracting a STI from a sexual partner.
    ○ True | ○ False
    Answer: False
15. Using spermicides can prevent STI/RTI transmission.
    ○ True | ○ False
    Answer: False
16. Condoms are the only barrier method proven to be highly effective against STI/RTI transmission and pregnancy prevention.
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Select only one answer. Place a tick mark ( ) in the left margin, next to the ??? correct answer.

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    c) Promoting widespread condom use.
    d) Giving women the skills to negotiate safer sex.
18. Which of the following is a critical component of STI/RTI management?
    a) Condom promotion.
    b) Partner notification.
    c) Counseling and education.
    d) All of the above.

Module 2

Public Health Importance of STIs / RTIs

MODULE 2

Public Health Importance of STIs/RTIs

Learning Objectives:

At the end of this module, the participants will be able to:

1. Describe the impact of STIs/RTIs on individuals and the community
2. Discuss the basic epidemiology of STIs/RTIs from a global, country and regionalperspective
3. Identify the major factors contributing to the spread of STIs/RTIs
4. Describe the need for the prevention and management of STIs/RTIs
5. Identify the challenges to STI/RTI prevention and management and ways to meet them

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Flip charts
- A flip chart with a figure of three concentric circles drawn on it (see Session 2)
- Marker pens

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Get to know the latest figures of STIs/RTIs in your state, region or institution as available, and use them during the session.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1	Introduction to Module 2	Interactive presentation and discussion
2	Basic terms used in STI/RTI management	
3	Epidemiology of STIs and RTIs: Global and country perspective	
4	Factors contributing to the spread of STIs/RTIs	
5	Impact of STIs/RTIs: Need forprevention and management	
6	Challenges to STI/RTI prevention and management	

Introduction

The purpose of this module is to help participants to understand the magnitude and urgency of the STI/RTI problem in India and in their own state or region. It also emphasizes the public health aspects of STIs/RTIs including basic epidemiological facts. It is important for the facilitator to assist the participants to relate the STI/RTI problem to the dreaded complications of these conditions as well as its link with HIV/AIDS.

SESSION 1

Introduction to Module 2

Objective:

At the end of this session, the participants will be able to:

- Provide an overview of the module including its objectives

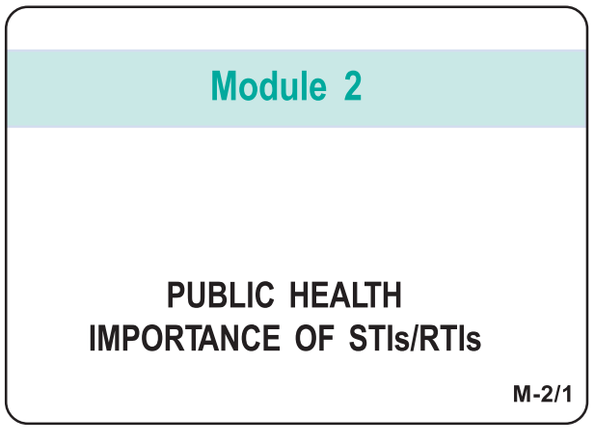
Show Slide 1 and say: "In this module, we are going to discuss various aspects of the STIs/RTIs prevalent in our country. These are: basic facts about STIs/RTIs, complications due to untreated or inadequately treated infections, their link with HIV, and diagnostic tools including clinical skills and laboratory tests."

Explain that besides treating STIs/RTIs, client education, counseling and community prevention with a focus on special high-risk groups are key components of a comprehensive approach to STI/RTI management.

Tell the participants that the doctors and paramedics working in designated STI/RTI clinics have an important role to play in effectively managing STI/RTI clients who use their services.

Say: "This module gives the background and magnitude of the STI/RTI problem in the world and in India. It aims at creating an understanding of the significance of STIs/RTIs by providing an overview of the STI/RTI problem and its implications on reproductive health. It also examines the perceptions and concerns of adults in respect of STI/RTI problems, and explores the rationale for the prevention and management of these infections. In fact, this module serves as the foundation for subsequent modules which deal with various topics pertaining to the prevention and management of STIs/RTIs in greater depth."

Slide 1



Show Slide 2 and present the objectives of Module 2. Reaffirm that the purpose of this session is to provide an overview of the STI/RTI problem; specific information and skills development will be taken up in later modules.

Remind and encourage the participants to put questions/suggestions, if any, in the *Mailbox* after the completion of each module.

Slide 2

OBJECTIVES: MODULE 2

- Describe the impact of STIs/RTIs on individuals and the community
- Discuss the basic epidemiology of STIs/RTIs from a global, country and regional perspective
- Identify the major factors contributing to the spread of STIs/RTIs
- Describe the need for the prevention and management of STIs/RTIs
- Identify the challenges to STI/RTI prevention and management and ways to meet them

M-2/2

SESSION 2

Basic terms used in STI/RTI management

Objective :

At the end of this session, the participants will be able to:

- Define STIs, RTIs and the basic terms used in STI/RTI management

Ask the participants:"What are RTIs? What are STIs? Are they different?"

Let 3-4 participants respond. Appreciate correct responses.

Now, show Slide 3 and explain the definitions by saying that all RTIs are not necessarily transmitted by the sexual mode. They could be transmitted by other means as we shall see in subsequent sessions.

Slide 3

DEFINITIONS

- **Reproductive Tract Infections (RTIs) :** Any infection of the reproductive tract in males and females
- **Sexually Transmitted Infections (STIs):** Infections caused by germs such as bacteria, viruses or protozoa that are passed from one person to another mainly through sexual contact

M-2/3

What are Reproductive Tract Infections (RTIs)?

The term RTI refers to any infection of the reproductive tract. In women, it includes infections of the external genitals, vagina, cervix, uterus, fallopian tubes, and/or ovaries. In men, RTIs involve the penis, testes, scrotum, and/or prostate.

What are Sexually Transmitted Infections (STIs)?

STIs are infections caused by germs such as bacteria, viruses, or protozoa that are passed from one person to another through sexual contact.

Explain both definitions and clarify that RTIs as well as STIs can occur in both males and females.

Show Slide 4 and provide examples of RTIs in men and women.

Slide 4

RTIs

- **RTIs in both men and women include:**
  STIs
- **RTIs in women also include:**
  - Disruption of normal vaginal flora (candidiasis and bacterial vaginosis)
  - Postpartum and postabortion infections
  - Infections following procedures (e.g. IUD insertion)
- **RTIs in men also include:**
  Prostatitis and epididymitis

M-2/4

Now, ask the group what they understand by HIV and AIDS. Again, appreciate participants who give correct and complete responses. Show Slide 5 and repeat the correct responses.

Slide 5

HIV AND AIDS

- HIV
- AIDS
- HIV is an STI
- Transmitted through the same behaviour (85% sexual route)
- Risk of STI = Risk of HIV

M-2/5

What are HIV and AIDS?

HIV stands for **H**uman **I**mmunodeficiency **V**irus, a retrovirus transmitted from an infected person through unprotected sexual intercourse, by exchange of body fluids such as blood, or from an infected mother to her infant. AIDS stands for Acquired Immunodeficiency Syndrome. AIDS is the stage of HIV infection that develops some years after a person has been infected with HIV. Since HIV is a STD and is transmitted through the same behavior that transmits other STIs, whenever there is a risk of STI, there is a risk of HIV infection as well (because almost 85% of HIV is known to be transmitted by the sexual route).

Now, pose a question to the group: "Some people use the term "STD" and others use "STIs". What would you prefer to use and why?"

Let 2-3 participants respond. If they respond correctly, repeat their answers to help reinforce the information. If you do not get a correct response, clarify that "STIs" is a better description as it includes all infections, both symptomatic and asymptomatic. The term "STD" denotes the full-blown disease but does not represent "asymptomatic infections".

Explain that from the standpoint of public health, it is essential that we take care of both symptomatic as well as asymptomatic infections in the community to help prevent these conditions in the long run.

STDs vs STIs

The term "STDs" stands for **S**exually **T**ransmitted **D**iseases. These are infections caused by germs such as bacteria, viruses or protozoa that are passed from one person to another through sexual contact. The term "**S**exually **T**ransmitted **I**nfections" (STIs) is used in place of STDs to indicate that infections do not always result in a disease. We consider these terms interchangeable in this training programme and will use the term "STI" for "STD" for the sake of simplicity.

Now, say: "You must have heard the term, "safe sex". What does it mean?"

Let 2-3 participants respond. Repeat the correct response clarifying that safe sex refers to managing a sexual act in such a way as to prevent both pregnancy and the transmission of sexually transmitted infections.

What is safer sex?

Safer sex refers to those practices that allow couples to reduce their chances of getting pregnant as well as of transmitting a STI. Generally, safer sex practices prevent contact with genital sores as well as the exchange of body fluids such as semen, blood and vaginal secretions.

Exercise

Next, take a flip chart with three concentric circles drawn on it . The outermost circle stands for RTIs, the middle one for STIs, and the innermost for HIV/AIDS.

Starting with the outer part of the outermost circle (representing RTIs), ask the participants to name as many RTIs as they can. Write the names on the flip chart on the outer side of the RTI circle. Complete the list using the content material.

Now, working inwards, ask the participants to name STIs. Write these names beside the middle circle (representing STIs), and complete the list using the content material. Finally, end with the innermost circle (HIV/AIDS). Make sure that all the content material is presented.

Ask: "What is the difference between HIV and AIDS, and why is it important to explain this when we counsel our clients?"

Possible responses could be:

– A person can be HIV-infected for years with no signs of illness and can continue a normal life, of course, always practicing prevention because s/he can infect another person.

– Early detection and treatment of opportunistic infections will have a positive impact on the progression of the disease.

– A person with AIDS must deal with illness that is often severe and eventually terminal.

If the response/s is/are incomplete, complete the discussion by supplementing relevant information.

SESSION 3

Epidemiology of STIs/RTIs: Global and country perspective

Objective:

At the end of this session, the participants will be able to:

- Discuss the basic epidemiology of STIs/RTIs from a global and country perspective

Say: "Now, let us discuss the extent of the STI/RTI problem in the world and in India. Before that, let us recall the definitions of two simple terms that we have studied during our basic medical education course."

Discuss the terms 'prevalence' and 'incidence' by giving illustrative examples of STIs/RTIs. Show Slide 6 and summarize, explaining the meaning of the two terms.

Slide 6

DEFINITIONS

- **Incidence**
  - New cases in a defined population in a specific time period
- **Prevalence**
  - Total cases (new and old) in a defined population at a specific point in time

M-2/6

What is prevalence?

Prevalence measures how much of some disease or condition there is in a population at a particular point in time. For example: "10% prevalence of chlamydia among pregnant women in a given population at a particular point in time" means that "10% of all pregnant women in the given population have chlamydial infection (both new and old cases) at that particular point in time.

What is incidence?

Incidence measures the rate of occurrence of new cases of a disease or condition in a population during a specified time period (usually a year). For example, the incidence of chlamydia in India in 2010 could be calculated by finding the number of new cases of chlamydia registered during 2010 and dividng that number by the population of India. As this incidence rate would be very small, the incidence rate is usually expressed as the number of new cases per 100,000 people.

Now, ask the participants to guess the number of STI cases worldwide and in India. After taking 2-3 responses, present WHO estimates of global and regional incidence and prevalence of curable STIs/RTIs by showing Slide 7.

Example: As per WHO estimates, about 340 million new curable STI/RTI cases occur globally, each year.

Slide 7

SITUATION IN THE WORLD

- 340 million new cases of curable STIs every year
  - 75-85% in developing countries
- 10 % adults newly infected with curable STIs
  - 12 million new cases of syphilis
  - 62 million new cases of gonorrhoea
  - 90 million new cases of chlamydia
  - 176 million new cases of trichomoniasis

M-2/7

Now, show Slide 8 and present the local statistics on STI/RTI trends in India.

Slide 8

SITUATION IN INDIA

Prevalence of **suggestive symptoms** of STIs/RTIs
- Women: 23 – 43%; Men: 4 – 9%
- 6% of men and 12% of women attending OPDs found to be having symptoms suggestive of STI/RTI (ICMR, 2005; multi-centric study, NIRRH, Mumbai)

STI clinic data indicate:
- Syphilis: 12.6 – 57% ; Chlamydia: 20-30%
- Chancroid: 9.9 – 34.7% ; Gonorrhoea: 8.5 – 23.9%

Hospital-based studies among men indicate:
- HSV : 3 –14.9%
- HPV: 4.9 –14.3%

Community-based **laboratory - supported** STI/RTI prevalence study, 2002 (ICMR-NACO)
- Prevalence of STIs/RTIs: 6% among adult population

M-2/8

Remember ...

- It would be ideal to get local statistics of STIs/RTIs from the State Directorate Office and the District MOH.
- Encourage participants to ask questions and raise concerns, if any.
- Encourage them to refer to various studies in India (see Annexure 1).

SESSION 4

Factors contributing to the spread of STIs/RTIs

Objectives:

At the end of this session, the participants will be able to:

- Describe the major factors contributing to the spread of STIs/RTIs
- Discuss why STIs/RTIs in women are different from STIs/RTIs in men

Initiate the discussion by asking the participants to name the major factors that contribute to the spread of STIs/RTIs in men and women.

The co-facilitator should write their responses on a flip chart.

After generating a list of about 5-6 factors, show Slide 9, compare and complete the participants' list. Explain each bullet point on the slide.

Slide 9

FACTORS CONTRIBUTING TO STI/RTI SPREAD

- Human behaviour – high-risk behaviour
- Lack of access to health care
- Lack of awareness about STIs/RTIs
- Migrant population
- Health care providers not adequately trained
- Poor medical services
- Hygiene and environmental factors
- Hormonal factors
- Socio-economic and other factors

M-2/9

Now, ask the participants to list various groups in the community who are at a high risk of contracting STIs/RTIs. If you do not get a spontaneous or expected response, name 1-2 high-risk community groups and encourage them to add to the list. After getting 3-4 responses, complete the discussion by showing the groups listed on Slide 10. Explain why each is a high-risk group.

Slide 10

HIGH-RISK & VULNERABLE GROUPS

Adolescent boys and girls
Women who have multiple partners
Sex workers and their clients
IDUs
Men and women who have to stay away from families for long
Men having sex with men, including transgender individuals
Partners of various high-risk groups
Street children

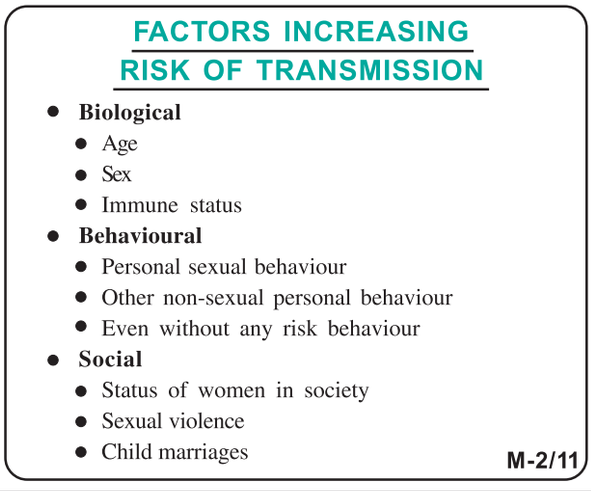
M-2/10

Next, ask: "Which three major factors increase the risk of STI/RTI transmission in an individual?"

The expected answers could be: biological, behavioral and social factors.

Show Slide 11 and explain why and how each factor on the slide increases the risk of STI/RTI transmission.

Slide 11

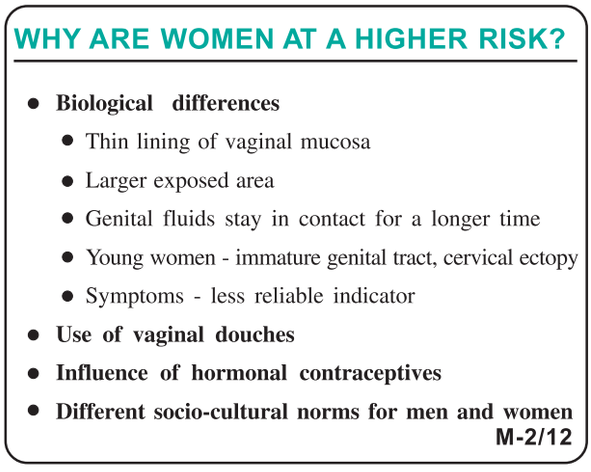


Now, ask the participants: "Who are at a greater risk of contracting RTIs/STIs, men or women?"

Let 2-3 participants respond. Ask them why they think so.

With the help of Slide 12, explain why women are more vulnerable to STI/RTI infections and why the management of STIs/RTIs can be more difficult in women than in men.

Slide 12



Conclude the discussion by emphasizing that health care providers need to pay special attention to vulnerable populations, high-risk groups, and women while providing STI/RTI services in their centres.

SESSION 5

Impact of RTIs/STIs: Need for prevention and management

Objective:

At the end of this session, the participants will be able to:

- Describe the impact of STIs/RTIs and understand the need for their prevention and management

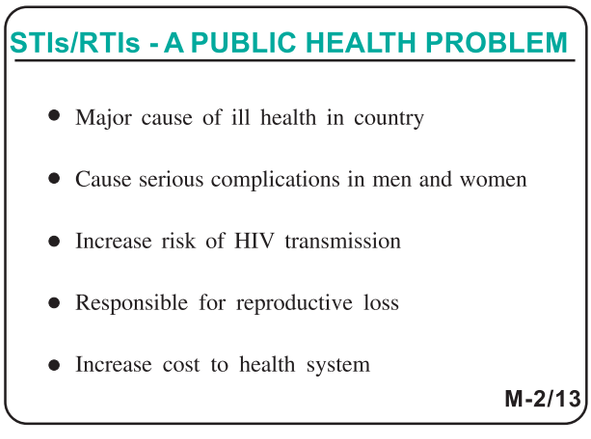
Summarize the earlier discussion by saying: "So far, we have talked about the definitions of basic STI/RTI management terms; the extent of the problem in the world, India and our state, and the factors that contribute to the spread of STIs/RTIs. We have also discussed why women are at a higher risk of contracting these infections."

Now ask: "Against the background of this information and from your own experience, can you tell us what makes STIs/RTIs an important public health problem in India?"

Write the responses on a flip chart.

Show Slide 13. Compare the participants' list with it and explain each bullet point on the slide to bring out the public health dimension of the STI/RTI problem in our country.

Slide 13



Why STIs/RTIs are an important health problem

- STIs/RTIs are increasing and constitute one of the major causes of ill health in our country as well as in the world. About 6% of the adult population in India suffers from a STI/RTI. This accounts for about 40 million episodes every year.
- STIs/RTIs increase the risk of HIV transmission.
- STIs/RTIs, if untreated, cause serious complications, including infertility, in men and women.

- STIs/RTIs are responsible for reproductive loss: spontaneous abortion, ectopic pregnancy, still birth, prematurity, and neonatal infections.
- In Indian women, one of the serious consequences of STIs/RTIs, if left untreated or inadequately treated, is cervical cancer.
- STIs/RTIs affect the larger community.
- Social impact of infertility:
  - ▲ Mother-to-child transmission causing perinatal mortality, morbidity such as disabilities, and maternal loss resulting in orphaned children
  - ▲ Maternal mortality due to bad obstetric practices
  - ▲ Socioeconomic impact of AIDS
  - ▲ Cost to national productivity
  - ▲ Decreased life expectancy
  - ▲ Increased cost to health systems
  - ▲ Psychosocial problems

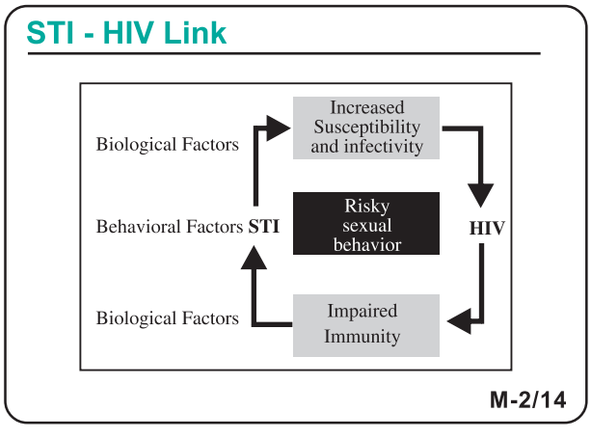
Say: "With the advent of HIV, the past two decades have seen STIs receiving greater attention. This is because of a strong and unique link between STIs and HIV."

Ask the participants: "What is the link between STIs and HIV?"

Let 2-3 participants respond. Look for correct and complete responses.

Now, show Slide 14 and explain the link.

Slide 14



HIV: Situation in the world

- According to the UNAIDS Global Report 2006, regions with the largest number of HIV infections include Sub-Saharan Africa, Asia, and Latin America.These are also the regions with the highest prevalence of curable STIs.
- In 2008, approximately 33.4 million people (including 2.1 million children under the age of 15) were infected with HIV whereas approximately 2.7 million people were newly infected with HIV.

  An estimated 2.0 million deaths due to AIDS were reported in 2008.

HIV: Situation in India

In India -

- Approximately 2.3 million people are living with HIV (2009).
- There are 195 Category A and B districts with a high prevalence of HIV.

Tips for Facilitators

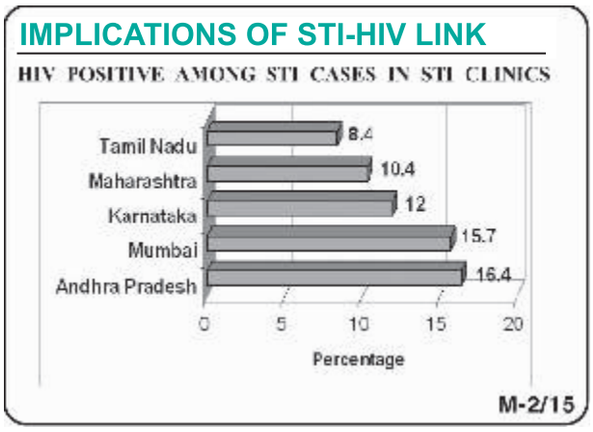
- ▲ Present the recent national statistics of HIV/AIDS. You can collect this from the Office of NACO.
- ▲ It is a good idea to get local statistics of HIV/AIDS from the State AIDS Control Society (SACS) and the District Hospital or MOH Office.
- ▲ Sentinel surveillance data are also available.

A person who has genital discharge due to chlamydial, gonorrhoeal, or trichomonas infection runs as much as four times the risk of contracting HIV from a sexual partner as a person who is not infected with one of these STIs. An ulcerative STI (such as genital herpes, syphilis, or chancroid) poses a significantly greater risk of HIV transmission per exposure than a non-ulcerative STI (such as gonorrhoea or chlamydia) because HIV can pass more easily through genital ulcers. However, STIs that do not cause ulcers also increase HIV risk because they increase the number of white blood cells (which have receptor sites for HIV) in the genital tract, and genital inflammation may result in damage that can allow HIV to enter the body more easily.

In addition, HIV infection may complicate the diagnosis and treatment of other STIs because HIV may change the pattern of the disease or the clinical manifestations of certain infections which, in turn, may affect laboratory tests. In people with HIV infection, STI symptoms may be more severe, the period of infectivity may be increased, and normal treatment regimens may fail.

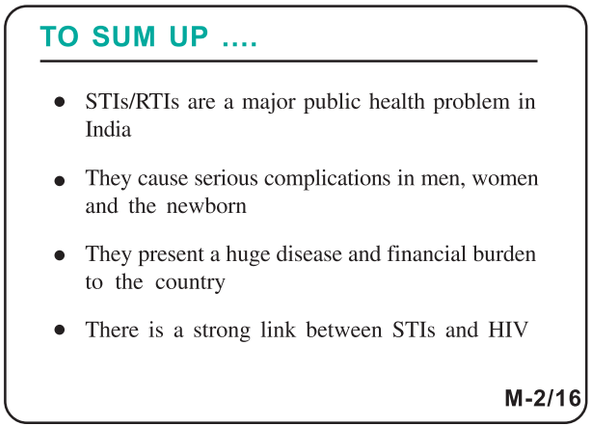
Now, show Slide 15 and explain how STI prevalence affects the spread of HIV. Give examples of the high prevalence states shown on the slide and explain the impact.

Slide 15



Finally, sum up the session, re-emphasizing the key issues mentioned on Slide 16.

Slide 16



SESSION 6

Challenges to STI/RTI prevention and management

Objective:

At the end of this session, the participants will be able to:

- List the challenges in to STI/RTI prevention and management and identify ways to meet them

Say: "In spite of the fact that STIs/RTIs and HIV are such a huge problem in our country, thereare still many barriers to treatment-seeking. Some barriers are at the level of the provider and/or the health system while others are at the level of the client. Let us try to identify the barriers at both these levels so that we can make the best possible attempt to overcome them."

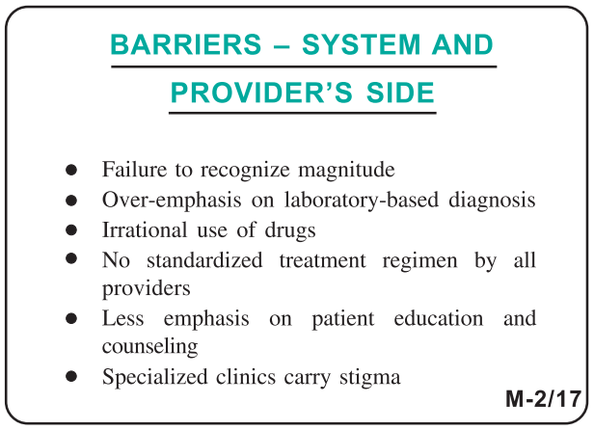
Quickly divide the participants into two groups, and ask the groups to list at least 5 barriers each for the provider/institution and the client.

Allow 2 minutes for group work.

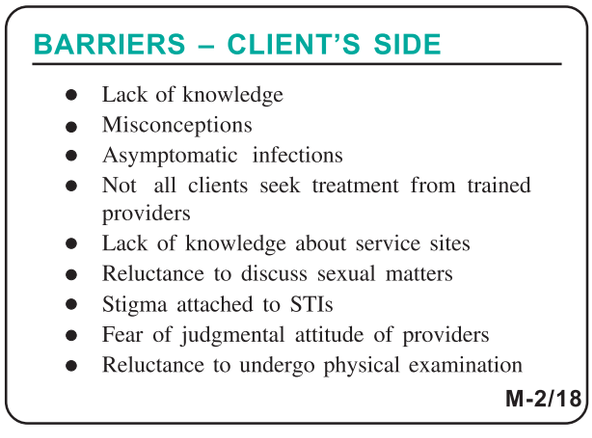
Ask one participant from each group to quickly read out the list prepared by her/his group.

Complete the discussion by comparing the lists with Slides 17 and 18.

Slide 17



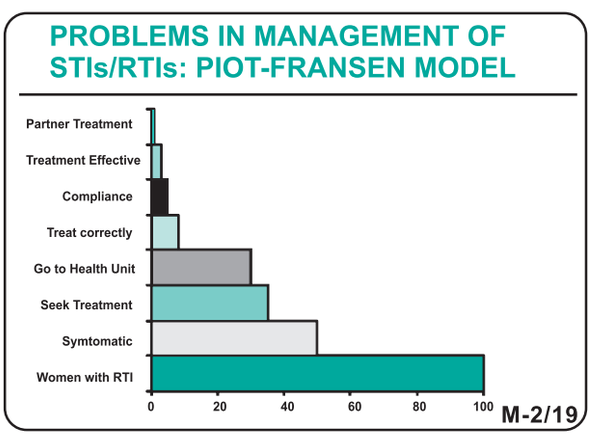
Slide 18



Show Slide 19 of a Piot-Fransen model and explain how the number of individuals with STIs/RTIs gets reduced as we move upwards from the lowermost bar to the topmost, and only a few get cured of the infection/s.

Emphasize that we can change this picture if we work together to tackle STIs/RTIs by going beyond treatment and providing education and counseling to individuals and the community at large.

Slide 19



The Piot-Fransen Model of STI/RTI Control

The Piot-Fransen model of STI/RTI management graphically sums up the problems in the treatment of STIs/RTIs. The model illustrates some of the obstacles to STI/RTI control. The lowermost bar represents all women with STIs/RTIs in a community while the subsequent bars show the number of individuals identified at each step. The difference between the bars illustrates lost opportunities for preventing STI/RTI transmission.

A comparison of the small topmost bar with the lowermost one shows the proportion of all people with STIs/RTIs in the community who are identified and correctly managed at health facilities. In the typical clinical approach to STI/RTI control, the contribution of clinical services is small. For example, suppose 100 women in your community have STIs/RTIs. Of these women, less than half are likely to have symptoms. Even among symptomatic women, however, perhaps only half will seek or have access to health care at a clinic. Thus, in this example, already less than one-quarter of the women with STIs/RTIs seek care from a qualified health worker.

Then, there are other obstacles:

- How many of the symptomatic women who come to your clinic are accurately diagnosed?
- Even when diagnosed correctly, do the women leave with effective medication and take all the prescribd medication?

- Finally, do women treated for a STI/RTI have their partners treated successfully at the same time to ensure that they are not re-infected?

These are some of the key issues to consider while deciding whether or notthe STI/RTI services that you provide will make a difference in your community.

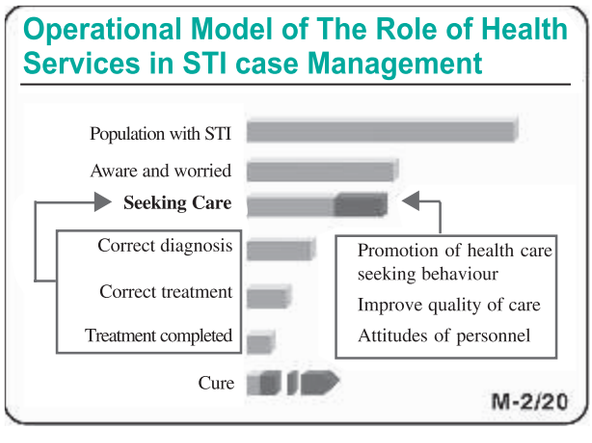
Improving STI/RTI case management at clinics expands the smallest bar resulting in higher cure rates among those who seek care. Nevertheless, it is apparent that improving services has its limits. Clients do not usually visit a health centre unless they have symptoms, and many do not visit even if they have symptoms. Moreover, even among those with symptoms, some choose to seek care from places other than clinics and hospitals. Self-treatment, direct purchase of antibiotics from pharmacists or drug peddlers, and consultation with traditional healers are among the many options available to an individual with STI/RTI symptoms.

In order to convince people to use clinic services, information about STIs/RTIs and the importance of prompt treatment must be available at the community level.

Now, show Slide 20 of a model presented by WHO, and explain by saying: "If strategies for improving health-seeking behaviour are implemented in the community, and supplemented by high-quality services and proper provider attitudes, more and more clients might seek STI/RTI services.

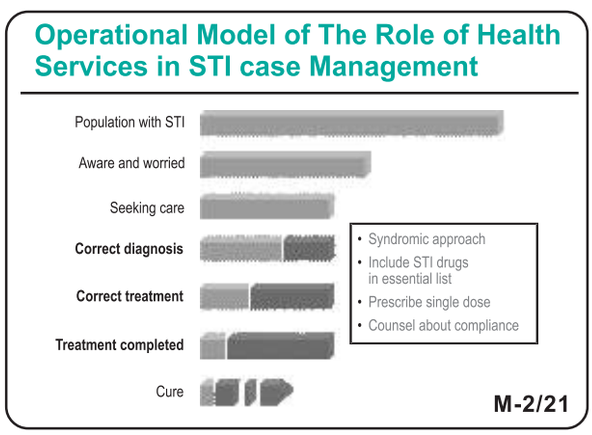
"High-quality services include correct and complete diagnosis and treatment that cures cases. Providing such services will motivate more clients to seek STI/RTI services."

Slide 20



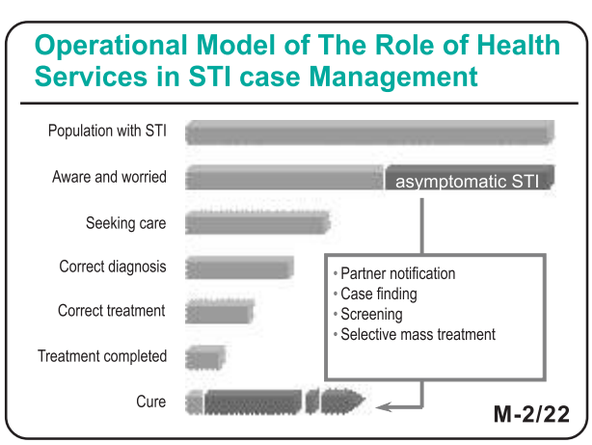
Next, show Slide 21 and explain that the use of the syndromic approach by health care centres will not only result in an increase in correct diagnosis and treatment at first visit but also in better client education and counseling. As a result, a higher proportion of clients will complete the treatment and get cured.

Slide 21



Now, show Slide 22 and clarify that the proper implementation of measures such as partner notification, screening for STIs/RTIs and selective mass treatment will result in increased detection and treatment of asymptomatic infections in the community.

Slide 22



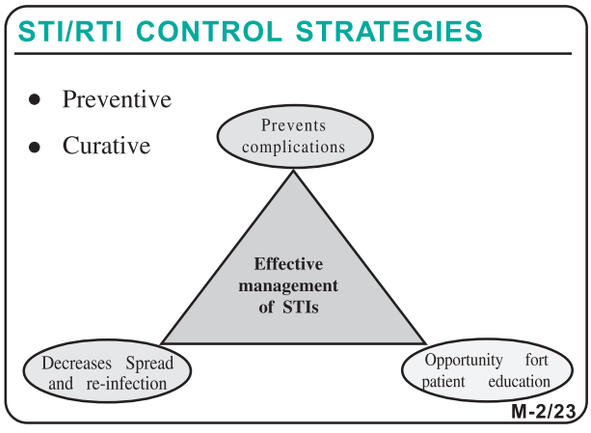
Wrap up the discussion on the Piot-Fransen model by saying: "Thus, there are definite strategies that health care providers can use to bring about a positive change in the situation shown in the Piot-Fransen model by offering high-quality STI/RTI services to needy population groups. We will discuss this aspect in subsequent modules and identify ways of contributing to these efforts."

Next, tell the participants that it is important to use a two-pronged strategy to deal with STIs/RTIs. This comprises preventive as well as curative strategies.

Show Slide 23 and explain that a curative strategy is not just about providing pharmaceutical treatment but also includes client education and prevention of complications and re-infection.

Assure the participants that we will discuss each of these issues in detail in subsequent sessionsto enable us to control STIs/RTIs in our town, state and country as a whole.

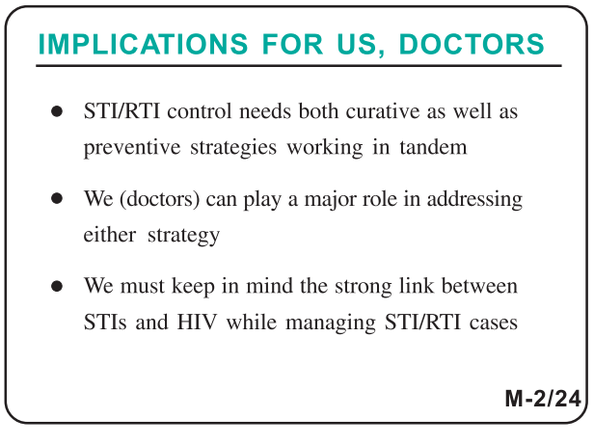
Slide 23



Finally, ask the participants to summarize the key issues discussed in the session and the key learning points that they have gathered as doctors providing STI/RTI services.

After taking a few responses, show Slide 24 and explain by saying: "Although, as doctors, we provide medical services to STI/RTI clients visiting our clinics, we must give equal importance to the preventive aspects of STIs/RTIs. This is because, since the advent of HIV, these infections have assumed a different and urgent dimension and are consuming the valuable resources of our health system."

Slide 24



Annexure 1:

Table 1: Published Prevalence of Sexually Transmitted Infections in Men in India

	Prevalence ranges (%)								
	Bacterial STIs				Protozoal STIs	Viral STIs			
Study Population	Gonorrhoea	Chlamydia	Syphilis	Chancroid (Clinical diagnosis)	Trichomon-iasis	Herpes simplex (Clinical diagnosis)	Human Papilloma Virus (Clinical diagnosis)	HbsAg (Hepatitis B surface antigen)	HIV (Human Immuno-deficiency Virus)
Community-based or convenience samples									
Male subjects aged 15 to 45 years (1)	3.4	2.0	0.3	-	-	-	-	6.0	1.4
Male participants of a community education programme (2)	1.7	15	-	-	5.6	-	-	-	0.4
Transport and industrial workers (3)	2.1	-	0.8-4.4	-	-	-	-	-	-
Facility-based									
STD clinic patients (4-11)	8.5-25.9	20.0-30.0	12.6-57.0	16.1-34.7	-	3.0-14.9	4.9-14.3	-	2.0-7.4
Patients attending primary health care centers(3)	-	-	3.6	-	-	-	-	-	-
Specific groups									
Spouses of women with Candida and Trichomonas infections (13)	-	-	-	-	60.6	-	-	-	-

[Source: **Diverse realities: Sexually transmitted infections and HIV in India**
S Hawkes[1] and K G Santhya[2]
[1] Clinical Research Unit, London School of Hygiene & Tropical Medicine, London, UK
[2] Population Council India, New Delhi, India
Sexually Transmitted Infections 2002; 78:31 © by BMJ Publishing Group Ltd
http://sti.bmjjournals.com/cgi/content/full/78/suppl1/i31#T1]

Annexure 1:

Table 2: Published Prevalence of Sexually Transmitted Infections in Women in India

	Prevalence ranges (%)								
	Bacterial STIs				Protozoal STIs	Viral STIs			
Study Population	Gonorrhoea	Chlamydia	Syphilis	Chancroid (Clinical diagnosis)	Trichomoniasis	Herpes simplex (Clinical diagnosis)	Human Papilloma Virus (Clinical diagnosis)	HbsAg (Hepatitis B surface antigen)	HIV (Human Immuno-deficiency Virus)
Community-based									
Ever/currently married women (14-17)	0.0-4.2	0.5-28.7	0.2-8.8	-	4.3-27.4	-	11.8	-	-
Unmarried and married women (1, 20, 21)	0.3-3.9	5.2	0.2-10.5	-	0.8-14.0	-	-	4.8	2.0
Facility-based and convenience samples									
STD clinic patients (4,7,8,10,11,22)	1.3-10.4	-	29.3-43.3	-	-	4.0-15.4	6.7-15.6	-	1.2-13.6
Commercial sex workers (22-24)	4.9-16.5	-	30.0-63	-	-	-	0.5	-	49.9
Gynecological OPD patients (25-35)	1.0-5.5	0.2-31.3	4.4-5.6	-	0.4-26.0	0.3-25.0	0.6-42.4	-	0.0
Antenatal patients (3, 25, 36-39)	-	2.3	1.0-6.2	-	17.8	-	-	-	0.1-1.2
Gynecological patients with "vaginitis" complaints (40-42)	0.0-2.6	2.6-12.2	2.2	-	1.6-17.6	-	-	-	-
Gynaecological patients with "cervical erosion" (43-44)	-	3.0	-	-	-	-	-	-	-
Infertility & PID patients (45-48)	0.1-11.0	0.5-24.2	0.5	-	0.5	-	-	-	-
Acceptors of tubal ligation (48-49)	0.1-2.2	0.0-0.2	0.5-7.0	-	0.9	-	-	-	-

[Source: **Diverse realities: sexually transmitted infections and HIV in India**

S Hawkes[1] and K G Santhya[2]

[1] Clinical Research Unit, London School of Hygiene & Tropical Medicine, London, UK

[2] Population Council India, New Delhi, India

Sexually Transmitted Infections 2002; 78:31 © by BMJ Publishing Group Ltd

http://sti.bmjjournals.com/cgi/content/full/78/suppl1/i31#T1]

Module 3

Common STIs/ RTIs and their Complications

MODULE3

Common STIs/RTIs and their complications

Learning Objectives:

At the end of this module, the participants will be able to:

1. Identify the sites of occurrence of STIs/RTIs in females and males
2. List and describe the signs and symptoms of common STIs/RTIs
3. Describe various ways of classifying STIs/RTIs
4. List the complications of STIs/RTIs

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Blank flip charts
- Two flip charts with drawings of the male and female reproductive system.
- 20 copies of the case study hand-out (for Session 4)
- Marker pens

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Keep the two flip charts with drawings of the male and female reproductive system.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1	Introduction to Module 3	Interactive presentation and discussions
2	STIs/RTIs and their signs and symptoms	
3	Classification of STIs/RTIs	
4	Complications of STIs/RTIs	

SESSION 1

Introduction to Module 3

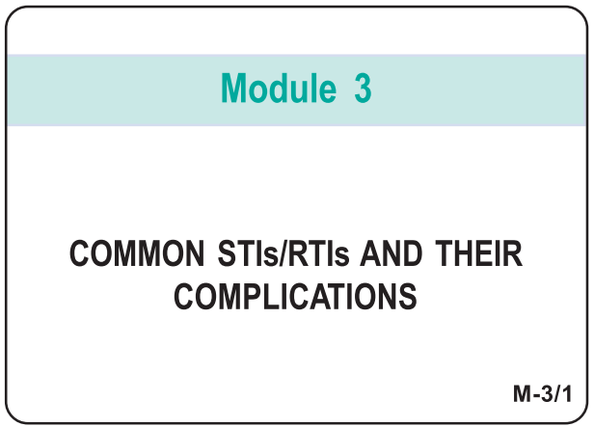
Objective:

At the end of this session, the participants will be able to:

- Provide an overview of the module including its objectives

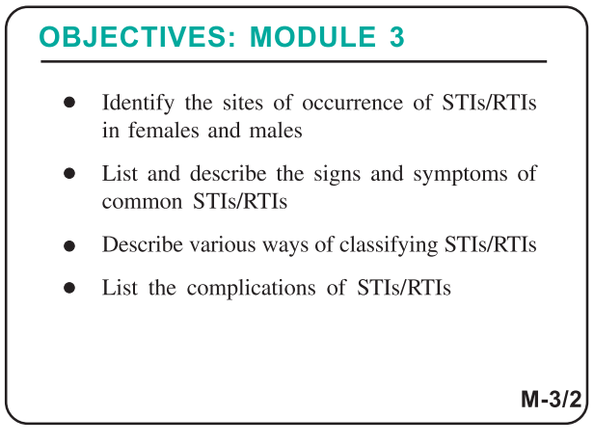
Show Slide 1 and tell the participants that this module will cover STIs/RTIs that commonly occur in men and women, their signs and symptoms, and ways of classifying them. Finally, we will look at the complications that can occur in men, women and neonates if these infections are not treated.

Slide 1



Now show Slide 2 and explain each objective of the module

Slide 2



SESSION 2
STIs/RTIs and their signs and symptoms

Objectives:

At the end of this session, the participants will be able to:

- List the different STIs/RTIs in males and females
- List and describe the signs and symptoms of common STIs/RTIs

Before the session begins, arrange two flip charts on stands, facing the class. Write "Male" at the top of one flip chart, and, "Female", at the top of the other. Divide each flip chart verticallyinto two columns. On both flip charts, write "STIs" at the top of one column and "RTIs" at the top of the other.

Begin the session by saying: "Now, we are going to discuss different types of STIs and RTIs in males and females."

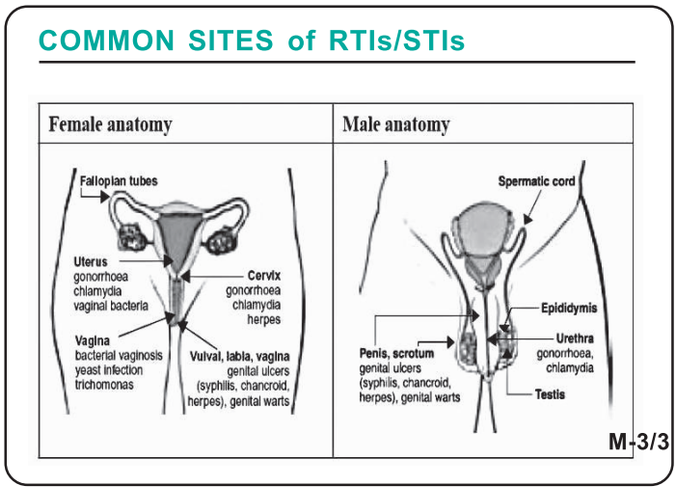
Tell the participants that there are two flip charts in front of them. Invite them to come forward, one by one, and write the name of one STI and one RTI on any one flip chart.

Involve as many participants as possible in listing STIs/RTIs.

After all of them have participated in the activity, show Slide 3 which depicts the female and male reproductive systems and the sites where STIs/RTIs commonly occur.

Next, show Slide 4 which presents the commonly occurrng STIs/RTIs in women and men. Compare the participants' lists with it and complete the lists.

Slide 3



Slide 4

COMMON STIs/RTIs

- Gonorrhoea
- Chlamydia
- Syphilis
- Chancroid
- Genital herpes
- LGV
- GV
- Trichomoniasis
- Genital warts
- Candidiasis
- HIV
- HBV
- Genital scabies
- Pubic lice
- Molluscum contagiousum
- Bacterial vaginosis

M-3/4

Now, ask the participants to think about some signs and symptoms suggestive of STIs/RTIs in men and women. Tell them not to consider a specific STI, but to think of the signs and symptoms that would make one suspect a STI.

Suggest that they list these separately for men and women. Ask half the participants to make a list for men and the other half, for women.

Allow 5 minutes for listing and take their responses. Request your co-facilitator to note the responses on a flip chart, separately for men and women.

Appreciate the group if you get a good list. Show Slides 5 to 7 and complete the list.

DO NOT FORGET TO MENTION THAT STIs/RTIs CAN BE ASYMPTOMATIC

Slide 5

SYMPTOMS AND SIGNS OF STIs/RTIs IN MEN

- Urethral discharge/ Burning or pain during micturition or urination / frequent urination
- Genital itching
- Inguinal swelling / scrotal swelling / swollen and painful testicles
- Blisters or ulcers on the genitals, anus or surrounding area, mouth, lips
- Itching or tingling in genital area
- Warts on genitals, anus or surrounding area
- Fever, body ache, muscle ache, dark-coloured urine, jaundice etc.

M-3/5

Slide 6

SYMPTOMS AND SIGNS OF STIs/RTIs IN WOMEN

- Unusual vaginal discharge
- Genital itching
- Abnormal and / or heavy vaginal bleeding
- Dyspareunia
- Lower abdominal pain (pain below the belly button, pelvic pain)

M-3/6

Slide 7

SYMPTOMS AND SIGNS OF STIs/RTIs IN WOMEN contd.....

- Blisters/ulcers on the genitals, anus or surrounding area, mouth, lips
- Burning during micturition
- Itching or tingling in genital area
- Warts on genitals, anus or surrounding area
- Fever, body ache, muscle ache, dark-coloured urine, jaundice etc.

M-3/7

SESSION 3

Classification of STIs/RTIs

Objective:

At the end of this session, the participants will be able to:

- Describe various ways of classifying STIs/RTIs

Tell the participants that STIs/RTIs can be classified in three different ways namely, according to the causative organisms (bacterial, viral, protozoal etc.), by their mode of transmission, and by the most common presenting symptoms.

Show Slide 8 and explain, giving 1-2 examples of each method of classification. Tell the participants that we will now discuss each method in detail.

Slide 8

WAYS OF CLASSIFYING STIs/RTIs

- According to causative organisms
- According to mode of transmission
- According to most common presenting symptoms

M-3/8

Take up the first method of classification based on the causative organisms. Ask the participants to give two examples of each category of organism - bacterial, viral, mixed etc. Show Slide 9 and provide more examples.

Slide 9

CLASSIFYING STIs/RTIs BY CAUSATIVE ORGANISMS

- **Bacterial:**
  - Gonorrhoea, Chlamydia, Syphilis
- **Viral:**
  HSV, HPV, HIV, HBV
- **Protozoal:**
  - Trichomoniasis
- **Fungal:**
  - Candidiasis
- **Mixed:**
  - PID, Epididymitis

M-3/9

Now, ask the participants if they can tell the group how STIs/RTIs can be classified according to the mode of transmission.

Let 2-3 participants respond. Commend them if you get the desired response/s. Complete the discussion by showing Slide 10.

Slide 10

CLASSIFYING STIs/RTIs BY MODE OF TRANSMISSION

- **Endogenous infections:**
  - Examples: yeast infection, vaginosis
- **Sexually Transmitted Infections:**
  - Examples: gonorrhoea, chlamydia, syphilis
- **Iatrogenic Infections:**
  - Examples: PID following abortion or transcervical procedures

M-3/10

Next, tell the participants that the third way of classifying STIs/RTIs is according to the most common presenting symptoms.

Provide some examples such as urethral discharge, genital ulcer, inguinal bubo etc.

Emphasize that this is the most practical and simple way of classifying STIs/RTIs as it makes it easy for the provider to diagnose a case. As a result, the "National Technical Guidelines" and Medical Officers Participant Handout also recommend this classification for defining various STI syndromes for syndromic management.

Conclude the session by assuring the participants that we will review this classification system in detail in the next module when we discuss syndromic management of STIs/RTIs

Slide 11

CLASSIFYING STIs/RTIs BY SYMPTOMS

Symptoms	Syndrome
Urethral discharge	Urethral discharge syndrome
Genital ulcers	Genital ulcer syndrome
Inguinal bubos	Inguinal bubo syndrome
Scrotal swelling	Painful scrotal swelling
Genital skin conditions	Genital warts, molluscum
Ano-rectal discharge	ARD (Ano-rectal discharge)
Vaginal Discharge	Vaginal Cervical Discharge Syndrome

M-3/11

SESSION 4

Complications of STIs/RTIs

Objective:

At the end of this session, the participants will be able to:

- List the complications of untreated STIs/RTIs in males, females and neonates

Give a brief summary of what has been discussed so far. Say: "So far, we have discussed the body sites where STIs/RTIs can occur, common STIs and RTIs and ways of classifying them. Now, let us discuss the complications or consequences of STIs/RTIs when they are left untreated."

Encourage the participants by saying: "I am sure you have a fair idea about the complications of untreated STIs/RTIs."

Assuming that the participants would be seated in a scattered table arrangement, assign the following topics to different table groups.

- Complications of untreated STIs/RTIs in men
- Complications of untreated STIs/RTIs in women
- Complications of untreated STIs/RTIs in neonates

Allow 5 minutes for group discussion. Ask the groups to note as many complications as possible. Encourage them to think beyond complications of the reproductive system.

After 5 minutes, ask a representative of each group to present her/his group's findings to the larger group. Request your co-facilitator to list these on separate flip charts for each group.

If a topic has been assigned to more than one group, request the groups not to repeat what has already been mentioned by other groups. Or. ask each group to name only 3-4 complications.

After the findings of all the groups have been listed on flip charts, complete the lists by comparing them with Slides 11 to 15.

Slide 11

COMPLICATIONS IN MEN

- Urethral stricture
- Phimosis / paraphimosis
- Disfigurement of genitals
- Infertility
- Meningovascular / Cardiovascular complications (syphilis)
- Epididymitis
- Orchitis

M-3/11

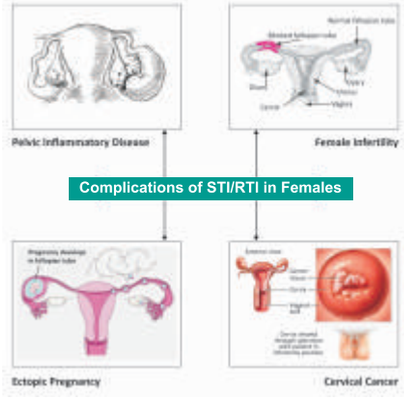
Slide 12

COMPLICATIONS IN WOMEN

- Pelvic Inflammatory Disease (PID)
- Infertility
- Ectopic pregnancy
- Spontaneous abortion
- Stillbirth
- Low birth weight babies
- Increased susceptibility to opportunistic infections
- Cervical cancer
- Chronic pelvic pain

M-3/12

Slide 13



M-3/13

Slide 14

COMPLICATIONS IN NEONATES

- Opthalmia neonatorum
- Sepsis
- Arthritis
- Meningitis
- Infant pneumonias
- Mental retardation
- Low birth weight

M-3/14

Slide 15

SYSTEMIC COMPLICATIONS

- Gastrointestinal: proctitis, proctocolitis, enteritis
- Renal: acute membranous glomerulonephritis
- Neurological: meningovascular involvement, tabes dorsalis, GPI
- Cardiovascular: myocarditis, aortitis, aneurysms
- Ophthalmic: aveitis, iritis, choroidoretinitis
- Musculoskeletal: osteomyelitis, arthritis, myopathy
- Septicemia

M-3/15

Finally, show Slide 16 and summarize the discussion, emphasizing the following:

- STIs/RTIs occur in both men and women and infect the reproductive organs.
- STIs/RTIs can be classified according to the causative organism and mode of transmission. However, classifying them by their presenting symptoms is more effective as it helps providers to make a quick and easy diagnosis and manage STIs/RTIs syndromically.
- There are many complications of STIs/RTIs in men, women and neonates. Therefore, providers must not waste any opportunity of treating STIs/RTIs at the first visit.

Slide 16

TO SUM UP .....

STIs/RTIs

- Occur both in men and women; infect the reproductive organs
- Classified according to the causative organism and mode of transmission
- Classification by presenting symptoms is practical for providers for easy and quick syndromic diagnosis and management of STIs
- Besides HIV infection, many other dreaded complications of STIs in men, women and neonates
- Therefore, health care providers must not waste any opportunity of treating STIs/RTIs at the first visit

M-3/16

Annexure 2 :

Complications of untreated STIs/RTIs

Disease	Complications/sequelae
Chlamydia	*In men:* Urethritis, epididymitis, Reiter's syndrome*, proctitis, infertility *In women:* Pelvic inflammatory disease (PID), ectopic pregnancy, infertility *Mother to infant:* Respiratory infection, pneumonia, eye infection.
Gonorrhoea	*In men*: Urethritis, epididymitis, urethral stricture, infertility *In women*: PID, ectopic pregnancy *Mother to infant*: Eye infection, joint infection, life-threatening blood infection
Trichomoniasis	*In men*: Urethritis, prostatitis, urethral stricture, infertility *In women*: Uncomfortable symptoms persist for years *Mother to fetus*: Low birth weight, prematurity
Syphilis	*In men & women*: Complications of late syphilis like cardiovascular syphilis (heart disease, aortitis, aneurysm), neurosyphilis (brain damage, blindness), destructive lesions of the skin and bones, death. *Mother to fetus*: Spontaneous abortion, still birth or neonatal death
Chancroid	*In men & women*: Slow and often incomplete resolution. Can lead to urethral fistulas in men, severe genital scarring in both
Herpes	*In men & women*: Primary infection can affect central nervous system (CNS), causing stiff neck, headache, and abnormal sensitivity to light. Proctitis *In women*: Cervicitis *Mother to infant*: Infant can be infected at birth if mother has the episode
Lymhogranuloma venereum	*In men & women*: Fibrous masses, scars, inguinal groove, fistula, chronic inflammation of lymph nodes, urethritis *In women*: Cervicitis

Module 4

History Taking and risk Assessment

MODULE 4

History Taking and Risk Assessment

Learning Objectives:

At the end of this module, the participants will be able to:

1. Get an overview of the module and its learning objectives
2. List the goals of taking a client history for STIs/RTIs
3. Identify the information and skills necessary for accurate history taking
4. Define risk assessment and explain its use in STI/RTI prevention and limitations in STI/RTI management

Demonstrate history taking and risk assessment using a standardized checklist

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Blank flip charts
- Two flip chart with drawings of the male and female reproductive system
- Marker pens

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1	Introduction to Module 4	Interactive presentation and group exercises
2	Goals and prerequisites of good history taking	
3	History taking steps and their sgnificance	
4	Risk assessment: Uses and limitations	
5	Demonstration of history taking and risk assessment	

SESSION 1

Introduction to Module 4

Objective:

At the end of this session, the participants will be able to:

- Provide an overview of the module including its objectives

The trainer should present the module introduction and objective using the prepared flipchart

Present the module introduction given below.

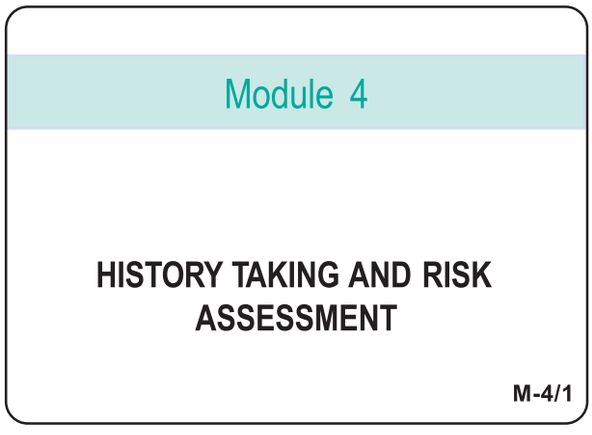
Introduction

Client/Patient history is taken to get the information that is required to make an accurate assessment of the client's problem/s and provide appropriate treatment. It is one of the most important and sensitive parts of patient encounter because we ask questions and probe the client's sexual behaviours and concerns. Risk assessment involves finding out how likely it is that the client has been or will be exposed to a STI/RTI.

In this module, we will cover the elements of history taking and risk assessment required to counsel patients in STI/RTI prevention and for syndromic management of STIs/RTIs. Counseling and communication skills will be covered in a subsequent module on "Client education and counseling".

Now, show slide 1. Remind the participants about the steps in management of a typical clinical case. The first step is to interview the client or take a client history.

Slide 1

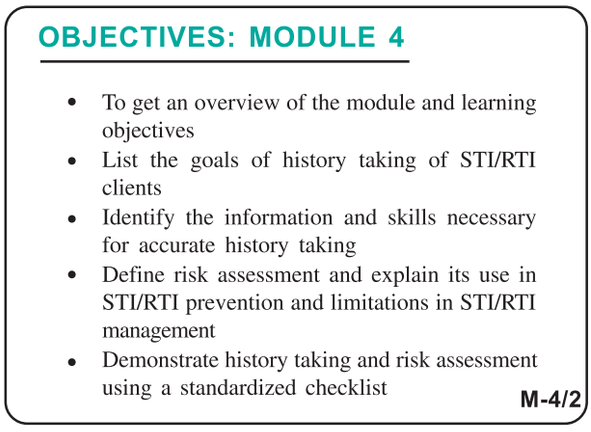


State that we will discuss various aspects of good history taking in this session. Acknowledge that, being doctors, most participants would know the major points of history taking. Therefore, the facilitators expect active participation from everyone.

Tell them that in addition to the routine points of taking client history, we will focus on the relevance of each point in the context of RTIs/STIs with an emphasis on "risk assessment'.

Now show Slide 2 on the objectives of the module and explain each objective.

Slide 2



SESSION 2

Goals and prerequisites of good history taking

Objectives:

At the end of this session, the participants will be able to:

- List the goals of taking the history of a STI/RTI client
- Describe the prerequisites of good history taking

Start the discussion by saying: "Being doctors, most of you must have taken a number of patient/client histories."

Ask: "What are the goals of taking a client history? What outcomes do you expect?"

Let 2-3 participants respond. You will probably get correct responses. Commend participants for correct responses.

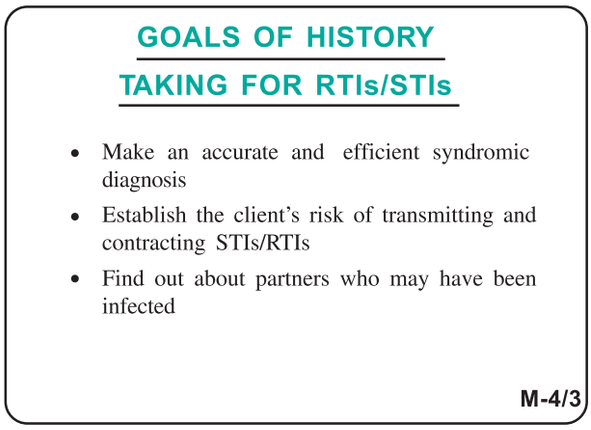
Now, ask: "What specific changes in routine history taking would you like to make if you were to suspect that your client is suffering from a STI/RTI?"

On getting 2-3 responses, show Slide 3 and explain the goals of taking the history of a STI/RTI client. Clarify that risk assessment is an integral part of STI/RTI history taking in addition to obtaining general information and the medical history of the client.

Say: "While general and medical histories will help you to arrive at a clinical diagnosis, the details obtained during risk assessment will provide clues for tailoring patient education messages to meet the individualized needs of the client."

Remind the participants that besides pharmaceutical treatment, partner treatment, patient education, and counseling are integral components of STI/RTI management.

Slide 3



Explain each goal clearly, emphasizing the sensitive nature of information-gathering which entails asking personal, sexuality-related questions about the client and her/his partners.

Ask: "Given this sensitive background, would the interviewer/service provider need certain special skills?"

Get responses from the participants. These may include: good communication skills, knowledge about STIs/RTIs, rapport building etc. These are good responses. Ask the respondents to elaborate and try to get the finer aspects or details of each response.

Now, show Slide 4 and explain the prerequisites of good history taking.

Slide 4

PREREQUISITES OF GOOD HISTORY TAKING

- Privacy and confidentiality
- Rapport building
- Good verbal and non-verbal communication skills
- Unbiased / non-judgmental attitude of provider

M-4/4

Ask the participants about the current arrangements for privacy in their clinics. Share your own experiences of visiting different clinics.

Ask them how important they think privacy is for getting correct and complete information from STI/RTI clients.

State that privacy can be ensured by raising physical barriers, but how would they assure confidentiality?

Inform the participants that under NACP III, all designated STI clinics should have visual and auditory privacy. Tell them to refer to the "Operational Guidelines" for further details.

Ask each participant to write 2-3 ways of assuring STI/RTI clients of confidentiality, in her/his own setting. Allow 2 minutes for writing and take their responses.

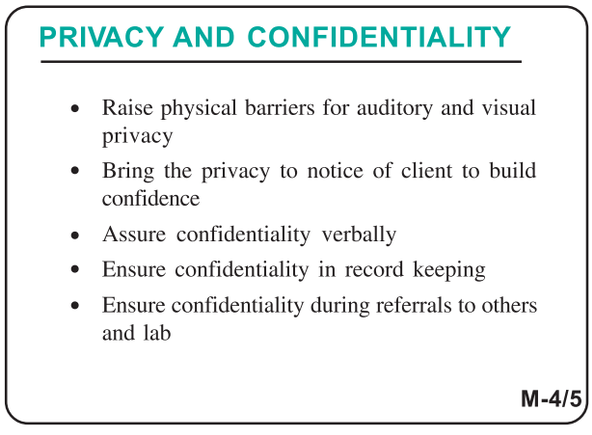
Clarify that many providers think and actually keep their conversations with patients very confidential. However, during history taking, it is not only important for providers to maintain their patients' confidentiality but to understand that their patients also need to be assured of the confidentiality of all the services that they receive.

Now, ask the participants to take a minute and think of 2-3 statements to say to a STI/RTI client to make her/him feel confident that the information that s/he gives her/him will be kept strictly confidential.

When the participants are ready with their responses, ask 3-4 of them to come forward and talk to you as if to a STI/RTI client and assure you of confidentiality and privacy.

After the exercise, show Slide 5 and summarize the importance of privacy and confidentiality. Remind them that in the absence of privacy and confidentiality, the client will not reveal all her/ his personal details to you, and this might affect your diagnosis and the overall management of the case.

Slide 5



Privacy and confidentiality

Privacy and confidentiality are paramount for accurate history taking, especially in the case of STIs/RTIs because the patient is required to reveal personal information when s/he is already under the tremendous pressure of stigma. Therefore, it is best to ensure auditory as well as visual privacy during both history taking and clinical examination of STI/RTI clients.

Now, initiate the discussion on communication skills.

Ask each participant to list 3-4 key elements of communication that are essential for accurate history taking and risk assessment.

Potential responses could include: asking good questions, using proper language, being polite, non-verbal skills etc. These are good responses. Appreciate them.

Affirm that it is important to establish good rapport with the client through verbal communication as well as by way of non-verbal communication or actions.

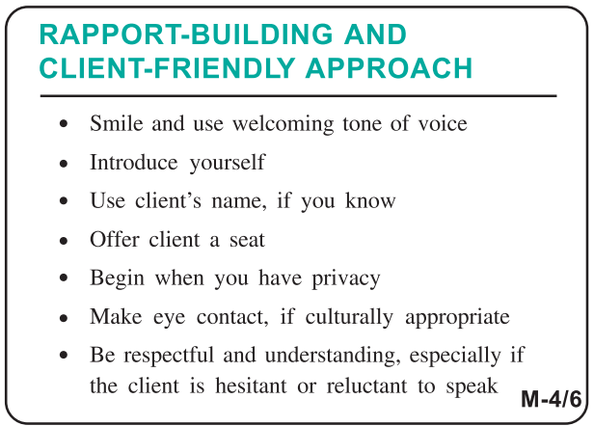
Remind the participants that we have already discussed the issue of privacy and confidentiality. Tell them that their clinic/centre has been provided with adequate grants/financial support for making structural changes to ensure client privacy and confidentiality.

Next, ask them to work in their table groups and list 5-6 actions that they would like to perform to make a client comfortable and ready for a good history taking session. Give them a clue that these actions could include verbal, non-verbal or physical actions.

Allow 5 minutes for group work. Then ask each group to share its findings with the larger group.

Summarize the discussion by showing Slide 6.

Slide 6

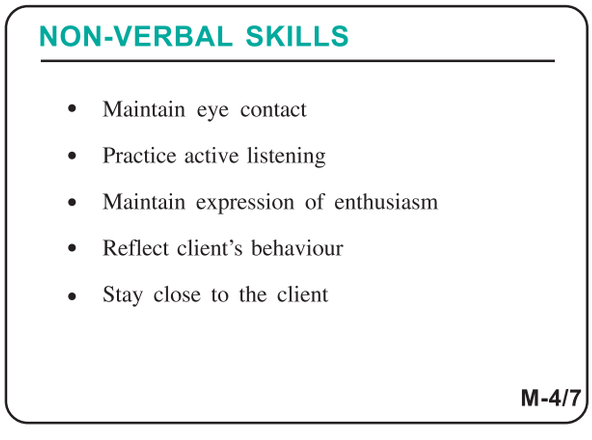


Now, ask the participants which non-verbal skills they would use to facilitate the process of gathering information during history taking.

Let 2-3 participants respond.

Show Slide 7 and explain each bullet point, using the text given below the slide.

Slide 7



Maintain eye contact: Where culturally appropriate, maintain eye contact with the client to make her/him feel that you are interested in what s/he is saying. It not only shows your confidence in yourr own competence as a doctor but more importantly, your confidence in your client and concern for her/ his problem which may help drive away the client's shyness or reluctance to talk.

Practice active listening: During the discussion, it is not enough to listen carefully; it is equally important to make the client feel that you are listening to her/him. This can be done through appropriate facial expressions, nodding the head (agreeing, disagreeing), verbal cues such as "hmm", what happened next" etc, and leaning slightly towards the client when s/he is talking.

Express empathy with your client: For example, sit when the client is sitting, stand when the client stands; lean forward or backwards when the client does so. This is a useful way of showing that you share your client's feelings. This also shows that you are equal - standing over someone can sometimes seem threatening.

Stay close to your client: Stay close to the client, as is culturally appropriate. A desk or table forms a barrier between the client and service provider. Therefore, it is better to sit at the corner of the desk or ask the client to sit on a stool close to your chair.

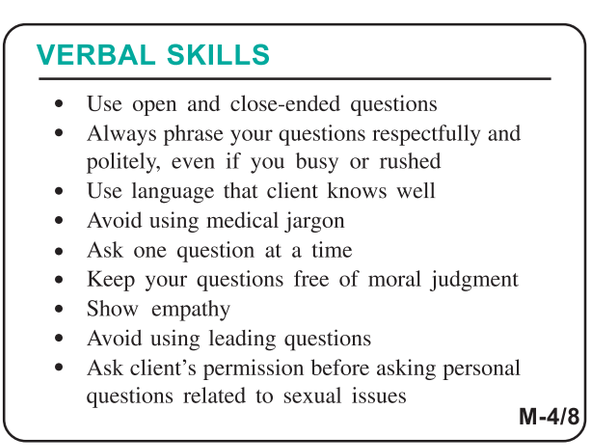
Inform the participants that we will soon be practicing these skills in the classroom and in the clinic during clinical practicum on Day 3 of the Workshop.

Now, initiate the discussion on verbal skills. Ask:"What are the verbal skills required for facilitating history taking?"

Note the responses.

Show Slide 8 and explain it using the text given below the slide. Emphasize the importance of using verbal and non-verbal skills in tandem.

Slide 8



Open- and close- ended questions

Open-ended questions are very important for getting detailed responses. Close-ended questions usually result in brief responses such as "yes" and "no".

Examples of open-ended questions:

- "What medicines are you taking for your problem?"
- "Can you describe how the condition progressed?"
- "What problems are you facing due to these symptoms?"

Examples of close-ended questions:

- "Is the swelling painful?"
- "Have you undergone any test for diagnosis?"

"Do you have a regular partner?"

Remember...

Open-ended questions enable the patient to state in detail, and in her/his own words, something that s/he thinks is important. Open-ended questions provide an opportunity to gather much more information that is important from the client's perspective than close-ended questions which call for a "yes" or "no" response. Also, clients usually find it difficult to talk about sexual issues; open-ended questions will help them to feel much more in control and express themselves more freely.

Appropriate language: Use language which clients understand and speak. This will help them to feel confident as well as free to express themselves. Avoid using medical terms while talking to clients. To be able to do this, you will have to know the local terminology for sexuality-related terms.

One question at a time: If more than one question is asked at a time, there is a possibility that you might end up getting a response to one or two questions only and the others will be skipped.

Avoid moral judgments: Do not comment on the personal behaviours of clients. Do not be judgmental especially on sexuality-related issues.

Avoid leading questions: Leading questions drive the client towards what the provider wants to hear. It usually ends in agreeing or disagreeing with the result that you do not get the desired information.

Ask permission before asking sexuality-related/personal questions: It is always recommended that you ask the client's permission before asking personal or sexuality-related questions. The provider should explain to the client why the information is important and how it might impact the diagnosis and thereby the correct management of the client's condition.

After completing the above discussion on verbal and non-verbal skills, organize a small exercise for the participants.

Exercise:

- Ask for two volunteers from the group. One will act as a service provider and the other as a STI/RTI client.
- Provide a small situation to the participant playing the client's role.
- Ask the two volunteers to come forward and organize two chairs as in a clinic.
- Tell the larger group that we will be seeing a typical clinic situation where a doctor is interacting with her/his client.
- Observe the interaction carefully and make notes on the verbal and non-verbal skills used by the "service provider".
- Do not inform or prompt the "service provider" as to what s/he should do. Let her /him handle the "client" extempore.
- Let the two volunteers role play the situation.
- Discuss the observations after 5 minutes of role play.

After the conclusion of the role play, first ask the two players to express their views on creating a conducive atmosphere for good history taking. Let both players respond.

Now, ask the other participants to make their observations on the verbal and non-verbal skills demonstrated by the "service provider". Has s/he succeeded in assuring the client of confidentiality?

Close the discussion summarizing the importance of privacy, confidentiality, rapport-building and the effective use of verbal and non-verbal skills in creating an atmosphere which our own clients must surely expect in our clinics.

Finally, summarize the session by saying that we have just discussed the goals of history taking which include the client's clinical history, risk assessment and information about partners.

SESSION 3

Steps of history taking and their significance

Objective:

At the end of this session, the participants will be able to:

- Identify the information and skills necessary for accurate history taking

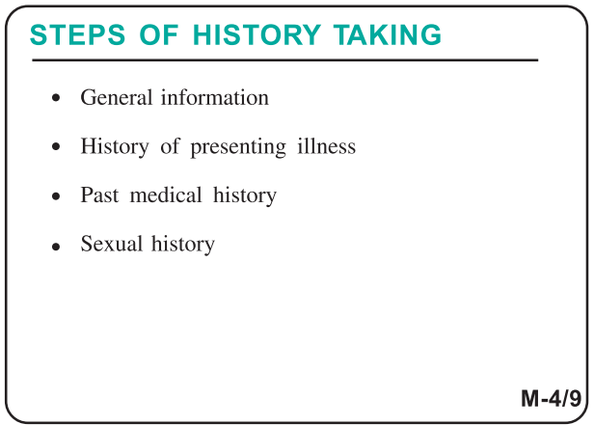
Begin by saying: "Now we will talk about the information gathered during history taking of STI/RTI clients."

Ask the participants: "What are the four broad areas you would like to explore when taking the history of a suspected STI/RTI client?"

Show Slide 9 and explain that these areas (steps) include:

1. General information
2. History of presenting illness
3. Past Medical history
4. Sexual history

Slide 9



Exercise:

Keep 4 flip charts ready, each with one of the four broad areas (on Slide 10) written on it.

Divide the participants into 4 groups.

Assign a topic and provide a flip chart to each group.

Ask the groups to note down the information they would like to gather from the client for the topic assigned to them.

Allow 7 minutes for group work. Ask each group to name one person as a presenter.

After the exercise, ask the groups to present their findings in the following sequence:

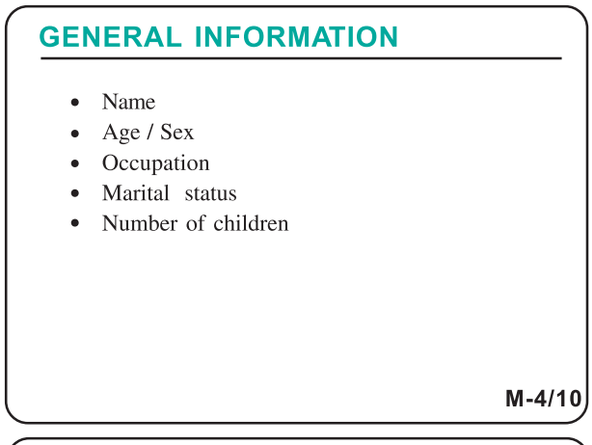
1) General information of client
2) History of present illness
3) Medical history, and
4) Sexual history.

After each group presention, ask the other groups to add or comment as necessary.

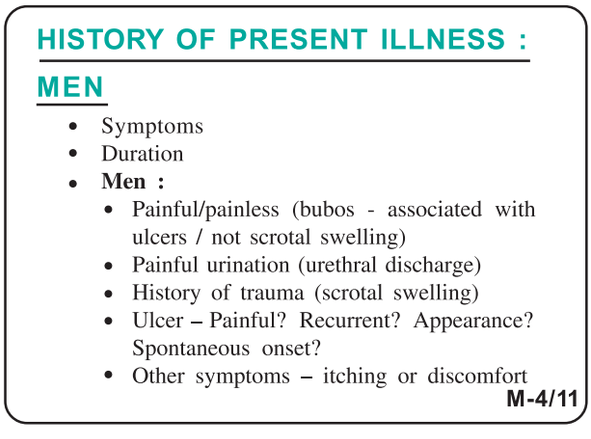
For each history taking question, ask the group why they would like to ask that particular question or what is the significance of the question. It is essential that every participant knows the rationale for asking a specific question during history taking. If s/he understands this, there is a greater possibility of her/his asking that particular question while interacting with actual clients.

Complete the discussion, showing Slides 10 to 14.

Slide 10



Slide 11



Slide 12

HISTORY OF PRESENT ILLNESS : WOMEN

- Painful urination and frequency (vaginal discharge)
- Vaginal bleeding
- Painful or difficult pregnancy or childbirth
- Painful or difficult menstrual periods
- Missed or overdue period
- If ulcer – Recurrent? Painful? Appearance?
- Spontaneous onset?
- Other symptoms – itching or discomfort

M-4/12

Slide 13

MEDICAL HISTORY

- Any past STIs? : Type? Dates? Any treatment / response? Results of test?
- Other illness: Type? Dates? Any treatment/ response? Results of test?
- Medication being taken currently
- Drug allergies

M-4/13

Slide 14

SEXUAL HISTORY

- Use of contraceptives, if any
- Menstrual and obstetric history
- Currently active sexually? If yes, number of current partners
- New partners in last 3 months
- Risky sexual and other behaviour

M-4/14

Respond to participants' questions, if any, and close the discussion.

SESSION 4

Risk assessment: Uses and limitations

Objective:

At the end of this session, the participants will be able to:

- Define risk assessment and understand its use in STI/RTI prevention and limitations in STI/RTI management

Ask the participants what they understand by risk assessment of STI/RTI clients, and why it is important.

Let 1-2 participants respond.

Show Slide 15 on the definition of risk assessment, and Slide 16 on its significance in sexual history taking. Explain the process of risk assessment, stating that it helps us to assess whether an individual is at risk of contracting a STI/RTI so that appropriate treatment and tailor-made counseling can be made available to her/him. Emphasize that every client is in a unique situation and hence it is important to perform a risk assessment of every client suspected of STI/RTI.

Use the text following Slide 16 to explain that health care providers routinely perform risk assessments of clients.

Slide 15

RISK ASSESSMENT

- **Risk assessment** is a process of confidentially asking a patient particular questions to determine his or her chance of contracting or transmitting a STI/RTI (e.g. many women may be at risk due to the behavior of their husbands or partners).

M-4/15

Slide 16

RISK ASSESSMENT: WHY?

- To determine STI/RTI treatment
- To tailor patient education messages
- To determine need for lab test
- To determine need for specific referrals (ICTC)

M-4/16

Health workers everywhere use risk assessment to diagnose different problems

For example:

- A man with a fever tells you he has just returned from a visit to his home where malaria is common. The provider assumes that there is a high risk of malaria.
- A 50 year-old woman complains of irregular vaginal bleeding. The provider knows that there is a risk of uterine cancer in women of this age who experience irregular bleeding.
- A 30 year-old woman comes to you complaining of vaginal discharge. She occasionally picks up casual partners at a local bar to supplement her small income. Her last sexual contact was with a truck driver one week ago. The provider assumes that she is at risk of STIs/RTIs

Now, ask: "Based on your experiences, what are the different situations which put individuals at risk for STIs/RTIs?"

Let 3-4 participants respond. Whenever the participant describes a situation, ask her/him why the individual in that situation is at risk. This will help them to understand the basis of each risk situation as well as recall it easily while working in their own clinics.

Now, show Slide 17 and provide examples of what puts people at risk for STI/RTIs.

Slide 17

WHAT PUTS PEOPLE AT RISK?

- Occupation: Sex worker, bar girl, truck driver
- Migration / long stays away from home
- Known history of STIs/RTIs
- Partner has history of STIs
- Problems during pregnancy
- Have casual partners

M-4/17

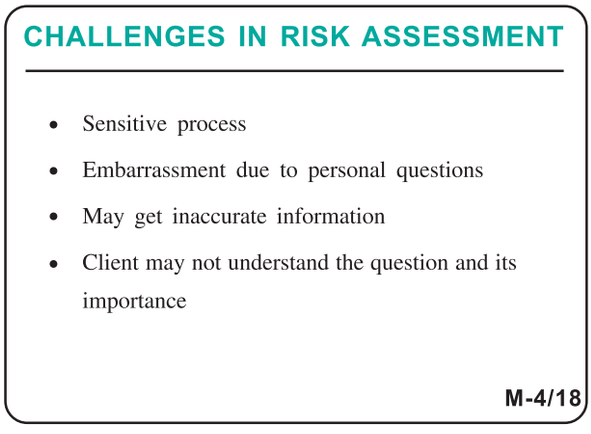
Say: "Although the risk assessment process sounds easy, actually it is quite challenging..Can you imagine why it so challenging?"

Let 2-3 participants respond.

Show Slide 18 and explain why it is challenging.

Explain that risk assessment is a very sensitive process as it involves questioning the person about her/his personal and sexual life. Therefore, the provider requires the right skills and sensitivity to obtain risk-related information from her/his clients.

Slide 18



Against the background of the challenges shown on Slide 19**,** ask the participants what can be done to overcome these challenges.

After listening to their responses, complete the discussion by showing Slide 19.

Emphasize that the health care provider has a major role to play in risk assessment. He has to use all his personal skills to put the client at ease and make her/him comfortable, assure confidentiality, and explain the consequences of incomplete or incorrect information.

Once the provider succeeds in making the client open up, it becomes easy to get complete information based on which a correct diagnosis can be made and personalized patient education provided for treating current infections as also for preventing the recurrence of infection.

Slide 19

MAKING BETTER RISK ASSESSMENTS

- Ensure privacy and confidentiality
- Tailor questions according to local needs
- Put questions according to local culture and sensitivities
- Explain to clients why the process is important and may affect diagnosis, treatment and advice

M-4/19

Now, hand out the case study given below to the participants and ask them to identify the risk factors.

Allow 5 minutes to consider and get their responses.

Complete the discussion, stressing the importance of risk assessment and how it helps health care providers to tailor their treatment to cure their clients' infections as well as client education messages and advice to help their clients to prevent future infections.

Case study

Radha, a 25 year-old woman, who has been married for three years but has no children, comes to a designated STI clinic because she wants to conceive. She tells you that her husband travels out of the local area on work, very frequently. He is away from home for at least two weeks every month. When you gently ask if she thinks that he may have other partners, she responds that she suspects so. She discloses that he came home one day and gave her some medicine to take; she thinks it may have been some treatment for a sexual disease. Sometimes, she gets lower abdominal pain for no apparent reason. When you ask her about her history of family planning practice, she looks uncomfortable and says that she has never tried family planning because she has been hoping to get pregnant. She says that despite his travel, she and her husband have intercourse regularly when he is home and at various times during the month. She also says that she is under considerable pressure from her husband's family, to bear a child. She wants to know what she can do. What would you tell her?

SESSION 5

Demonstration of history taking and risk assessment

Objective:

At the end of this session, the participants will be able to:

- Demonstrate history taking and risk assessment using a standardized checklist

Do a quick recapitulation of the topics covered so far in this module.

Tell the participants that we will now try to put our learning into action by means of a role play.

Situations for Role Play:

1. Manorama, a 30 year-old married woman, comes to a designated STI clinic for copper T insertion. She complains of white discharge.
2. Shankar, a 25 year-old, recently-married man, comes with a complaint of burning while passing urine.

Now, show Slide 20 and explain the role play.

Role play:

- Ask two participants to volunteer. Assure them that the task will be simple.
- Assign the role of a doctor to one of them and that of a patient to another.
- Read out loudly and explain the role of the patient to the entire group except the participant playing the doctor's role by requesting her/him to go out of the room for two minutes while you are explaining. This is necessary because we want the doctor to play her/his role as naturally as possible - as a doctor who does not know in advance what the patient is going to complain of or how s/he will react.
- Instruct the "client" to behave like a normal client - not too submissive and not too difficult.
- Bring the participant playing the role of the doctor back into the room.
- Organize the role play in the front of the classroom so that everyone can see and hear clearly. Ask the players to talk loudly so that the entire group can hear their conversation.
- Ask the participants to note their observations during the role play.

Slide 20

ROLE PLAY

- Open the checklist for history taking
- Observe the role play carefully
- Note which steps are followed
- Be ready to share one thing you liked during the role play
- One step that you would have done differently

M-4/20

After the role-play, commend the players for volunteering. Ask them for their reactions about their own performance and the overall interaction.

Ask the participant playing the client's role how s/he felt as a client. Is s/he satisfied with the doctor's communication and overall conduct during the role play?

Request the remaining participants to give very crisp and specific comments.

It is not necessary for the facilitator to get the reactions of the entire group. Ask for 4-5 participant reactions; provide an opportunity to others during subsequent exercises.

If a participant states that s/he did not like or very much liked something in the role-play, ask her/him what exactly s/he liked or disliked. In case the participant did not like something, ask the particpant how s/he would have behaved in a similar situation.

Close the discussion by saying that history taking has always been a routine part of their job as health care providers. However, in STI/RTI cases, sexual history taking and risk assessment are sensitive processes wherein the doctor needs to be cautious and sensitive and use effective communication skills.

Finally, end the session by asking 2-3 participants to tell the group about the new information they have gained from this discussion.

Show Slide 21 and explain each bullet point, emphasizing the importance of good history taking and risk assessment using effective verbal and non-verbal skills and respecting the dignity of the client.

Slide 21

TO SUM UP .....

- Goal of history is to get information for good diagnosis and treatment, establish risk and provide tailor-made advice
- Sexual history is an essential component of history taking
- Make yourself and your client comfortable during risk assessment
- Good communication skills are paramount for history taking and risk assessment
- Risk assessment provides you important cues for appropriate treatment and prevention

M-4/21

Module 5

Clinical Examination for STIs/RTIs

MODULE 5

Clinical Examination for STIs/RTIs

Learning Objectives:

At the end of this module, the participants will be able to:

1. Discuss the importance of a clinical examination for STI/RTI clients
2. Identify the resources and skills required for an efficient clinical examination
3. Describe the steps of a clinical examination of male and female STI/RTI clients
4. Demonstrate clinical examination skills using a standardized checklist

Materials :

- Overhead/LCD projector
- PowerPoint slides for the session
- Blank flip charts
- Marker pens
- Pelvic model
- Penis model
- Demonstration videos of clinical examinations of male and female STI/RTI clients

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Keep the pelvic and penis models and other supplies for clinical examination ready.
- Keep the clinical examination videos ready for projection.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1	Introduction to Module 5	Interactive presentation and group work
2	Importance of clinical examinations of STI/RTI clients	
3	Resources and skills for efficient clinical examinations	
4	Steps of clinical examination of male and female STI/RTI clients	
5	Clinical examinations: Video demonstration and practice	

SESSION 1

Introduction to Module 5

Objective:

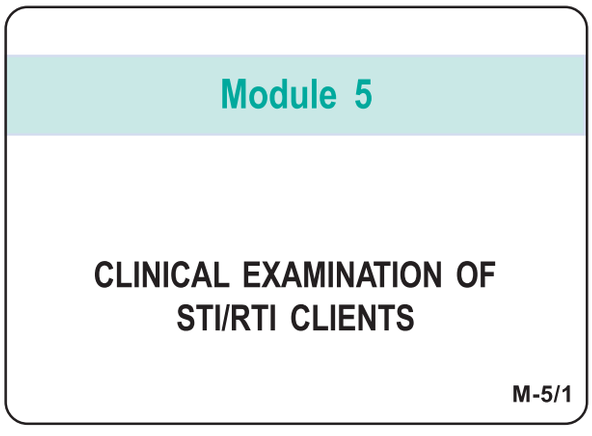
At the end of the session, the participants will be able to:

- Provide an overview of the module including its objective

Begin the session by showing Slide 1, and reminding the participants about the steps involved in the clinical examination of STI/RTI clients.

Say: "We have completed history taking. Now we will talk about the 'why' and 'how' of a clinical examination."

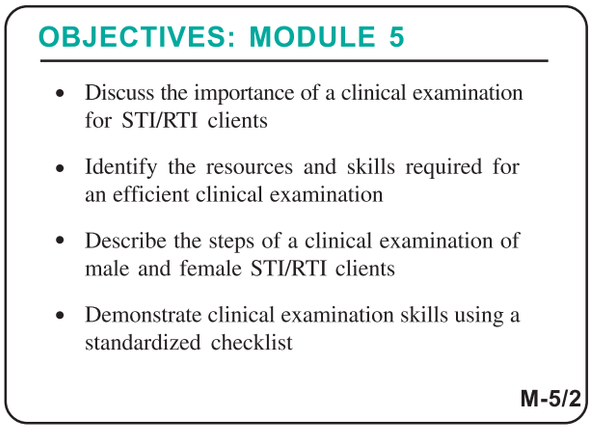
Slide 1



Now, say: "Since a clinical examination should be a MUST for every client and certain special steps are involved in the clinical examination of STI/RTI clients, encourage the participants to actively participate in the session and practice clinical examination skills."

Show Slide 2 and explain the objectives of the module.

Slide 2



SESSION 2

Importance of clinical examinations for STIs/RTIs

Objective:

At the end of this session, the participants will be able to:

- Discuss the importance of a clinical examination of STI/RTI clients

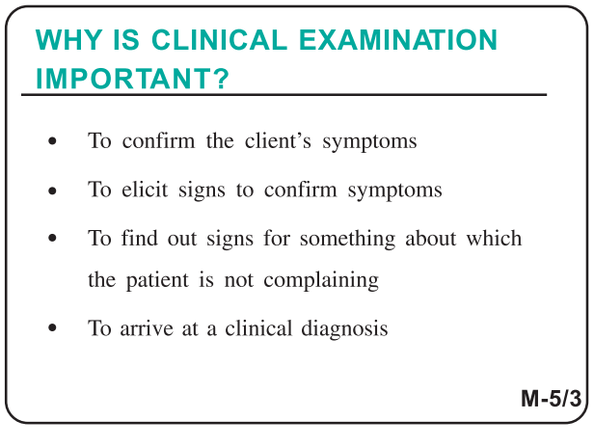
Say: "You must have performed a good number of clinical examinations in your clinic. Can you tell us why it is important to perform a clinical examination of STI/RTI clients? "

Also ask: "Why is it a MUST for every provider to conduct a clinical examination of STI/RTI clients?"

Let 1-2 participants respond. Appreciate correct responses.

Show Slide 3 and explain each bullet point, affirming the importance of a clinical examination.

Slide 3



SESSION 3

Resources and skills for efficient clinical examinations

Objective:

At the end of this session, the participants will be able to:

- Identify the resources and skills necessary for performing an efficient clinical examination

Say: "Often, providers give the excuse of the lack of resources for not performing a clinical examination of STI/RTI clients. What is your opinion? Do you think you have enough resources available at your site for performing clinical examinations?"

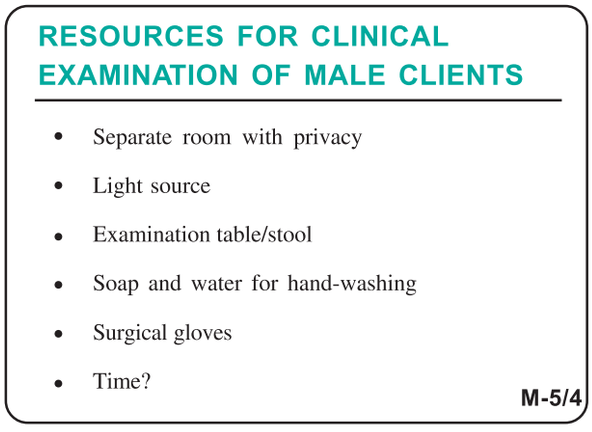
Let 2-3 participants respond. Choose participants from various sites such as a medical college, a district hospital, and a hospital below the district level.

Whatever the response, say: "Let us try to list the resources required for the clinical examination of male and female STI/RTI clients."

Put up a flip chart and with the help of your co-facilitator list the resources based on participant responses. Make separate lists for male and female clients.

When the participants run out of ideas, show Slides 4 (male clients) and 5 (female clients), compare them with the participants' lists and complete the lists.

Slide 4



Slide 5

RESOURCES FOR CLINICAL EXAMINATION OF FEMALE CLIENTS

- Separate room / Privacy
- Light source
- Examination table
- Sim's speculum with anterior wall retractor or Cusco's speculum
- Alli's forceps, sponge holder
- Tray with lid (for instruments)
- Stainless steel bowls
- Disposable and clean gloves
- Cotton
- Cloth drape
- Savlon / Betadine
- Soap and water for hand-wash
- Time?? And Attitude??

M-5/5

Say: "It is evident from the above lists that the resource requirements for the clinical examination of male and female STI/RTI clients are small. On most occasions, it is the lack of attitude and so-called constraints that prevent service providers from performing a clinical examination."

Ask the participants for their opinions. If they disagree with the point about the service provider's attitude, then say: Shall we assume that all of you sitting here neither have a problem of attitude nor of physical resources? If they say "yes", appreciate their spirit and state that you would like to see them in action when you visit their site for a follow up of this Workshop.

If the participants (all or some) agree that attitude is a concern, ask them what it means. Does it mean that we will not be able to do a clinical examination of STI/RTI clients at all in our clinics? Most of them will possibly retreat and say that it is difficult but they would try to do it.

Ask them about the physical resources listed on Slides 4 and 5. If some of them lack the infrastructure in their clinics, inform them that NACO-NRHM has provided an adequate budget to their centre/unit for making these resources, including privacy, available. Hence, they should contact the person in-charge of their clinic and request her/him to provide these facilities at the earliest.

Now, say: "We have talked about the physical resources needed for examining STI/RTI clients in our clinics. However, it has been observed on many occasions, that STI/RTI clients themselves are reluctant to undergo a physical examination. Based on your experience, what could be the reasons for this reluctance on the part of clients?"

Let 2-3 participants respond. The responses could include: shame, privacy, stigma etc.

Now, show Slide 6, compare it with the participants' responses and complete the list.

Slide 6

WHY ARE CLIENTS UNWILLING TO BE EXAMINED?

- Shyness, culturally inappropriate to expose private parts
- Shame
- Fear
- Worried about privacy and confidentiality
- Judgmental attitude of provider

M-5/6

Before completing the discussion on Slide 6, ask: "If these are some of the reasons for clients not undergoing a clinical examination, what can we do about it?" Or: "What kind of skills should service providers have to encourage or motivate patients to undergo a clinical examination?"

Take responses from participants who are currently conducting clinical examinations regularly.

Now, show Slide 7and explain the bullet points.

State that if the providers have certain professional skills, they will definitely be able to create confidence in their clients and perform an efficient clinical examination.

Say: "Some of these skills are listed on Slide 7. Would you like to exercise these skills routinely for the benefit of your clients and perform clinical examinations on a routine basis"

Take a commitment from the participants.

Slide 7

PROFESSIONAL BEHAVIOUR DURING A CLINICAL EXAMINATION

- Take client's permission to perform the examination
- Ensure privacy (visual and auditory)
- Explain what you are going to do and why
- Assistant of same sex as that of client, if examining opposite sex
- Approach in a confident way
- Never be rough or examine against patient's will
- Use effective communication
- Explain the findings of your clinical examination

M-5/7

SESSION 4

Steps of clinical examination of male and female clients

Objective:

At the end of this session, the participants will be able to:

Describe the steps of a clinical examination of male and female STI/RTI clients

Start the session by saying: "Now, we will discuss the steps involved in the clinical examination of male and female STI/RTI clients."

There will always be some participants who have a wide experience of performing clinical examinations of female clients. Take the best advantage of their experience during the session.

Say: "Let us start with the clinical examination of female clients."

Ask the participants to name the major steps of the clinical examination of a female client suspected of a STI/RTI.

On taking 5-6 responses, show Slide 8 and explain each step. Get the participants' agreement on these steps.

Slide 8

MAJOR STEPS OF CLINICAL EXAMINATION OF FEMALE CLIENTS

- An external abdominal examination
- An external examination of genital area including separation of labia and anal/perianal area for ulcers and/or discharge
- A speculum examination of vagina and cervix
- A bimanual examination of vagina, cervix, uterus, ovaries and tubes
- Palpation of inguinal region for swelling and pain in lymph nodes

M-5/8

Now, ask the participants: "How many of you have performed the clinical examination of a female client using all the steps listed in Slide 8?"

You may have a few participants who perfom these steps routinely. Identify such participants to help you during the remaining part of this session and during clinical practicum on Day 3 of the Workshop. Request these participants openly to help other participants during the practice sessions with a pelvic model.

Show the video presentation of the clinical examination of a female client. Ask the participants to concentrate on the steps and methods of examination. After the presentation, discuss the various aspects of the clinical examination.

Take the discussion forward by asking the participants how they would prepare a female client for a clinical examination. Let them list all the steps. Summarize them, showing Slide 9.

Slide 9

PREPARATION FOR CLINICAL EXAMINATION OF FEMALE CLIENTS

- Ensure privacy
- Ask woman to empty bladder
- Wash hands with soap and water
- Ask to loosen her clothing, cover her body with a cloth/sheet
- Ask her to lie on the back with heels close to her bottom and knees up
- Explain what you are about to do
- Put on a clean glove

M-5/9

Ask the experienced participants if they follow all these steps for preparing the client. If not, ask them the reason/s for not doing so. Explain the importance of each step emphasizing issues such as privacy, hygiene, dignity of the client and the client's right to know what is being done to her.

Now proceed with Step 1 of the clinical examination (Slide 8)- the external examination of the abdomen. Use the text given at the end of this session to explain each step.

Request one of the experienced participants to say what exactly is being examined during the process and what signs the service provider is looking for.

Let one or two experienced participants list the points. Finally, show Slide 10 which lists the areas the provider should examine and the signs s/he should look for.

Slide 10

EXTERNAL ABDOMINAL EXAMINATION

- Bowel sounds
- Areas that hurt the most
- Guarding
- Softness/hardness
- Sharp rebound pain

M-5/10

Take up each bullet point on Slide 10 and explain what to look for and where. Also explain the implications of each sign.

Emphasize that the dignity of the client should be maintained throughout the examination by covering parts of the body that are not to be examined, keeping her informed about what you are about to do, and telling her not to be afraid.

Summarize the discussion and initiate another discussion on the examination of the external genitals including the anal/perianal area.

Ask the participants: "Which body parts would you examine and what signs would you look for when you examine the external genitals?"

After generating a list of 5-6 responses, show Slides 11 and 12 and explain the areas to be examined and the signs to look for.

Slide 11

EXTERNAL GENITAL EXAMINATION : WHAT TO EXAMINE

- Vulva
- Labia majora and minora
- Clitoris
- Urethra
- Vaginal opening
- Anal/perianal area
- Inner thighs

M-5/11

Slide 12

EXTERNAL GENITAL EXAMINATION : WHAT SIGNS TO LOOK FOR

Signs to look for	Possible diagnosis
Discharge and redness of vulva - common signs of vaginitis Discharge is white and curd-like – yeast infection	Vaginal discharge
Ulcers, sores or blisters	Genital ulcer
Swelling or lumps in the groin	Inguinal bubo

M-5/12

Request the experienced participants to add to the list on the basis of their own experiences.

Now, go to the step of speculum examination.

Ask the participants to explain the procedure and the precautions to be taken. Ask them what exactly one should look for during a speculum examination.

After showing the video of a speculum examination, explain the steps for conducting a speculum examination and the method of specimen collection.

Show Slides 13 and 14, and explain each bullet point.

Slide 13

SPECULUM EXAMINATION

- Speculum must be sterilized
- Adequate light source
- Finger followed by Cusco's speculum
- Look at cervix
- Vaginal wall
- Foul smell
- Pap smear, if facility available

M-5/13

Slide 14

SPECULUM EXAMINATION : WHAT SIGNS TO LOOK FOR

Signs to look for	Possible diagnosis
Vaginal discharge and redness of vaginal wall–Vaginitis Discharge is curd-like–Yeast infection	Vaginal discharge
Ulcers, sores or blisters	Genital ulcer
If cervix bleeds easily on touch or the discharge appears mucopurulent with discoloration	Cervical infection
If examined after childbirth, abortion or miscarriage, look for bleeding, tissue fragments; check if the cervix is normal	Complications of abortion
Tumors or other abnormal tissues on cervix	Carcinoma, refer for Pap smear or cytology

M-5/14

Summarize the procedure of speculum examination with the help of the participants. Emphasize:

- Sterilization of instruments
- How to use a speculum - insertion and withdrawing
- What signs to look for and where

Move on to the next step of clinical examination, i.e. bimanual examination.

Ask the participants about the steps of a bimanual examination. List the steps on a flip chart.

Ask: "What are the signs to look for?"

Let 2-3 participants respond.

Show them the video of a bimanual examination.

Show Slides 15 and 16 and explain each of the steps and signs.

Use the text given below Slide 16 for providing appropriate clarifications on all the steps of a clinical examination of female clients.

Slide 15

BIMANUAL EXAMINATION

- Feel the opening of cervix
- Feel the uterus:
- Soft and large – Probably pregnancy
- Lumpy and hard – May be fibroid
- Hurts on touching – Probably an infection
- Does not move freely – Scars of previous PID
- Feel for tubes and ovaries:
- Painful – Probably infection
- Painful lump and missed period – Ectopic pregnancy
- Vaginal wall – For unusual lumps or sores

M-5/15

Slide 16

BIMANUAL EXAMINATION : WHAT SIGNS TO LOOK FOR

Signs to look for	Possible diagnosis
Lower abdominal tenderness when pressing down over the uterus with the outside hand	Lower abdominal pain
Cervical motion tenderness (obvious from expressions) when cervix is moved from side to side with fingers of gloved hands inside the vagina	Lower abdominal pain
Uterine or adnexal tenderness when pressing outside and inside hands together over the uterus (center) and adnexe (sides of the uterus)	Lower abdominal pain
Any abnormal growth or hardness to the touch	Refer for Pap smear or cytology

M-5/16

STEPS OF CLINICAL EXAMINATION OF FEMALE PATIENTS

A. Examination of the Abdomen

1. Before you start, ask the patient to empty her bladder if she has not done so in the last half hour. (Make sure this happens in your clinic before the patient is brought to the examination room).
2. Explain what you are going to do. Ask her to undress or to pull up her clothing so that you can see her abdomen from just below her breasts down to her pubic hair. If possible, cover her from the pubic hair down to save her from embarrassment. Use a sheet or her own clothing.
3. Ask her to lie flat on her back on a firm bed or table with knees comfortably bent. Tell her to relax her abdominal muscles as much as she can. This may be difficult for someone who is in pain.
4. Listen for bowel sounds by putting a stethoscope on her abdomen. If you do not hear anything for 2 minutes, this is a sign of danger.
5. Ask her to point to the area that hurts the most. Then begin pressing gently on the other side. Keep pressing gently as you move around her abdomen to see where it hurts most.
6. As you press her abdomen, feel for lumps or masses. Also, check to see if she has guarding, if her abdomen is soft or hard, and if she can relax it under your hand. Note down if the body temperature is raised.
7. To make sure that she does not have a life-threatening problem like appendicitis, an infection in her gut, or PID, slowly but firmly press on her abdomen on the left side, then the right side, just above where the leg joins the body (the groin).
8. Press until it hurts a little. Then quickly remove the hand. If she gets a very sharp pain (rebound pain) when the hand is removed, she may have a serious infection. Refer her immediately. If she does not have rebound pain, complete the examination and move on to examine the genitals.

B. Examination of the External Genitals

1. Explain to the client what you are going to do and what she might feel at each step of the examination.
2. Cover the parts of the body that will not be examined to save her from embarrassment. Use a sheet or her own clothing.
3. While she is lying flat on her back on a firm bed or table, ask her to bend her knees, put her feet near her buttocks and let her knees fall apart.
4. Put a clean glove on the hand that will be inserted in her vagina. Usually, this is the hand you write with. The glove need not be sterile; however, if it is a reusable glove, do not use the same glove for another patient unless it is sterilized.
5. Point your light source towards the vagina. (If it is a torch, you will need someone to hold it for you).
6. Using your gloved hand to pull back the skin folds of the vulva and labia, examine the labia majora and minora, clitoris, urethra, vaginal opening, anal area, and inner thighs for sores, abscesses, warts, vesicles, discharges, and rashes.

C. Speculum Examination

1. Ensure that the speculum is high-level disinfected or sterilized, warmed if possible, and lubricated with clean water.
2. Be sure the light source is pointed towards the vagina.

3. Insert the index (first) finger of your gloved hand in the vagina, pushing gently downward towards the anus. Advance your finger slowly inward until it reaches the cervix, which will feel like the tip of your nose. Ask the client to relax her muscles around your finger.
4. With your other hand, hold the speculum blades together between the index and middle fingers. Turn the blades sideways and slip them into the vagina, taking care not to press on the urethra or clitoris above. When it is half-way in, turn the speculum by 90 degrees so that the handle of the speculum is down.
5. *Gently open the blades a little and look for the cervix. Move the speculum slowly and gently until you can see the cervix between the blades. Tighten the screw on the speculum so that you can examine the cervix properly.
6. Examine the cervix. Note any abnormalities such as discharge from the os, inflammation, or bleeding. Abnormal looking, white or fungating lesions or sores could be cancerous and should be referred. If the cervix looks bluish, she may be pregnant.
7. If facilities are available, a Pap smear should be collected before the bimanual examination even if the cervix does not show any growth as it will help in detecting early cancer (microscopic) or pre-cancer. This may be the only chance this woman may have for screening for cervical cancer. The smear has to be immediately spray-fixed and sent to the referral laboratory.
8. *Pull back slightly on the speculum, bring the blades together just a little, and turn the speculum sideways so you can see the walls of the vagina. Look for inflammation or discharge along the vaginal walls.
9. *To remove the speculum, gently pull it toward you until the blades are clear of the cervix. Then loosen the screw and bring the blades almost together and gently pull back.
10. Examine the blades of the speculum and note the color, odor, consistency, and amount of any discharge.
11. Be sure to disinfect the speculum again before using it. Otherwise, you will be responsible for any cross-infection that may occur.

***These steps require practice with the speculum alone. If you do not bring the blades almost together as you pull out, it will cause the woman pain. If you close them completely you may pinch the vaginal tissue and cause pain.**

Note : Specula do not need to be sterilized for a normal vaginal examination. They should be high-level disinfected using the following 3-step procedure:

- Soak in chlorine bleach solution for 10 minutes immediately after use.
- Wash with soapy water and a brush until clean.
- Boil or steam in a covered pot for 20 minutes.

A set of at least 5 disinfected specula and 5 gloves should be ready before each OPD starts.

D. Bimanual Pelvic Examination

1. Insert the index finger of your gloved hand in the woman's vagina. As you put your finger in, push gently downward on the muscles surrounding the vagina. When the woman's body relaxes put the middle finger in also. Turn the palm of your hand up and advance gently until you reach the cervix.
2. Feel the opening of the cervix to see if it is firm and round. Then put one finger on either side of the cervix and move the cervix gently from side to side. It should move easily, without causing

pain. If it does cause pain, she may have an infection of the uterus, tubes or ovaries. If her cervix feels soft, she may be pregnant.

3. Feel the uterus by gently pushing on her lower abdomen with your 'outside' hand – this moves the uterus, tubes, and ovaries closer to your 'inside' hand. The uterus may be tipped forward or backward. If you do not feel it in front of the cervix, gently lift the cervix with your 'inside' hand and feel around it for the body of the uterus. If you feel the uterus under the cervix, it is pointed to the back.
4. When you feel the uterus, feel for its size and shape. Do this by moving the fingers of your 'outside' hand to the sides of the cervix. Then 'walk' the fingers of your 'outside' hand around the uterus, feeling the uterus between your two hands. It should feel firm, smooth, and smaller than an average-sized lemon.

   If the uterus:

   - Feels soft and large, she is probably pregnant.
   - Feels lumpy and hard, she may have a fibroid or other growth.
   - Hurts when you touch it, she probably has an infection inside.
   - Does not move freely, she could have scars from an old PID infection.
5. Feel for the tubes and ovaries. If these are normal, they will not be felt. But if you feel any lumps that are bigger than an almond or that cause severe pain, she could have an infection or other emergency. If she has a painful lump and her period is late, she could have an ectopic pregnancy.
6. Feel along the inside of the vagina for unusual lumps or sores.
7. If anything feels abnormal and you do not know what the problem is or how to treat it, refer the patient to a higher facility.
8. On completion of the examination, record data regarding the presence or absence of findings relevant to your diagnosis.
9. Watch the face of the patient while you are examining her so that you will notice when she experiences pain on palpation.

Now, ask the participants to summarize the discussion using the following points:

- How to make the client comfortable
- How to prepare the client for a clinical examination
- Major steps of a female clinical examination
- Special precautions to be taken during the procedure
- Main signs to look for
- STI/RTI syndromes in women

Tell them that we will practice female clinical examinations on a pelvic model during clinical practicum.

Now, initiate a discussion on conducting the clinical examinations of a male STI/RTI client.

Say that the clinical examination is relatively easy. No deep internal examination is required.

Ask the participants to list the major steps.

Show Slide 17 and explain each step.

Slide 17

MAJOR STEPS OF CLINICAL EXAMINATION OF MALE CLIENTS

- Visual inspection of genital area, including the anal/perianal area, looking for ulcers or discharge
- Visual inspection of undergarments for discharge
- Retract foreskin
- Milking of urethra
- Palpation scrotum and testes for swelling and/or pain
- Examination of inguinal lymph nodes

M-5/17

Next, ask the participants what signs they would look for in a man suspected of a STI/RTI.

Show the video on male clinical examination.

Show Slide 18 and share the major signs and diagnosis based on the signs.

Slide 18

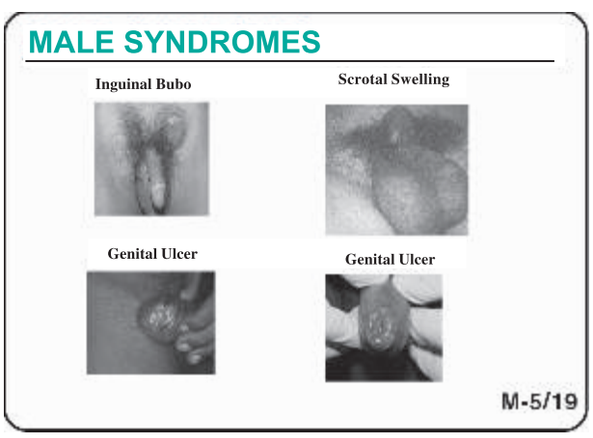
CLINICAL EXAMINATION IN MEN : WHAT TO LOOK FOR

Signs to look for	Possible diagnosis
Urethral discharge	Urethral discharge
Ulcers, sores, or blisters	Genital ulcer
Swellings or lumps in groin (inguinal lymphadenopathy)	Inguinal bubo
Swollen painful testes	Painful scrotal swelling

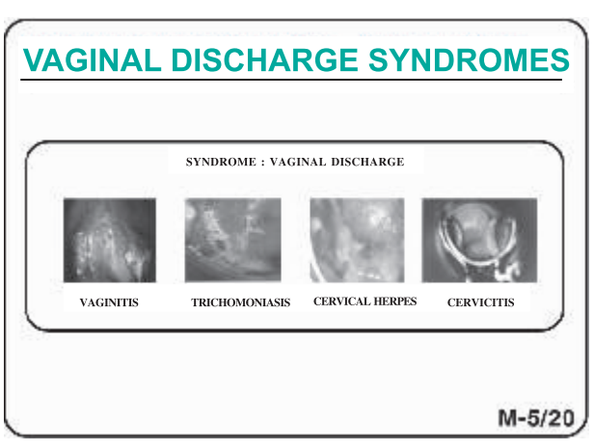
M-5/18

Now, show photographs of clinical examination findings in men and women by showing Slides19 and 20 respectively, and close the discussion.

Slide 19



Slide 20



SESSION 5

Clinical examinations: Video demonstration and practice

Objective:

At the end of this session, the participants will be able to:

Demonstrate clinical examination skills in STI/RTI clients using a standardized checklist

Say: "Now we are going to practice what we have discussed so far in this session."

Show Slide 21.

Divide the participants into two or three groups depending on the number of facilitators available. (At least three facilitators are recommended during this practice session).

Assign one facilitator to each group.

The facilitators should demonstrate a complete clinical examination, narrating each step.

Keep asking questions to the participants, such as:

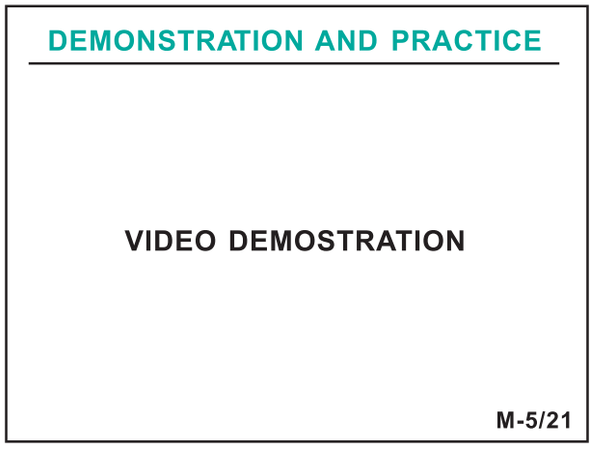
- What is the next step?
- What is the importance of this particular step?
- What possible findings you can expect during this specific step?

When the facilitator completes the demonstration, ask the participants to take turns and practice the procedure, especially in women, as it is a complex procedure.

Finally, close the practice session reminding the participants that they have to practice these skills on actual patients.

Respond to their queries, if any.

Slide 21



Remember …

Before the actual clinical practical session begins it is the facilitator's responsibility to assess the competence of each participant using direct observation of the simulated clinical examinations either during practice (during Session 5) or at other times arranged with the participants.

If necessary, make pelvic models available to the participants for practice during their leisure time.

Complete the module showing Slide 22 which summarizes the key points. Encourage the participants to join you in summarization.

Slide 22

DOCTORS MUST REMEMBER .....

- Clinical examination is an integral part of syndromic management.
- Clinical examination of women is a complex process. However, it can be mastered by regular practice.
- Privacy and confidentiality are paramount for the clinical examination of STI/RTI cases.
- Clinical examination requires minimal resources.
- The results of clinical examination should be explained to the client.
- Be professional and conduct the examination efficiently.

M-5/22

Module 6

Approches to STI/RTI Management

MODULE 6

Approaches to RTI /STI management

Learning Objectives:

At the end of this module, the participants will be able to:

1. Define the term "STI/RTI case management"
2. List and describe the critical steps of STI/RTI management
3. Describe and compare the three main approaches to STI/RTI management
4. Explain the relevance of the syndromic approach in current health care settings in India
5. Classify different STIs/RTIs according to syndromes
6. Demonstrate the use of flowcharts using case studies

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Flip charts
- Marker pens
- 15-20 cards, each with a case study of syndromic management written on it (from the case study exercises given in Session 4).

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session

Module outline

Session No.	Topic	Methodology
1.	Introduction to Module 4 & Critical steps of STI/RTI case management	Interactive presentation and group work
2.	Approaches to STI/RTI management	
3.	Classification of STIs/RTIs by syndromes	
4.	Use of flowcharts in STI/RTI management	

Introduction

Traditionally, doctors and other health providers have been trained to diagnose STIs/RTIs based on the results of laboratory tests that identifies the specific organism causing the infection (etiological diagnosis). Another approach is to identify STIs/RTIs based on the provider's judgment of the patient's signs and symptoms (clinical diagnosis). The limitations of these methods, particularly in primary health care settings, prompted the development of the syndromic approach which uses symptoms and easily identifiable physical signs to diagnose and treat patients for all possible STIs/RTIs that may cause the syndrome rather than for specific STIs/RTIs. Syndromic management should be used only when a patient presents with a STI/RTI complaint and not for screening for STIs/RTIs because it is not so accurate.

This module presents an overview of the main approaches to STI/RTI management includingsyndromic management which has been widely adopted and proven useful for most syndromes. However, vaginal discharge is an exception because it is poorly correlated to the major causes of cervicitis namely, gonorrhoea and chlamydia.

SESSION 1

Introduction to Module 6 and Critical steps of STI/RTI case management

Objectives:

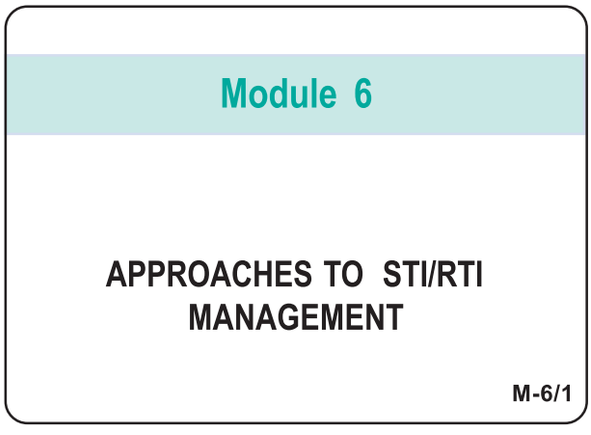
At the end of this session, the participants will be able to:

- Provide an overview of the module including its objectives
- Define the term "STI /RTI case management"
- List and describe the critical steps of STI/RTI management

Begin the session by showing Slide 1.

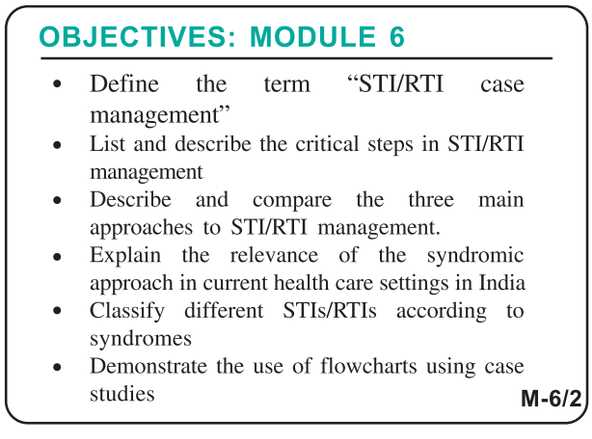
Say: "In this module, we are going to talk about the key steps of STI/RTI management and compare the main approaches used to manage STIs/RTIs with a view to identify the most relevant approach for a typical clinical setting in a primary health care centre. We will also discuss the classification of STIs/RTIs by syndromes, and the use of flowcharts for managing STIs/RTIs."

Slide 1



Now, show Slide 2 and explain the objectives of the module.

Slide 2

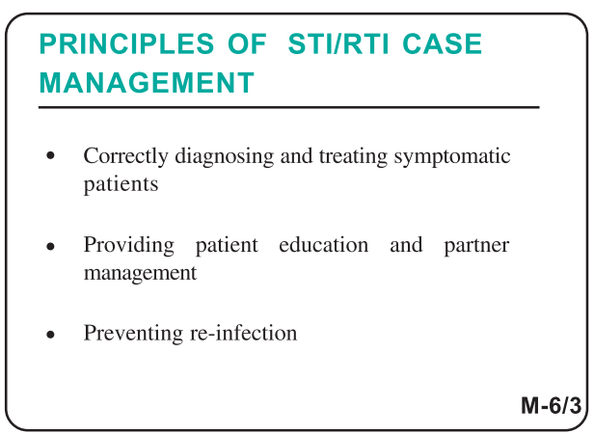


Say: "Now , can you tell me what the three principles of comprehensive STI/RTI management are?"

The expected responses should include: correct diagnosis, correct and complete treatment, patient education, and partner treatment.

Show Slide 3 after taking the participants' responses, and state the three principles of STI/RTI case management.

Slide 3



Next, present a case study and ask the participants to write a prescription for the case. Give them 10 minutes to complete the prescription. Audit the prescriptions. You will find that most participants prescribe differently. Tell them about the importance of standardizing the treatment and reinforce the need for standardized treatment regimens.

Now, pose a question to the group: "What are the different steps involved in the management of **any** clinical case?"

The expected responses should include the steps listed on Slide 4.

Appreciate correct responses. If you get partial responses, complete the steps by showing Slide 4 and close the discussion.

Slide 4

STEPS OF CLINICAL CASE MANAGEMENT

- History taking
- Clinical examination
- Laboratory tests
- Diagnosis
- Treatment
- Advice and counseling
- Follow up

M-6/4

SESSION 2

Approaches to STI/RTI management

Objectives:

At the end of this session, the participants will be able to:

- Describe and compare the three main approaches to STI/RTI management
- Explain the relevance of the syndromic approach in current health care settings in India

Begin the discussion by telling the participants that there are three main approaches to the management of STIs/RTIs. Ask: "Can anyone name them?"

The expected responses would be: traditional clinical, laboratory-assisted, and syndromic approaches.

Show Slide 5naming the three approaches.

Slide 5

Say: "Now, let us discuss these approaches and find out which one works best for STI/RTI management and why."

Start the discussion with the traditional clinical approach.

Remind the participants of the 7 steps used in traditional clinical case management, and ask them what they understand by the traditional clinical approach and the steps involved in it.

Take their responses. The expected responses are: history, physical examination, clinical diagnosis, treatment and patient education/advice, and counseling.

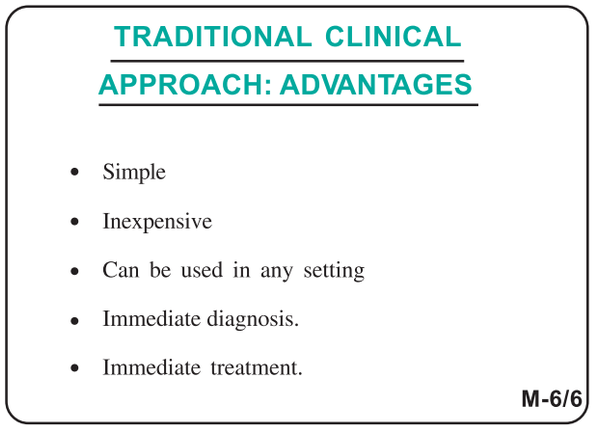
If you do not get complete responses, clarify using the 7 steps. Emphasize that in the traditional clinical approach, the doctor uses her/his clinical judgment to make a diagnosis. Laboratory tests are not involved.

Now, ask: "If these are the steps of traditional clinical case management, what are its advantages and limitations?"

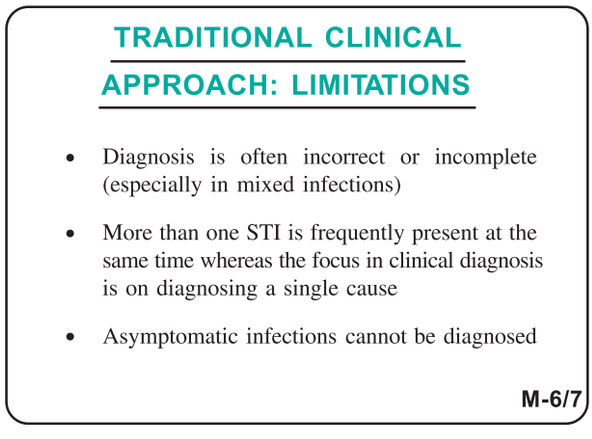
Start with the advantages and follow with the limitations.

Show Slides 6 and 7 and complete the discussion.

Slide 6



Slide 7



Summarize the discussion, emphasizing that in the traditional clinical approach the doctor uses her/his clinical judgment to make a diagnosis. Laboratory tests are not involved.

Now, move on to a discussion on the laboratory-assisted approach.

Ask the participants about the steps involved in the laboratory-assisted approach. The expected response should be; In addition to the steps of the traditional clinical approach, the doctor uses laboratory tests to arrive at a diagnosis and provides treatment for the specific organism identified by the laboratory test.

Ask them to tell you the advantages of the laboratory-assisted approach.

Ask your co-facilitator to list their responses on a flip chart. On getting 5-6 responses, show Slide 8 and complete the list.

Slide 8

LABORATORY-ASSISTED APPROACH: ADVANTAGES

- Possible to get an exact diagnosis using laboratory tests
- Avoids over-treatment
- Avoids wrong treatment
- May avoid antibiotic resistance
- Avoids the negative consequences of telling someone s/he has a STI if s/he does not

M-6/8

Repeat the same process for listing the limitations of the laboratory-assisted approach and show Slide 9 to complete the participants' list.

Slide 9

LABORATORY-ASSISTED APPROACH: LIMITATIONS

- Expensive
- Trained laboratory technicians are needed
- Infrastructure and supplies are needed
- Patient must return for test results
- Patient must wait for treatment
- All STIs cannot be identified by laboratory tests as each test has its own sensitivity and specificity

M-6/9

Close the discussion on the laboratory-assisted approach by saying that laboratory-based diagnosis is considered as the "gold standard". However, it has many limitations such as unavailability, high cost, waiting for laboratory test results to start treatment etc.

Now, take the discussion forward to syndromic management. It is expected that many participants having attended earlier round/s of training, would know about it.

Ask them to list the steps involved in syndromic management which should include: identification of the syndrome using flowcharts and treatment of the syndrome rather than any specific infection. Show Slide 10

Slide 10

SYNDROMIC MANAGEMENT APPROACH

- Diagnosis is based on the identification of **syndromes** which are a combination of the symptoms the client reports and the signs the health care provider observes
- The recommended treatment is effective for all the diseases that could cause the identified syndrome
- Provides single-dose treatment as far as possible
- Comprehensive: it includes patient education and counseling

M-6/10

Now, ask the participants to enumerate the major advantages of syndromic management. After taking 4-5 responses, show Slide 11 and complete the list.

Slide 11

SYNDROMIC MANAGEMENT: ADVANTAGES

- Fast—the patient is diagnosed and treated in one visit
- Highly effective for selected syndromes, especially urethral discharge and genital ulcer disease (GUD). Also good for lower abdominal pain/PID.
- Relatively inexpensive since it avoids use of laboratory tests
- No need for patient to return for lab results
- All possible STIs causing signs and symptoms are treated at once
- Scientifically tested in many part of the world
- Easy for health workers to learn and practice for patients
- Integrated into other primary health care services more easily
- Can be used by providers at all levels
- It standardizes treatment regimens

M-6/11

Follow a similar process for the limitations of syndromic management. Complete the discussion by showing Slide 12.

Slide 12

SYNDROMIC MANAGEMENT : LIMITATIONS

- Not useful in asymptomatic individuals
- Over-treatment if patient has only one STI that causes a syndrome
- Financial cost of over-treatment, side-effects
- Increases potential for creation of antibiotic resistance especially if full course is not completed
- Not effective in some cases such as vaginal discharge

M-6/12

After completing the discussion on the advantages and limitations of all the three approaches, request the participants to look at these approaches using the same steps that were discussed for traditional clinical case management, and identify the similarities and differences between them.

Show Slide 13 which gives a comparison of the three approaches.

Re-emphasize the underlined text under syndromic management such as picking up relevant flow charts, making syndromic diagnoses, and providing syndromic treatment.

Assure the participants that it is evident from the comparison table that basically, the steps involved in all the three approaches are similar. The only major difference lies in syndromic diagnosis and treatment.

Slide 13

COMPARISON OF APPROACHES

Traditional clinical approach	Laboratory-assisted approach	Syndromic approach
Interviews patient for symptoms	Interviews patient for symptoms	Interviews patient for symptoms **Picks the relevant flowchart**
Does a clinical examination	Does a clinical examination	Does a clinical examination for finding signs **Uses flowcharts as tools**
Uses clinical experience to identify symptoms and signs of a specific STI	Collects samples for testing / refers to laboratory for tests	**Syndrome identification**
Treats for the specific STI	Treats for STIs identified by the results of the laboratory tests	Treats patient for the most common organisms responsible for that syndrome (usually 2-3 STIs)
Educates patient for compliance & prevention, promotes condoms and emphasizes the importance of partner management	Educates patient for compliance and prevention, promotes condoms and emphasizes the importance of partner management	Educates patient for compliance and prevention, promotes condoms and emphasizes the importance of partner management

M-6/13

Now, ask: "Why is the syndromic approach considered most suitable for the management of STIs/RTIs?"

Let 2-3 participants respond. Show Slide 14 and explain the public health importance of STIs/RTIs and the necessity of treating all STI/RTI cases at the first visit, at any level of health care.

Also ask the participants to go through the Appendices at the end of this module namely, Appendix 1 which provides evidence of the effectiveness of syndromic management, Appendix 2 on further references on the subject for reading, and Appendix 3 on some references on the limitations of this approach.

Slide 14

WHY DOES SYNDROMIC MANAGEMENT HAVE SPECIFIC RELEVANCE TO STIs/RTIs?

- STI clients hesitant to approach doctors
- Often choose far-off doctors
- Do not prefer to revisit
- First visit may be the last chance
- If opportunity missed the first time – it is like pushing client towards HIV (2-9 times)
- Dealing with 1 STI case is an opportunity to treat at least 1 more case (may be more)
- IT IS A PUBLIC HEALTH PROBLEM, not about one individual

M-6/14

Clarify the points on Slide 14 by saying:

- "Like many other doctors, you must have experienced that STI/RTI clients are hesitant to approach a doctor because of the shame and stigma attached to STIs/RTIs.
- "They usually go to a far-off centre or a private doctor for treatment to avoid beingrecognized.
- "Most of them do not return for follow up visits; again, because they want to remain unidentified due to the stigma and/or fear that the doctor may scold them.
- "As a result, for practical purposes, their first visit could be the last visit for us. This means that our only chance of treating them is NOW!
- "If we miss this opportunity, we are almost allowing the person not only to walk on the path of the dreaded complications of STIs/RTIs that we have discussed, but to contract HIV, which can easily infect (2-9 times greater chances) a person co-infected with a STI/RTI.
- "Moreover, when we deal with one STI patient, there is at least one partner at the other end who also needs treatment. There could even be more partners. So, it also gives us an opportunity to provide treatment and advice to the partners.
- "And finally, please remember that this is not only about the individual sitting in front of you but many more partners related to that individual. Therefore, it is a public health problem and not an individual problem.

"Since syndromic management allows you to treat all the most common infections possible at first visit, and many with single-dose therapy, it is the most relevant management approach available for containing STIs/RTIs, and thereby HIV infection, in our respective work areas as well as in our country."

Finally, close the discussion by saying that although the syndromic approach is the best approach in our health care settings, the support of simple laboratory tests, if available, could be taken to know more about the infection/s. This will not only help us to enhance the effectiveness of syndromic management but also provide us with valuable epidemiological data on STIs/RTIs. The approach of using laboratory tests in conjunction with the syndromic approach is called enhanced syndromic management.

However, caution participants that under no condition should syndromic treatment be delayed or denied to any STI/RTI patient during his/her first visit to the clinic due to pending laboratory results.

CAUTION

- It is very essential for facilitators not to show disrespect toward any particular management approach during discussion. Many doctors are very egoistic about their clinical skills. Also, doctors who have their own laboratories think that the laboratory-assisted approach is the best. Therefore, be non-judgmental or unbiased during this discussion.
- While explaining Slide 14 about the public health relevance of the syndromic approach, facilitators must proceed step-by-step and explain the situation described in the first three bullet points. Most doctors will agree about the reluctance of patients to make clinic/doctor visits and revisits for follow up.
- Emphasize that the first visit could be the client's only visit and doctors should make the best use of this opportunity by providing correct and complete treatment including client/health education and counseling.
- It is extremely important for all the participants/doctors to be completely convinced about the relevance of syndromic management of STIs/RTIs in our current settings.
- It is possible that participants may raise certain common concerns given in Appendix **4** at the end of this module**.** Read all the information about these concerns/criticisms thoroughly and be ready to respond to any expressed concern.
- Respond to concerns only if the participants raise them. If not, do not discuss them. Just ask the participants to read these at leisure from their "National Technical Guidelines".

SESSION 3

Classification of STIs/RTIs by syndromes

Objective:

At the end of the session, the participants will be able to:

- Classify different STIs/RTIs according to syndromes

Remind the participants about the three ways of classifying STIs/RTIs discussed in the last session, namely -

- According to the causative organisms
- According to the mode of transmission, and
- According to the presenting symptoms or syndromes

Tell them that we have discussed the first two classifications in Module 3.

Say: "Since we have discussed the syndromic approach for STI/RTI management, it is now appropriate to look at the classification of STIs/RTIs according to their presenting symptoms or syndromes."

Take the example of urethral discharge or genital ulcer and explain how different STIs/RTIs are covered under one syndrome depending on the major presenting symptoms.

Close the discussion showing Slides 15 and 16 on STI/RTI syndromes in men and women respectively. Tell the participants that since these syndromes will be covered in later sessions, they should remember the causative organisms of these syndromes. This would help them to identify the appropriate drug for treating each organism.

Slide 15

STI/RTI SYNDROMES IN MEN

Symptoms	Syndrome	Common STIs/RTIs
Urethral discharge	Urethral discharge syndrome	Gonorrhoea, chlamydia, trichomoniasis
Genital ulcers	Genital ulcer syndrome	Chancroid, syphilis, genital herpes
Inguinal bubos	Inguinal bubo syndrome	Lymphogranuloma venerium, chancroid
Scrotal swelling	Painful scrotal swelling	Gonorrhoea, chlamydia Genital skin conditions
Genital skin conditions	Genital warts, molluscum	contagiosum, pediculosis pubis, genital scabies
Ano-rectal discharge	ARD (Ano-rectal discharge)	Gonorrhoea, chlamydia
Cough and throat irritation	Gonococcal pharyngitis	Gonorrhoea, chlamydia

M-6/15

Slide 16

STI/RTI SYNDROMES IN WOMEN

Symptoms	Syndrome	RTIs/STIs
Vaginal discharge	Vaginal cervical discharge syndrome	Cervicitis: gonorrhoea, chlamydia, trichomoniasis, herpes simplex,vaginitis: trichomoniasis, candidiasis, bacterial vaginosis
Lower abdominal pain	Lower abdominal pain	Gonorrhoea, chlamydia, mycoplasma gardnerella, anaerobic bacteria (bacteroids, eg. gram positive cocci)
Genital Ulcers	Genital ulcer syndrome	Syphilis, chancroid,genital herpes
Genital skin conditions	Genital skin conditions	Genital warts, molluscum contagiosum, pediculosis pubis, scabies
Ano-rectal discharge	Ano-rectal discharge	Gonorrhoea, chlamydia
Cough and throat irritation	Gonococcal pharyngitis	Gonorrhoea, chlamydia

M-6/16

SESSION 4

Use of flowcharts in STI/RTI management

Objective:

At the end of this session, the participants will be able to:

Use case studies to demonstrate the use of flowcharts for decision-making in STI/RTI management

Summarize the previous discussion by saying: "So far, we have seen that among the three approaches, the syndromic approach for STI/RTI management is the most relevant option in our health care settings. We have also seen how different STIs/RTIs can be classified according to their major presenting symptoms or syndromes and looked at different STI/RTI syndromes in men and women. Now, we are ready to discuss the use of flowcharts."

Ask the participants whether they have used a flowchart before. Most of them would not have used one.

Next, ask participants who have used a flowchart to describe what a flowchart is and how it works,

After getting responses from 1-2 participants, show Slide 17 and explain how flowcharts work.

While explaining, you may want to use one of the flowcharts in the next module as an example.

Slide17

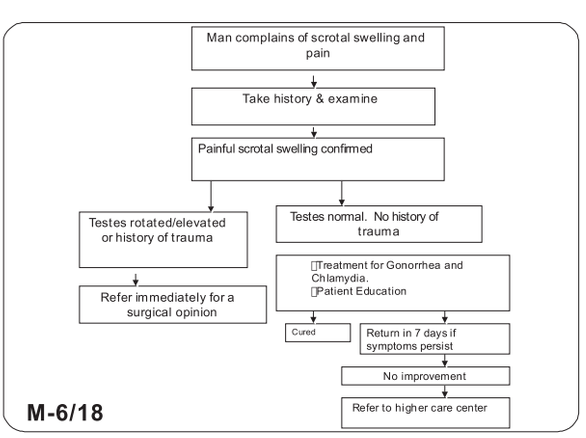
USING FLOWCHARTS

- Determine the clinical problem
- Pick up appropriate flowchart by looking at the clinical problem box at the top
- Take history
- Perform clinical examination
- Make decisions based on history and clinical examination
- Follow more boxes to consider and make choices
- Follow the arrows
- Do not skip steps
- Take one step at a time until you reach the end of the branch
- Each exit path leads to an action box that tell you how to manage the case

M-6/17

Now, show Slide 18 and explain the use of a flowchart for scrotal swelling in males (Page 70-71) of the "Medical Officer Handout").

Slide18



M-6/18

After ensuring that all the participants have understood the use of flowcharts, ask them to see Pages 68 to 81 of the "Medical Officer Handout" showing actual flowcharts.

Remind them about the different syndromes addressed through flowcharts.

Now, show Slide 19 and tell them that we will quickly practice how to choose an appropriate flowchart using the major presenting symptoms stated by the patient.

Slide19

IDENTIFYING APPROPRIATE SYNDROMIC MANAGEMENT FLOWCHARTS

- Case studies
- Read the case
- Look at the symptoms of the patient
- Identify the syndrome
- Decide which flowchart to pick up for further action

M-6/19

Next, hand out the previously prepared case study cards to the participants (Write one case study on each card from the case studies given below this shaded box). Depending on the number of participants and the number of cards available, either provide one case study per participant or ask them to work in pairs (with the person next to them).

Ask them to read the case study describing the major presenting symptoms and identify the syndrome and the flowchart they would use for it.

Allow two minutes to consider and ask each participant/pair to read out the case study loudly and name the syndromic flowchart to be used. Appreciate good work.

CASE STUDIES FOR EXERCISE

1. Pandit is a 30 year-old man who is married and has five children. He has come to the clinic with urethral discharge and admits that he frequently has unprotected sex with women other than his wife.
   Response: Urethritis discharge flowchart
2. Shankar, a 24 year-old married man, comes to the clinic for a sore on the penis. He admits to having had unprotected sexual intercourse with a female sex worker.
   Response: Genital ulcer flowchart
3. Radha, a 25 year-old woman who has been married for three years and has no children, visits

a designated STI clinic. She complains of lower abdominal pain for no apparent reason and vaginal discharge since tha last five days.

Response: Lower abdominal pain flowchart

4. Suman, a 26 year-old woman, comes to a designated STI clinic for a family planning method. During a family planning counseling session with the nurse, Suman mentions that she has been having unusual vaginal discharge.

   Response: Vaginal discharge flowchart

5. Raghu, a 21 year-old college student, comes to a designated STI clinic for swelling and pain in the inguinal region. He had visited four commercial sex workers in the last two months.

   Response: Inguinal bubo flowchart.

6. Salim, a 20 year-old college student, visits a designated STI clinic for swelling and pain in the scrotal region. He has a history of unprotected sexual exposure once during the last 15 days.

   Response: Painful Scrotal swelling flowchart.

7. Fatima, a 23 year-old woman, visits a designated STI clinic for oral ulcers. She also gives a history of ulceration in the genital region with discharge. On enquiry, she reveals that she is a commercial sex worker.

   Response: Oral and anal STIs flowchart

8. Madan, a 33 year-old man, visits a designated STI clinic for soft, non-painful swelling in the anal region. He gives a history of indulging in anal sex with men.

   Response: Ano-genital warts.

9 Ganga, a 28 year-old married woman, brings her five year-old child to the designated STI clinic for multiple boils over the hands and legs with severe itching. On enquiry, she gives a history of itching in the genital region.

Response : Genital skin conditions (scabies)

MORE CASE STUDIES FOR EXERCISE

1. Reena, a 28 year-old married woman, has itching in the genital region. She also complains of vaginal discharge and burning while passing urine.

   Answer: VCD

2. Kanta, a 30 year-old married woman with a single partner, comes to your clinic with vaginal discharge.

   Answer: VCD

3. Mala is a 24 year-old recently-married woman with a single partner who has a genital ulcer.

   Answer: GUD

4. Rajesh is a 30 year-old marrried man who has come to the clinic with urethral discharge.

   Answer: UD

5. Geeta is a 16 year-old student who has a boy friend and has recently had relations with him on two or three occasions. Now, she is complaining of white discharge and fever.
   Answer: VCD

6. Veera is a 25 year-old married woman with a complaint of abdominal pain. On enquiry, shegives a history of vaginal discharge off and on for one year.
   Answer: LAP

7. Sangita, a 35 year-old woman, is a commercial sex worker who has multiple sores on the genitals.
   Answer: GUD

8. Rekha, a 40 year-old woman, has come with chronic lower abdominal pain and low backache.
   Answer: LAP

9. Harish, 22 year-old unmarried student, who has come to the clinic with pain and swelling in the genital region.
   Answer: IB

10. Pratap, a 35 year-old married man, has come with pain and a burning sensation while passing urine.
    Answer: UD

Now, show Slide 20 summarizing the key points of the session. Draw the participants' attention to the bold and underlined text.

Slide 20

ROLE OF DOCTORS IN SYNDROMIC MANAGEMENT

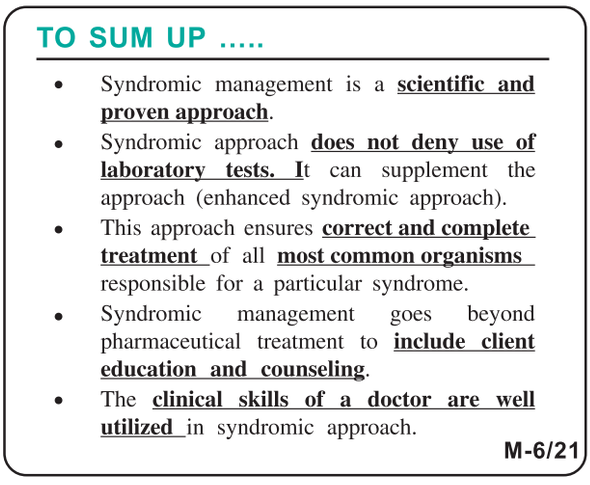
- Use syndromic management for providing correct and complete cure to STI/RTI clients.
- Even if you have a simple or modern lab support, never delay the treatment waiting for the laboratory results. Provide syndromic regimens. The client may not wait or come back.
- Pharmaceutical treatment must be supplemented with client education and counseling for better impact of your treatment and for prevention of infections in future.

M-6/20

Finally, show Slide 21 and describe the crucial role that doctors can play in implementing syndromic management of STIs/RTIs.

Close the session by saying that we will take up all the syndromic management flowcharts in the next module. Tell them that we will visit each syndrome in detail and discuss syndromic diagnosis, treatment, patient education. and follow up action.

Slide 21



APPENDIX 1 (Module 6)

IMPORTANT EVIDENCE OF THE EFFECTIVENESS OF THE SYNDROMIC APPROACH FOR STI MANAGEMENT

Reference No.	Studies/titles	Key Findings
1.	Health Care Provider Survey in Healthy Highways Project, India	The study found that STI treatment in India was not addressing best and current medical standards.
2.	Mwanza, Tanzania Study: Improvement in treatment services significantly reduced the prevalence of sexually transmitted diseases in rural Tanzania: results of a randomized controlled trial.	The WHO-advocated syndromic approach to STI treatment reduced HIV incidence by 42 percent. In the absence of sexual behaviour change, the most plausible explanation for the reduced HIV incidence was a shortening of the average duration of STIs, thus effectively reducing the probability of HIV transmission.
3.	Research in Malawi: Treatment of urethritis reduces the concentration of HIV-1 in semen: implications for prevention of transmission of HIV-1	The study provides strong evidence that STIs are associated with higher HIV infection rates and that syndromic management of STIs can make HIV-positive men less infectious. HIV concentrations in the seminal plasma of HIV seropositive men with urethritis were eight times higher than in seropositive men without urethritis. Antimicrobial therapy directed against STIs based on syndromic management, resulted in a significant decrease in the concentration of HIV in the semen of urethritis patients.
4.	The HIV/AIDS Prevention and Control SYNOPSIS Series	The report synthesizes project experiences of FHI in 14 countries in Latin America and the Caribbean region and discusses the importance of syndromic management of STIs in STI/HIV control.
5.	Mwanza, Tanzania study: Cost-effectiveness of improved treatment services for sexually 5transmitted diseases in preventing HIV-1 infection in Mwanza Region, Tanzania	A study of the cost-effectiveness of improved treatment services for STDs through syndromic management in preventing HIV infection obtained favourable results. The study suggests that cost-effectiveness should further improve when the intervention is applied on a larger scale and recommends that resources be made available for this highly cost-effective HIV control strategy.
6.	China study: Is syndromic management better than the current approach for treatment of STDs in China?: Evaluation of the cost-effectiveness of syndromic management for male STD patients.	An evaluation of the cost-effectiveness of syndromic management for male STI patients in resource poor settings of China showed that syndromic management can provide better treatment for men with STIs at a significantly lower cost.

Reference No.	Studies/titles	Key Findings
7.	Pune Study : The etiology of genital ulcer disease by multiplex polymerase chain reaction and relationship to HIV infection among patients attending sexually transmitted disease clinics in Pune, India:	A review of current studies found that flowcharts used in the syndromic diagnosis and treatment of urethral discharge and genital ulcer disease in men had high sensitivities or cure rates (urethral discharge: 87-99%; genital ulcer disease: 68-98%).
8.	Syndromic management of sexually transmitted diseases: is it rational or scientific?	Syndromic management is scientific and rational
9.	Presumptive specific clinical diagnosis of genital ulcer disease (GUD) in a primary health care setting in Nairobi.	
10.	Genital ulcers: etiology, clinical diagnosis, and associated immunodeficiency virus infection in Kingston, Jamaica.	
11.	Dangor Y et al. Accuracy of clinical diagnosis of genital ulcer disease.	
12.	The clinical diagnosis of urethral discharge	Even highly skilled STI specialists will misdiagnose or miss concurrent infections in a significant proportion of cases of genital ulcers and urethral discharge, when making diagnoses on the basis of their own clinical experience

APPENDIX 2 (Module 6)

REFERENCES ON SYNDROMIC MANAGEMENT OF STIs

1. Taylor N. Sofres: Health Care Provider Survey in Healthy Highways Project, India (with technical assistance from Family Health International and funded by the UK Department for International Development) 2000.
2. Mayaud P et al: Improvement treatment services significantly reduce the prevalence of sexually transmitted diseases in rural Tanzania: Results of a randomized controlled trial. AIDS.11(15):1873-80, 1997.
3. Cohen M et al: Treatment of urethritis reduces the concentration of HIV-1 in semen: implications for prevention of transmission of HIV-1.The Lancet. 349 (9069):1868, 1997.
4. Hoffman, I and Vuylsteke, B: "STD syndromic management". In HIV/AIDS Prevention and Control SYNOPSIS Seriesa, Family Health International, AIDS Control and Prevention Project, Latin America and Caribbean Regional Office, November 1997.
5. Gilson, Lucy et al: Cost-effectiveness of improved treatment services for sexually transmitted diseases in preventing HIV-1 infection in Mwanza Region, Tanzania. The Lancet. 350:1805-1809,1997.
6. Hongjie, L et al: Is syndromic management better than the current approach for treatment of STDs in China?: Evaluation of the cost-effectiveness of syndromic management for male STD patients. Sex Transm Dis. 30(4):327-330, 2003.
7. Risbud A et al: The etiology of genital ulcer disease by multiplex polymerase chain reaction and relationship to HIV infection among patients attending sexually transmitted disease clinics in Pune, India. SexTransm Dis. 26(1):55-62, 1999.
8. Bosu, WK: Syndromic management of sexually transmitted diseases: is it rational or scientific?. Trop Med and Int Health. 4(2):114–119, 1999.
9. Ndinya-Achola JO et al: Presumptive specific clinical diagnosis of genital ulcer disease (GUD) in a primary health care setting in Nairobi. Int J STD AIDS. 7(3):201-5, 1966.
10. Behets, FMT et al:Genital ulcers: etiology, clinical diagnosis, and associated immunodeficiency virus infection in Kingston, Jamaica. Clin Infect Dis. 28:1086-1090, 1999.
11. Dangor, Y et al: Accuracy of clinical diagnosis of genital ulcer disease. Sex Transm Dis..17: 184-189, 1990.
12. Rothenberg, R et al: The clinical diagnosis of urethral discharge. Sex Transm Dis. 10:24-28, 1983.
13. Pettifor, Audrey et al: How Effective Is Syndromic Management of STDs: A Review of Current Studies. Sex Transm Dis. 27(7):371-385, 2000.
14. AIDSCAP/Family Health International: HIV/AIDS Prevention and Control Series: STD Syndromic Management, Published by Latin America and Caribbean Regional Office, AIDSCAP/Family Health International, November 1997.
15. World Health Organization: WHO training publication: STD Case Management — The Syndromic Approach for Primary Health Care Settings, Module 2.

APPENDIX 3 (Module 6)

RERERENCES ON SOME LIMITATIONS OF SYNDROMIC CASE MANAGEMENT

1. Hawkes S et al: Reproductive-tract infections in women in low-income, low-prevalence situations: assessment of syndromic management in Matlab, Bangladesh. *The Lancet,* 354:1776-81, 1999.

2. Dallabetta GA, Gerbase AC and Holmes KK: Problems, solutions, and challenges in syndromic management of sexually transmitted diseases. *Sex Transm Infect.*74 Suppl 1: S1-11, 1998.

3. Vuylsteke B: Current status of syndromic management of sexually transmitted infections in developing countries. *Sex Transm Infect.* 80**:**333-4, 2004.

4. Hoyo C et al: Improving the accuracy of syndromic diagnosis of genital ulcer disease in Malawi. *Sex Transm Dis.* 32**:**231-7,2005.

APPENDIX 4 (MODULE 6)

COMMON CONCERNS ABOUT SYNDROMIC MANAGEMENT

1. Why does the national programme focus on STI management?

The rapid spread of HIV infection and its strong link with STIs is the reason for recommending early detection and effective management of STIs, preferably "at points of first contact" between patients and their selected health care providers. By increasing effective and patient-satisfying treatment early in an STI patient's disease expression, the chances of decreasing the spread of STIs as well as decreasing the STI patient's susceptibility to HIV are increased.

Another reason for this new attention to STIs is obvious: the sexual behaviours that lead to STIs also promote the spread of HIV.

A major recent and respected study of the Health Care Provider Survey in the Healthy Highways Project, India found that STI treatment was not addressing best and current medical standards. [1] Hence, one of the strategies of the NACO project is to increase awareness among medical providers of the recent and improved medical approaches to STI treatment of male clients of female sex workers - often the key spreaders of STIs including HIV into the general population.

2. Are there studies confirming the validity of syndromic management of STIs for HIV prevention?

The following studies confirm and support the validity of syndromic management of STIs for the HIV prevention strategy:

In a landmark pilot study in Mwanza, Tanzania, the use of the syndromic approach to STI treatment advocated worldwide by WHO, reduced HIV incidence by 42 percent.[2] The most plausible explanation for this observed reduction which occurred in the absence of sexual behavior change was that the STI treatment programme reduced HIV incidence by shortening the average duration of STIs, thus effectively reducing the probability of HIV transmission.

Subsequent research in Malawi[3] produced strong evidence that STIs are associated with higher HIV infection rates and that syndromic management of STI treatment can make HIV-positive men less infectious. In the Malawi study, HIV concentrations in the seminal plasma of HIV seropositive men with urethritis was eight times higher than in seropositive men without urethritis. After the urethritis patients received antimicrobial therapy directed against STIs based on syndromic management, the concentration of HIV in semen decreased significantly.

The HIV/AIDS Prevention and Control SYNOPSIS Series,[4] of Family Health International, AIDS Control and Prevention Project, Latin America and Caribbean Regional Office, has synthesized project experiences in 14 countries in the region. This report discusses the importance of syndromic management of STIs in STI/HIV control.

3. Is syndromic management a cost-effective HIV prevention strategy?

The Mwanza, Tanzania study,[5] on the cost-effectiveness of improved treatment services for STDs through syndromic management in preventing HIV infection obtained favourable results. The study suggests that cost-effectiveness should improve further when the intervention is applied on a larger scale, and recommends that resources be made available for this highly cost-effective HIV control strategy.

4. **The syndromic approach wastes money: it requires us to waste a lot of drugs by treating patients for infections they may not have.**

   A study[6] on the evaluation of the cost-effectiveness of syndromic management for male STI patients in resource poor settings of China shows that syndromic management can provide better treatment for men with STIs at significantly lower cost.

   WHO indicates that the syndromic approach actually makes STI care less expensive in the long run because:

   - The equipment, skills, and systems needed to make an etiological (laboratory-assisted) diagnosis are expensive.
   - Failed treatment or incorrect clinical diagnosis that results in inappropriate or incomplete treatment make the cost of treating patients higher because they have to be treated again, may develop complications that are more expensive to treat, and may continue to spread the infection.

5. **The syndromic approach does not use a doctor's clinical skills and experience like the traditional clinical approach does. The approach does not seem scientific enough.**

   For many clinicians, it is difficult to accept that using clinical judgment alone (traditional clinical approach) could be a problem. A review of current studies[7] reports that flowcharts used in the syndromic approach for the diagnosis and treatment of urethral discharge and genital ulcer disease in men had high sensitivities or cure rates (urethral discharge, 87-99%; genital ulcer disease, 68-98%).

   WHO states that that even highly experienced STI specialists using clinical diagnosis will often fail to make the correct diagnosis and indicates that clinical diagnosis is accurate for only 50% of STI cases and also misses mixed infections (when the patient has more than one STI).

   Evidence from several studies[7-11] also shows that the syndromic approach is scientific and rational.

   Clinical diagnosis can be problematic because:

   - STIs often vary in the way they appear upon examination (i.e., they often do not appear as a "textbook" case).
   - A person may have more than one infection at a time, making clinical diagnosis even more difficult.
   - Previous self-treatment or previous treatment by another provider (or a traditional healer) may alter the signs and symptoms by the time the person comes to the clinic.

   Although the laboratory-assisted approach can be reliable for management of STIs, it is often not available to health providers in our country because it depends on trained laboratory technicians, availability of laboratory supplies and, in some cases, expensive specialized equipment. Additionally, from the public health point of view, this method may require the patient to return for a second visit to collect laboratory results and receive treatment, thereby causing a delay in starting treatment and possible additional exposures and spread of STIs before treatment. Sometimes, STI patients may not return to the doctor for treatment after testing. During this time, they remain infectious and complications can occur.

   Even highly skilled STI specialists will misdiagnose or miss concurrent infections in a significant proportion of cases of genital ulcers and urethral discharge,when making a diagnosis on the basis of their own clinical experience.[11, 12]

   WHO states that the algorithms (flowcharts) suggested in syndromic management are based on

epidemiological studies conducted throughout the industrialized and developing world and a number of validation comparisons of syndromic diagnosis with laboratory-assisted diagnosis have found them to be similar in terms of accuracy. As a result, syndromic diagnosis has been recommended by WHO in many settings all over the world and the Indian government (NACO) has also adopted this approach for our country.

6. **The approach treats only the most common causes.**
   It is better to treat the patient for the most common causes first, and treat him/her for other causes only if the symptoms do not improve. It is more effective to treat the patient immediately than to require return visits for treatment. In many settings, it is difficult for patients to make repeat visits to a clinic. Additionally, if a patient is not cured of symptoms by the initial treatment, the patient is less likely to return to the clinic for additional treatment— or may even seek inappropriate alternatives or self-treatment. In addition, patients who become asymptomatic or are not treated for other potential causes of the syndrome immediately may continue to spread the infection to partners.

7. **What about the increased potential for antibiotic resistance with this approach?**
   Antibiotic resistance occurs when people do not take enough antibiotics to cure an infection completely. The syndromic approach encourages doctors to give standardized treatment using the most effective medications available for a given syndrome and to use single-dose therapy whenever possible, thereby preventing problems of patient compliance. Effective communication between the doctor and patient, as suggested in the syndromic approach, also makes it more likely that patients will continue to take the medication as requested after they leave the clinic.

Module 7

Flowcharts for Syndromic Management of STIs/RTIs

MODULE 7

Flowcharts for syndromic management of STIs/RTIs

Learning Objectives:

At the end of this module, the participants will be able to:

1. Name the precise steps on the flowcharts for the syndromic management of STIs/RTIs given in this module and explain the rationale for the suggested treatment
2. Use case studies to write prescriptions for the index patient and her/his partner/s

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Flip charts
- Marker pens
- Flowcharts
- Situation slips for various STI/RTI syndromes

  7-8 small prizes (for winners of flowchart exercises)

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Keep the handouts for the flowchart exercises ready.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1	Introduction to Module 7 & Syndromic management of STIs/RTIs	Interactive presentation, group work and exercises
2	Using flowcharts for syndromic management of STIs/RTIs	
3	Flowchart exercises	

SESSION 1

Introduction to Module 7 & Syndromic management of STIs/RTIs

Objective:

At the end of this session, the the participants will be able to:

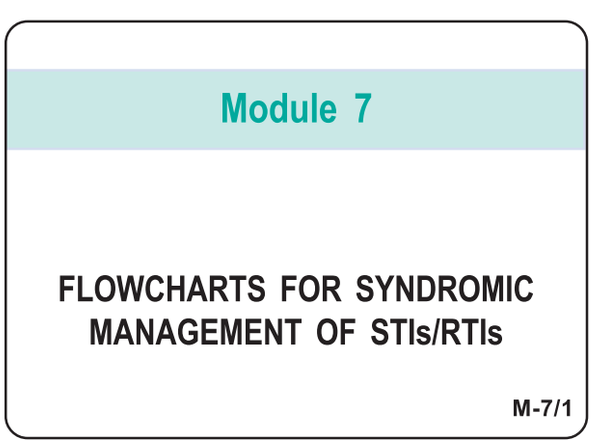
- Provide an overview of the module including its objectives
- Describe the benefits of syndromic management and the criteria for selecting appropriate drugs

Begin by summarizing the key learning points of Module 4. Say:

- "We have discussed the different approaches to STI/RTI management and concluded that syndromic management is the most relevant approach in our settings.
- "We have listed various STI/RTI syndromes in men and women.
- "We have also learnt how to select an appropriate flowchart based on the major presenting symptoms of the patient."

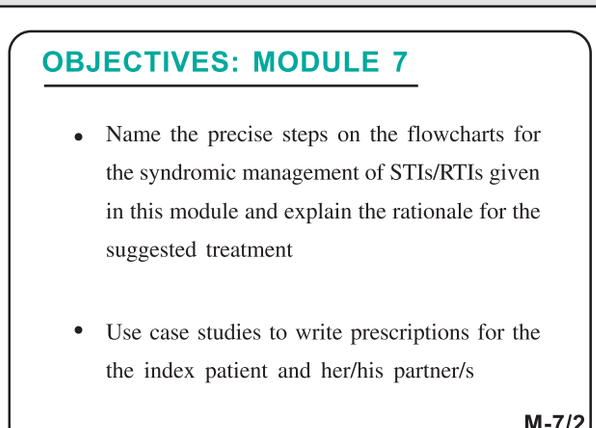
Show Slide 1 and say: "In this module we will talk about syndromic management and discuss the use of flowcharts including the rationale for suggested treatment. We will also use case studies to write prescriptions for index patients and their partners.

Slide 1



Now, show Slide 2 and explain each module objective.

Slide 2



Discuss the following introductory statements to motivate the participants to use syndromic flowcharts for treating patients with STIs/RTIs. Show Slide 3.

Slide 3

WHY SYNDROMIC MANAGEMENT?

- Simple
- Treatment at first visit
- Treatment for all common causative organisms
- Standardized at all sites
- Patient education and counseling is an integral part

M-7/3

Introduction

Since its introduction in 1991, the syndromic management approach has been implemented in many countries through numerous programmes and research and evaluation projects supported by the WHO, UNAIDS (Joint United Nations Program on HIV/AIDS), the Commission of the European Communities, Medical Research Council (U.K.), USAID (US Agency for International Development) and others.

WHO states that the flowcharts suggested for syndromic management are based on epidemiological studies conducted throughout the industrialized and developing world and that a number of validation comparisons of syndromic diagnosis with laboratory-assisted diagnosis have found them to be similar in terms of accuracy

Now, using Slide 4 and the notes given below it, explain how the drugs mentioned in the flowcharts have been selected.

Slide 4

CRITERIA FOR SELECTION OF DRUGS

- High efficacy (at least 95%)
- Low cost
- Acceptable toxicity and tolerance
- Organism resistance unlikely to develop or likely to be delayed
- Single dose
- Oral administration
- Not contraindicated for pregnant or lactating women

M-7/4

In many parts of the world, antimicrobial resistance of several sexually transmitted pathogens has been increasing thereby making certain low-cost regimens ineffective. Recommendations to use more effective drugs frequently raise concerns about cost and possible misuse. The drugs used for STI treatment in all health care facilities should have an efficacy of at least 95%. The criteria for the selection of drugs are given on Slide 4.

Based on these criteria, appropriate treatment regimens (deemed to be effective in the Indian context) have been recommended for the syndromic treatment of STIs. In general, the suggestion is to choose the most simple and shortest, yet effective treatment.

SESSION 2

Using flowcharts for syndromic management of STIs/RTIs

Objectives:

At the end of this session, the participants will be able to:

- Demonstrate the use of flowcharts for the syndromic management of STIs/RTIs
- Prescribe treatment for index clients and their partner/s

Say: "Now, we will discuss the use of flowcharts for the management of STIs/RTIs in men and women. Let us discuss, in detail, one example each of male and female syndromes."

Tell the participants to go through the remaining flowcharts on their own; in case they have any queries, they can ask the facilitator/s.

The facilitator must keep her/his own flowcharts ready (given on the next few pages of this session) for reference and discussion.

Now, facilitate a discussion on the steps shown in the flowchart.

Ask the participants to open Pages 68-69 of the "Medical Officer Handout" which gives flowcharts on syndromic management and look at the first flowchart on 'Urethral Discharge in Men'.

State that a male patient comes to you saying that he has noticed a discharge from his penis. Ask the participants how they would proceed to treat his case.

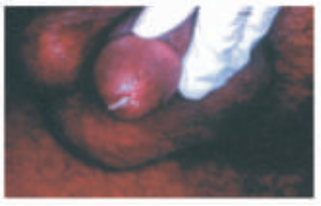
Discuss each step as you go along the steps of the flowchart.

The facilitator should ask facilitating questions so that s/he is able to offer the additional information which follows the flowchart on urethral discharge.

1. Flowcharts for Management of STI/RTI Syndromes

Flowchart: Management of Urethral Discharge/Burning Micturition in Males

SYNDROME: URETHRAL DISCHARGE IN MALES



STI/RTIs: GONORRHOEA, CHLAMYDIAL INFECTION, TRICHOMONIASIS

Causative organisms

- *Neisseria gonorrhoea*
- *Chlamydia trachomatis*
- *Trichomonas vaginalis*

History of

- Urethral discharge
- Pain or burning while passing urine, increased frequency of urination
- Sexual exposure of either Partner including high risk practices like oro-genital sex

Examination

Look for

- The urethral meatus for redness and swelling
- If urethral discharge is not seen, then gently massage the urethra from the ventral part of the penis towards the meatus and look for thick, creamy greenish-yellow or mucoid discharge

Laboratory investigations (if available)

- Gram stain examination of the urethral smear will show gram-negative intracellular diplococci in case of gonorrhoea,
- In non-gonococcal urethritis more than 5 neutrophils per oil immersion field (1000X) in the urethral smear or more than 10 neutrophils per high power field in the sediment of the first void urine are observed

As dual infection is common, the treatment for urethral discharge should adequately cover therapy for both, gonorrhoea and chlamydial infections.

Recommended regimen for uncomplicated gonorrhoea + chlamydia

Uncomplicated infections indicate that the disease is limited to the anogenital region (anterior urethritis).

- Tab. Cefixime 400 mg orally, single dose Plus
- Tab Azithromycin 1 gram orally single dose under supervision
- Advise the Client to return after 7 days of start of therapy

When symptoms persist after adequate treatment for gonorrhoea and chlamydia in the index client and partner(s), they should be treated for Trichomonas vaginalis.

If discharge or only dysuria persists after 7 days

- Tab. Secnidazole 2gm orally, single dose (to treat for T. vaginalis)

If the symptoms still persists

- Refer to higher centre as early as possible

Syndrome specific guidelines for Partner management

- Treat all recent Partners
- Treat female partners (for gonorrhoea and chlamydia) on same lines after ruling out pregnancy and history of allergies
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate about correct and consistent use
- Refer to ICTC for testing of HIV & Syphilis
- Schedule return visit after 7 days

Management of pregnant Partner

Pregnant partners of male clients with urethral discharge should be examined by doing a per speculum as well as per vaginal examination and should be treated for gonococcal as well as chlamydial infections.

- Cephalosporins to cover gonococcal infection are safe and effective in pregnancy
- Tab. Cefixime 400mg orally, single dose or
- Ceftriaxone 125mg by intramuscular injection +
- Tab. Erythromycin 500mg orally four times a day for seven days or
- Cap Amoxicillin 500mg orally, three times a day for seven days to cover chlamydial infection
- Quinolones (like ofloxacin, ciprofloxacin), doxycycline are contraindicated in pregnant women.

Follow up

After seven days

- To see symptomatic relief
- To see reports of tests done for HIV & syphilis
- If symptoms persist, to assess whether it is due re-infection
- For prompt referral if required

Urethral discharge in men

A male patient complains of urethral discharge and/or burning during micturition:

Step 1: Take the patient's history and examine him for urethral discharge; milk the urethra if necessary: This box asks you to take the patient's history and examine him to confirm that he has urethral discharge. Also, examine the external genitalia and the entire region looking for other STIs that may be present, not forgetting the inner surface of the foreskin. If you cannot see any discharge, then milk the urethra.

> Ask the participants what they would do in such a situation.

Discharge seen: This box confirms the presence of a discharge and leads to the action box directly below it.

Laboratory tests: If a discharge is seen and your facility has a well-equipped laboratory, get a gram stain examination of the discharge to look for gonococcus which is the most common organism responsible for urethral discharge.

No discharge seen: Give analgesics for pain. Re-evaluate the next day withholding urine:

If you do not see any discharge on the first day, ask the patient to return the next morning before passing urine. Re-examine for urethral discharge. Meanwhile, treat for pain.

Treat for gonorrhoea and chlamydia:

Provide treatment. Relieve pain. Educate for treatment compliance and risk reduction. Promote/provide condoms. Advise to return or go to another clinic after 7 days if symptoms persist.

This box tells you how to manage the patient. Follow all the steps in the box to complete the patient's care. The syndrome is identified and you are encouraged to give immediate treatment for the infections that could cause the syndrome you have identified.

> Ask the participants about the patient education messages they would give a patient suffering from urethral discharge while prescribing the treatment regimen.

There is also a reminder that the doctor needs to offer education for:

1. **Possible side effects of medication from the list below:**

   Cefixime: Diarrhoea, nausea, vomiting, dyspepsia, abdominal pain, skin rash, urticaria, drug fever, pruritus, dizziness, headache.

   Azithromycin: Nausea, epigastric distress, vomiting, diarrhoea, dizziness, headache, flatulence, fever, skin rash, cholestatic jaundice, ototoxicity.

   Secnidazole: Allergic reactions, seizures, numbness or tingling, unpleasant metallic taste in mouth, darkening of urine, nausea, vomiting and loss of appetite, reaction with alcohol characterized by intense flushing, breathlessness, headache, increased or irregular heart rate, low blood pressure, nausea and vomiting.

   Ceftriaxone: Nausea, vomiting, diarrhea, superinfection, skin rash, urticaria, pseudomembranous colitis, pain at the site of injection.

2. **Treatment compliance:** Ensure that the patient takes the medication under your direct observation. If the patient is given a regimen other than a single dose, s/he should be told not to stop taking

medication if the symptoms go away because the infection will not have been cured and s/he could fall ill again. Also s/he would continue to infect partners.

3. Azithromycin 1 gm is best taken one hour before or 2 hours after meals.
4. The patient should be educated in risk reduction.
5. In addition, to minimize further transmission of infection, the doctor would need to promote abstinence or correct and consistent condom use for 7 days after single-dose therapy or until completion of a 7-day regimen. The doctor should supply condoms or suggest from where the patient can obtain them, give prescriptions/medicines for partner/s, refer the patient to the ICTC and be reviewed after 7 days if symptoms persist.
6. During the follow up visit, the doctor should confirm if the patient has been cured. If not, s/he should determine if failure of treatment is due to non-compliance or re-infection and manage accordingly. Also, review the reports of tests recommended at the ICTC.

Rationale for suggested treatment:

Cefixime 400 mg (for gonorrhoea) and Azithromycin 1 g (for chlamydia) is the current treatment of choice for males presenting with urethral discharge. There is no reported resistance to this therapy. Many studies, particularly those conducted in South Asia, have reported fluoroquinolone-resistance in gonorrhoea. Therefore, fluoroquinolones such as Ciprofloxacin and Norfloxacin should not be used for treating gonorrhoea.

Cured:The patient is considered cured from infection if he is totally symptom-free at the end of 7 days of starting the treatment.

Return for follow-up after **7 days if symptoms persist. Check compliance/re-infection:** Take patient history and examine for urethral discharge. If the history confirms that the patient has not taken the full course of treatment or has been re-infected, repeat the entire treatment. If he has taken the full treatment and there is no re-infection, treat for trichomoniasis.

Treat for Trichomoniasis

Educate not to take alcohol while on these drugs and up to 24-48 hours after the last dose. Avoid sexual intercourse or practice consistent condom use until both partners are adequately treated. Treat partner. Refer to the ICTC for tests on HIV and syphilis.

There is also a reminder that you should educate the patient about the precautions to be taken during treatment and seek treatment compliance. In addition, you should discuss the precautions to be taken in case the female partner is pregnant.

Precautions:

The patient should -

- Avoid taking alcohol while on these drugs, and up to 24-48 hours after the last dose.
- Come for follow up if symptoms persist.
- Avoid sexual intercourse until both partners have been adequately treated.

Patients not cured with an initial single dose of Metronidazole, often respond very well to 7 days' repeat treatment with Metronidazole.

In special conditions such as pregnancy:

Treat the pregnant partner:

- Pregnant partners of male clients with urethral discharge should be examined by doing a per speculum as well as per vaginal examination and treated for gonococcal as well as chlamydial infections.
- As per the "National Technical Guidelines", the use of cephalosporins, to cover gonococcal infection, is safe and effective in pregnancy. Therefore, Cefixime or Ceftriaxone could be given along with erythromycin or amoxicillinto cover both the infections.
- In case the vaginal discharge continues after 7 days of treatment, the woman should be treated for trichomoniasis. Remember, Metronidazole and Tinidazole are contra-indicated in the first trimester of pregnancy, but may be used during the second and third trimesters.
- Give the minimum effective dose of Metronidazole, 400 mg orally twice daily for 7 days.
- In symptomatic women in the first trimester of pregnancy and those intolerant to Metronidazole / Tinidazole, Imidazole pessaries / cream may be given for 7 days.
- For lactating women, give a single oral dose of 2 g of Metronidazole or Tinidazole.

Rationale for suggested treatment: Trichomoniasis is a common STI that affects both women and men, although the symptoms are more commonly seen in women. However, some men may temporarily have an irritation inside the penis, mild discharge or slight burning after urination or ejaculation.

"*Trichomonas Vaginalis is also a causative organism of urethral discharge (based on data from STI clinics in India). Hence, treatment for trichomonas infection is given only in cases of persistent UD after ensuring treatment for gonorrhoea and chlamydia. The WHO and NACO UD flowcharts give the same recommendation - treat for gonorrhoea and chlamydia first; if still not cured, then treat for trichomoniasis*."

Treatment of sex partners increases the cure rate and reduces the possibility of further transmission or re-infection. Sexual intercourse should be avoided or condoms should be used consistently during treatment until the symptoms have gone away.

Alcohol or vinegar and Metronidazole interact to cause a violent reaction of nausea, vomiting, sweating, weakness and other symptoms.

There is increasing evidence of an association between infection with *T. vaginalis* and premature rupture of the chorio-amniotic membrane and low birth weight. *Data from studies conducted in Africa have shown an association between trichomoniasis and HIV infection, suggesting a two-fold to three-fold increase in HIV transmission.*

No improvement: Refer to a higher care centre: These cases would need referral to a place where specialist and advanced laboratory services are available.

The use of syndromic management flowcharts for treating urethral discharge in men has been largely successful. Sensitivities reported by evaluation studies have ranged from 87% to 99%. Some studies used cure rates to evaluate the success of the flowcharts; these values were equally high, ranging from 92% to 99%.

During and after completing the above discussion, encourage the participants to ask questions for clarification, as and when needed. Respond to their questions with relevant scientific explanations.

When the discussion on urethral discharge in males is complete, take the discussion forward to one of the female syndromes.

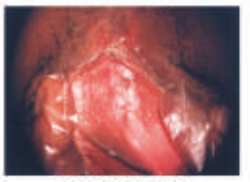
Take the example of vaginal discharge syndrome because it is a complex situation to diagnose and manage (compared to other syndromes). Moreover, recently, there has been a change in the approach used to manage this syndrome.

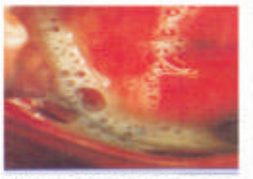
Ask the participants how they usually proceed when they come across a woman complaining of vaginal discharge.

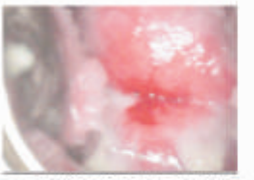
Listen carefully to their responses so that you can make corrective suggestions during the discussion that follows.

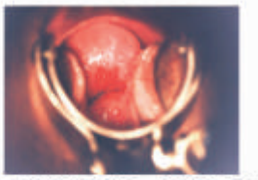
Flowchart: Management of Vaginal Discharge in Females

SYNDROME: VAGINAL DISCHARGE


VAGINITIS


TRICHOMONIASIS


CERVICAL HERPES


CERVICAL HERPES

Causative organisms
Vaginitis

- *Trichomonas vaginalis (TV)*
- *Candida albicans*
- *Gardnerella vaginalis, Mycoplasma*

Causative organisms
Cervicitis

- *Neisseria Gonorrhoea*
- *Chlamydia trachomatis*
- *Trichomonas vaginalis*
- *Herpes simplex virus*

History

- *Menstrual history to rule out pregnancy*
- Nature and type of discharge (amount, smell, color, consistency)
- Genital itching
- Burning while passing urine, increased frequency
- Presence of any ulcer, swelling on the vulval or inguinal region
- Genital complaints in sexual Partners
- Low backache

Examination

- Per speculum examination to differentiate between vaginitis and cervicitis.

a) Vaginitis:

Trichomoniasis - greenish frothy discharge

Candidiasis - curdy white discharge

Bacterial vaginosis – adherent discharge

Mixed infections may present with atypical discharge

b) Cervicitis:

Cervical erosion /cervical ulcer/mucopurulent cervical discharge

- Bimanual pelvic examination to rule out pelvic inflammatory disease
- If Speculum examination is not possible or Client is hesitant treat both for vaginitis and cervicitis

Laboratory investigations (If available)

- Wet mount microscopy of the discharge for Trichomonas vaginalis and clue cells
- 10% KOH preparation for Candida albicans
- Gram stain of vaginal smear for clue cells seen in bacterial vaginosis
- Gram stain of endocervical smear to detect gonococci

Treatment

Vaginitis (TV+BV+Candida)

- Tab. Secnidazole 2gm orally, single dose or
  Tab. Tinidazole 500mg orally, twice daily for 5 days
- Tab. Metoclopropramide taken 30 minutes before Tab. Secnidazole, to prevent gastric intolerance
- Treat for candidiasis with Tab Fluconazole 150mg orally single dose or local Clotrimazole 500mg vaginal pessaries once

Treatment for cervical infection (chlamydia and gonorrhoea)

- Tab cefixim 400 mg orally, single dose
- Plus Azithromnycin 1 gram, 1 hour before lunch. If vomiting within 1 hour, give anti-emetic and repeat
  - If vaginitis and cervicitis are present treat for both
  - Instruct client to avoid douching
  - Pregnancy, diabetes, HIV may also be influencing factors and should be considered in recurrent infections
  - Follow-up after one week

Specific guidelines for Partner management

- Cervicitis: Treat all Partners for gonorrhea and Chlamydia.
- Vaginitis: Generally partner treatment is not required. If Partner is symptomatic, treat Partner for the symptom.
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate about correct and consistent use
- Schedule return visit after 7 days

Management in pregnant women

Per speculum examination should be done to rule out pregnancy complications like abortion, premature rupture of membranes

Treatment for vaginitis (TV+BV+Candida)

In first trimester of pregnancy

- Local treatment with Clotrimazole vaginal pessary/cream only for candidiasis. Oral Flucanozole is contraindicated in pregnancy.
- Metronidazole pessaries or cream intravaginally if trichomoniasis or BV is suspected.

In second and third trimester oral metronidazole can be given

- Tab. Secnidazole 2gm orally, single dose or
  Tab. Tinidazole 500mg orally, twice daily for 5 days
- Tab. Metoclopropramide taken 30 minutes before Tab. Metronidazole, to prevent gastric intolerance

Management of pregnant women with cervicitis

Pregnant women with cervical discharge should be examined by doing a per speculum as well as per vaginal examination and should be treated for gonococcal as well as chlamydial infections.

- Cephalosporins to cover gonococcal infection are safe and effective in pregnancy
  - Tab. Cefixime 400 mg orally, single dose or
  - Ceftriaxone 125 mg by intramuscular injection +
  - Tab. Erythromycin 500mg orally four times a day for seven days or
  - Cap Amoxicillin 500mg orally, three times a day for seven days to cover chlamydial infection
  - Quinolones (like ofloxacin, ciprofloxacin), doxycycline are contraindicated in pregnant women.

SYNDROMIC MANAGEMENT OF VAGINAL DISCHARGE

As mentioned earlier, the syndromic management of vaginal discharge is a complex process.

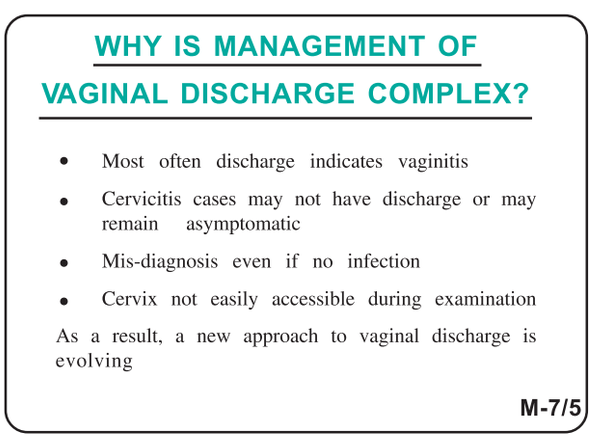
Ask the participants: "Do you have any idea why it is complex?"

Let 1-2 participants respond. Appreciate the responses, depending on their quality.

Explain that it is complex because it bears a poor correlation with the major causes of cervicitis namely, gonorrhoea and chlamydia.

Show Slide 5 and explain it further.

Slide 5



Limitations of syndromic management in women with vaginal discharge

Syndromic management has been widely adopted and has proven useful for most syndromes. However, syndromic management of vaginal discharge is an exception because of its poor correlation with the main causes of cervicitis – gonorrhoea and chlamydia.

It is normal for women to have vaginal discharge. Women may notice it to be particularly excessive during a specific phase of the menstrual cycle, during and after sexual activity, and during pregnancy and lactation. Usually, women complain of vaginal discharge when they think it is unusual for them or if it causes itching or discomfort. In general, they may not seek medical attention if they consider it to be normal.

Women develop symptoms of vaginal discharge when they have vaginitis (infection of the vagina) or cervivitis (infection of the cervix) or both. It is important to distinguish between these two conditions because one of them - cervicitis, leads to serious complications which would require the patient's sexual partner/s to be treated as well, in order to avoid re-infection.

Distinguishing points between vaginitis and cervicitis

Vaginitis	Cervicitis
Caused by candidiasis, trichomoniasis or bacterial vaginosis	Caused by gonorrhoea or chlamydia
Most common cause of vaginal discharge	Less common cause of vaginal discharge
Easy to diagnose	Difficult to diagnose
No serious complications	Major complications
Treatment for partner unnecessary, except for trichomoniasis	Need to treat partner/s for gonorrhoea and chlamydia

Management of vaginal discharge has the following problems:

1. Most often, vaginal discharge indicates vaginitis. A number of studies have shown that the most common causes of vaginal discharge are bacterial vaginosis (BV), trichomonas vaginalis (TV), and candidiasis. Of these, only TV is sexually transmitted. The signs and symptoms previously thought to be associated with STIs such as yellow vaginal discharge are not specific for STIs and may be more common with non-sexually transmitted vaginitis.
2. Many women with cervicitis do not have vaginal discharge or lower abdominal pain. In fact, most women with cervicitis do not have any symptoms.
3. Syndromic management of vaginal discharge has been misused as a screening tool. This happens when women, who present at a health facility for other reasons, are asked if they have vaginal discharge and then managed as if they had come with an initial complaint of vaginal discharge. We know that, often, vaginal discharge is either normal or related to vaginal infections. In many settings, 40-50% of women will say "yes" when asked if they have a discharge. This can lead to massive over-treatment of STIs. Studies of the validity of syndromic management have shown that vaginal discharge should not be used as a routine screening tool.
4. The cervix is not easily accessible. There is some evidence that syndromic management of vaginal discharge can be improved by examining the cervix by speculum to determine whether there is a cervical discharge or inflammation, but this requires skill-building training, equipment such as Cusco's speculum and other supplies.

Evolution of the syndromic management approach for vaginal discharge

As a result of these continuing problems, the approach to vaginal discharge management has been evolving over time. The original aim of the WHO vaginal discharge flowcharts was to provide a simple tool for providers to manage vaginal discharge when it is the woman's chief complaint. The serious effects of gonorrhoea and chlamydia infections in women and the perception that these infections often go untreated, led to a flowchart where all women with vaginal discharge were treated for all possible infections of the vagina and cervix. This strategy does have the advantage of treating more women with vaginal discharge who might have a cervical infection. However, because cervical infection is much less common than vaginal infection, many women get treated for cervicitis unnecessarily.

Show Slide 6 and explain the text on the new approach for the syndromic management of vaginal discharge which follows Slide 6, in a step-wise manner

Slide 6

NEW APPROACH FOR SYNDROMIC MANAGEMENT OF VAGINAL DISCHARGE

- Definite benefits of treating vaginitis
- Assess risk of STIs in vaginal discharge cases
- Treat as vaginitis only, unless you strongly suspect STIs
- Treat with antifungals if you suspect candida infection
- Try making diagnosis of specific STI in symptomatic women with low risk
- Preferably do external and internal examinations
- Tailor management approach to suit your settings – privacy for examination, availability of lab tests, if she is undergoing any internal procedure such as IUD or abortion
- Try finding partners of those at higher risk **M-7/6**

A new approach to the syndromic management of vaginal discharge

1. We now know that vaginitis itself may have serious consequences. Bacterial vaginosis is associated with PID. BV and trichomoniasis are associated with pre-term labor and also with an increase in HIV transmission. Hence, there is more benefit from treating vaginitis than previously thought.
2. Assess the STI risk of clients with vaginal discharge carefully. If you or she suspect high risk, based on the prevalence of STIs in your patient population (her occupation or her partner's symptoms, occupation or behaviour), treat her for cervicitis and vaginitis and try to ensure partner treatment. The higher her risk, the greater is the need to treat her immediately at first visit. Genital examination will provide a wealth of information and help you to decide treatment modalities
3. Treat vaginal discharge without cervical involvement as vaginitis only, unless you have convincing reasons to believe that the patient is at a high risk for STIs. This means not treating her partner initially.
4. Use every method you have to make a better, more accurate diagnosis of STIs in women who have symptoms but are at lower risk. Always explain and motivate the patient to undergo a thorough genital examination which includes palpating the abdomen, checking for cervical motion tenderness and a bimanual examination. Always try to perform the minimal bedside laboratory tests. All this will add to the accuracy (increased sensitivity, specificity, and predictive value) of your diagnosis.
5. Tailor the syndromic management approach according to your clinical setting. Consider how high the risk to your population is (prevalence), how much of the examination you are capable of doing well, and the availability of useful diagnostic tests and effective treatment. Also consider the reason for a woman's visit: does she have vaginal discharge or has she come for another reason? Is she going to have a procedure (IUD insertion or abortion) which puts her at increased risk if she is infected with a STI?

6. One of the best ways to reach women at risk who are without symptoms is to target their partners. Find ways to welcome men to your clinic, reach out to men in the community and make sure any men you treat for STIs have their partners treated and know how to use condoms.

Encourage the participants to ask questions and clarify issues, if any. Provide scientific answers to all the questions raised during the discussion.

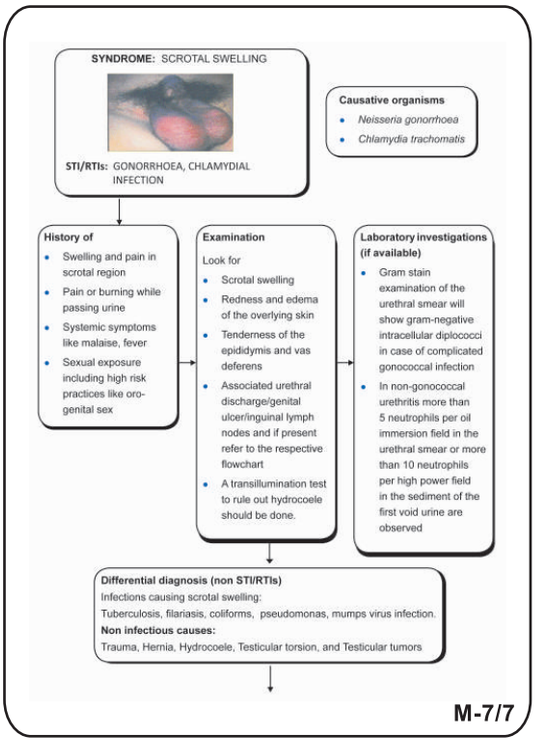
On completion of the discussion on the two flowcharts, facilitators should ensure that all the participants review the remaining flowcharts (Pages 68 to 81 of the "Medical Officer Handout")

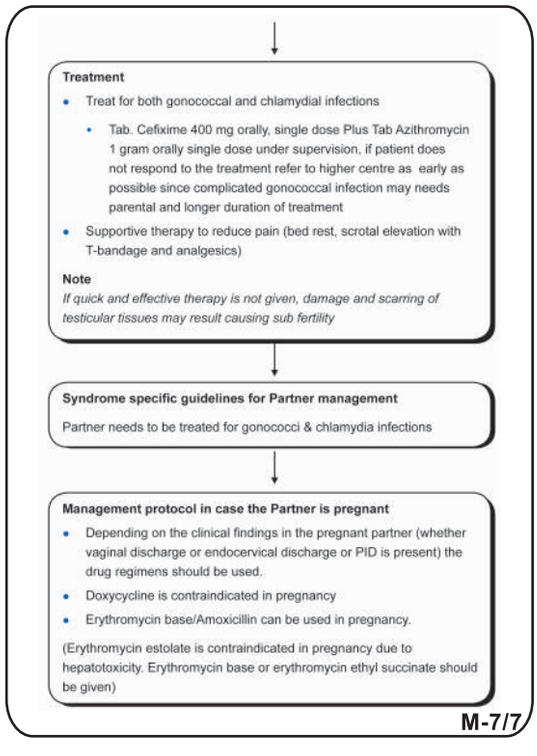
Allow 30 minutes for reviewing and solicit questions from the participants. Respond to their queries individually and as a group.

Finally, close the discussion on flowcharts stating that it is important that all of us follow the procedure, treatment regimens and the points on patient education mentioned in the flowcharts. This will ensure that everyone uses a standardized and proven approach for STI/RTI management in men and women.

Assure the participants that facilitator/s will be available throughout the Workshop and even after the Workshop for clarifications, if any, regarding the flowcharts or syndromic management.

Slide 7

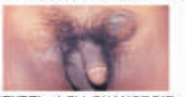




Slide 8

Flowchart: Management of Inguinal Bubo

SYNDROME: INGUINAL BUBO



STI/RTIs: LGV, CHANCROID

Causative organisms

- *Chlamydia trachomatis serovars L1, L2, L3, causative agent of lympho granuloma venerum (LGV)*
- *Haemophilus ducreyi causative agent of chancroid*

History of

- Swelling in inguinal region which may be painful
- Preceding history of genital ulcer or discharge
  - Sexual exposure of either partner including high risk practices like oro-genital sex etc
  - Systemic symptoms like malaise, fever

Examination

Look for

- Localized enlargement of lymph nodes in groin which may be tender and fluctuant
- Inflammation of skin over the swelling
- Presence of multiple sinuses
- Edema of genitals and lower limbs
- Presence of genital ulcer or urethral discharge and if present refer to respective flowchart

Laboratory investigations (if available)

- Diagnosis is on clinical grounds

Differential diagnosis

- Mycobacterium tuberculosis, filariasis
- Any acute infection of skin of pubic area, genitals, buttocks, anus and lower limbs can also cause inguinal swelling

If malignancy or tuberculosis is suspected refer to higher centre for biopsy.

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Treatment

- Start Cap. Doxycycline 100mg orally twice daily for 21 days (to cover LGV) Plus
- Tab Azithromycin 1g orally single dose OR
- Tab. Ciprofloxacin 500mg orally, twice a day for three days to cover chancroid
- Refer to higher centre as early as possible.

Note:

- A bubo should never be incised and drained at the primary health centre, even if it is fluctuant, as there is a high risk of a fistula formation and chronicity. If bubo becomes fluctuant always refer for aspiration to higher centre.
- In severe cases with vulval edema in females, surgical intervention in the form of vulvectomy may be required for which they should be referred to higher centre.

Syndrome specific guidelines for Partner management

- Treat all Partners who are in contact with Client in last 3 months
- Partners should be treated for chancroid and LGV
- Tab Azithromycin 1g orally single dose to cover chancroid
  +
  Cap Doxycycline 100mg orally, twice daily for 21 days to cover LGV
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate on correct and consistent use
- Refer to ICTC for HIV & syphilis testing
- Schedule return visit after 7 days and 21 days

Management of pregnant Partner

- Quinolones (like ofloxacin, ciprofloxacin), doxycycline, sulfonamides are contraindicated in pregnant women.
- Pregnant and lactating women should be treated with the erythromycin regimen, and consideration should be given to the addition of a parenteral amino glycoside (e.g., gentamicin)

Tab. Erythromycin base, 500mg orally, 4 times daily for 21 days and refer to higher centre.

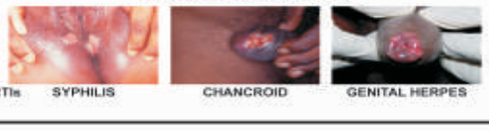
(Erythromycin estolate is contraindicated in pregnancy due to hepatotoxicity. Erythromycin base or erythromycin ethyl succinate should be given)

M-7/8

Slide 9

Flowchart: Genital Ulcers

SYNDROME: GENITAL ULCERS



STI/RTIs — SYPHILIS — CHANCROID — GENITAL HERPES

Causative organisms

- *Treponema pallidum (syphilis)*
- *Haemophilus ducreyi (chancroid)*
- *Klebsiella granulomatis (granuloma inguinale)*
- *Chlamydia trachomatis (lymphogranuloma venerum)*
- *Herpes simplex (genital herpes)*

History of

- Genital ulcer/vesicles/ Recurrence
- Burning sensation in the genital region
- Sexual exposure of either partner including high risk practices like oro-genital sex

Examination

- Presence of vesicles
- Presence of genital ulcer- single or multiple
- Associated inguinal lymph node swelling and if present refer to respective flowchart

Ulcer characteristics:

- Painful vesicles/ulcers, single or multiple - Herpes simplex
- Painless ulcer with shotty lymph node - Syphilis
- Transient Ulcer with inguinal lymph nodes - LGV
- Painful ulcer sometimes single giant ulcer associated with painful bubo - Chancroid

Laboratory investigations

- RPR test for syphilis
- For further investigations refer to higher centre

M-7/9

Treatment

- If vesicles or multiple painful ulcers are present treat for herpes with Tab. Acyclovir 400mg orally, three times a day for 7 days
- If vesicles are not seen and only ulcer is seen, treat for syphilis and chancroid and counsel on herpes genitalis

To cover syphilis give Inj Benzathine penicillin 2.4 million IU IM after test dose in two divided doses (with emergency tray ready) (In individuals allergic or intolerant to penicillin, Doxycycline 100mg orally, twice daily for 14 days)

+

Tab Azithromycin 1g orally single dose or

Tab. Ciprofloxacin 500mg orally, twice a day for three days to cover chancroid

Treatment should be extended beyond 7 days if ulcers have not epithelialized i.e. formed a new layer of skin over the sore)

If both ulcers (GUD-NH) & blisters (GUD-H) are present or when the provider is not able to differentiate between the two then treat for both GUD – NH and GUD herpetic infections.

Refer to higher centre

- If not responding to treatment
- Genital ulcers co-existent with HIV
- Recurrent lesion

Syndrome specific guidelines for Partner management

- Treat all Partners who are in contact with client in last 3 months
- Partners should be treated for syphilis and chancroid
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate about correct and consistent use
- Refer to ICTC for HIV & Syphilis testing
- Schedule return visit after 7 days

Management of Pregnant Women

- Quinolones (like ofloxacin, ciprofloxacin), doxycycline, sulfonamides are contraindicated in pregnant women
- Pregnant women who test positive for RPR should be considered infected unless adequate treatment is documented in the medical records and sequential serologic antibody titers have declined.
- Inj Benzathine penicillin 2.4 million IU IM after test dose (with emergency tray ready)
- A second dose of benzathine penicillin 2.4 million units IM should be administered 1 week after the initial dose for women who have primary, secondary, or early latent syphilis.
- Pregnant women who are allergic to penicillin should be treated with erythromycin and the neonate should be treated for syphilis after delivery.
- Tab. Erythromycin 500mg orally four times a day for 15 days

(Note: Erythromycin estolate is contraindicated in pregnancy because of drug related hepatotoxicity. Only Erythromycin base or erythromycin ethyl succinate should be used in pregnancy)

- All pregnant women should be asked history of genital herpes and examined carefully for herpetic lesions.
- Women without symptoms or signs of genital herpes or its prodrome can deliver vaginally.
- Women with genital herpetic lesions at the onset of labour should be delivered by caesarean section to prevent neonatal herpes.
- Acyclovir may be administered orally to pregnant women with first episode genital herpes or severe recurrent herpes.

M-7/9

Slide 10

Flowchart: Management of Lower Abdominal Pain in Females

SYNDROME: LOWER ABDOMINAL PAIN

Pelvic inflammatory disease

Causative organisms

- *Neisseria gonorrhoea*
- *Chlamydia trachomatis*
- *Mycoplasma,Gardnerella, Anaerobic bacteria (Bacteroides sp,gram positive cocci)*

History

- Lower abdominal pain
- Fever
- Vaginal discharge
- Menstrual irregularities like heavy, irregular vaginal bleeding
- Dysmenorrhoea
- Dyspareunia
- Dysuria, tenesmus
- Low backache
- Contraceptive use like IUD

Examination

- General examination: temperature, pulse, blood pressure
- Per speculum examination: vaginal/ cervical discharge, congestion or ulcers
- Per abdominal examination: lower abdominal tenderness or guarding
- Pelvic examination: Uterine/adnexal tenderness, cervical movement tenderness,

Note: *A urine pregnancy test should be done in all women suspected of having PID to rule out pregnancy.*

Laboratory investigations (if available)

- Wet smear examination
- Gram stain for gonorrhoea
- Complete blood count and ESR
- Urine microscopy for pus cells

Differential diagnosis

- Ectopic pregnancy
- Twisted ovarian cyst
- Ovarian tumor
- Appendicitis
- Abdominal tuberculosis

M-7/10

Treatment (Out Client treatment)

In mild or moderate PID (in the absence of tubo ovarian abscess), Out Client treatment can be given. Therapy is required to cover Neisseria gonorrhoea, Chlamydia trachomatis and anaerobes.

- Tab. Cefixim 400 mg orally Stat + Tab. Metronidazole 400mg orally, twice daily for 14 days
  +
- Doxycycline, 100mg orally, twice a day for 2 weeks (to treat Chlamydial infection)
- Tab. Ibuprofen 400mg orally, three times a day for 3-5 days
- Tab. Ranitidine 150mg orally , twice daily to prevent gastritis
- Remove intra uterine device, if present, under antibiotic cover of 24-48 hours
- Advise abstinence during the course of treatment and educate on correct and consistent use of condoms
- Observe for 3 days. If no improvement (i.e. absence of fever, reduction in abdominal tenderness, reduction in cervical movement, adnexal and uterine tenderness) or if symptoms worsen, refer for in Client treatment.
- Schedule return visit after 3 days, 7 days & 14 days to insure compliance.

Caution: *PID can be a serious condition. Refer the Client to the hospital if she does not respond to treatment within 3 days and even earlier if her condition worsens.*

Hospitalization of Clients with acute PID should be seriously considered when:

- The diagnosis is uncertain
- Surgical emergencies e.g. appendicitis or ectopic pregnancy cannot be excluded
- A pelvic abscess is suspected
- Severe illness precludes management on an outpatient basis
- The woman is pregnant
- The Client is unable to follow or tolerate an out regimen
- The Client has failed to respond to outpatient therapy

Note: *All Clients requiring hospitalization should be referred to the district hospital*

Syndrome specific guidelines for Partner management

- Treat all Partners
- Treat male Partners for urethral discharge (gonorrhoea and chlamydia)
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate on correct and consistent use
- Refer to ICTC for HIV & Syphilis testing
- Inform about the complications if left untreated and sequelae

Management of pregnant women

Though PID is rare in pregnancy,

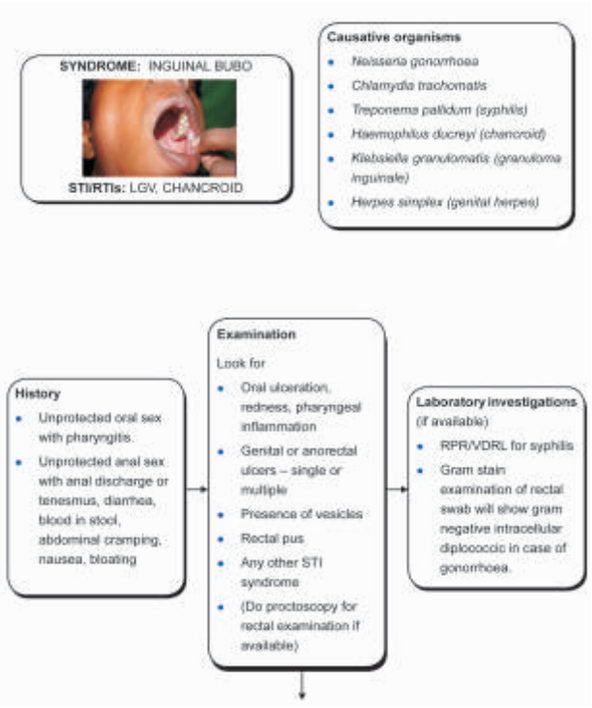
- Any pregnant woman suspected to have PID should be referred to district hospital for hospitalization and treated with a parenteral regimen which would be safe in pregnancy.
- Doxycycline is contraindicated in pregnancy.

Note: Metronidazole is generally not recommended during the first three months of pregnancy. However, it should not be withheld for a severely acute PID, which represents an emergency.

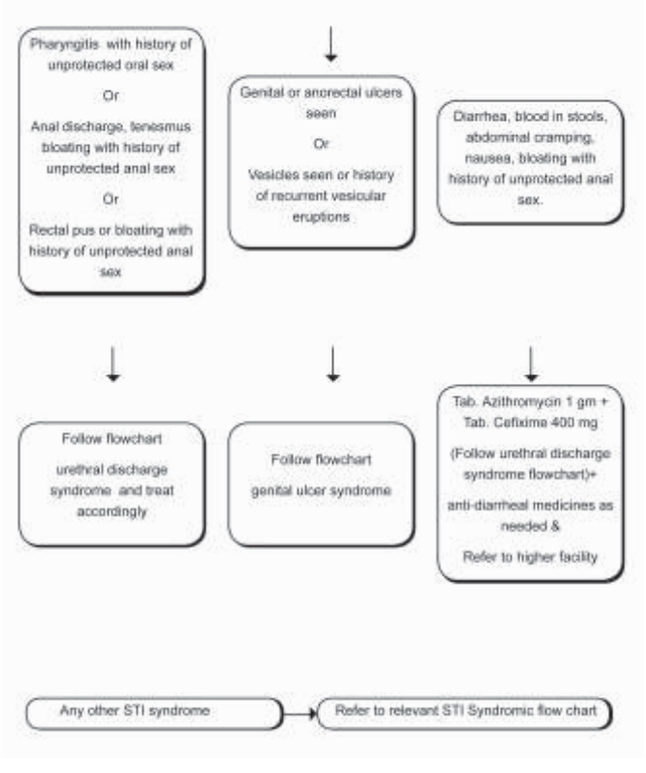
M-7/10

Slide 11

Flowchart: Management of Oral and Anal STI



M-7/11

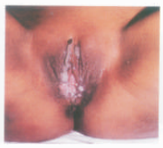


M-7/11

Slide 12

Management of Anogenital warts

SYNDROME: **Anogenital warts**



Causative organisms
Virus: Human Papilloma Virus (HPV)

Clinical features

•Single or multiple soft, painless, pink in color, "cauliflower" like growths which appear around the anus, vulvo-vaginal area, penis, urethra and peri-neum.

•Warts could appear in other forms such as papules which may be keratinized.

Diagnosis

Presumptive diagnosis by history of exposure followed by signs and symptoms.

Treatment

Recommended regimens:

Penile and perianal warts

20% Podophyllin in compound tincture of benzoin applied to the warts, while carefully protecting the surrounding area with Vaseline, to be washed off after 3 hours. It should not be used on extensive areas per session.
Treatment should be repeated weekly till the lesions resolve completely.

Note: *Podophyllin is contra-indicated in pregnancy. Treatment should be given under medical supervision. Clients should be warned against self-medication.*

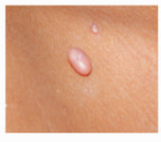
Cervical warts
Podophyllin is contra-indicated.
Biopsy of warts to rule out malignant change.
Cryo cauterization is the treatment of choice. Cervical cytology should be periodically done in the sexual Partner(s) of men with genital warts.

M-7/12

Slide 13

Management of Molluscum contagiosum

Molluscum contagiosum



Causative organisms
Pox virus

Clinical features

•Multiple, smooth, glistening, globular papules of varying size from a pinhead to a split pea can appear anywhere on the body. Sexually transmitted lesions on or around genitals can be seen.
•The lesions are not painful except when secondary infection sets in. When the lesions are squeezed, a cheesy material comes out.

Diagnosis

Diagnosis is based on the above clinical features

Treatment

- Individual lesions usually regress without treatment in 9-12 months.
- Each lesion should be thoroughly opened with a fine needle or scalpel. The contents should be exposed and the inner wall touched with 25% phenol solution or 30% trichloracetic acid.

M-7/13

Slide 14

Management of Pediculosis pubis

Causative organisms
Lice - Phthirus pubis

Clinical features

•There may be small red papules with a tiny central clot caused by lice irritation.

•General or local urticaria with skin thickening may or may not be present. Eczema and Impetigo may be present.

Treatment

Recommended regimen:
•Permethrin 1% creme rinse applied to affected areas and wash off after 10 minutes

Special instructions

•Retreatment is indicated after 7 days if lice are found or eggs observed at the hair-skin junction.
•Clothing or bed linen that may have been contaminated by the Client should be washed and well dried or dry cleaned.
•Sexual Partner must also be treated along the same lines.

Special instructions

•Clothing or bed linen that have been used by the Client should be thoroughly washed and well dried or dry cleaned.

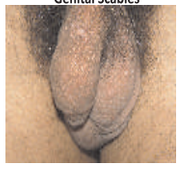
•Sexual Partner must also be treated along the same lines at the same time.

M-7/14

Slide 15

Management of Genital Scabies

Genital Scabies



Causative organisms
Mite - Sarcoptes scabiei

Clinical features

Severe pruritis (itching) is experienced by the Client, which becomes worse at night. Other members of family also affected (apart from sexual transmission to the Partner, other members may get infected through contact with infected clothes, linen or towels).

Diagnosis

The burrow is the diagnostic sign. It can be seen as a slightly elevated grayish dotted line in the skin, best seen in the soft part of the skin.

Treatment

Recommended regimens:

•Permethrin cream (5%) applied to all areas of the body from the neck down and washed off after 8--14 hours.

•Benzyl benzoate 25% lotion, to be applied all over the body, below the neck, after a bath, for two consecutive nights.

Client should bathe in the morning, and have a change of clothing. Bed linen is to be disinfected.

M-7/15

SESSION 3

Flowchart exercises

Objective:

At the end of this session, the participants will be able to:

Use flowchart exercises to write prescriptions for the index patient and her/his partner/s

Exercise on syndromic management flowcharts

- Divide the participants into three or four groups (depending on the total number of participants in the Workshop. Each group should have at least 5 participants).
- Tell them that they have 15 minutes to complete the missing information in the flowchart provided to them.
- Announce that the group completing the exercise first and correctly will get a prize. Keep 7- 8 small prizes ready for distribution.
- Provide one flowchart to each group from the flowcharts given at the end of this session
- After 10 minutes (or when all the groups are ready, whichever is earlier), ask the groups to review the work of other groups.
- The facilitator/s should also review the work of all the groups.
- Make comments, as necessary.
- Finally, distribute the prizes to the members of the winning group.

End the session by showing Slide 16 and sum it up.

Slide 16

TO SUM UP .....

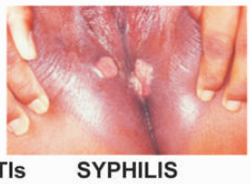
- The drugs used in syndromic management are chosen based on scientific criteria
- Syndromic management is a comprehensive approach to include:
- Treatment of index client
- Treatment of partners
- Risk reduction
- Client education and counseling
- Referral to ICTC (under opt-out policy)
- Referral to other services, as necessary

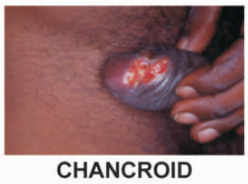
M-7/16

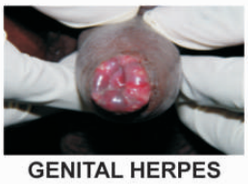
MANAGEMENT OF GENITAL ULCERS

(FOR EXERCISE ONLY)

SYNDROME: GENITAL ULCERS







STI/RTIs **SYPHILIS** **CHANCROID** **GENITAL HERPES**

Causative organisms

- *Treponema pallidum (syphilis)*
- .....
- .....
- .....
- .....

History of

- Genital ulcer/vesicles/ Recurrence
- Burning sensation in the genital region
- Sexual exposure of either partner including high risk practices like oro-genital sex

Examination

- Presence of vesicles
- Presence of genital ulcer- single or multiple
- Associated inguinal lymph node swelling and if present refer to respective flowchart

Ulcer characteristics:

- Painful vesicles/ulcers, single or multiple - Herpes simplex
- Painless ulcer with shotty lymph node - Syphilis
- Transient Ulcer with inguinal lymph nodes - LGV
- Painful ulcer sometimes single giant ulcer associated with painful bubo - Chancroid

Laboratory investigations

- .....
- For further investigations refer to higher centre

Treatment

- If vesicles or multiple painful ulcers are present treat for herpes with .....
  .....
- If vesicles are not seen and only ulcer is seen, treat for syphilis and chancroid and counsel on herpes genitalis

To cover syphilis give Inj Benzathine penicillin 2.4 million IU IM after test dose in two divided doses (with emergency tray ready) (In individuals allergic or intolerant to penicillin, Doxycycline 100mg orally, twice daily for 14 days)

+

Tab Azithromycin 1g orally single dose or

Tab. Ciprofloxacin 500mg orally, twice a day for three days to cover chancroid

Treatment should be extended beyond 7 days if ulcers have not epithelialized i.e. formed a new layer of skin over the sore)

If both ulcers (GUD-NH) & blisters (GUD-H) are present or when the provider is not able to differentiate between the two then treat for both GUD – NH and GUD herpetic infections.

Refer to higher centre

- If not responding to treatment
- Genital ulcers co-existent with HIV
- Recurrent lesion

Syndrome specific guidelines for Partner management

- Treat all Partners who are in contact with client in last 3 months
- Partners should be treated for syphilis and chancroid
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate about correct and consistent use
- .....
- .....

Management of Pregnant Women

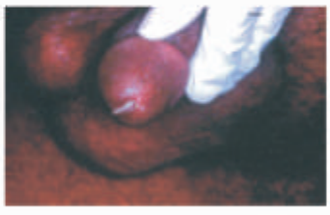
- Quinolones (like ofloxacin, ciprofloxacin), doxycycline, sulfonamides are contraindicated in pregnant women.
- Pregnant women who test positive for RPR should be considered infected unless adequate treatment is documented in the medical records and sequential serologic antibody titers have declined.
- Inj Benzathine penicillin 2.4 million IU IM after test dose (with emergency tray ready)
- A second dose of benzathine penicillin 2.4 million units IM should be administered 1 week after the initial dose for women who have primary, secondary, or early latent syphilis.
- Pregnant women who are allergic to penicillin should be treated with erythromycin and the neonate should be treated for syphilis after delivery.
- Tab. Erythromycin 500mg orally four times a day for 15 days

  (Note: Erythromycin estolate is contraindicated in pregnancy because of drug related hepatotoxicity. Only Erythromycin base or erythromycin ethyl succinate should be used in pregnancy)
- All pregnant women should be asked history of genital herpes and examined carefully for herpetic lesions.
- Women without symptoms or signs of genital herpes or its prodrome can deliver vaginally.
- Women with genital herpetic lesions at the onset of labour should be delivered by caesarean section to prevent neonatal herpes.
- Acyclovir may be administered orally to pregnant women with first episode genital herpes or severe recurrent herpes.

MANAGEMENT OF URETHRAL DISCHARGE/BURNING MICTURITION IN MALES

(FOR EXERCISE ONLY)

SYNDROME: URETHRAL DISCHARGE IN MALES



STI/RTIs: GONORRHOEA, CHLAMYDIAL INFECTION, TRICHOMONIASIS

Causative organisms

- *Neisseria gonorrhoea*
- .....
- .....

History of

- Urethral discharge
- Pain or burning while passing urine, increased frequency of urination
- Sexual exposure of either Partner including high risk practices like oro-genital sex

Examination

Look for

- The urethral meatus for redness and swelling
- If urethral discharge is not seen, then gently massage the urethra from the ventral part of the penis towards the meatus and look for thick, creamy greenish-yellow or mucoid discharge

Laboratory investigations (if available)

- Gram stain examination of the urethral smear will show gram-negative intracellular diplococci in case of gonorrhoea,
- In non-gonococcal urethritis more than 5 neutrophils per oil immersion field (1000X) in the urethral smear or more than 10 neutrophils per high power field in the sediment of the first void urine are observed

As dual infection is common, the treatment for urethral discharge should adequately cover therapy for both, gonorrhoea and chlamydial infections.

Recommended regimen for uncomplicated gonorrhoea + chlamydia

Uncomplicated infections indicate that the disease is limited to the anogenital region (anterior urethritis).

- .....
- .....
- .....

When symptoms persist after adequate treatment for gonorrhoea and chlamydia in the index client and partner(s), they should be treated for Trichomonas vaginalis.

If discharge or only dysuria persists after 7 days

- .....

If the symptoms still persists

- Refer to higher centre as early as possible

Syndrome specific guidelines for Partner management

- .....
- .....
  .....
  .....
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate about correct and consistent use
- Refer to ICTC for testing of HIV & Syphilis
- Schedule return visit after 7 days

Management of pregnant Partner

Pregnant partners of male clients with urethral discharge should be examined by doing a per speculum as well as per vaginal examination and should be treated for gonococcal as well as chlamydial infections.

- Cephalosporins to cover gonococcal infection are safe and effective in pregnancy
- Tab. Cefixime 400mg orally, single dose or
- Ceftriaxone 125mg by intramuscular injection
  +
- Tab. Erythromycin 500mg orally four times a day for seven days or
- Cap Amoxicillin 500mg orally, three times a day for seven days to cover chlamydial infection
- Quinolones (like ofloxacin, ciprofloxacin), doxycycline are contraindicated in pregnant women.

Follow up

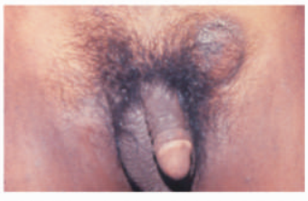
After seven days

- .....
- .....
- If symptoms persist, to assess whether it is due re-infection
- For prompt referral if required

MANAGEMENT OF INGUINAL BUBO

(FOR EXERCISE ONLY)

SYNDROME: INGUINAL BUBO



STI/RTIs: LGV, CHANCROID

Causative organisms

- .....
  .....
  .....
- .....
  .....

History of

- Swelling in inguinal region which may be painful
- Preceding history of genital ulcer or discharge
  - Sexual exposure of either partner including high risk practices like oro-genital sex etc
  - Systemic symptoms like malaise, fever

Examination

Look for

- Localized enlargement of lymph nodes in groin which may be tender and fluctuant
- Inflammation of skin over the swelling
- Presence of multiple sinuses
- Edema of genitals and lower limbs
- Presence of genital ulcer or urethral discharge and if present refer to respective flowchart

Laboratory investigations (if available)

- Diagnosis is on clinical grounds

Differential diagnosis

- Mycobacterium tuberculosis, filariasis
- Any acute infection of skin of pubic area, genitals, buttocks, anus and lower limbs can also cause inguinal swelling

If malignancy or tuberculosis is suspected refer to higher centre for biopsy.

Treatment

- .....
- .....
- .....
- Refer to higher centre as early as possible.

Note:

- A bubo should never be incised and drained at the primary health centre, even if it is fluctuant, as there is a high risk of a fistula formation and chronicity. If bubo becomes fluctuant always refer for aspiration to higher centre.
- In severe cases with vulval edema in females, surgical intervention in the form of vulvectomy may be required for which they should be referred to higher centre.

Syndrome specific guidelines for Partner management

- Treat all Partners who are in contact with Client in last 3 months
- Partners should be treated for chancroid and LGV
- Tab Azithromycin 1g orally single dose to cover chancroid
  +
  Cap Doxycycline 100mg orally, twice daily for 21 days to cover LGV
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate on correct and consistent use
- Refer to ICTC for HIV & syphilis testing
- Schedule return visit after 7 days and 21 days

Management of pregnant Partner

- Quinolones (like ofloxacin, ciprofloxacin), doxycycline, sulfonamides are contraindicated in pregnant women.
- Pregnant and lactating women should be treated with the erythromycin regimen, and consideration should be given to the addition of a parenteral amino glycoside (e.g., gentamicin)

Tab. .....

(Erythromycin estolate is contraindicated in pregnancy due to hepatotoxicity. Erythromycin base or erythromycin ethyl succinate should be given)

Module 8

Partner Management

MODULE 8

Partner Management

Learning Objectives:

At the end of this module, the participants will be able to:

1. Explain the purpose of timely partner management
2. Define partner management
3. Discuss critical issues in partner treatment
4. Describe the main approaches to partner management

Materials :

- Overhead/LCD projector
- PowerPoint slides for the session
- Flip charts
- Marker pens
- Flow charts
- Situation cards for various STI/RTI syndromes

Preparation by facilitator :

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1.	Introduction,to Module 8 & Importance of partner management	Interactive presentation and group work
2.	Critical issues of partner treatment	
3.	Approaches to partner management	

SESSION 1

Introduction to Module 8 and Importance of partner management

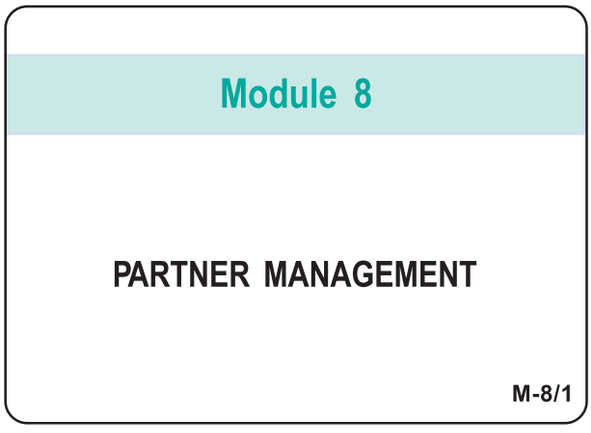
Objectives :

At the end of this session, the participants will be able to:

- Provide an overview of the module including its objectives
- Define "partner management "
- Discuss the importance of partner management

Begin the session by stating that partner management is an important component in the control and prevention of STIs/RTIs. Unless all the partners are treated, the index client is likely to get re-infected. At the same time her/his partner/s not only have the infection but can also transmit it to other partners. Show Slide 1.

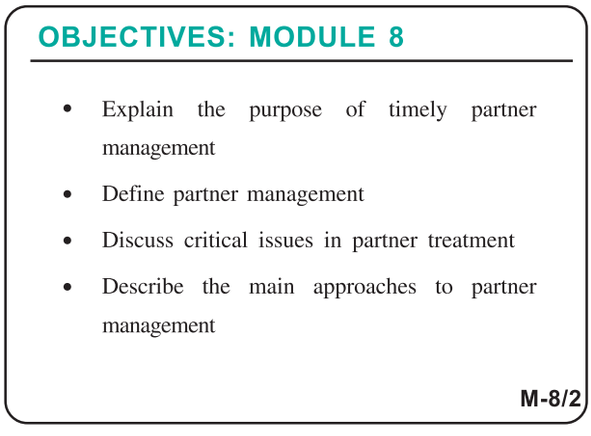
Slide 1



Now, say: "Often, the client's partners do not seek services for various reasons such as being asymptomatic or fearing lack of confidentiality. In this module, we will discuss the critical issues surrounding partner management and the different approaches to successful partner management."

Show Slide 2 and explain the objectives of this module.

Slide 2

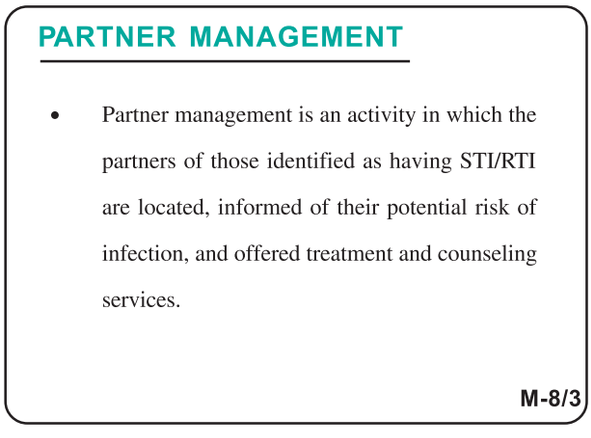


Say: "We have talked about partner management in the previous modules. Let us discuss its finer aspects in detail here so that you can implement it in your centres to manage your STI/RTI clients effectively. Let us first define "partner management".

Ask 1-2 participants to define "partner management".

Show Slide 3 and explain the definition. Say: "Partner management includes all the partners of the index client. It is not just about providing pharmaceutical treatment to the partners but providing a comprehensive package of services to them such as educating them about the potential risk of infection and counseling them to use safer sex practices to prevent re-infection."

Slide 3



Now, ask the participants: "Why is partner management necessary?"

Allow 2-3 participants to respond. While they are making their points, encourage them to elaborate by also giving the implication/s of each point. Appreciate correct responses.

Show Slide 4 and repeat the importance of timely partner management. Emphasize that the word "timely" is very important from the viewpoint of arresting the transmission of infection/s.

The assumption among common people is that there is no need for any treatment in the absence of symptoms. Clarify that partner treatment not only helps in the prompt treatment of the index client and her/his partner/s but also breaks the transmission chain of infection. Therefore, partner management plays a key role in the treatment of asymptomatic partners.

Slide 4

IMPORTANCE OF PARTNER MANAGEMENT

- Prevention of re-infection in index client/s
- Prevention of transmission in partner/s
- Timely treatment of symptomatic partners
- Identification of asymptomatic partners and their treatment

M-8/4

SESSION 2

Critical issues of partner treatment

Objective :

At the end of this session, the participants will be able to:

Identify the barriers to partner treatment and identify ways to overcome them

Ask the participants to narrate their experiences of partner notification and management. Ask them if, as health care providers, they have tried it with STI/RTI clients visiting their centres/ clinics. If so, ask them to describe their clients' response.

Let 1-2 participants share their experiences. By and large, the experiences would be related to non-compliance on the part of clients. Let positive examples of full compliance by clients, if any, also be shared.

Next, ask them to reflect on their experiences and list reasons for non-compliance to partner management.

Write the reasons given by the participants on a flip chart.

Now, show Slide 5, compare the participants' list with the slide and complete the list. Clarify each bullet point on the slide in detail.

Repeat the exercise for provider/system-related issues that could be responsible for non-compliance. Show Slide 6, complete the participants' list, and explain each bullet point on the slide.

Slide 5

CLIENT-RELATED ISSUES

- Stigma attached to the problem
- Lack of confidentiality at centres/clinics
- Hesitation due to shame
- Lack of knowledge regarding importance and availability of services
- Unaware about consequences
- Fear of revealing facts to partners

M-8/5

Slide 6

PROVIDER AND SYSTEM-RELATED ISSUES

- Privacy and confidentiality
- Voluntary reporting
- Client-initiated partner management
- Availability of services

M-8/6

Now,, ask: "What can we do to overcome these barriers?"

Let 3-4 participants respond. Show Slide 7.

Explain each bullet point on the slide and relate it to situations that most providers face at their clinics/centres.

Slide 7

HOW TO OVERCOME BARRIERS

- Privacy: Ensure privacy at the clinics, make it visible, inform clients about it, let clients experience it
- Client awareness: Make efforts through every media and interaction.
- Provide appropriate counseling and client education services to every client.
- Demonstrate non-judgmental attitude with clients attending clinic/center.
- Use examples of satisfied clients and quality of services for creating confidence among client groups.

M-8/7

SESSION 3

Approaches to partner management

Objective :

At the end of this session, the participants will be able to:

- Describe the main approaches to partner treatment

Initiate the discussion by stating that many participants must have managed STI/RTI clients in their centres/clinics.

Encourage 1-2 participants to share the steps followed by them for managing their clients.

Listen to the responses and make a note of the steps.

Now, show Slide 8 and share the two approaches to partner management.

State that the client referral option is a more preferred option as it is more economical, does not require additional manpower, and the client is involved in motivating her/his partner/s to take treatment and preventive measures.

Now, explain the provider-led approach and ask the participants which approach they would like to adopt and why.

Slide 8

APPROACHES TO PARTNER MANAGEMENT

- **Referral by index clients:**
  - Index clients inform partners
  - Does not involve extra staff; hence inexpensive
  - May include client-initiated therapy

Referral by providers:

Providers approach partner/s through referral card/s

Needs extra staff; hence expensive

M-8/8

Say: "The approaches mentioned above are for bringing the partners to the clinic/treatment centre or provider. Now let us see what a provider needs to do when the partner actually reports at the clinic/centre."

Try to explore the current practices followed by the participants for treating partner/s of index clients.

Show Slide 9 on the general principles of partner management and explain that the partners of index clients need to be treated for the same STI/s as the index client except in the case of genital herpes where the partners will be treated only if they are symptomatic.

Also emphasize that utmost care should be taken in the case of female clients suffering from vaginal discharge or PID before labeling them as STI clients.

Suitable incentives such as coupons or free treatment cards, if available, should be publicized and made available to partners with a view to motivate other clients and their partners to seek treatment.

Use the additional information on partner management including approaches and general principles, given below Slide 9, while discussing these aspects.

Slide 9

GENERAL PRINCIPLES OF PARTNER MANAGEMENT

- Partner/s to be treated for same infection/s as index client
- Provider should be reasonably sure of presence of STI, especially in vaginal discharge cases
- Special care of PID cases due to serious complications
- Provide "partner reporting card" or "coupon for free examination" as an incentive
- Call for follow up – for compliance/cure and to see test reports, if advised

M-8/9

Approaches to partner management

There are two approaches to partner management:

1. **Referral by index client**

   In this approach, the index client informs her/his partner/s of possible infection. This appears to be a feasible approach because it does not involve extra personnel, is inexpensive and does not require any identification of partners. A partner notification card with a relevant diagnostic code is given to each index client, where partner management is indicated. This approach may also include the use of client-initiated therapy for all contacts.

2. **Referral by service/health care provider**

   In this approach, the service provider contacts the client's partner/s by issuing an appropriate partner notification card. The information provided by the client is used confidentially to trace and contact the partner/s directly. This approach needs extra staff and is expensive.

General principles of partner management

- In general, partners should be treated for the same STI as the index client, whether or not they have symptoms or signs of infection.
- Health care providers should be as sure as possible about the presence of an STI before informing and treating the partner, and should remember that other explanations,such as vaginal discharge, are possible for most RTI symptoms.
- Special care is required in notifying partners of women with lower abdominal pain who are being treated for possible PID. Because of the serious potential complications of PID (infertility, ectopic pregnancy), partners should be treated to prevent possible re-infection. It should be recognized, however, that the diagnosis of PID on clinical grounds is inaccurate and the couple should be adequately counseled about this uncertainty. It is usually better to offer treatment as a precaution to preserve future fertility than to mislabel someone as having an STI when they may not have one.
- Health care providers should issue a Partner Reporting Card. They can also give incentives such as a "coupon for a free examination/treatmen

- Follow up visits should be advised -
- To see reports of tests done for HIV, syphilis and Hepatitis B.
- If the symptoms persist. Advise the client to come back for follow up after 7 days. In case of PID, follow up should be done after 2 to 3 days.

Two-step strategy for partner management

A two-step strategy can be used where the client herself/himself is first asked to contact her/his partner/s. If no response is received for one to two weeks, the clinic or health department staff can attempt to trace the contact for treatment.

Next, show Slide 10, describing partner treatment.

Slide 10

PARTNERS TREATMENT

Syndrome of index patient	Treatment for partner/s
Urethral discharge	Treat partner/s for gonorrhoea & chlamydia
Genital ulcer	Treat partner/s for syphilis and chancroid
Vaginal discharge: Patient treated for vaginitis and cervicitis Patient treated for vaginitis	Treat partner/s for gonorrhoea and chlamydia Not necessary for partners to be treated unless there is recurrent discarge
Pelvic inflammatory disease	Treat partner/s for gonorrhoea and chlamydia
Scrotal swelling	Treat partner/s for gonorrhoea and chlamydia
Inguinal bubo	Treat partner lymphogranuloma venereum & Chancroid
Neonatal conjunctivitis	Treat both parents for gonorrhoea and chlamydia

M-8/10

Exercise:

At the end of the session, give an exercise to the participants to get a commitment from them to improve partner treatment in their respective centers. Display Slide 11 during the exercise.

Ask each participant to imagine that a STI/RTI client is sitting in front of him/her.

Say: "You have diagnosed the client as a case of STI and provided appropriate treatment. Now, you have to talk and motivate the client for partner treatment. List 6-7 actions (talking points and other actions) that you would perform to motivate her/him for ensuring effective partner management."

Allow 5 minutes for listing and take their responses.

Note the responses on a flip chart.

Ask one of the participants to read out the list loudly, and say: "Now, we ourselves have identified number of actions that we can perform to ensure effective partner management. Can we promise ourselves that we will try all these actions the next time we come across a STI/RTI client?"

Slide 11

EXERCISE

- Imagine that an STI/RTI client is sitting in front of you
- You have diagnosed him/her as a case of STI and provided appropriate treatment
- Now it is time to talk and motivate (or empower) the client for partner treatment
- List 4-5 actions (talking points and other actions) you will perform to motivate him/her to ensure effective partner management

M-8/11

Finally, show Slide 12 and emphasize that it indicates some of the actions that a doctor can take in her/his clinic to enhance partner notification and treatment.

After taking the participants' commitment on it, commend them and close the session.

Slide 12

MY COMMITMENT

I can do the following to ensure partner management–

- Provide adequate **privacy and confidentiality** to clients and their partners.
- Always make best attempts to **motivate and help** index clients to **get their partners treated**.
- **Appreciate if the partners report for treatment**, especially if they come on their own.
- **Appreciate index clients** whenever they succeed in bringing partners for treatment.
- Provide **correct and complete treatment to partners, including education and counseling on prevention**.
- Encourage reported partners to **share the news with peers**.

M-8/12

Module 9

Laboratory Tests for RTIs/STIs

MODULE 9

Laboratory tests for STIs/RTIs

Learning Objectives:

At the end of this module, the participants will be able to:

1. Explain the role of the laboratory in STI/RTI control
2. Explain the limited usefulness of laboratory tests at the primary health care level
3. Describe laboratory services that are appropriate at the primary health care level

Materials :

- Overhead/LCD projector
- PowerPoint slides for the session
- Blank flip charts
- Marker pens

Preparation by facilitator :

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1	Introduction to Module 9	Interactive presentation
2	Role of the laboratory in STI/RTI control	
3	Laboratory tests for STIs/RTIs: Limitations and availability	

Introduction

Although the syndromic approach does not require the diagnosis of specific diseases with the help of a laboratory facility, a clinical understanding of the diseases and the addition of a few simple laboratory tests can definitely enhance the management and prevention of STIs/RTIs. Since our public health standards and laboratory facilities have been improving with time even at the primary health care level, it is now possible for us to make use of simple laboratory tests to make syndromic management even more effective.

In this module, we will discuss the common laboratory tests used for detecting STIs/RTIs and their role in controlling these infections.

SESSION 1

Introduction to Module 9

Objective:

At the end of this session, the participants will be able to:

- Get an overview of the module and its objectives

Begin the session by reminding the participants that so far, we have discussed the syndromic management of STIs/RTIs in which we arrive at a diagnosis based on the major presenting signs and symptoms and provide treatment for the most common organisms responsible for the syndrome.

Ask the participants if there is there any role for laboratory tests in syndromic management. Tell them to clarify either response, "yes" or "no".

Now, explain that the syndromic approach is the most suitable approach in low-resource settings where high-level services such as reliable laboratory tests are not available.

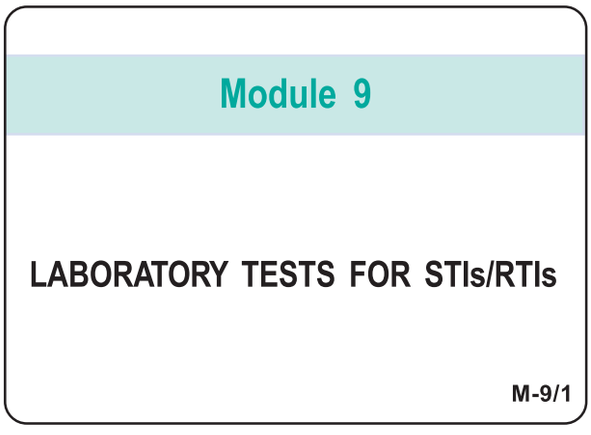
However, with the changing times, our country has made good progress in the public health field as well as in resource availability. As a result, certain simple laboratory tests can now be provided even at designated STI clinics.

Although we do not rely completely on laboratory tests for the treatment of STIs/RTIs, the national programme has incorporated some simple laboratory tests in the syndromic management approach as a support, but not as a replacement to syndromic treatment.

Therefore, this module has been planned to acquaint us with these simple laboratory tests which can be used at the primary health care level/designated STI clinics.

Show Slides 1 and 2 and share the objectives of the module

Slide 1



Slide 2

OBJECTIVES: MODULE 9

- Explain the role of the laboratory in STI/RTI control
- Explain the limited usefulness of laboratory tests at the primary health care level
- Describe laboratory services that are appropriate at the primary health care level

M-9/2

SESSION 2

Role of the laboratory in STI/RTI control

Objective:

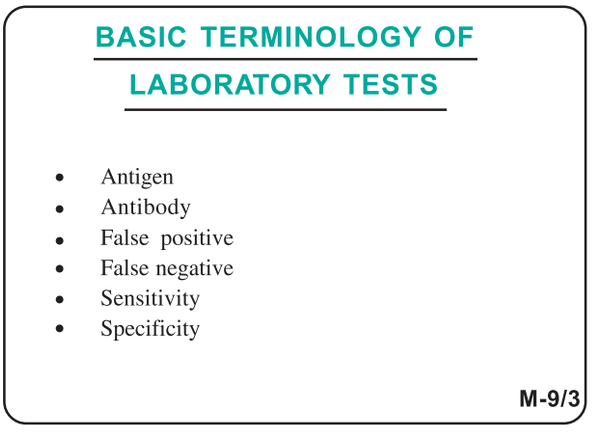
At the end of this session, the participants will be able to:

- Explain the role of the laboratory in STI/RTI control

State that before initiating the discussion on the laboratory tests used for detecting STIs/RTIs, let us quickly recapitulate some terms that are commonly used in the laboratory.

Show Slide 3 and ask the participants to define the terms on the slide. Most participants should be able to define all the terms. If not, explain the terms using the definitions given below Slide 3.

Slide 3



Antigen: A molecule which is recognized by the immune system and induces an immune reaction (the organism itself).
Antibody: A class of serum proteins which are induced following contact with the antigen (an infectious organism).
False positives: Uninfected people diagnosed as positive.
False negatives: Infected people diagnosed as negative (missed infections).

Sensitivity:

- Indicates how good a test is at identifying people who are infected.
- The higher the sensitivity, the lower the rate of false negatives (missed infections).
- Example: If the sensitivity of a test is 95% and 100 infected people are tested, 95 will have positive test results and 5 will have negative test results (even though they are infected)
- The minimum number of organisms needed in a sample for a test to be positive varies from one type of test to another. The lower the number of organisms that can be detected, the greater the sensitivity of the test. The new amplified DNA techniques (e.g., PCR, LCR) are extremely sensitive and can detect between 1 and 50 organisms in the test sample.

Specificity:

- Indicates how good a test is at identifying people who are not infected.
- The higher the specificity, the lower the rate of false positives.
- Example: If the specificity of a test is 95% and 100 people who are not infected are tested, 95 will have negative test results and 5 will have positive test results (even though they are not infected).

Sensitivity and specificity are used to give an indication of how good a diagnostic test is. Ideally, one would like a test that has 100% sensitivity (i.e. everyone who is infected, tests positive) and 100% specificity (i.e. everyone who is not infected, tests negative).

Now, ask the participants to share their thoughts on the utility of laboratory tests in STI/RTI control.

After getting a few responses from them, show Slide 4 and explain that the laboratory can play a role not only in detecting individual infections, but also in screening asymptomatic individuals. Also explain how the laboratory can enhance the effectiveness of syndromic diagnosis and treatment and contribute to the collection of epidemiological data for programmatic decision making. Emphasize the value of laboratory tests in sentinel surveillance and in controlling antimicrobial resistance.

Slide 4

USE OF THE LABORATORY IN STI/RTI CONTROL

- Screening and detection
- Screening asymptomatic cases in high-risk population
- To diagnose single and mixed infections
- Improve diagnostic value of syndromic management
- Detect infection in asymptomatic individuals
- Epidemiological data – prevalence, incidence
- Testing for antimicrobial resistance
- Sentinel surveillance
- Accurate etiological diagnosis

M-9/4

SESSION 3

Laboratory tests for STIs/RTIs: Limitations and availability

Objectives:

At the end of this session, the participants will be able to:

- Describe the common laboratory tests for STIs/RTIs and explain their limited usefulness at the primary health care level
- Describe laboratory services that are appropriate at the primary health care level

Begin the session by asking the participants to name the laboratory tests used to detect STIs/RTIs.

Let 2-3 participants respond.

Show Slides 5 and 6 and explain the tests briefly, using the Participant Handout for Medical Officer (Module 9 Page 101-114) & "Laboratory Technicians Guidelines" (Module 3 Page 17-30)

Explain that although many tests are available, the common tests used in our settings are limited. Ask them to cite their experiences of their centre/site.

Slide 5

DIAGNOSTIC TESTS FOR STIs/RTIs

- **Microscopic examination:**
  - Wet mount- Trichomoniasis, candida, bacterial vaginosis
  - Gram staining – Gonorrhoea, Bacterial vaginosis
- **Vaginal pH: Bacterial vaginosis**

M-9/5

Slide 6

LABORATORY TESTS FOR DETECTION OF COMMON STIs/RTIs

- Vaginal pH
- Wet mount microscopy
- Whiff test
- Gram stain microscopy
- Rapid Plasma Reagin (RPR) for syphilis and
- TPHA for confirmation

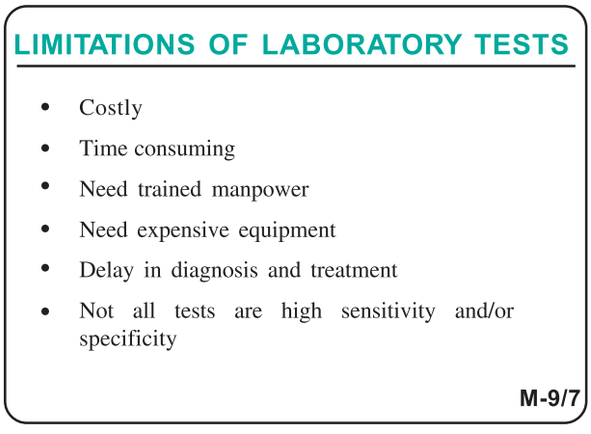
M-9/6

Now, say: “There is no doubt that laboratory tests add value to the diagnosis and overall management and control of STIs/RTIs. Nevertheless, there are many constraints that prevent the availability and wide use of these tests across the country.”

Show Slide 7 and discuss the limitations. Clarify that in addition to the cost and availability of trained manpower, delays in getting test results are another limiting factor.

State that we have already seen that STI/RTI clients hesitate to seek treatment due to the stigma attached to these infections. In such situations, syndromic management involving the limited use of rapid tests serves as a convenient and useful option.

Slide 7



Finally, state that the details of certain laboratory tests that can be performed at STI/RTI clinics, are given in the "Medical Officer Handout"

Ask the participants to open their copies of the "Medical Officer Handout" and glance through the tests (Pages 101-114). Tell them to read the tests in detail during their free time. Also suggest that they visit the laboratory in their own centre/clinic and actually see how the tests are performed and how the results are read and interpreted.

Remember ...

Take the participants to the laboratory during clinical practicum, show/demonstrate the common laboratory tests for STIs/RTIs and respond to their queries.

Now, show Slides 8 and 9 and close the session.

Slide 8

SUGGESTED READING & ACTIVITIES

- Read Medical Officer Handout
- Read the details of common lab tests for STIs/ RTIs from National Guidelines on Prevention, Management and control of RTIs including STIs
- Visit laboratory in your clinics and see the procedure for each test and how to read the results

M-9/8

Slide 9

DOCTORS MUST REMEMBER .....

- Some simple laboratiry tests can assist us to enhance the effectiveness of syndromic management
- Do not delay syndromic treatment for the sake of laboratory test results
- Laboratory tests can be useful for specific diagnosis of disease and for collecting epidemiological data

M-9/9

Module 10

Client Education and Counseling

MODULE 10

Client education and counseling

Learning Objectives:

At the end of this module, the participants will be able to:

1. Explain the difference between client education and counseling
2. Explain the importance of client education and counseling in STI/RTI prevention and management
3. Describe the goals and principles of effective client education
4. Identify the major information needs of STI/RTI clients
5. List the steps of counseling and identify ways to overcome barriers to counseling
6. Demonstrate effective counseling skills through role play

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Blank flip charts
- Flip chart with situations written on it (for Session 4)
- Marker pens

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session with your co-facilitator beforehand and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1	Introduction to Module 10	Interactive presentation and Group exercise and Demonstration
2	Comparing client education and counseling	
3	Client education and counseling: Significance in STI/RTI control programmes	
4	Client education: Goals, principles and client information needs	
5	Counseling: Steps, barriers and ways to overcome barriers	
6	Safer sex practices	
7	Practicing client education and counseling skills	

SESSION 1

Introduction to Module 10

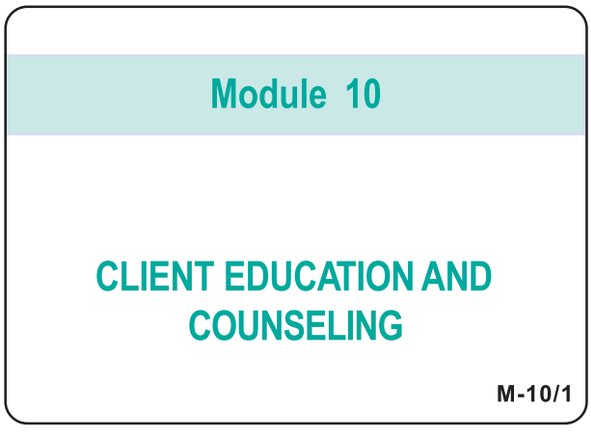
Objective:

At the end of this session, the participants will be able to:

- Provide an overview of the module including its objectives

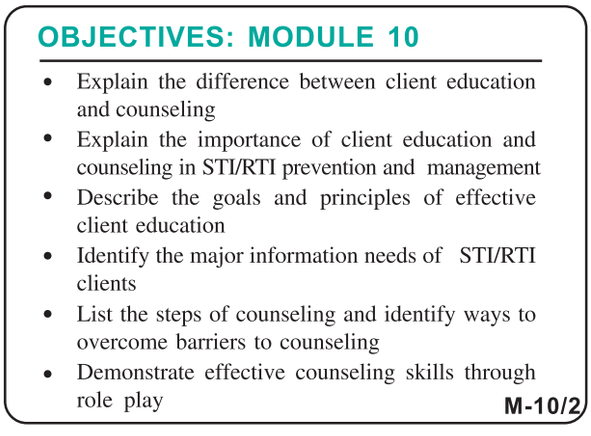
Show Slide 1 and state that besides pharmaceutical treatment, client education and counseling are integral parts of the syndromic management of STIs/RTIs.
Say: "Now, we will initiate a discussion on this important subject.
"Client education is necessary in order to increase awareness of STIs/RTIs among clients and the overall community. When clients come to the health centre, they are very concerned about their health and therefore, are most receptive to the health care provider's advice and suggestions. Therefore, health care providers must not lose any opportunity to educate their clients about treatment and prevention of STIs/RTIs.
"Client education and counseling need special skills including verbal and non-verbal communication skills, and sensitivity to the client's situation and needs.
"In this module, we will discuss all these aspects of client education and counseling to enable us to deal more confidently and effectively with our clients and contribute to the successful management and prevention of STIs/RTIs."

Slide 1



Now, show Slides 2 and explain the objectives of the module in your own words.

Slide 2



Slide 3

OBJECTIVES: contd...

- List the steps and barriers to counseling and identify ways to overcome the barriers
- Demonstrate effective counseling skills using role play
- Develop a plan for health facility-based prevention of STIs/RTIs

M-10/3

SESSION 2

Comparing client education and counseling

Objective:

At the end of this session, the participants will be able to:

- Explain the difference between client education and counseling

Initiate the discussion by stating that the participants must have heard about the terms 'client education' and 'counseling'. Ask them if the two terms are the same or different? If different, what is the difference between the two?

Take responses from 2-3 participants.

Now, use Slides 4 and 5 and explain the definitions of health/client education and counseling respectively.

State that health education is merely the process of providing information to clients on a pre-defined subject, say STI prevention. It requires teaching and group facilitation skills. However, counseling is a more dynamic process between two individuals wherein a counselor tries to understand the unique circumstances and problem/s of an individual (client), provides various options and helps the client to take a decision.

Counseling is a much more complex and specialized skill compared to client education. A properly educated client is an easy candidate for counseling as s/he already possesses facts and other information about the subject.

Client education makes the client aware of subject-related facts to enable her/him to make informed choices. Counseling goes further, and encourages her/him to apply those facts in her/his own situation and make appropriate decisions or choices to prevent infections in future and to protect her/his partner/s.

Slide 4

HEALTH EDUCATION

- It is the **provision of accurate and truthful information** so that a person can **become knowledgeable about the subject** and can **make an informed choice**
- For STIs, information on infections, transmission, recommended treatment, prevention, risk reduction, behavior change and partner referral
- This information can be communicated one-on-one, in group settings in the clinic; and via posters, videos, brochures etc. It should involve all possible staff

M-10/4

Slide 5

COUNSELING

- It is a **two-way interaction between a client and provider**. It is an **interpersonal, dynamic communication process** that involves a **contractual agreement between a client and counselor** who is trained to an acceptable standard and who is bound by a code of ethics and conduct.
- It requires empathy, genuineness, and the absence of any moral or personal judgment.

M-10/5

SESSION 3

Client education and counseling: Significance in STI/RTI control programmes

Objective:

At the end of this session, the participants will be able to:

- Explain why client education and counseling are vital for STI/RTI management and prevention

Say: "Now that you know what client education and counseling are, can you use this information and your own experiences to analyze why these two processes are important in the context of STIs/RTIs."

Let 3-4 participants respond.

Show Slides 6 and 7. Use the text following this shaded box to explain the relevance of client education and counseling.

Emphasize that the aims of the STI/RTI control program are to -

- treat individuals suffering from these infections
- prevent re-infections in these individuals
- prepare them to avoid such infections in future
- treat all their partners
- educate their partners in infection prevention

Unless clients and individuals of high-risk groups are made aware of STI/RTI-related facts through client/health education and helped to adopt suitable options for avoiding such infections, RTIs and STI/s will continue to spread in the community.

Importance of providing education and counseling

Client education and counseling are important because:

- Clients are more likely to comply with or follow the treatment if they understand why it is essential to do so.
- Individuals with STIs have high chances of re-infection.
- A sustained change in behavior is required for preventing re-infection. Clients often need education and counseling to enable them to change behavior patterns and adopt safer sex practices.
- Satisfied clients return for other services.
- Satisfied clients also recommend services to others.

Education and counseling are a MUST at the service provision site because:

- Patients are more likely to listen carefully and follow the service provider's advice when they or their near ones actually suffer from a disease.
- The treatment visit provides a unique opportunity to the provider to emphasize the importance of preventing STIs/RTIs.

Slide 6

IMPORTANCE OF CLIENT EDUCATION AND COUNSELING

- Better compliance to treatment if clients know the logic/reasons
- To reduce chance of re-infection
- To enable clients change behavior
- Satisfied clients return for other services too
- Satisfied clients refer others to health center

M-10/6

Slide 7

WHY CLIENT EDUCATION AND COUNSELING ARE A MUST AT TREATMENT SITES

- Clients and partners are more receptive during actual suffering
- Treatment visit – an opportunity for service providers

M-10/7

SESSION 4

Client education: Goals, principles and client information needs

Objectives:

At the end of this session, the participants will be able to:

- Define the goals and principles of client education
- Identify topics for effectively educating STI/RTI clients, including negotiation with partner/s

Say: "We have discussed the definitions of client education and counseling – the two essential processes for enhancing the effectiveness of treatment regimens for current infections and preventing similar infections in the long run.

"We have also discussed the importance of client education and the key issues related to STI/RTI management in earlier modules. Based on this information, can you help the group to define the goals and principles of client education?"

Let the participants try to frame the goals.

Now, show Slide 8 and explain the goals of client education.

Slide 8

GOALS OF CLIENT EDUCATION

- Help clients resolve current infections
- Prevent future infections
- Make sure that sex partners are also treated and educated

M-10/8

Explain that as mentioned in the definition, the ultimate goal of client education in STI/RTI cases is the comprehensive management of STIs/RTIs. It is not limited to the management of current infections but also considers possible future infections and the management of infections in the client's partner/s.

Say: "Now, let us discuss the principles of client education."

Show Slide 9. Encourage the participants to explain the meaning and importance of each principle of client education shown on the slide.

Clarify that although client education is about providing information, it is a process which involves verbal and non-verbal communication and a certain amount of emotion, the entire focus being on the client. Thus, the provider needs to tailor her/his communication and messages to suit the needs of the client.

Slide 9

PRINCIPLES OF CLIENT EDUCATION

- Shows respect and concern for the safety of the client through body language, telling the client that you are concerned, being attentive to and acknowledging the client's feelings, and giving the client adequate time for interaction
- Is client-centered: messages are tailored for each individual – different messages for married women, adolescents and sex workers
- Involves 3 kinds of learning: through ideas, actions, and feelings (cognitive, psychomotor, and affective)
- Uses multiple channels (eyes, ears and face-to-face/ visual, auditory, interpersonal). Delivers messages via the eyes, ears, and face-to-face communication.

M-10/9

Say: "Based on our discussions thus far on various issues related to STI/RTI management, let us try to identify the topics related to STIs/RTIs that are essential for effective client education or a meaningful discussion with clients."

Quickly divide the participants into 3 groups and provide a blank flip chart to each group. Assign one topic from the following list to each group.

1. Prevention of STIs/RTIs
2. Information about STIs/RTIs
3. Treatment of STIs/RTIs

Ask the groups to list the key issues or important information that they would like to share with their clients about the topic assigned to them.

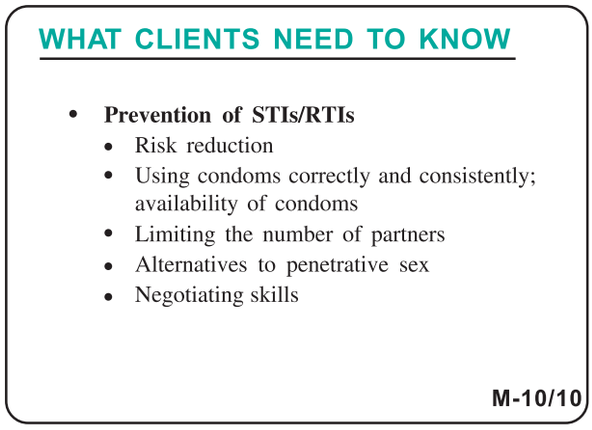
Allow 5 minutes for listing. Ask each group to appoint a representative to present the group work.

Ask each group representative to read out loudly her/his group work to the larger group. Allow the other groups to add or comment.

After the group presentations, show Slide 10. Explain the issues identified by the groups, emphasizing those that were not listed by them.

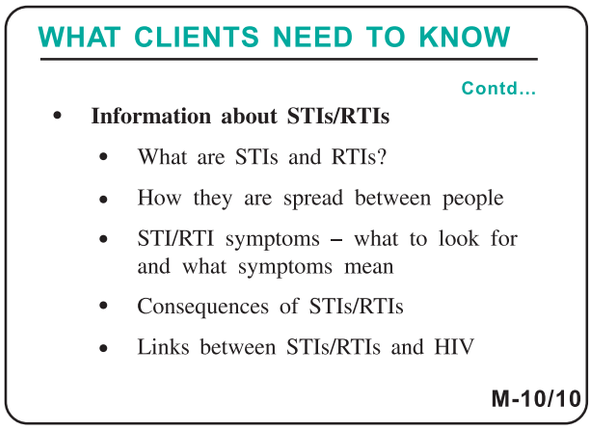
Clarify that the focus of preventive messages is on condom use which helps clients to prevent the transmission of their current infection/s, and on other safer sex practices which reduce the possibility of contracting a new infection as well as the transmission of current infection/s to their partner/s.

Slide 10



Now, show Slide 11 and explain that it is important for all health care providers to make their clients aware of the ways by which STIs/RTIs are spread and the consequences of untreated, incorrectly treated or inadequately treated infections. Further, in order to enable them to access health care services promptly, they should be informed about the major symptoms of STIs/RTIs. Clients should also be made aware of the close link between STIs/RTIs and HIV.

Slide 11



Next, show Slide 12 and explain that if the client has already contracted the infection and is under treatment, s/he should be told to take the recommended treatment in the prescribed doses. S/he should also be instructed to make a follow up visit to the service provider or clinic if the symptoms do not subside with the treatment.

Most importantly, clients must be made aware of the consequences of not treating their partner/s. They should be encouraged to get all their partners treated in order to prevent re-infection and development of the disease in their partner/s.

Slide 12

WHAT CLIENTS NEED TO KNOW

Contd...

- **STI/RTI Treatment**
  - How to take medication
  - Signs that call for a return visit to the clinic
  - Importance of partner referral and treatment
  - Acknowledge gender inequalities which may impact male partners coming forward to seek services

M-10/12

While explaining the bullet points on each of these slides, clarify that each point has its finer aspects which need to be explained to the client.

Take the example of ”alternative to penetrative sex”– suggest the type of non-penetrative sex that could be practiced such as rubbing, hugging, kissing etc.

Another example is that of “the consequences of STIs/RTIs” – explain the consequences depending upon the infection the client is suffering from.

Give one more example from Slide 12– “How to take medication” which means providing answers to: What dose of medication should be taken and its frequecy? - Does it have any relationship with the timing or type of food intake? - Are any special precautions to be taken while on medication? - What are its common side effects? etc.

Now ask the participants to name the different areas in their clinic, including available personnel, where client education can be provided using different media.

Show Slide 13 and explain that it is possible to create many opportunities for client education in our clinics.

Slide 13

CREATING OPPORTUNITIES FOR CLIENT EDUCATION

- Use every place that the client is likely to visit – OPD, waiting room, laboratory, medicine counter
- Use every interaction as an opportunity – doctor, nurse, laboratory technician, pharmacist
- Use various media – talks, posters, pamphlets, videos, brochures
- Reinforce consistent messages

M-10/13

Emphasize that in every clinic/centre, there are many areas where client education can be given. Recommend that they motivate their staff to make the best use of every interaction with clients to create awareness of STIs/RTIs/HIV prevention and treatment.

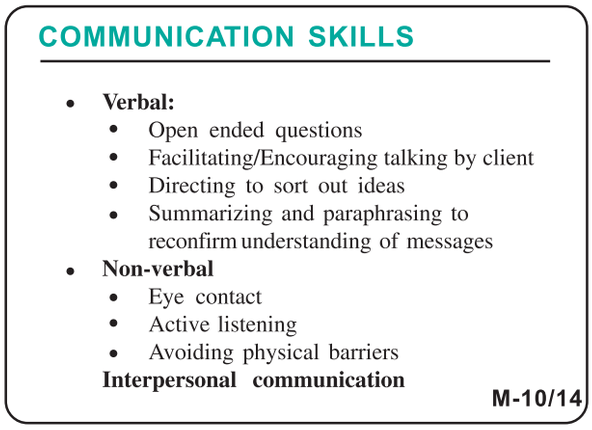
Also recommend that the participants equip their clinic with adequate and appropriate posters and visuals for conveying key STI/RTI messages to visiting clients.

Say: "Now, we have a fair idea of the key issues of client education. We also know that one of the major prerequisites for effective one-to-one client education and counseling is effective communication skills. We have already discussed these skills during history taking (Module 4). Let us review them."

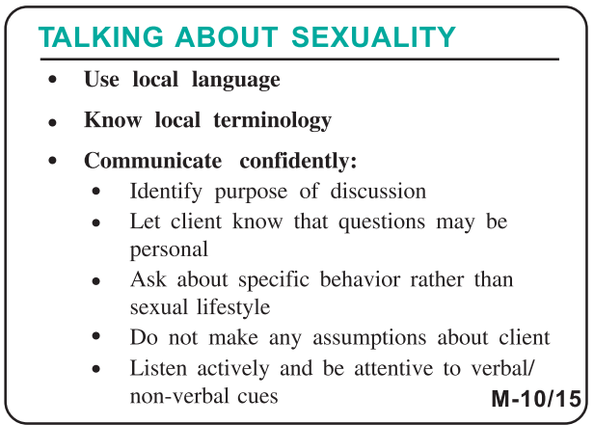
Show Slides 14 and 15. Ask the participants to read and explain the bullet points on the slides one by one, stating their importance and giving examples.

As a facilitator, provide the explanation if a participant skips a key issue.

Slide 14



Slide 15



Re-emphasize the importance of asking open-ended questions in order to get detailed information from clients.

Ask 1-2 participants to quickly frame 2-3 open-ended questions.

Remind them of the value of active listening to encourage clients to share information freely.

Now, put up the previously prepared flip chart and give the following exercise to the participants:

Exercise:

Put up the flip chart with the two situations for the exercise.

Now, say: "Read the two situations given on the flip chart carefully and try to take the history of the client. Communicate with the client in the local language without using any technical terminology."

1. Manoj is complaining of a wound and pain in his "private parts"

2. Rani complains of "pain down there"

Let 1-2 participants volunteer to answer.

Now, say: "The health care provider must be well acquainted with the local terminology and verbal expressions of the client. If the provider uses the client's local language and terminology, it will encourage the client to open up and provide correct and complete information about the disease more confidently."

Summarize the discussion, emphasizing the importance of effective communication skills and the use of local language and terminology.

SESSION 5

Counseling: Steps, barriers and ways to overcome barriers

Objectives:

At the end of this session, the participants will be able to:

1. List the steps of counseling and identify ways to overcome barriers to counseling
2. Demonstrate effective counseling skills through role play

Say: "Now, we will move on to the discussion on counseling."

Ask the participants: "What do we mean by counseling?"

Quickly recapitulate the definition of counseling discussed earlier in this module and ask them if they know the major components of counseling.

Provide clues using the definition of counseling.

Show Slide 16 and explain the components of counseling. Say that one of the key assumptions of counseling is that the situation of each client is unique and, therefore, a standard solution or answer may not work for all.

Slide 16

ELEMENTS OF COUNSELING

- Try to understand how a person's situation may increase risk and vulnerability
- Provide information
- Identify barriers
- Help people find the motivation to reduce their risk
- Establish goals for risk reduction
- Offer real skills
- Offer choices/options

M-10/16

Say that the counselor has to communicate with each client to identify what puts her/him at risk of STIs/RTIs.

After assessing the client's risk situation, the counselor should explain to the client what has happened to her/him (the client), why and how it could have been prevented, and what is putting her/him at risk. Also explain the possible barriers that prevent the client from adopting safer sexual behavior.

The counselor should further counsel the client to avoid risky behaviours. Help her/him to agree to avoid such behavior. When the client indicates her/his willingness to change her/his risky behavior, discuss the available options for averting risks.

Remember, do not provide passive advice. Provide relevant information and options to the client to enable her/him to make an informed decision about preventing infections in future.

Talk about and discuss real and practical solutions that are possible in the unique personal situation of each client.

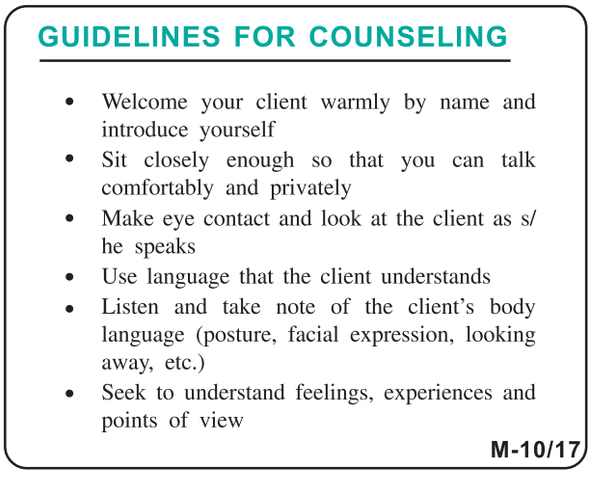
Explain that counseling is a specialized skill that can be acquired through practice. It is about helping clients to make an informed decision on how to prevent future infections and manage their partners.

Ask the participants: "Now that we know the process of counseling, can you tell me how we can make it a facilitative process in which the client feels free to discuss personal issues with you and to choose an appropriate option for preventing STIs?"

Let 1- 2 participants respond.

Now, show Slide 17.

Slide 17



State that effective verbal and non-verbal skills play a major role in making the client comfortable during the counseling process and in making the process facilitative so that the client can express herself/himself freely.

Show openness to various possible and realistic options for preventing STIs. Explain that physical barriers such as a table between the client and health care provider can sometimes create a sense of "distance", and not equality. Avoid it.

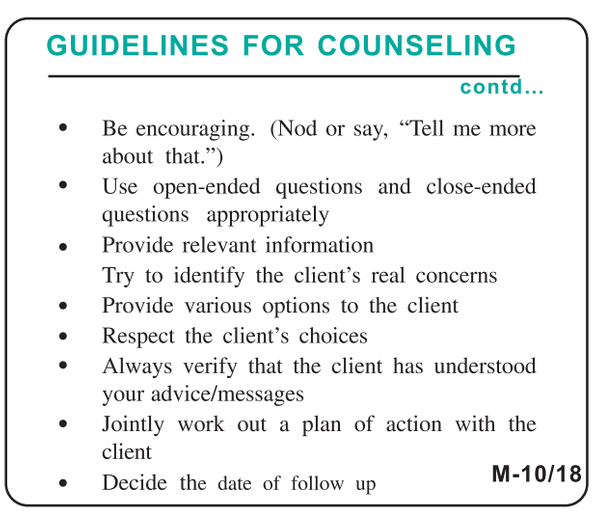
Further, listening should not be limited to verbal communication. The health care provider should also try to understand the feelings, emotions and non-verbal cues reflected on the client's face and in her/his overall body movements.

Now, show Slide 18 and say: "It is important for health care providers to encourage clients to express their thoughts freely. This can be achieved through active listening and making the client feel that you are listening.

"Therefore, ask facilitative questions during the interaction. Try to understand the real concern of the client. For example, the client might be willing to treat her/his partner/s; but her/his real concern could be about revealing the news of infection to the partner.

"Understanding the real concern is a critical part of counseling because unless it is achieved, it is impossible to offer and discuss real and feasible options. And, if realistic options are not offered to the client, the client may not choose an option and, even if s/he does so, may not follow it."

Slide 18



Further say that finally, during the interaction, the provider must verify from time to time whether the client has understood the issue/s being discussed. If and when the client chooses to prevent future infections, the provider must respect the client's choice without any criticism. The provider may want to direct the discussion to help the client to arrive at an appropriate solution or make a suitable choice to manage her/his own or her/his partner's/partners' infection.

Remember, every individual would want to particpate in the process of making any decision that has definite implications on her/his health and overall life. So, never be persuasive and forceful. Be open, friendly and facilitative rather than patronizing.

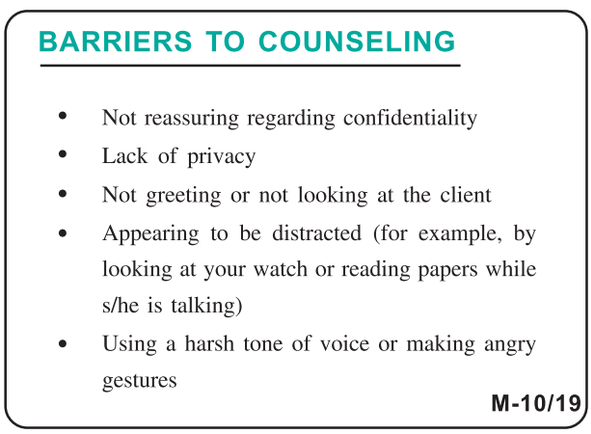
Say: "Now that we have learnt about the key components of good counseling, let us use this information and try to identify the situations, factors and behaviours that act as barriers to good counseling."

Ask the participants to close their eyes and imagine that they are in their respective clinics. Ask them to think about the overall atmosphere and physical arrangements of the clinic that could act as barriers to good counseling.

Allow 2-3 minutes to consider and list the barriers.

Show Slides19 and 20 and ensure that all the barriers are covered during the ensuing discussion.

Slide 19



Slide 20

BARRIERS TO COUNSELING

contd....

- Sitting while the client stands or sitting far away from client
- Allowing interruptions during the consultation
- Being critical, judgmental, sarcastic or rude
- Interrupting the client
- Making the client wait for a long time
- Not allowing enough time for the visit

M-10/20

Ask 8-10 participants randomly, to read out any one barrier that they have noted.

Have a flip chart ready with 2 columns - 'Barriers' and 'Solutions'. Write down all the barriers mentioned by the participants in the "Barriers" column with the help of your co-facilitator.

Now, ask the participants to tell you how they would get rid of each barrier. Involve participants who had not participated in the earlier discussion. Note the solution for each barrier in the "Solutions" column of the flip chart. Avoid repetitious responses.

Say: "So far, in this module, we have talked about client education and counseling. Now, let us see how they complement each other."

Show Slide 21 which summarizes client education and couseling, and explain that client education makes the client knowledgeable about various aspects of STIs/RTIs such as how STIs/RTIs are contracted, how they can be prevented, and how the infection is treated. However, the process of counseling is about assisting the client to make the best use of this information and make a choice about dealing with STIs/RTIs using real-life options.

Slide 21

SUMMARY TABLE FOR CLIENT EDUCATION AND COUNSELING

Health education			Counseling
To raise awareness	**For prevention**	**As a part of STI/RTImanagement**	
Talk about STIs/RTIs and their complications	Promote correct and consistent condom use	Emphasize compliance with treatment	Discuss risk and vulnerability
Explain symptoms and how to recognize them	Encourage fewer sexual partners	Promote condom use (including during treatment to avoid re-infection)	Examine barriers to prevention
Promote early use of services	Support delay in starting sex (for young individuals)	Encourage referral of partners for treatment	Discuss solutions and build skills for safe sex
			Make a plan and follow up

M-10/21

Finally, end the discussion by saying: "Now we know the practical difficulties or barriers that we may have to face when we counsel STI/RTI clients in our clinics. However, we also know how we can overcome these barriers. Hence, we should be in a position to find solutions to any obstacles that we may come across and offer good quality counseling services to our clients."

Can we (the facilitators) get a commitment from you (participants) that you will make conscious efforts to practice good counseling and surmount the barriers that you may happen to encounter in your own clinics?

Close the session by thanking the participants for their commitment, and wishing them much success.

SESSION 6

Safer sex practices

Objectives:

At the end of this session, the participants will be able to:

1. List safer sex practices for preventing STIs/RTIs
2. Describe the key issues in negotiating safe sex

Remind the participants that we have discussed risk behaviours several times during earlier sessions. Ask them to pair up with the person next to them and list the behaviours which they consider as "risk-behaviours" from the point of view of STI/RTI transmission.

Allow 3 minutes for discussion and listing. Now, randomly ask the pairs to read out loudly, one of the risk-behaviours noted by them and explain why it is a "risky behaviour".

Note the responses on a flip chart with the help of your co-facilitator.

When all the responses have been noted, show Slides 22 and 23 and compare them with the list generated by the participants.

Discuss the behaviours not listed by the participants and explain why they are "risky".

Slide 22

WHAT MAKES SEX UNSAFE?

- Unprotected vaginal sex if you don't know whether your partner is infected
- Sex with a partner who has signs of a STI
- Sex with a partner who has other partners
- Unprotected anal sex
- Unprotected oral sex
- Use of alcohol or drugs with sex

M-10/22

Slide 23

WHAT MAKES SEX UNSAFE?

Contd...

- Sex with an intravenous drug user
- Multiple partners
- Casual sex or sex with strangers
- Frequent change of partners
- Douching
- Use of vaginal drying agents

M-10/23

Now, show Slide 24 and explain how sexual interactions can be made safer.

Slide 24

SAFE SEX RULES

- Mutually faithful relationship between two uninfected partners
- Sex between faithful partners only
- Reducing the number of sex partners
- Using a barrier such as a condom for all types of intercourse
- Non-penetrative sexual practices such as kissing, hugging, rubbing, and masturbating
- Avoiding sex when either partner has signs of a STI
- Abstinence till partner is cured of STI

M-10/24

Close the session by saying: "Now we know 'which behavior makes sex risky' and 'safer sex practices'. We also know the concept and process of client education and counseling and how this information must be used by the health care provider to help clients adopt safer sex practices."

Ask the participants how comfortable they feel about discussing these issues with their male and female clients.

Emphasize that treating a client without educating her/him about safer sex practices will not bring positive results. This is because not only will an ill-informed or un-informed client always be at a high risk of re-infection but s/he will also transmit the infection/s to her/his partners.

Explain that a typical situation of practicing safer sex, especially with women or sex workers, involves the partner's resistance to use a condom during sexual intercourse and the woman's/ sex worker's poor negotiation skills.

Therefore, it is important that health care providers prepare their clients to deal with such situations.

Show Slide 25 and explain the options that can be used by clients to negotiate condom use with their partners.

The provider must explain to her/his clients that they should focus on the issue of "safety" of both partners while negotiating condom use.

Slide 25

HELPING CLIENTS IN NEGOTIATING SKILLS

- Use condoms
- Bargain for safer sex
- Focus on safety
- Use other people as examples
- Ask for help if you need it

M-10/25

SESSION 7

Practicing client education and counseling skills

Objective:

At the end of this session, the participants will be able to:

- Demonstrate skills for providing client education and counseling to STI/RTI clients

Say: "So far, we have discussed the different elements of client education and counseling. Now, let us try to practice these skills through role play."

Show Slide 26.

Organize a role play by facilitators. One facilitator should play the role of a client and the other, that of a Medical Officer.

Role play situation:

Bhagat, a 35 year-old coolie comes to the clinic with a complaint of blisters on the penis since the last 7 days. He also complains of itching and intense pain in the genital area.

The Medical Officer has made a syndromic diagnosis of Herpetic Genital Ulcer.

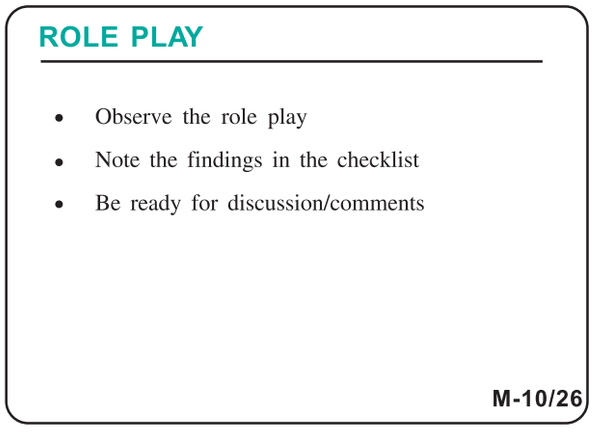
Now, it is time for client education and counseling.

Instruct the participants to note down the steps followed during the role play.

Organize the role play in such a way that everyone can see and hear it clearly.

Let the role play continue for 10 minutes.

Slide 26



After the role play, generate a discussion by asking specific questions.

Request the participants to avoid general comments.

Take the participants' opinion on:

- Did the Medical Officer (MO) follow all the steps of counseling?
- Did s/he cover all the steps for providing information on treatment, prevention and safer sex
- Did s/he provide different options for partner treatment and help the client arrive at a decision?
- Did the MO encourage the client to use condoms?
- Did the MO ask open-ended questions?
- Did the MO practice active listening?

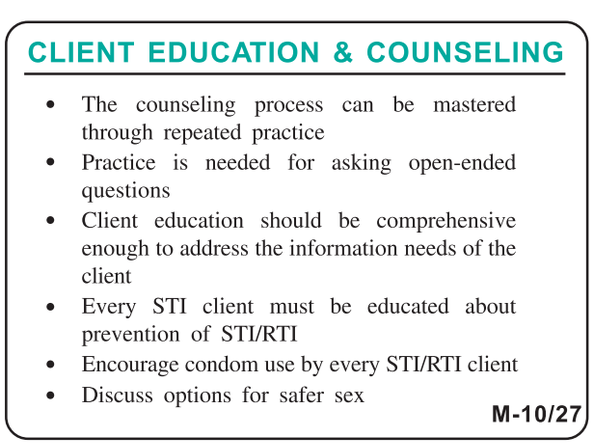
Take the participants' responses.

Ask them what they found challenging about the role play.

Summarize the discussion by showing Slide 27 and emphasizing –

- The counseling process can be mastered through repeated practice.
- We need more practice in asking open-ended questions.
- Client education should be comprehensive enough to address the information needs of the client.
- Every STI client must be educated in the prevention of STIs/RTIs.
- We must encourage condom use by every STI/RTI client
- The doctor must discuss options for safer sex

Slide 27



After completing the discussion, ask the participants to summarize the key issues discussed during the entire module.

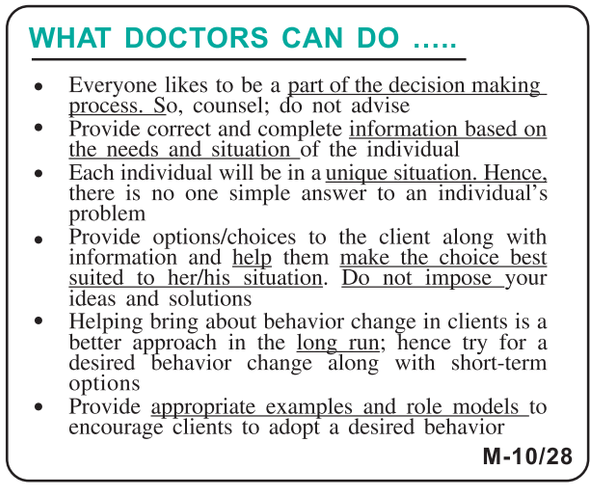
While summarizing, do not let the participants merely enumerate the key issues; ask them to also explain the key actions that they can implement during their routine management of STI/RTI clients.

Finally, show slide 28 and summarize the main issues with explanations.

Emphasize that an informed client will always be in a better position to identify the risks in her/his behaviour and identify and apply feasible options for averting the risk. Also state that the knowledgeable client will respond better to the treatment provided by the providers and thereby, contribute to the prevention and control of STIs/RTIs in the community.

Conclude the session by informing the participants that the ICTCs can play a major role in STI/RTI client education and counseling.

Slide 28



Module 11

Making Condoms work Better

MODULE 11

Making condoms work better

Learning Objectives:

At the end of this module, the participants will be able to:

1. Describe the key features of the male and female condom, including their effectiveness in offering protection against STIs/RTIs
2. Demonstrate how to give instructions for male and female condom use

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Blank flip charts
- Marker pens
- Penis model
- Pelvic model
- Male and female condoms (4-5 each)

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1	Introduction to Module 11	Interactive presentation
2	Male and female condoms	
3	How to use the male and female condom	Interactive presentation and return demonstration

SESSION 1

Introduction to Module 11

Objective:

At the end of this session, the participants will be able to

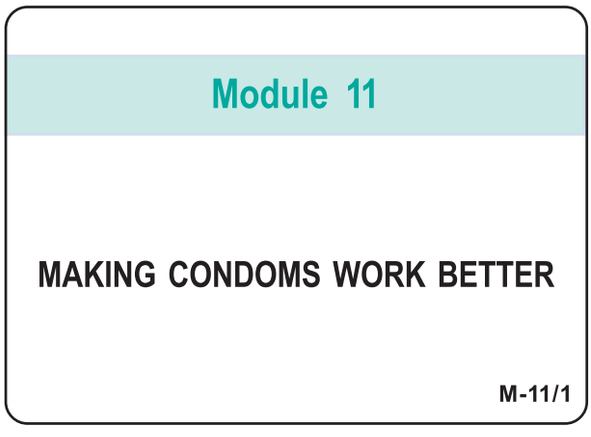
- Provide an overview of the module including its objectives

Show Slide 1 and state that with the urgency created by the AIDS epidemic, reproductive health providers need to focus on the prevention of pregnancy and sexually transmitted disease. As in the family planning programme, providers of STI/RTI services are promoting and,teaching condom use and negotiation skills more actively. Further, community strategies like social marketing have also increased condom use substantially. Nevertheless, family plannng providers need to think of ways of reaching men as well as women with condom messages.

The male condom used consistently and correctly is still the most effective method for preventing STIs/RTIs. The female condom may also be effective although, currently, its cost is too high to permit widespread use. Other barrier methods that could be used for disease protection such as the diaphragm and cervical cap offer less protection than the male condom.

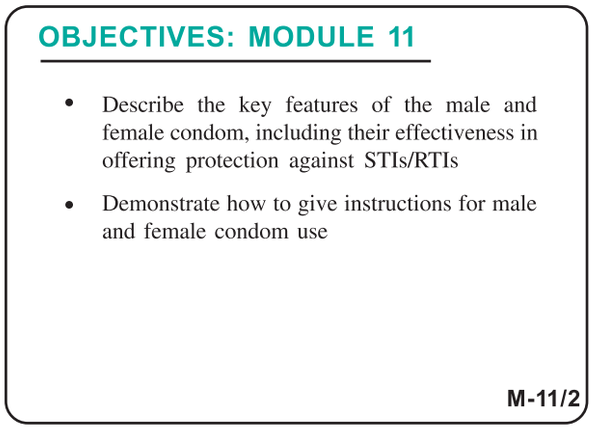
Getting clients to think in terms of protection against disease and pregnancy is an example of the natural linking of STI/RTI control and family planning goals. This link has the potential to be an important first step in integration. For young women or women in new relationships, the promotion of condom use with emergency contraceptive pills (ECP) as a backup may work well.

Slide 1



Now, show Slide 2 and explain the objectives of the module. Clarify that besides talking about common issues such as the usefulness and importance of the condom, we will discuss the steps for using the male and female condom correctly. Also, in the last session of the module, we will practice the correct use of the condom on an anatomical model, and during clinical practicum on Day 3 of the Workshop, we will try to demonstrate these skills by interacting with actual clients.

Slide 2



SESSION 2

Male and female condoms

Objective:

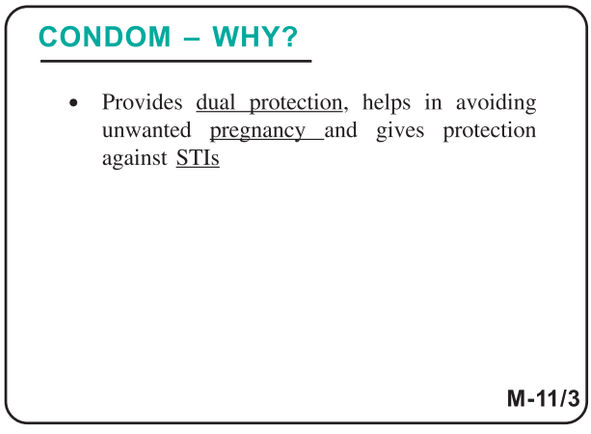
At the end of this session, the participants will be able to:

- Describe the key features of the male and female condom, including their effectiveness in offering protection against STIs/RTIs

Begin the session by asking the participants: "How does the condom help in providing protection against STIs/RTIs/HIV?"

By and large, all the participants will know that the condom is a barrier method which provides protection against STIs/RTIs by raising a physical barrier and not allowing the exchange of body fluids. If you do not get a complete response, show Slide 3 and explain.

Slide 3



Next, say: "We will now discuss the main features of male and female condoms. Let us start with the male condom."

Ask: "What do you know about condoms? How effective are they in providing protection against STIs/RTIs/HIV?"

Let 2-3 participants respond.

Now, show Slide 4 and highlight the main features of the male condom. Display a male condom and allow the participants to handle it during the discussion.

Emphasize that the protection offered by the male condom depends on its correct and consistent use. Explain that the condom offers protection by not allowing the exchange of body fluids such as semen or vaginal fluids. Therefore, the condom is not effective against STIs which can affect parts not covered by the condom. Give examples of pubic lice and genital warts.

Explain that the condom is made of thin latex and offers good protection against HIV too.

Slide 4

THE MALE CONDOM: MAIN FEATURES

- Barrier method
- Made of thin latex
- Various sizes, shapes and colours
- Rate of HIV infection 0-2 % if condom used correctly
- No full protection against STIs not covered by condoms (pubic lice, genital warts, genital herpes)

M-11/4

Now ask the participants: "What do you know about the female condom?"

It is possible that they may not have complete information about the female condom as it is not widely used in our country. Note the gaps in information or incorrect information in their responses so that you can correct them during the discussion.

Now, show Slide 5 and discuss the main features of the female condom. Show the female condom and allow the participants to handle it.

Explain that the female condom is made of polyurethane and is big enough to cover the cervix, vagina and external genitalia of the female. Say that it is much more expensive than the male condom, and give the names of brands available in the local market and their prices.

Tell them, further, that the female condom also offers considerable protection against STIs/RTIs, including HIV, if used correctly and consistently.

Slide 5

THE FEMALE CONDOM: MAIN FEATURES

- Polyurethane plastic pouch
- Covers cervix, vagina and part of external genitals
- Much expensive than male condom
- Effectiveness for STIs being studied
- Not easy to insert
- Impervious to HIV and STIs/RTIs

M-11/5

SESSION 3

How to use the male and female condom

Objective:

At the end of this session, the participants will be able to:

- Demonstrate how to give instructions for the effective use of the male and female condom

Ask the participants whether they know how to use a male condom? If you get a positive response, request one of the participants to come forward and demonstrate to the group.

Allow her/him to complete the demonstration. Do not comment or criticize even if the steps are not fully correct.

Say: "Now, we are going to discuss the steps of male condom use. Let us start with the initial instructions to be given to a condom user."

Ask the participants to think of 3-4 instructions and note them down.

Next, show Slides 6 and 7 on the instructions that a condom user must follow to ensure maximim protection. Explain each bullet point on the slides. Emphasize that the client must be informed that a condom can be used only once and hence, s/he should have a new condom ready for use the next time s/he has sex. Most condoms are lubricated and do not need additional lubrication.

Further emphasize that if the condom shows any of the indications of a non-usable condom mentioned on Slide 7, it should be rejected and a fresh condom obtained.

Tell the participants that they must never assume that the client would know these simple facts about the condom and its proper use. They should ask each client to repeat all the instructions to ensure that the client has understood them fully.

Slide 6

USING CONDOMS? –
THINGS TO REMEMBER

- The condom does not include spermicide
- Use a new condom each time you have sex
- Use a condom only once
- For best results, store condoms in a cool, dry place
- Do not use a condom that may be old or damaged

M-11/6

Slide 7

USING CONDOMS? – THINGS TO REMEMBER Contd.

- **Do not use the condom, if:**
- The package is broken (not sealed)
- The condom is brittle or dried up
- The color is uneven or has changed
- The condom is unusually sticky

M-11/7

From this point onwards, the discussion and demonstration of condom use should be done in the clinic during clinical practicum.

Ensure that most of the participants get an opportunity to demonstrate condom use to actual clients.

Say: "Now, we are going to see and practice how condoms are used. Let us start with the male condom."

Tell them that you are going to demonstrate the use of the male condom. Clarify that after your demonstration, each participant will have to perform a return demonstration.

Start the demonstration using the following instructions:

- Organize the demonstration in the form of a role play.
- Ask one of the participants to play the role of a client.
- Ask the participants to open Page 135 of the "Medical Officer Handout" on "How to use a male condom" and carefully demonstrate all the four steps.
- As you demonstrate each step, say it out loudly.
- Demonstrate as though you are dealing with an actual client.
- Follow all the steps of counseling, using appropriate terminology.
- Use the local language for the demonstration.

Use Slide 8 to recapitiulate the major steps of male condom use.

After you complete the demonstration, ask the participants if they have any questions and respond to their queries.

Slide 8

USING THE MALE CONDOM

- Step 1 : Open the package
- Step 2 : Put it on
- Step 3 : Ensure that it is in the right position
- Step 4 : During sex – ensure that it is in place
- Step 5 : Dispose off the condom

M-11/8

Now, divide the participants into 3 groups (provided there is one facilitators per group), and ask them to take turns and perform the demonstration.

Provide feedback as necessary.

Once the groups are comfortable with the demonstration of male condom use, follow the same procedure for the female condom.

Emphasize the use of checklists. If pelvic models are available, demonstrate the procedure on a pelvic model.

Use slide 9 to recall the major steps of female condom use.

Allow the participants to perform a return demonstration under the facilitator's supervision.

Finally, request the participants to practice the skills during breaks/free time.

Slide 9

USING THE FEMALE CONDOM

- Step 1 : Open the package
- Step 2 : Put it in
- Step 3 : Ensure that it is in the right position
- Step 4 : During sex – ensure that it is in place and you are protected
- Step 5 : Dispose off the condom

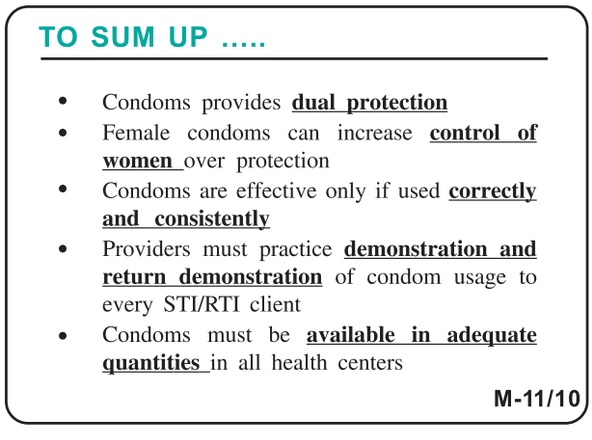
M-11/9

End the session by‘showing Slide 10 and summarizing the highlights of the discussion.

Ask to participant to open Page 136 of "Medical Officer Handout" on "How to use a female condom." and carefully demonstrate all the steps

Remind the participants that the condom is an effective way of preventing the transmission of STIs/RTIs and HIV, provided it is used correctly and consistently. The most common reason for the failure of condoms is poor knowledge about its proper use. Therefore, it is essential for every health care provider to motivate her/his STI/RTI clients to use condoms correctly and consistently, and help them learn how to use it properly by carefully observing the demonstration presented by the provider and performing a return demonstration.

Slide 10



Module 12

Management of STIs/RTIs in Sexual Violence

MODULE 12

Management of STIs/RTIs in sexual violence

Learning Objectives:

At the end of this module, the participants will be able to:

1. Define "sexual violence" and identify the health services required for cases of sexual violence
2. Describe the management of a case of sexual violence

Materials :

- Overhead/LCD projector
- PowerPoint slides for the session
- Flip charts
- Marker pens

Preparation by facilitator :

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1	Introduction to Module 12	Interactive presentation and group exercise
2	Health services and management of sexual violence	

SESSION 1

Introduction to Module 12

Objective:

At the end of this session, the participants will be able to:

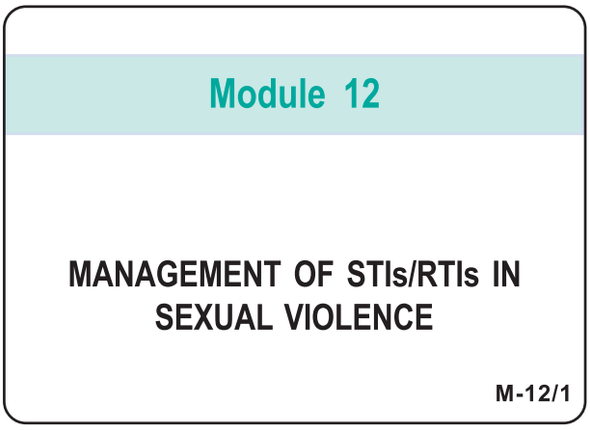
Provide an overview of the module including its objectives

Show Slide 1 and say: "Almost always", victims of sexual violence feel uncomfortable to talk about their traumatic experience/s and may come to the clinic with other non-specific complaints or for a check-up. The chances of having STIs/RTIs is very high among such individuals. Therefore, identifying and treating them adequately is a challenge to health care providers.

"In this module, we will discuss various issues regarding the management of sexual violence."

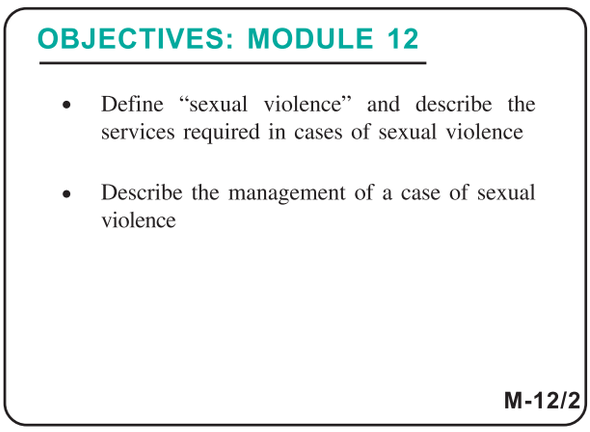
Show slide 2 and explain that we will discuss the definition of sexual violence and elaborate on what services when a client of sexual violence comes to our clinics. Also, we will discuss what we can do to help the victims prevent STIs, HIV or HBV.

Slide 1



Next, show Slide 2 and explain the objectives. State that we will look at the definition of sexual violence and discuss the services that should be given to a victim of sexual violence. We will also discuss what we can do to help the victim prevent STIs, HIV or HBV.

Slide 2



SESSION 2

Health services and sexual violence

Objectives:

At the end of this session, the participants will be able to:

- Define "sexual violence"
- Identify and describe the services required to manage a case of sexual violence

Begin the session by saying that the participants would have seen and managed unfortunate victims of sexual violence in their clinic/health centre."

Ask: "How would you define "sexual violence?"

Let 1-2 participants respond. Show Slide 3 and clarify the definition of "sexual violence". Emphasize the underlined words on the slide about the actions which amount to abuse, relationship with the victim, and setting.

Slide 3

SEXUAL VIOLENCE

- Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a woman' s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work.

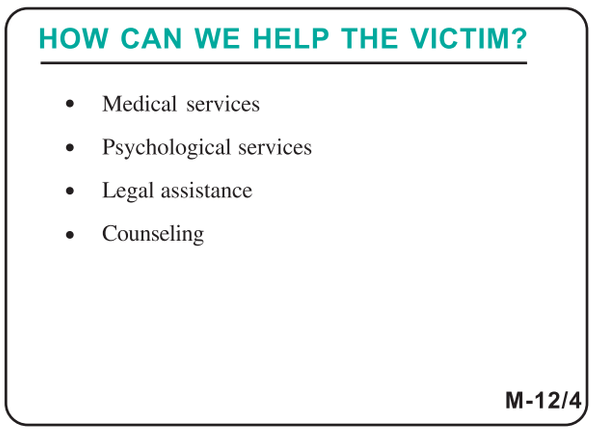
M-12/3

Now, ask the participants to tell the group about the kind of help that a victim of sexual violence would need.

After getting 2-3 responses, show Slide 4 and discuss each step of assisting a victim of sexual violence.

Besides medical services, psychological and legal assistance are also equally important – the former to improve the psychological status of the victim and the latter to assist her to seek the required legal services.

Slide 4



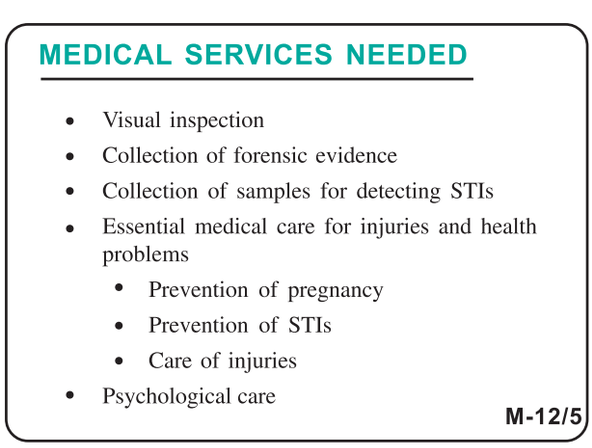
Now, ask: "What medical services would you provide to an unfortunate victim of sexual violence at your clinic?"

Take 2-3 responses. Show Slide 5 and explain the steps of medical management of sexual violence victims.

Clarify that the medical examination of the victim is a legal process. Hence, utmost care should be taken to document every finding meticulously.

Make it very clear that it is important to obtain informed consent for any examination, treatment, or referral in cases of sexual assault.

Slide 5



Remind the participants that while the provision of medical care is one of the key steps in the management of victims of sexual violence, within that is a step of post-exposure prophylaxis of STIs. Therefore, let us discuss the treatment regimens to be used for various STIs.

Show Slide 6 and explain the treatment regimens for common STIs. Clarify that individuals weighing above and below 45 kg would require different dosages.

Slide 6

POST-EXPOSURE PROPHYLAXIS FOR STIs

- Different dosages for adults and children (wt. 45 kg above +

For Adults:

- Gonorrhoea + Chlamydia: + Chancroid Azithromycine 1 gm + Cefixime 400 mg
- Trichomoniasis: Metronidazole/Tinidazole 2 gm stat

For children & Adults (under 45 Kg)*

- Chlamydia and Chancroid– Azithromycin 20 mg/kg body wt, in single dose orally
- Gonorrhoea: Inj. CEFTRIAXONE 125 mg IM in single dose
- For Trichomoniasis: Metronidazole 15 mg body wt, three times a day X 7 days orally

* Sexually Transmitted Disease, 4th edition, King K Homes

M-12/6

Show Slide 7 and explain that the prophylaxis for HIV and HBV is possible only at higher centres such as district hospitals or medical colleges.

Emphasize that victims of sexual violence need sensitive handling and counseling to be able to cope with their physical and psychological trauma. Also tell them that they can take the help of a professional psychologist for the purpose.

Explain that they should assist and cooperate with the legal authorities to document facts and also assist the victim to contact an appropriate legal service or support institution for follow up support.

Slide 7

HIV, HBV AND PSYCHOLOGICAL SERVICES

- HIV: Refer to district hospital (follow NACO guidelines)
- HBV: If not vaccinated, provide vaccination
- Psychological: counseling, supportive services

M-12/7

Show Slide 8 and summarize by repeating the steps of managing victims of sexual violence and emphasizing the importance of providing post-exposure prophylaxis for STIs.

Slide 8

TO SUM UP.....

- **Sexual violence victims need post-exposure prophylactic STI services**
- **They need post-exposure prophylaxis for HIV and HBV**
- **They also require psychological and legal support**

M-12/8

Now, ask the participants to think for 2 minutes and list a few actions they can individually perform at their centres to offer high-quality services to victims of sexual violence.

After 2 minutes, take responses from 3-4 participants. Show Slide 9 and try to gather agreement from all the participants on what they can do at their centres.

Finally, commend them for identifying good points and encourage them to try these out at their centres.

Slide 9

WHAT I CAN DO .....

- Ensure **privacy and confidentiality**
- Be **sensitive and gentle** in interacting with and examining the sexual violence victim
- Provide **psychological support**
- Be **non-judgmental**
- Provide **appropriate medical prophylaxis**
- **Refer to appropriate agencies** for legal and psychological support

M-12/9

Module 13

Management of STIs/RTIs in Sex Workers

MODULE 13

Management of STIs/RTIs in sex workers

Learning Objectives:

At the end of this module, the participants will be able to:

1. Define the term "sex worker" and explain the role of sex workers in the STI/HIV/AIDS epidemic
2. Identify ways to make services user-friendly for women at high risk for STIs
3. Identify treatment strategies to care for sex workers in the clinical setting
4. Demonstrate how to counsel sex workers in safer sex and negotiating condom use
5. Identify community strategies to improve the health of sex workers

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Blank flip charts
- Marker pens

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1.	Introduction to Module 13	Interactive presentation
2.	Sex workers and STIs/RTIs	
3.	Prevention and control of STIs/RTIs in sex workers	
4.	Sex workers: Treatment strategies and counseling in a clinical setting	

Introduction

Preventing transmission of STIs/RTIs among people who have the highest number of partners is the single most effective strategy for reducing the number of new infections within the general population. Women and men who exchange sex for money, services, or favors on a regular basis are exposed to and can transmit infections at a higher rate than other individuals in the population.

Like all sexually active women and men of reproductive age, these women and men have RH needs and may come to a family planning clinic for services. Providers need skills to help them to recognize women and men at high risk, to welcome them non-judgmentally, and to treat them with the same care as their other clients. Because of their high potential to transmit infections to others, sex workers need effective treatment whenever and wherever they present for care, as well as the knowledge and skills to promote condom use with their regular partners and customers. Health workers have a public health role to play in advocating for a policy of 100% condom use for all sex workers and their customers, and in working with the community to make this a reality.

SESSION I

Introduction to Module 13

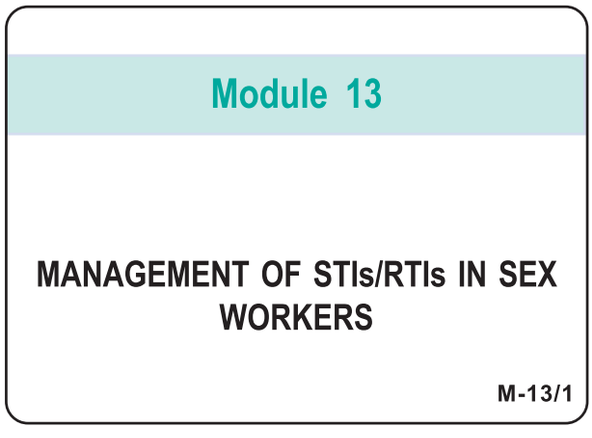
Objective:

At the end of this session, the participants will be able to:

- Provide an overview of the module including its objectives

Begin by showing Slide 1 and saying that this module focuses on a special population group namely, sex workers who are a high-risk group which needs urgent and sustained attention so that our efforts, as heath care providers, to prevent, manage and control STIs/RTIs meet with greater success.

Slide 1



Now, show Slide 2 and explain the objectives of the module.

Explain that for sex workers, sex is a means of livlihood, either by choice or by force. As a result, they are exposed to diverse partners who may be healthy or even infected with STIs/RTIs. This puts them at a greater risk of contracting these infections including HIV. Since society looks at sex workers with a bias, they find it difficult to seek quality services for these infections at appropriate centres.

The purpose of this module is to discuss the various dimensions of this issue and identify how we, as health care providers, can treat sex workers and help them to prevent STIs/RTIs.

Explain to the participants that the government has taken various initiatives to reach out to this group. There are many designated STI clinics in the country which cater to individuals in high-risk professions such as sex workers, IDUs, MSM and so on.

Slide 2

OBJECTIVES : MODULE 13

- Define the term "sex worker" and explain the role of sex workers in the STI/HIV/AIDS epidemic
- Identify ways to make services user-friendly for women at high risk for STIs
- Identify treatment strategies to care for sex workers in the clinical setting
- Demonstrate how to counsel sex workers in safer sex and negotiating condom use
- Identify community strategies to improve the health of sex workers

M-13/2

SESSION 2

Sex workers and STIs/RTIs

Objective:

At the end of this session, the participants will be able to:

- Define the term "sex worker" and explain the role of sex workers in the STI/HIV/AIDS epidemic

Show Slide 3 and initiate the session by asking: "Has a sex worker ever visited your clinic for services? If yes, how have you treated her (medically)? Did she need any special treatment and advice for STIs/RTIs compared to a woman who is not engaged in sex work?"

Let the participants respond. Their responses will provide many clues which will help you to facilitate the remaining part of the session.

The responses could indicate -

- How the participants look at sex workers - in the same way as they do any other client or differently?
- If they are aware that sex workers need the same medical treatment (drugs) for STIs/RTIs and should receive it with the same dignity and respect
- If they know that individuals who take up sex work as a means of livelihood, need to be counseled differently in respect of safe sex practices and that this requires special communication /counseling skills.
- If they understand that managing STIs/RTIs in sex workers is one of the major interventions for controlling STI/RTI transmission in society.

Do not react in any way to their responses. Tell them that we will discuss these issues within the next few minutes to see whether our thinking is correct.

Now, ask: "What do you understand by the term "sex worker?"

If the responses are limited to women, ask them: If men sell sex, can they also be considered as sex workers? Clarify the term saying that it includes both men and women who trade in sex.

Explain that age does not matter in sex work as long as one is able to get clients. A sex worker could be a young girl or a woman with 4-5 children. Whatever be their age or sex, the one thing that is common to all sex workers is that they are more vulnerable to contracting and transmitting STIs/RTIs. Show Slide 3.

Slide 3

SEX WORKER

- Any individual who sells sex for money or favor
- Mostly women, but men too
- Age does not matter – child to elderly to having many children
- One common thing for all: their work puts them at high risk of STIs/RTIs

M-13/3

It has been observed that in some communities, as many as 6 out of 10 sex workers are infected with HIV. Providing services to sex workers such as distributing free condoms and STI treatment, and enabling them to adopt safer behaviour can have the greatest impact on slowing STI transmission in the larger community.

Ask the participants about the last statement: "Why are all sex workers at a higher risk of STIs/ RTIs?"

By and large, you will end up getting correct and complete responses.

Now show Slide 4. Compare it with the participants' responses. Add and explain any missing points.

Slide 4

WHY ARE SEX WORKERS A HIGH-RISK GROUP?

- Large number of sexual contacts
- Varied partners
- No choice of partner
- Aggravated if:
- Poor general health
- Poor access to health services
- Added habits such as IV drugs/substance abuse

M-13/4

SESSION 3

Prevention and control of STIs/RTIs in sex workers

Objectives:

At the end of this session, the participants will be able to:

- Identify ways to make services user-friendly for women at high risk for STIs/RTIs

State that our society considers sex work unethical. As a result, individuals engaged in sex work feel alienated and do not come forward to seek health care services.

Say: "There are other reasons too why sex workers do not seek timely services from appropriate health care centres. Let us try to identify these barriers and see if we can do something to overcome them."

The facilitator can organize a game similar to the one in Session 5 of Module 9 on 'Client Education and Counselling', in which one group mentions a barrier and the other group responds by identifying a way to overcome the barrier and make services user-friendly.

Prepare a list of barriers and solutions to these barriers on a flip chart as the groups call out barriers and their solutions.

Finally, show Slides 5 and 6 and discuss the key issues.

Slide 5

BARRIERS TO SERVICES FOR SEX WORKERS

- Stigma
- Provider's attitude (judgmental?)
- Location of service sites
- Lack of confidentiality
- Cost of STI/RTI services

M-13/5

Slide 6

HOW TO OVERCOME THE BARRIERS

- Make efforts to change provider and staff attitudes
- Providers must be non-judgmental
- Have clinics near sex workers' workplace
- Assure and maintain confidentiality
- Provide free or subsidized services

M-13/6

SESSION 4

Sex workers: Treatment strategies and counseling

Objectives:

At the end of this session, the participants will be able to:

1. Identify treatment strategies to care for sex workers in a clinical setting
2. Demonstrate how to counsel sex workers in safer sex and negotiating condom use

State: "So far, we have talked about sex workers and the reasons for their high vulnerability to STIs/RTIs. We have also identified the barriers which prevent them from seeking treatment and discussed solutions to overcome these barriers. Now, let us discuss the treatment and other services you could offer a sex worker visiting your centre for treatment."

Ask the participants if they have any idea about treating STIs/RTIs in sex workers.

Recall some of the responses from Session 1 of this module and state that some of us are of the opinion that …….

Say: "Now, let us discuss what the "National Technical Guidelines" recommend."

Show Slide 7 and explain that the treatment strategy is two-pronged, and includes treatment of symptomatic individuals as well as screening for STIs/RTIs to identify and treat asymptomatic individuals.

Slide 7

TREATMENT STRATEGIES

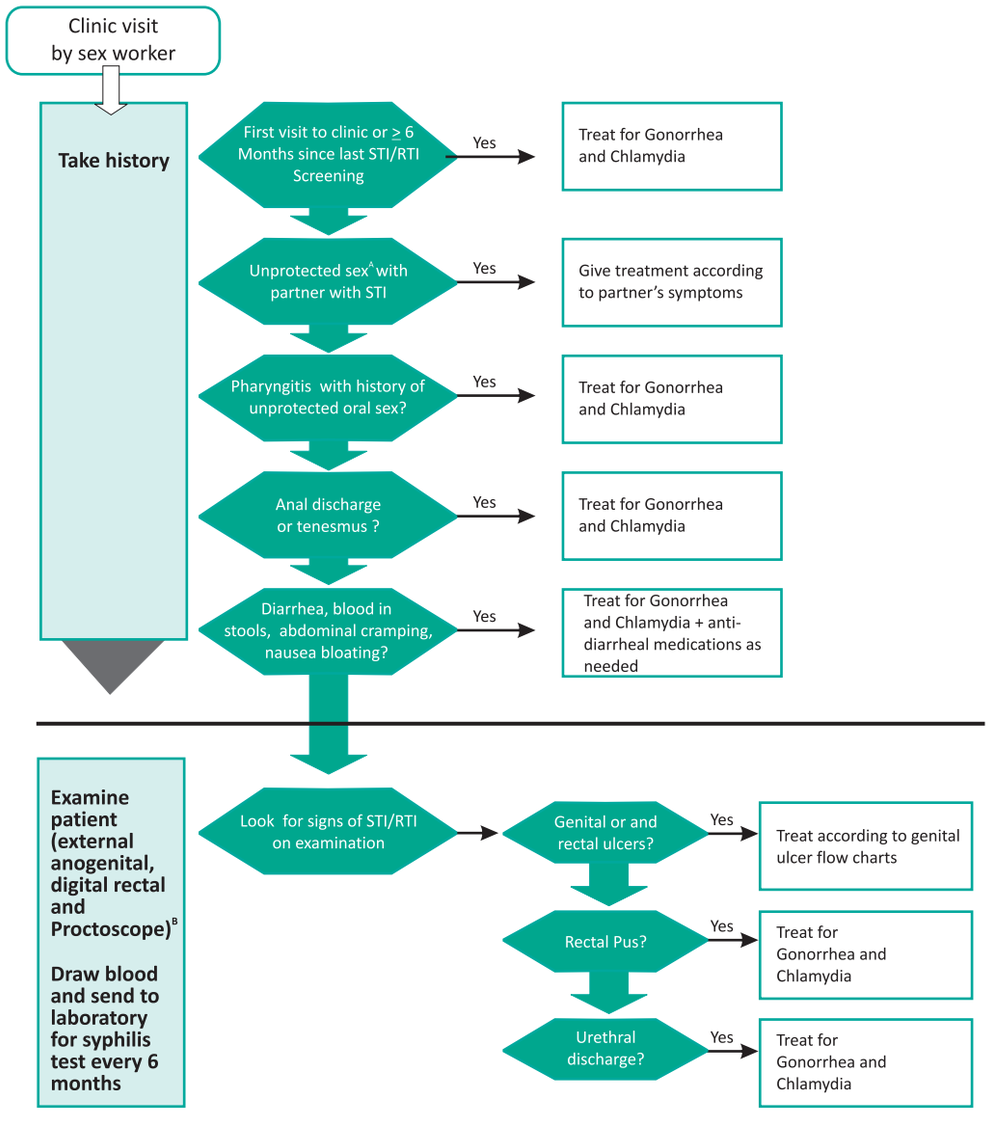
- **Treatment of symptomatic infections**
- Treat as per National Guidelines
- **Screening and treatment of asymptomatic infections**
  - If it is a first visit; or
  - 6 months since visited last
- Periodic history taking, clinical examination and laboratory tests
- Presumptive treatment – gonococcal and chlamydial infections
- Semi-annual serological screening for syphilis

M-13/7

Now, show Slide 8, and tell the participants that, in a way, the treatment strategy is not different from the STI/RTI treatment strategy for the general population. Ask them to look at the flowcharts for sex workers on Page 66-67 Annexure X of the "Operational Guidelines". Explain each step, giving special attention to the treatment regimen and counseling points.

Slide 8A

Management of STI/RTI During Routine Visit of a Male or Transgender Sex Worker

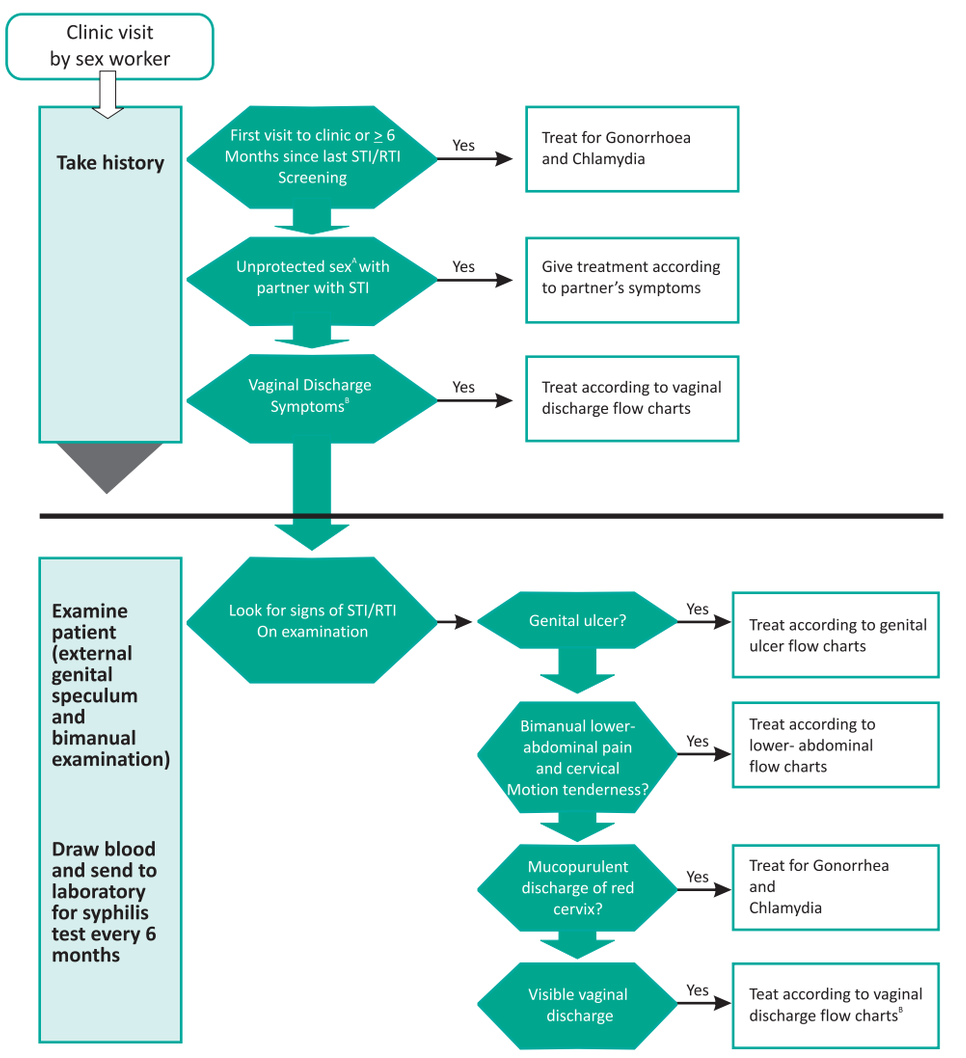


A. Without condom or condom failure.
B. If asymptomatic, digital rectal and proctoscope examination only if acceptable

M-13/8A

Slide 8B

Management of STI/RTI During Routine Visit of a Female Sex Worker



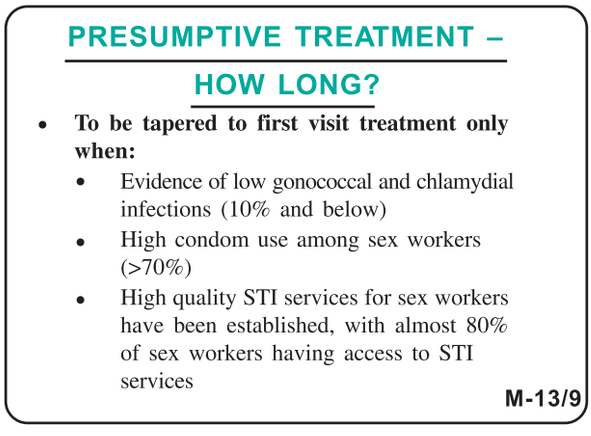
A. Without condom or condom failure.
B. All currently active sex workers have positive risk and should be treated for Gonorrhea and Chlamydia

M-13/8

Next, show Slide 9, and explain that the treatment of symptomatic individuals is the same as that for the general population. Draw the participants' attention to presumptive treatment and explain the frequency of treatment and the reasoning behind it.

Explain that we may be able to get rid of presumptive treatment if the load of STIs/RTIs among sex workers shows a reduction along with a concomitant increase in safer sex practices.

Slide 9



Tell the participants that the treatment of asymptomatic infections in sex workers is a special initiative to reduce the burden of disease in this population group.

Now, show Slide 10 and affirm: "The best strategy is to supplement it with activities such as counseling, routine check-up and treatment, health education, and skills for negotiating condom use with their partners. This will help prevent STIs/RTIs in this group in the long run."

Explain that whereas clinic and field/outreach staff of treatment centres can do a limited job of increasing awareness, the use of peer educators would be a more effective and sustainable solution.

Slide 10

OTHER ACTIVITIES....

- Regular contact for routine examination and education
- Using every interaction as counseling opportunity
- Promoting condom use
- Outreach through field staff, peer educators

M-13/10

Now, ask the participants to mention the points/issues they would like to address while counseling sex workers?

Show Slide 11 and explain that counseling should include increased condom use, regular check ups, and semi-annual serological screening. Additionally, sex workers should be trained to negotiate condom use with their clients as the condom can offer protection against most STIs/RTIs.

Slide 11

COUNSELING

- Safer sex practices
- Condom use
- Condom negotiation with clients
- Regular check up visits at least once in 3 months
- Complete treatment
- Get serological tests done, when offered
- Avoid:
- *Douching*
- *Genital wash with harsh chemicals*
- *Putting drying agent or herbs in vagina*

M-13/11

Negotiating Condom Use

In order to get a man to use condoms, he must believe that it is in his own interest.

Explain to him that condoms can:

- Protect him as well as you, from disease.
- Make him less likely to pass on a STI to his wife or other women.
- Make his pleasure last longer.

Assure him that sex will still be good for him.

If he practices oral sex, teach him how to do it with the condom worn on the genitals.

Next, ask the participants to summarize the key issues in the management of STIs/RTIs in sex workers.

Show Slide 12 and let them respond to the questions. Add and explain any missing key points.

Slide 12

LET US RECALL .....

- Why are sex workers at a higher risk?
- What are the main barriers to management and what can we do about them?
- What are the 2 treatment strategies?
- What specific issues should be included when counseling a sex worker?

M-13/12

Finally, show Slides 13 and 14, summarize and close the discussion.

Slide 13

TO SUM UP.....

- Sex workers carry a high risk of contracting and transmitting STIs/RTIs
- Main barriers for seeking health services include stigma, provider attitudes, availability of services
- Health care providers and centres can overcome the barriers
- Treatment modalities include treatment of symptomatic as well as asymptomatic cases
- Correct and complete treatment together with counseling on safe sex and condom negotiation can help in prevention

M-13/13

Slide 14

WHAT CAN I DO AT MY CENTRE?

- Ensure **privacy and confidentiality**
- **Be a role model for others** by showing **non-discriminatory behavior**
- Be **non-judgmental** during interactions in the clinic
- Treat sex workers with the **same respect and dignity** as other clients
- Motivate them for **regular/periodic screening**
- Encourage them to **refer their infected clients** to a clinic
- Help them with **safer sex practices**
- Help them understand "**how to negotiate safer sex**"

M-13/14

Module 14

Preventing STIs/ RTIs in Adolescents and Youth

MODULE 14

Preventing STIs/RTIs in adolescents and youth

Learning Objectives:

At the end of this module, the participants will be able to:

1. Describe the magnitude of STIs/RTIs among adolescents and youth
2. Describe the factors that put adolescents and youth at high risk for STIs/RTIs
3. List the barriers that prevent adolescents and youth from obtaining information and services related to STIs/RTIs
4. Develop strategies for involving adolescents and youth in STI/RTI prevention, treatment and outreach activities to establish youth-friendly services

Materials :

- Overhead/LCD projector
- PowerPoint slides for the session
- Flip charts
- Marker pens
- Flowcharts
- Situation slips for various STI/RTI syndromes
- A few small gifts (such as ball point pens) for rewarding good responses

Preparation by facilitator :

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1	Introduction to Module 14	Interactive presentation and group work
2	STIs/RTIs in adolescents and youth	
3	Strategies for making STI/RTI services youth-friendly	

SESSION 1

Introduction to Module 14

Objective:

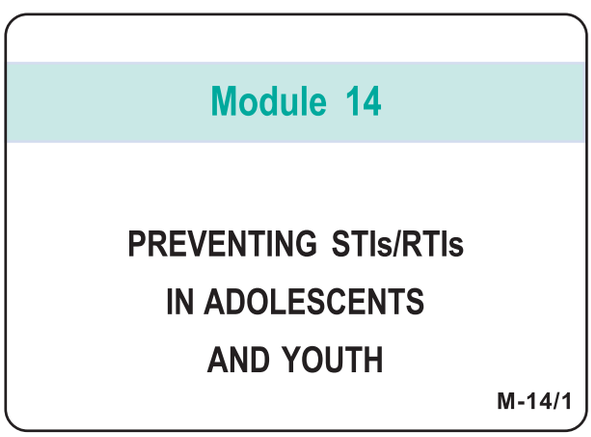
At the end of this session, the participants will be able to:

- Provide an overview of the module including its objectives

Open the discussion by saying: "There is one more important population group in our society which needs special attention with regard to STIs/RTIs."

Show Slide 1 and say: "Now we will discuss the prevention of STIs/RTIs among adolescents and youth."

Slide 1



Make introductory remarks; say: "Adolescents and youth in the 10-24 age group constitute about 30% of our population. Data from various Indian studies indicate that adolescents indulge in pre-marital sex more frequently and at an early age. STIs, including HIV, are more common among adolescents in the 15-24 age group, and more so among young women. The physiological risk of increased susceptibility to infections among adolescent girls is due to the presence of greater cervical ectopy which makes the cervix more susceptible to gonorrhoea, chlamydia and HPV Infection.

"Further, adolescent girls and boys are particularly vulnerable to STIs since they are less likely to have access to health services and recognize symptoms. Health services for adolescent boys are also extremely limited.

"Lack of education about sexual health among both boys and girls leaves them ill-equipped to make important choices to protect themselves against unwanted sex, pregnancy, and STIs. The AIDS epidemic gives a new urgency to STI prevention and is also an opportunity to protect new generations from the devastating effects of AIDS by making information and services available."

Show Slide 2. Tell the participants that we are going to discuss some important dimensions of preventing STIs/RTIs in adolescents and youth in this module, and explain each objective of the module.

Slide 2

OBJECTIVES: MODULE 14

- Describe the magnitude of STIs/RTIs among adolescents and youth
- Describe the factors that put adolescents and youth at high risk of STIs/RTIs
- List the barriers that prevent adolescents and youth from obtaining information and services for STIs/RTIs
- Develop strategies for involving young people in STI/RTI prevention, treatment and outreach activities to establish youth-friendly services

M-14/2

SESSION 2

STIs/RTIs in adolescents and youth

Objectives:

At the end of this session, the participants will be able to:

1. Describe the magnitude of the STI/RTI problem in adolescents and youth
2. Describe the factors that put adolescents and youth at high risk of STIs/RTIs

Ask the participants whether STIs/RTIs are a major health problem among youth. If the response is "yes", ask them why they think so. Allow 1-2 participants to share their clinic experiences, if any.

Now, show Slide 3 and explain the extent of the STI/RTI problem among youth, based on the Indian studies cited in the slide.

Say: "Based on the statistics shown on the slides, it is clear that adolescents are at a higher risk of STIs/RTIs, and among adolescents, young girls (female children) are at a higher risk than young boys."

Slide 3

MAGNITUDE OF PROBLEM - ESTIMATES

- 1 in 20 youth contract STIs/RTIs each year
- One-third of all STIs occur among 13-20 year-olds (110 million STIs/year)
- Up to 20% of all births are to women 15-19 years of age
- 40–70% of women have become pregnant or mothers by the end of their teens
- 35% of women hospitalized for septic abortion are under age 20
- Maternal deaths are 2–3 times greater in women 15-19 years of age than in women aged 20–24 years

M-14/3

Next, ask the participants why STIs/RTIs pose a greater risk for adolescents and youth. Provide clues by saying that the reasons could be biological, social or behavioural.

List their responses on a flip chart.

Show Slide 4 and complete the list by comparing it with the slide. Re-emphasize that in addition to biological factors, social factors play a major role in putting adolescents at a high risk of STIs/RTIs.

Slide 4

WHY ARE ADOLESCENTS AND YOUTH AT GREATER RISK OF STIs/RTIs?

- **Individual factors:**
  - Indulge in sex early, at young age
  - Physiological risk of increased susceptibility in girls
  - Poor knowledge about safe sex and related issues
  - More risk-taking and experimentation
  - Multiple, concurrent sexual relationships
  - Lack of information about STIs/RTIs
  - Lack of access to quality services

M-14/4

Finally, close the session by saying: "Adolescents in our society and country are at a higher risk of STIs/RTIs due to various biological, behavioural and social factors. As health care providers, we need to think of ways of tackling these factors so that adolescents can obtain the services of qualified doctors. We also need to explore avenues for providing young people with appropriate knowledge during treatment sessions, at social events etc in order to prevent infection/re-infection.

Emphasize that in girls, most infections are asymptomatic or present somewhat differently. Take 1-2 examples such as vaginal discharge in girls and chlamydial infection in boys.

Show Slide 5 and explain the signs and symptoms of STIs/RTIs in young individuals.

Inform the participants that in the next session, we will identify the factors that prevent adolescents from seeking STI/RTI services and find solutions to these barriers.

Slide 5

CLINICAL PRESENTATION

- **Girls:**
  - Endogenous vaginitis, a common cause of vaginal discharge rather than STI
  - Most gonococcal and chlamydial infections asymptomatic
  - Only symptoms – vulval itching, minor discharge
  - Candida albicans – uncommon
  - Syphilis presentation – same as in adults
- **Boys:**
  - Gonorrhoea – proctitis, urethal discharge, penile edema
  - Chlamydia – urethritis

M-14/5

Clinical presentation of STIs/RTIs in adolescents

Girls:

- In general, endogenous vaginitis, rather than STI, is the main cause of vaginal discharge among adolescent females.

- Approximately 85% of gonococcal infection in females is asymptomatic. However, there may be vulval itching, minor discharge, urethritis or proctitis. In pre-pubescent girls, a purulent vulvo-vaginitis may occur.
- Similarly, chlamydia trachomatis infection is asymptomatic in the majority of cases. Symptoms that may occur in the adolescent are inter-menstrual bleeding, postcoital bleeding and an increase in vaginal secretions.
- Candida albicans is uncommon in adolescents prior to puberty. If present, the adolescent may have a discharge, vulval itching, dyspareunia, perianal soreness or a fissuring at the introitus. Attacks of candida vulvitis may be cyclical in nature and correspond to menstruation.
- Bacterial vaginosis does not produce vulvitis and the adolescent will not complain of itching or soreness.
- The signs of acquired syphilis in children present with small chancres or mucocutaneous moist lesions either on the vulva or anus. Presentation of syphilis is similar in adolescents and adults.

- **Boys:**
  - Gonorrhoea among boys presents as proctitis, urethral discharge, asymptomatic pyuria, penile edema, epididyimitis and testicular swelling. Disseminated gonorrhoea presents with multiple systemic manifestations.
  - Chlamydia in males presents as urethritis.

SESSION 3

Strategies for making STI/RTI services youth-friendly

Objectives:

At the end of this session, the participants will be able to:

1. List barriers that prevent youth from obtaining information and services related to STIs/RTIs
2. Develop strategies for involving youth in STI/RTI prevention, treatment, and outreach activities to establish youth-friendly services

Begin the session by asking the participants:

- "Do adolescents or youth attend your clinics for STIs/RTIs or other reproductive health problems?"
- "If yes, how do they present themselves?"
- "Do they approach the providers confidently and freely?"
- "What do you think about their knowledge regarding STIs/RTIs- or RH-related matters such as sexuality, pregnancy, condom use etc?"

Allow 3-4 experienced participants to share their views for about 5 minutes.

By and large, their experiences will not be very positive.

Next, ask: "What prevents adolescents or youth from accessing STI/RTI or RH services?"

Tell them that the moment they think of a barrier, they should also think of a suitable solution to overcome the barrier.

Announce that the best responses will be rewarded. Keep simple gifts (such as ball pens etc.) ready for distribution.

Allow 5 minutes for individual work and initiate the discussion. The facilitator/s should randomly select respondents and instruct them not to repeat the responses shared earlier.

Note the responses on a flip chart with the help of your co-facilitator. Note both barriers and proposed solutions.

Now, show Slide 6 and compare the barriers listed on it with the participants' responses. If most of the points on the slide have been covered, appreciate the participants for good thinking; If not, add and explain the missing points.

Slide 6

BARRIERS TO SERVICES FOR ADOLESCENTS AND YOUTH

- Lack of services: Little access to family planning or services for treatment or prevention of STIs
- Lack of access to condoms
- Provider, parent, teacher, and community attitudes about youth and sexuality
- False belief that young people are not sexually active and that information will increase sexual activity
- Lack of messages targeted at youth
- Lack of providers trained to deal with youth

M-14/6

Now show Slides 7 to 9 and discuss various youth-friendly services and outreach activities for improving STI/RTI services for adolescents and youth.

Slide 7

YOUTH-FRIENDLY SERVICES

- Providers who want to work with youth, have special training and are non-judgmental.
- Convenient and confidential services.
- Special hours (after school, evenings, weekends, drop-ins).
- Comfortable for young men and young couples.

M-14/7

Slide 8

YOUTH-FRIENDLY SERVICES

contd....

- Private examination and consultation rooms
- Wide choice of contraceptives
- Emphasize barrier methods with Emergency Contraceptive Pills (EC Pills) for backup against pregnancy
- Emphasis on communication skills for young people

M-14/8

Slide 9

OUTREACH SERVICES

- School-based education programs
- Peer education programs
- Target out-of-school youth
- Target married youth
- Word-of-mouth about location of clinic services

M-14/9

Finally, summarize the session by involving the participants in the following exercise.

Ask them to use a sheet of paper from their notebooks.

Put up Slide 10 and ask them to respond to 3 questions individually.

Emphasize that this is going to be a self-commitment. Therefore, they should try to be honest and identify one action that they can perform as a stand-alone provider in order to improve adolescent STI/RTI services in the clinic where they work.

Ask 3-4 volunteers to read out their commitments loudly.

Appreciate the participants for making such commitments and wish them luck in fulfilling their commitments to the best of their ability.

Slide 10

WHAT I CAN DO AT MY CENTRE

- Provide **privacy and confidentiality**
- Treat adolescents and youth with **respect and dignity**
- Be **non-judgmental**
- **Be friendly** and offer suggestions
- Provide **correct and complete information**
- Suggest **options for safer sex**
- **Involve them in decision-making** for their own risk behaviors
- Suggest that they spread the **information among their peers**

M-14/10

Module 15

Involving Men in STI/RTI Prevention and Control

MODULE 15

Involving men in STI/RTI prevention and control

Learning Objectives:

At the end of this module, the participants will be able to:

1. Discuss how reaching men can improve the reproductive health of men, women, and children
2. Develop strategies for involving men in STI/RTI awareness, prevention, treatment, and partner referral
3. Identify the challenges of reaching men with STI/RTI services, and the ways to meet these challenges

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Blank flip charts
- Marker pens

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session with your co-facilitator beforehand and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1	Introduction to Module 15	Interactive presentation and group exercise
2	Involving men in STI/RTI programmes: Why and how?	
3	Meeting the challenges of male involvement in STI/RTI programmes	

SESSION 1

Introduction to Module 15

Objective:

At the end of this session, the participants will be able to:

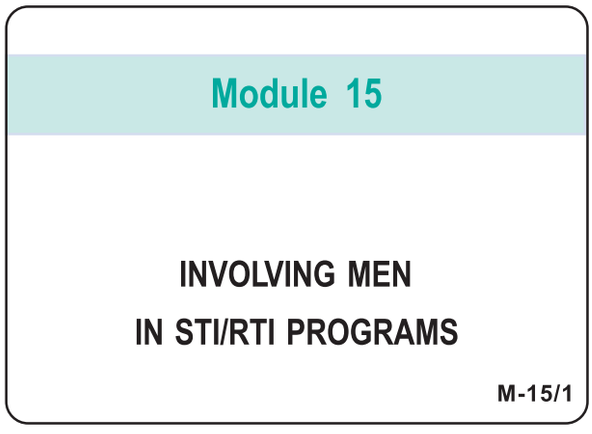
- Provide an overview of the module including its objectives

Show Slide 1 and tell the participants to look at the title of the session carefully. Ask them: "Can you tell us why we are considering men as a separate group for discussion even after having had a wide discussion on STI/RTI management in both women and men during our earlier sessions."

The expected responses could be: men are at a higher risk, or their social position increases their chances of contracting and transmitting STIs etc.

Tell the participants that it is important to give special consideration to certain population groups because they have a greater chance of contracting and/or transmitting STIs/RTIs due to biological, social and behavioural factors. These groups include men, adolescents, sex workers etc.

Slide 1



Say: "In this session, we are going to discuss why men should be given special consideration in STI/RTI management and what the programme as a whole, and we as individual health care providers, can do for this population group."

Show Slide 2 and explain the objectives of the module.

Explain that men are often the bridging group/population that acquires STIs/RTIs from and transmits the infection to high-risk partners such as sex workers, and then carries it home to their regular partners. In this way, STIs/RTIs spread even to women who have only one partner. Reaching men with prevention messages and condoms and treating their STIs/RTIs early and correctly are very effective ways of preventing the spread of STIs/RTIs to their regular partners. A key strategy is to get men with STIs/RTIs to refer or bring their regular partners for treatment, thereby reaching many women who may appear to be at low risk and have no symptoms.

Slide 2

OBJECTIVES: MODULE 15

- Discuss how reaching men can improve the reproductive health of men, women and children
- Develop strategies for involving men in STI/RTI awareness, prevention, treatment, and partner referral
- Identify the challenges of reaching men with STI/RTI services and the ways to meet these challenges

M-15/2

SESSION 2

Involving men in STI/RTI programmes: Why and how?

Objectives:

At the end of this session, the participants will be able to:

1. Discuss why reaching men can improve the reproductive health of men, women and children
2. Develop strategies for involving men in STI/RTI awareness, prevention, treatment, and partner referral

State that every STI/RTI client, whether male or female, needs equal treatment and help in order to get cured of the infection/s and prevent its/their transmission to others. Howevr, since our society is male-dominated, men can play a vital role in the prevention and control of STIs/RTIs.

Ask the participants to give the rationale for involving men in the STI/RTI or overall reproductive health programme?

Let 3-4 participants respond. Note their responses. Ask them to explain the reason/s for each response.

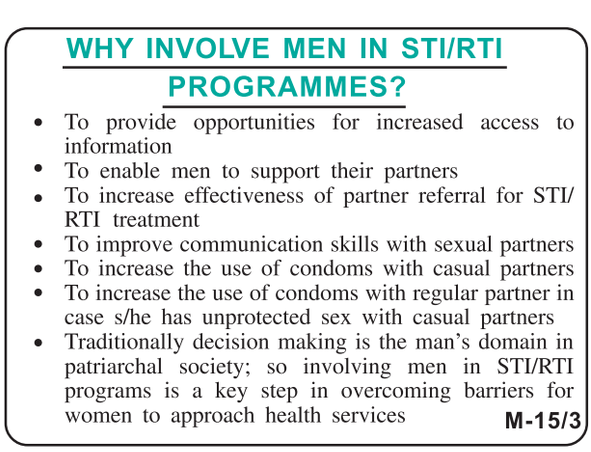
Show Slide 3 and add points not mentioned by the participants to the list.

Explain each bullet point on the slide. Clarify that unless specific attention is given to the male population and men are made aware of the preventive measures to be taken to save themselves as well as their families and friends from STIs/RTIs, and ultimately HIV, they may not feel adequately empowered to talk to or advice others.

Say: "It is also necessary to help men to improve their communication skills so that they can convey correct and complete messages. If most men could be motivated to use condoms and practice safer sex, a substantial number of STI/RTI problems would be prevented."

Inform the participants that health care providers and staff of RH clinics can play a major role in building these skills and confidence in men and empowering men to take the mission against STIs/RTIs forward.

Slide 3



Say: "Now that we know why it is important to involve men in the prevention and control of STIs/RTIs, let us focus our attention on ways of encouraging men to participate in these programmes."

Divide the participants into 2 groups and give them the following tasks:

Group 1: What can a STI/RTI treatment clinic/centre (as a complete unit) do to increase the involvement of men in STI/RTI prevention and control?

Group 2: As a doctor (individual), what I can do to involve men in the STI/RTI prevention programme?

Allow 5-7 minutes for group work.

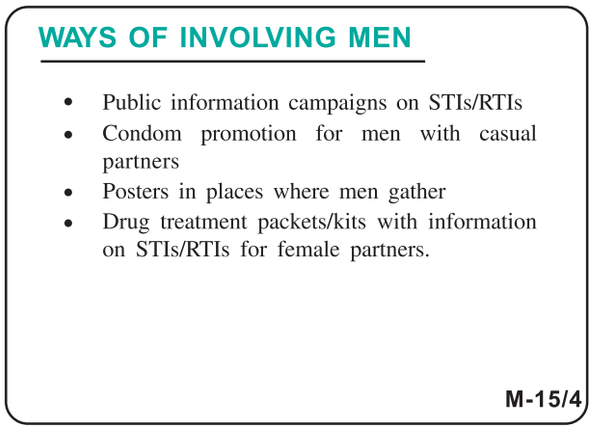
Ask each group to present its findings to the larger group.

List (or, ask one of the participants to list) the findings of each group on separate flip charts. Let a representative selected by the groups present the findings of her/his group.

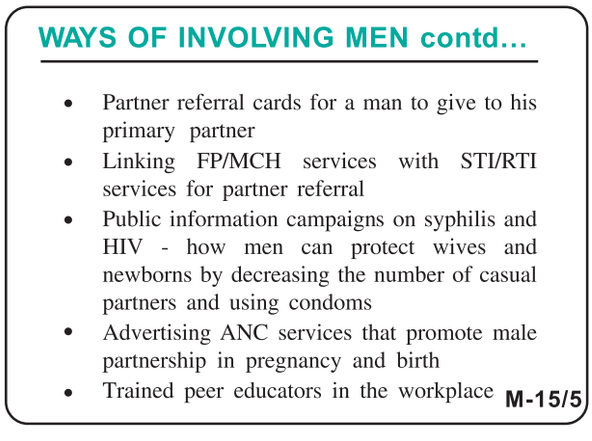
After the groups have presented their work, show Slides 4 and 5 and complete the lists. Explain each bullet point on the slides.

Finally, summarize the discussion by saying: "It is evident from your own thinking and the points mentioned on the slides that several things can be done at the health centre as well as at your own, individual level to involve men in the STI/RTI programme."

Slide 4



Slide 5



Say: "Since this is a list of actions that you yourselves have generated, can we (facilitators) assume that you will put all these points into action and make the best possible attempts to involve men in the STI/RTI control and prevention programme?"

Commend the participants for making a commitment and close the discussion.

SESSION 3

Meeting the challenges of male involvement in STI/RTI control programmes

Objective:

At the end of this session, the participants will be able to:

- Identify the challenges of involving men in STI/RTI control programmes and ways to meet these challenges

Say: "We are going to process this discussion through an interesting exercise."

Preparation for facilitator:

Six challenges facing male involvement have been listed on Slides 6 and 7.

Keep 2 sheets of paper ready with Challenge Nos. 1, 3 and 5 written on one sheet and Challenge Nos. 2, 4 and 6 written on the other.

Now, divide the participants into two groups. Give the first sheet of paper to one group and the second sheet to the other.

Explain the exercise and rules. Say: "Each group will pose a challenge to the other group which has to respond within 90 seconds, and describe how it will handle the challenge."

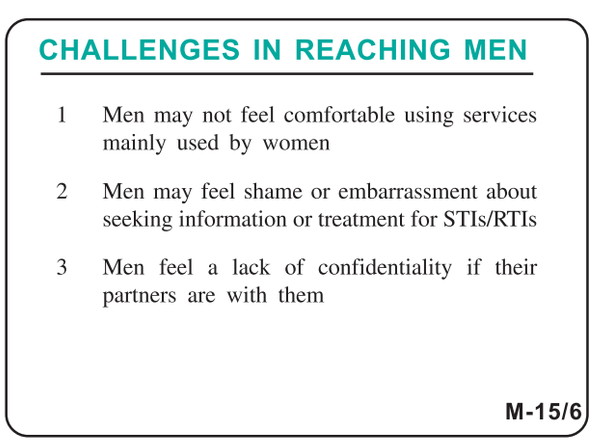
Start the exercise. The facilitator/s should listen carefully to the responses so that s/he /they can add, comment or give suggestions to meet the challenge under discussion.

Clarify that every time a challenge is posed to the group, a new participant should respond (do not allow the same participant to respond).

Allow the group posing the question to make additional suggestions, if any.

One of the facilitators should note the responses on a flip chart for summarization at the end of the exercise.

Slide 6



Slide 7

CHALLENGES IN REACHING MEN

Contd...

4 Treating men may take time and resources away from women
5 Treating men may require different facilities and more male providers
6 Treating men requires new skills from providers

M-15/7

At the end of the exercise, show Slide 8 and revise all the points on ways of meeting the challenges in order to enhance male participation in the prevention and control of STIs/RTIs.

Slide 8

ADDRESSING CHALLENGES....

Challenges	How to address the challenges
Men may not feel comfortable using services mainly used by women	• Establish men only clinics or have dedicated hours for male services • Ensure privacy and confidentiality
Men may feel shame or embarrassment about seeking information or treatment for STIs/RTIs	• Create general public awareness • Provide better experiences to those attending clinic so they recommend others for services • Provide adequate information to those attending the clinic to help spread the word among peers and in the community
There is lack of confidentiality for men if their partners are with them	• Have proper arrangements for privacy for men and women in the clinic • Assure and maintain confidentiality • Try couple counseling rather than individual
Treating men may take time and resources away from women Treating men may require different facilities and more male providers	• Assign adequate time to both men & women • Provide enough resources and manpower to handle the load of STI/RTI and RH clinics • Provide adequate resources including manpower for establishing men-only clinics
Treating men requires new skills from providers	• Train providers to respond to STI/RTI management needs of both men as well as women

M-15/8

Finally, show Slide 9 and sum up the key points of the entire session, emphasizing that although there is greater utilization of RH clinics by women, we must create a space for men and involve them actively so that we can treat their conditions as well as create opportunities for them to play a vital role in the STI/RTI prevention and control programme.

Slide 9

TO SUM UP .....

- Reach men with prevention messages and condoms
- Treat men with STIs/RTIs early and correctly to prevent the spread to regular partners
- Encourage men to bring their partners for treatment to treat asymptomatic clients
- Efforts are possible at the centre as well as individual level

M-15/9

Module 16

Operational Guidelines: Relevance, Framework and components

MODULE 16

Operational Guidelines: Relevance, framework and components

Learning Objectives:

At the end of this module, the participants will be able to:

1. Explain the relevance of the "Operational Guidelines" for the effective implementation of STI/RTI services
2. Describe the framework for STI/RTI service delivery at various levels
3. List the components of quality STI/RTI service delivery

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Flip charts
- Marker pens
- One copy of NACO's "Operational Guidelines", 2011

Preparation by facilitator:

- Read and understand the "Operational Guidelines" thoroughly.
- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1.	Introduction to Module 16	Interactive Presentation
2.	Operational Guidelines: Relevance and components	

SESSION 1

Introduction to Module 16

Objective:

At the end of this session, the participants will be able to:

- Provide an overview of this module including its objectives

Introduction

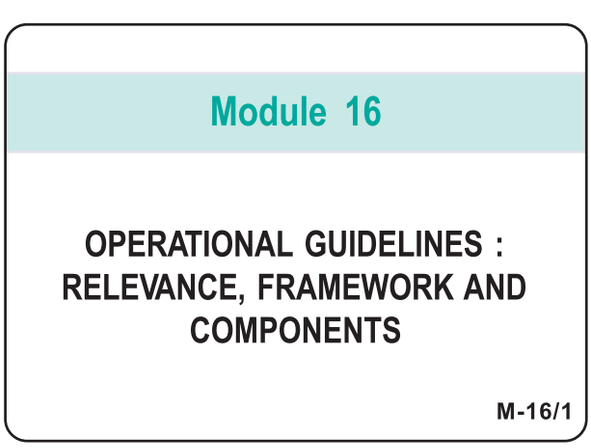
This module seeks to help the participants to understand why NACO has issued the "Operational Guidelines". It is essential for the facilitator to acknowledge that technical knowledge of STI/RTIs alone is not sufficient for the control and prevention of these infections. A proper management of clinic-level service delivery and the team work of service providers is vital for delivering comprehensive services.

Show Slide 1 and introduce the module by reading out its title.

Now, show Slide 2 and explain the objectives of the module. Say: "This module explains the significance of the "Operational Guidelines" developed by NACO for the effective delivery of STI/RTI services at the clinic level by defining the minimum standards for the optimal functioning of STI/RTI clinics."

Clarify that this module, in addition to explaining the relevance of the "Operational Guidelines", serves another important purpose – that of helping the participants to recognize that team work is vital for delivering high-quality STI/RTI services. Unless the clinic staff works in perfect coordination, any single cadre of providers may not be able to deliver all the essential services such as diagnosis, treatment, counselling, laboratory tests and client follow-up.

Slide 1



Slide 2

OBJECTIVES: MODULE 16

- Explain the relevance of the "Operational Guidelines" for the effective implementation of STI/RTI services
- Describe the framework for STI/RTI service delivery at various levels
- List the components of quality STI/RTI service delivery

M-16/2

SESSION 2

Operational Guidelines: Relevance and components

Objectives:

At the end of this session, the participants will be able to:

- Explain the importance of the "Operational Guidelines" for the effective implementation of STI/RTI services
- Describe the framework for delivering STI/RTI services at the clinic level
- Name the components of quality STI/RTI service delivery

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Flip charts
- Marker pens
- One copy of NACO's "Operational Guidelines", 2011

Preparation by facilitator:

- Read and understand the "Operational Guidelines" thoroughly.
- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Begin the session by telling the participants that we will now do an exercise to understand the roles and responsibilities of various cadres of clinic staff as also the importance of team work for delivering high-quality services.

Divide the participants into 3 groups. Tell any one group to play their own role as doctors, and assign the role of nurses and laboratory technicians to the other two groups respectively.

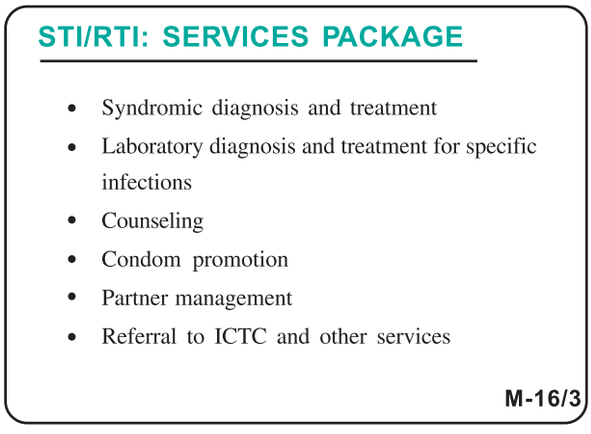
Hand out a sheet of A4 size paper or a coloured card to each participant. Ask them to list at least 3-4 actions/activities they can perform (or usually perform) individually to help STI/RTI clients get quality services at their own clinics.

Allow 5 minutes for listing; then ask each participant to read out her/his card loudly.

It will be evident from the responses that the participants in the doctors' group will take the lead in STI case management activities such as history taking, diagnosis and treatment; those in the nurses' group in counselling, client education and explaining the treatment; and the participants in the third group of laboratory technicians, in performing the prescribed laboratory tests.

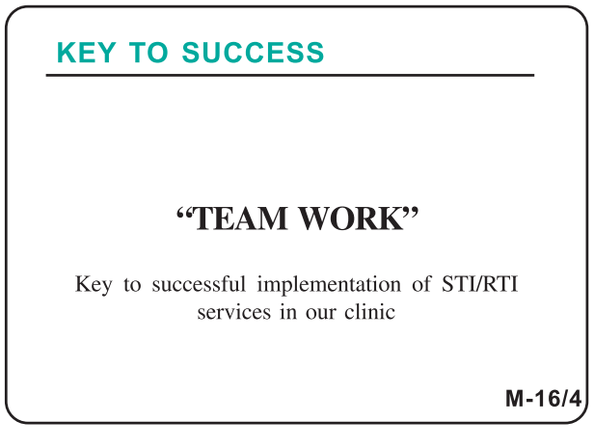
Show Slide 3 and say: "As we all know, and is also evident from your responses, these are the essential components of a quality STI/RTI services package. It also indicates clearly that each of us has a definite and different role to play in the effective management of a STI/RTI case, and that we will be able to provide the complete package of quality services to our clients only if each one of us performs her/his own task/s efficiently. Therefore, it is imperative that we work as a team for the effective management and control of STIs/RTIs."

Slide 3



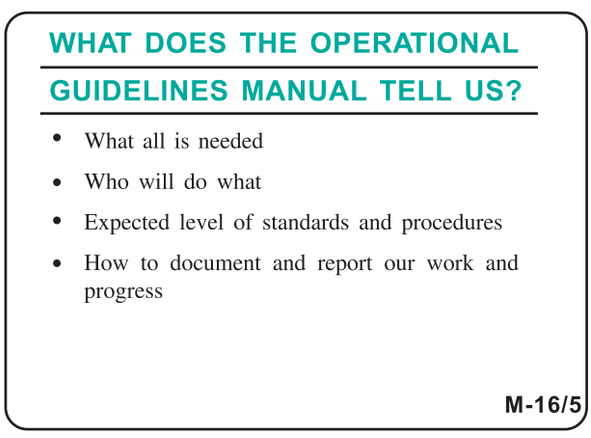
Now, show Slide 4 and emphasize the need for the entire clinic staff to work as a unified team for running an efficient and successful STI/RTI control programme.

Slide 4



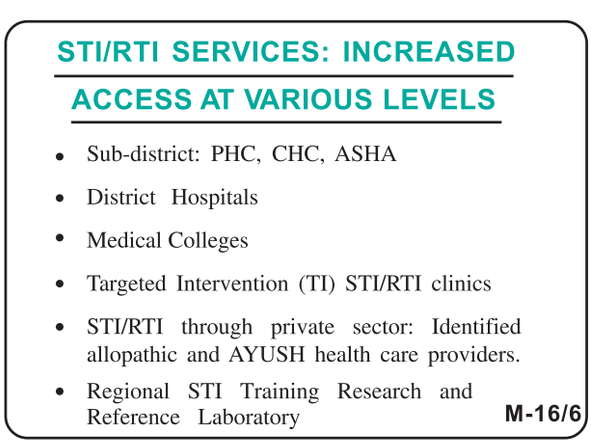
Show Slide 5 and say: "We have just discussed the technical aspects of STI/RTI management. Now, it is time to apply this technical knowledge and skills, effectively and systematically, in our real-life situations that is, in our clinic/centre." Show them the "Operational Guidelines" Manual and continue: "It is with this in view that NACO has issued the "Operational Guidelines" for STI/RTI management. The purpose of these guidelines is to help us understand how, as a team, we can effectively manage the clients who come to us. The guidelines also clarify the roles and responsibilities of each cadre of clinic staff for providing high-quality STI/RTI services. Further, they also include guidance on setting up a good clinic, making it fully operational and ensuring appropriate recording and reporting for monitoring progress."

Slide 5



Now, show Slide 6 and explain that under NACP III, STI/RTI services will be provided at different levels of clinics across the country. Ask the participants to open Page 2 of her/his copy of the "Operational Guidelines" and ask any one participant to read loudly the description that applies to her/his own clinic. For example, if the participant is from a targeted intervention clinic, ask her/him to read the description on Page 3 – the last part of the table: STI clinics with targeted interventions for HRGs. Explain as necessary.

Slide 6



Start the discussion with "location of clinic". Clarify that the government is aiming at making STI/RTI services available at all health care facilities starting from community-level facilities to the highest referral centres.

Explain that the level and range of services provided by each of these facilities would be different. For example, the function of a community-level health sub-centre would be to create community awareness about the signs and symptoms of STIs/RTIs, prevention strategies and sites of nearby clinics. However, PHCs and CHCs would be expected to provide diagnostic services, treatment and counselling services.

Emphasize that whatever the level of service delivery at her/his facility, the syndromic approach is the foundation of all STI/RTI services. Laboratory services can be used wherever available for enhanced syndromic management.

Now, show the caption of Slide 7 and ask: "If you were asked to deliver 'quality STI/RTI services', what key elements would it include?"

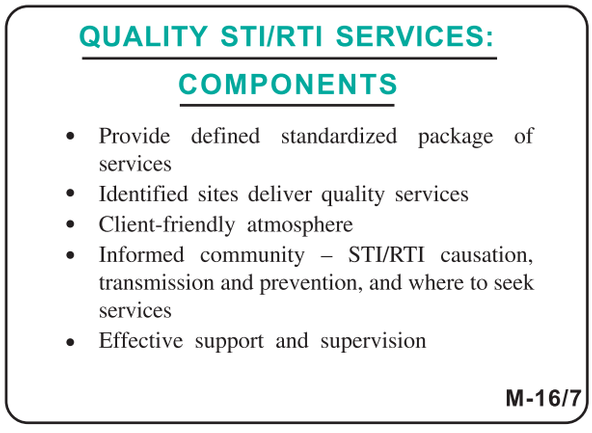
Let 3-4 participants respond. If the responses are limited to service delivery within the clinic, give them a hint to think beyond the clinic.

Finally, show the entire Slide 7 and state that availability, accessibility, quality and demand creation are the four key elements of quality service delivery.

Explain that merely having a "fully-equipped" clinic or the passive presence of experts/specialists is not enough to attract clients. The clinic should be geographically within the reach of the community; it should have a good, optimally functioning staff team; and the overall atmosphere and behaviour of its service providers and staff should be client-friendly. Most importantly, the community should be made aware of the range of services available at the clinic as well as how STIs/RTIs are caused, transmitted, and can be prevented by seeking the services of an appropriate facility.

Explain further that to ensure that a clinic has all the four components all the time, a strong support and supervision system must be in place. Emphasize the words "support system". Clarify that the supervision system can only be effective if it provides the necessary support for filling gaps in the system, if any, and not if it only finds faults with the clinic or system.

Slide 7



Module 17

Minimum Standards for Quality STI/RTI Services

MODULE 17

Minimum standards for quality STI/RTI services

Learning Objectives:

At the end of this module, the participants will be able to:

1. Discuss the minimum infrastructure requirements and clinical standards for quality STI/RTI services
2. Describe the role and responsibilities of STI/RTI clinic staff

Materials:

- Overhead / LCD projector
- PowerPoint slides for the session
- Flip charts
- Marker pens
- Samples of pre-packaged STI drug kits (3-4 sets of all 7 colour-coded kits)

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1.	Introduction to Module 17	Interactive Presentation
2.	Minimum requirements for an efficient STI/RTI clinic	

SESSION 1

Introduction to Module 17

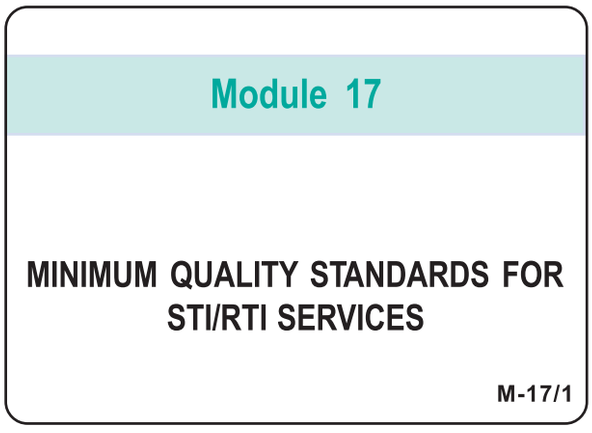
Objective:

At the end of this session, the participants will be able to:

- Provide an overview of this module including its objectives

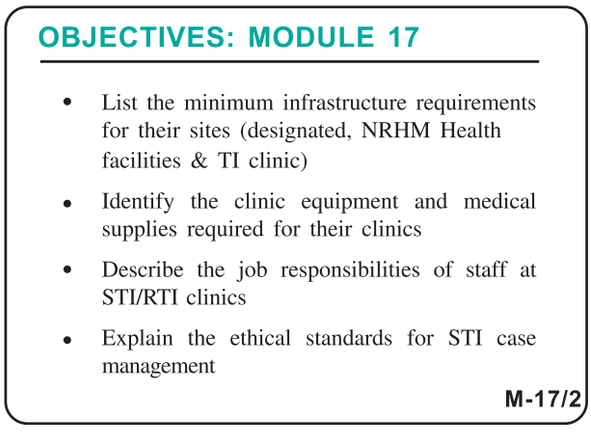
Show Slide 1 and tell participants that in this module we will discuss the minimum criteria for a good STI/RTI clinic and review the facilities in our own clinic to see if they meet these criteria.

Slide 1



Show Slide 2 on Module objectives and explain each objective in your own words.

Slide 2



SESSION 2

Minimum requirements
At a STI/RTI clinic

Objectives:

At the end of this session, the participants will be able to:

- List the minimum infrastructure requirement for their sites (designated NRHM Health Facilities & TI clinic)
- Identify the clinic equipment and medical supplies required for their clinics
- Describe the job responsibilities of the staff at STI/RTI clinics
- Explain the ethical standards for STI case management

Show Slide 3 and ask the participants to open their notebooks and note down the 4 clinic areas mentioned on the slide.

Slide 3

MINIMUM STANDARDS: INFRASTRUCTURE

- Waiting area
- Consultation area
- Laboratory area
- Counseling area

M-17/3

Now, show Slide 4 and ask them to recall and note the current situation of each of these clinic areas or sections using the points on Slide 4. For example, if there is a waiting area in the clinic, what is its size, whether it is sufficient for the daily client load, etc.

Slide 4

HOW DOES OUR CLINIC LOOK NOW?

- Does this area exist?
- What is its size?
- Is it enough for the current client load?
- Why and why not?
- What minimum facilities does it have? - Furniture, privacy etc.

M-17/4

Allow 2-3 minutes for noting, and ask one of the participants to read out the description or bullet points relating to the waiting area in her/his clinic.

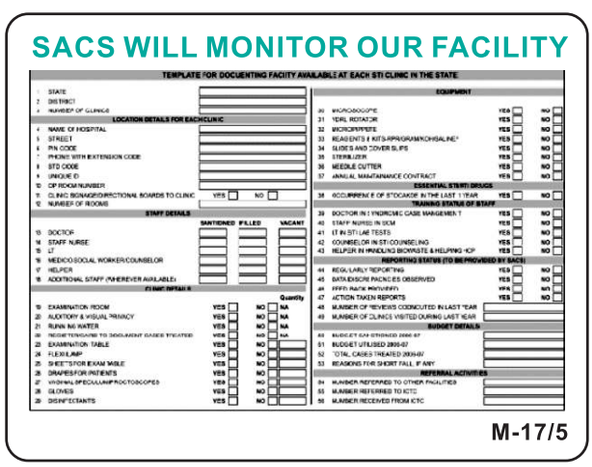
At the same time, ask the other participants to open Page 8-9 of the "Operational Guidelines" and match the description with the NACO-NRHM prescribed standards.

Using the same process, analyze the current situation of other sections of the STI clinic, such as consultation area, laboratory and counselling area.

Emphasize that the intention of prescribing infrastructure standards is not to make the clinic look fancy but to make it suitable for addressing the basic needs of STI clients such as comfort when they enter the clinic, auditory and visual privacy, assigned space for a proper clinical examination, and basic infection prevention facilities like hand-washing.

Clarify that these are absolute essentials for every STI/RTI clinic and that NACO-NRHM has provided an adequate budget to every STI clinic to provide these basic facilities. Therefore, money should not be a constraint or an excuse for not providing these facilities in your clinic.

Slide 5



Now, ask the participants to form 2 or 3 groups (depending upon the number of participants). All participants from similarly located clinics should be in one group. Give them a flip chart and ask them to do the exercise given on Slide 6.

Ask each group to draw a map of client movements from the time a client enters the clinic, till s/he leaves it. Ask the groups to specify which different sections of the clinic/hospital the STI/RTI client has to visit. Suggest that they name the staff (designation, not actual names) responsible for each of these clinic areas/sections which the client is expected to visit.

Allow 5 minutes for group work.

Slide 6

EXERCISE

- Draw a map of patient movement in your clinic.
- Start from registration.
- Till the patient leaves the clinic.

M-17/6

Now, show Slide 7 and ask the participants to open Annexure 1 on Page 53 of the "Operational Guidelines". Proceed in a stepwise manner to compare the map prepared by each group with the client-flow diagram recommended by NACO-NRHM. Encourage them to identify similarities and differences. Identify a station/section, if any, that may be missing completely

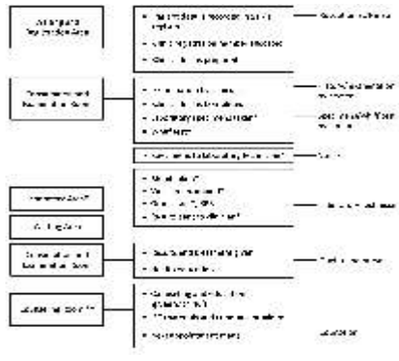
Ask one of the participants to read out the designation of the person responsible for a certain section of the clinic and the key activities that are expected to happen in that specific area.

Summarize the discussion by saying: "Now we know the important sections that a STI/RTI clinic must have. We have also talked about the staff in-charge/responsible for each of these sections and the key role s/he has to play." (Point out clearly any specific area or staff missing in any of the clinics. Suggest that the clinic team could take up the matter with the clinic head and establishe such specific clinic sections at the earliest).

Clarify again that SACS will regularly monitor the physical facilities in each STI/RTI clinic.

Slide 7

CLIENT FLOW MAP OF A TYPICAL CLINIC



M-17/7

Remember ...

The purpose of this activity is to help clinic staff to visualize the different sections that are needed in their respective clinics as well as the key job responsibilities of the person responsible for each of these sections. A detailed discussion on the job descriptions of clinic staff will be taken up later in this module.

Equipment and supplies

Say: "So far, we have discussed how much space and which sections are required for appropriate client management. Now let us see what essential equipment and general items are needed in an STI/RTI clinic to ensure proper service delivery. Let us start with the general items."

Suggest that the participants refer to the client flow diagram which they have drawn on the flip chart and list the furniture and other general items needed in those sections or rooms in order to ensure smooth and effective service delivery.

Allow 2-3 minutes for listing.

Now, ask them to open Page 8-9 of the "Operational Guidelines" Annexure II Page 54 – Minimum furniture and general items for STI/RTI provision. Also show Slide 8.

Slide 8

GENERAL ITEMS

- Cupboards for safety of documents and medicines
- Storage for condoms and stationery
- Sink with running water
- Furniture for staff and clients
- Light and ventilation
- Safe drinking water for staff and clients
- Waste disposal system

M-17/8

Ask them to go through it item by item and mark the items that are available and those that are missing in her/his clinic currently.

Allow them to work as a one-clinic group. However, suggest that they divide the work within the group as follows:

Nurse: General items, waiting and registration area, medical supplies-consumables

Doctor: Consultation and examination room – for examination, general medical, instruments and sterilization

Counsellor: Counselling room.

Slide 9

When the participants have identified the missing items, ask them to retain the list and share it with their clinic in-charge after the Workshop.

Remind them again that NACO-NRHM has provided an adequate budget for procuring these items in sufficient quantities.

Suggest that they paste these lists of items in the relevant sections of the respective clinic areas (laboratory, examination or counselling room etc.) of her/his clinic as a reminder of the essential requirements.

Job responsibilities

Now, initiate a discussion on the roles and responsibilities of clinic staff for providing quality STI/RTI services.

Ask the participants to note down 5-6 key activities or duties that they, as doctors, are currently performing in the STI/RTI clinic, as also 5-6 key activities performed by other cadres of service providers namely, nurses, laboratory technicians and counsellors.

Ask them to open Annexure II on 'Job responsibilities of various clinic staff' on Page 56-58 of the "Operational Guidelines" and go through the job responsibilities.

Ethical standards

Now, say: "As we all know, dealing with clients who need sexual health care is a very sensitive matter. Therefore, in order to provide high-quality services and gain their confidence, it is mandatory that sexual health/STI/RTI clinics maintain certain ethical standards."

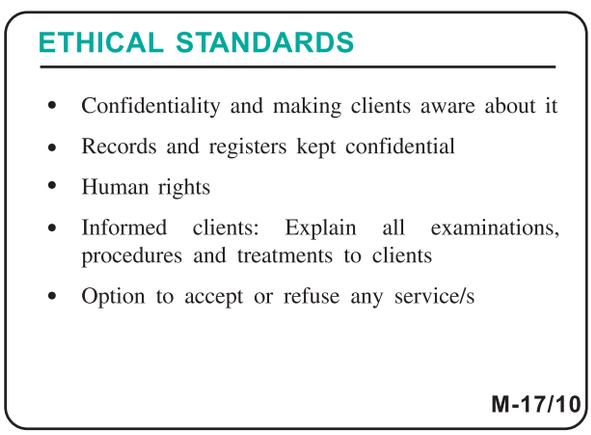
Encourage the participants to think of such ethical issues. By and large, they will talk about good behaviour, privacy and confidentiality. These are good responses.

Ask these participants to elaborate by describing how this could be done and why it is necessary or what the impact of following a particular ethical standard would be.

Finally, show Slide 10 and clarify each point, avoiding repetition if mentioned earlier.

Emphasize that confidentiality is the client's right and is also vital for gaining the client's confidence and thereby, increasing her/his faith in the clinic and its services besides improving client turnover. Put up the 'confidentiality statement' in different parts of the clinic to reinforce that you and your clinic endorse confidentiality.

Slide 10



Drugs and consumables

Say: "So far, we have discussed the infrastructure and essential equipment and supplies required for STI/RTI services. Now, let us discuss the drugs and consumables that are needed for providing quality STI/RTI services. If our aim is to provide quality services to our clients, the minimum requirement is that they are diagnosed correctly and treated properly so that they are cured of infection."

Remind the participants that they have discussed the treatment of various STI syndromes and RTIs in earlier sessions.

Encourage volunteers to come forward and list the STI syndromes in men and women on a flip chart. If incomplete, take the help of other participants to complete the list.

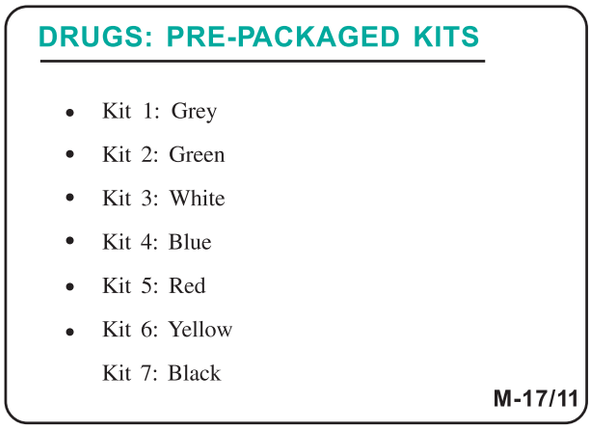
Now, ask the participants to write prescriptions for each of these syndromes. Assign a different syndrome to each participant.

Allow 5-7 minutes for prescription writing.

Tell the participants that NACO has decided to provide STI/RTI drugs in the form of kits in which all the necessary drug regimens will be pre-packaged using different colour codes.

Keep the pre-packaged STI treatment kits handy and show all the 7 coloured kits to the participants. Show Slide 11 and ask them to open Page 15 of the "Operational Guidelines" and see the table describing essential STI/RTI kits and their contents.

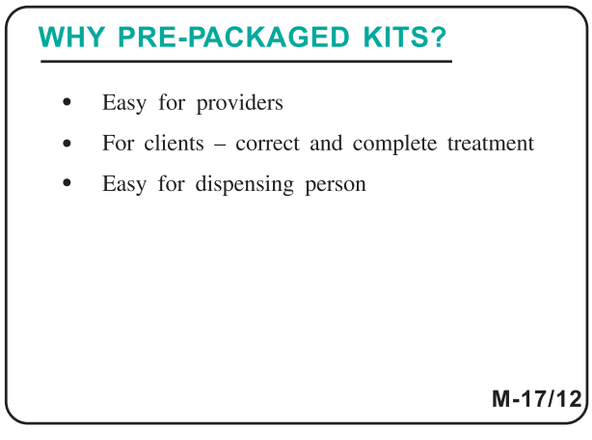
Slide 11



Now, show Slide 12 and explain that there are many advantages of pre-packaging drugs:

- To make it easy for service providers to prescribe all the necessary drugs in the right quantity for treatment of a specific syndrome.
- To ensure that the client gets correct and complete treatment every time.
- To help the person dispensing the kit to identify the right drug combination.
- To inform the participants that although SACS will be responsible for supplying these medicine kits to their clinics, they would have to take certain actions at their end to ensure adequate supplies and the availability of appropriate kits at any point of time.

Slide 12



Next, show Slide 13 and explain the responsibilities of the clinic team in maintaining the supply chain management system & formats of drug record as given on Page 17-20. The following should be looked by the clinic team.

- Keep a proper record of drugs and consumables, with expenditure records.
- Ensure proper storage of drugs and consumables.
- Submit a monthly drug report to SACS before the 5th of every month.
- Monitor the expiry dates of the STI/RTI kits.

Always maintain 3 months' stock at the clinic.

Slide 13

DRUGS SUPPLY SYSTEM:
SYSTEM AND REPORTING

- Free supply from NACO/SACS
- Monthly report to SACS before 5th
- Monitoring expiry dates
- Minimum 3 month stock

M-17/13

Show Slide 14 and ask the participants to open Page 22 of the "Operational Guidelines" and go through the list of essential supplies at different level of health facilities.

Clarify that some additional STI treatment-related drugs are also included in this list. The doctors in the clinic can use these additional drugs, as needed, Annexure IV Page 59. However, the pre-packaged STI/RTI treatment kits must always be available in stock and used for treating specific STI/RTI syndromes.

Slide 14

OTHER ESSENTIAL SUPPLIES

Essential supplies at
1. Designated STI/RTI Clinic
2. Targeted Intervention Project Clinic
3. NRHM sub district level health facilities

M-17/14

Also inform the participants that both male as well as female condoms must be available in their clinics in adequate quantities, at all times. The condoms must be monitored for appropriate storage as well as expiry dates.

In targeted intervention clinics (TI clinics) where cases of anal sex will also be treated, condoms and water-based lubricants in small pouches should also be available in the prescribed quantity.

In addition to the above-mentioned items, specific job aids should be available in various sections of the clinic to assist clinic staff to provide correct and complete treatment, client education and counselling. Various jobs aids for different sections are given in Annexure XVII of the "Operational Guidelines" and include -

- Doctor's chamber: Syndromic management flowcharts, infection prevention poster, condom demonstration kit, wall chart on anaphylaxis management, list of various drug kits.
- Waiting area: Client education-related posters providing basic information about STIs/RTIs.
- Drug dispensing section: List of pre-packaged drug kits.
- Laboratory: List of laboratory reagents and consumables, client education posters and procedures of important laboratory tests.

A penis model and checklists for the correct use of condoms must also be available in each clinic so that service providers can demonstrate correct condom use to STI/RTI clients.

Module 18

Efficient Management of Clinical Services

MODULE 18

Efficient management of clinical services

Learning Objectives:

At the end of this module, the participants will be able to:

List and describe the minimum clinical standards for STI/RTI case management, including laboratory tests

Materials:

- Overhead / LCD projector
- PowerPoint slides for the session
- Flip charts
- Marker pens

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1.	Introduction to Module 18	Interactive Presentation
2.	Clinical standards for STI/RTI case management	

SESSION 1

Introduction to Module 18

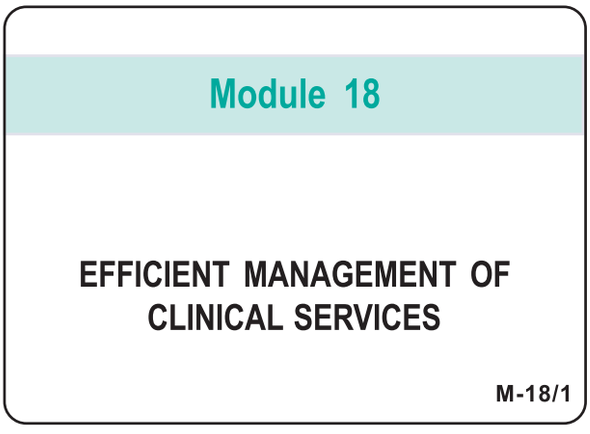
Objective:

At the end of this session, the participants will be able to:

- Provide an overview of this module including its objectives

  Display Slide 1 and say that this module will focus on the minimum clinical standards for all types of STI/RTI clinics.

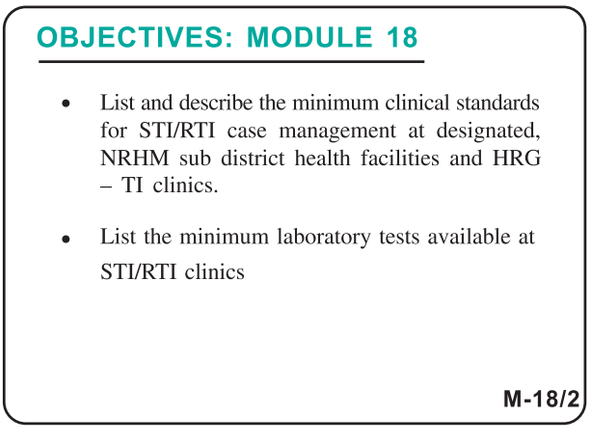
Slide 1



Show Slide 2 and explain each objective of the module.

Inform the participants that in addition to the minimum clinical standards for STI/RTI case management at various level of health care (Table 2 Page 12) we will also look at the minimum laboratory tests to be performed at all these health facilities Page 13-14.

Slide 2



SESSION 2

Clinical standards for STI/RTI case management

Objectives:

At the end of this session, the participants will be able to:

- Describe the minimum clinical standards for STI/RTI case management at designated, NRHM sub district health facilitiesand HRG – TI clinics
- List the minimum laboratory tests available at STI/RTI clinics

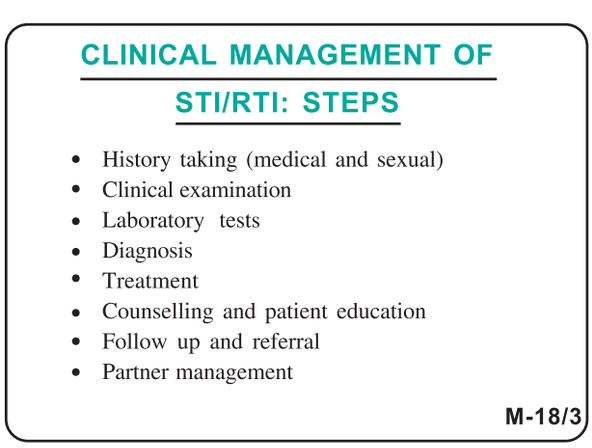
Ask the participants to list the steps of clinical management of STI/RTI patients in their notebooks. Remind them that we have discussed these steps during the session on clinical management of RTIs/ STIs.
After 2-3 minutes, ask them to read out the steps loudly.

Show Slide 3 and clarify that there are 8 steps in the clinical management of STIs/RTIs.

1. History taking (medical and sexual)
2. Clinical examination
3. Laboratory tests
4. Diagnosis
5. Treatment
6. Counselling and patient education
7. Follow up and referral
8. Partner management

Explain, saying: "Each of these steps has been discussed in detail during earlier sessions. Today, we are going to remind ourselves of the essential elements of STI/RTI management. "
Now, show Slide 4 and clarify that these are the minimum clinical standards prescribed by NACO-NRHM for delivering quality STI/RTI services.

Slide 3



Slide 4

MINIMUM CLINICAL STANDARDS

- History taking – medical and sexual
- Physical examination
- Syndromic diagnosis and treatment
- Counseling – 4 "Cs" – Condom, Compliance to treatment, Counseling, Contact tracing
- Follow-up care

  Partner management

  Referral

M-18/4

Continue the discussion further, focusing on history taking and clinical examination.

Remind the participants that they already know the steps of history taking and the questions to be asked. Also remind them that visual and auditory privacy is an important prerequisite of history taking, and therefore, every STI/RTI clinic must have appropriate arrangements for visual and auditory privacy.

Ask them why it is an essential and sensitive step in STI case management.

Take responses from 2-3 participants.

Show bullet point 1 on Slide 4 and emphasize that sexual history taking is a very sensitive process.

Explain that it involves enquiry into the intimate sexual life of an individual. Therefore, health care providers must make it a point to explain the significance of sexual history taking to the client and gain her/his confidence. Providers must be completely non-judgmental during history taking, or rather, during the entire process of case management. Clients must be assured of the confidentiality of client-provider interactions / communication as well as her/his records and reports.

Show bullet point 3 on Slide 4 and remind the participants that although syndromic management looks simple, it includes a complete clinical examination of the male or female patient. Therefore, the doctor must be well prepared to perform a thorough clinical examination using appropriate equipment such as a speculum or proctoscope etc.

Draw the attention of all the participants to the fact that irrespective of the level of the clinic in which case management occurs, syndromic management remains the mainstay of STI/RTI treatment.

Explain that the use of syndromic management at all levels and clinics will help in providing standardized, correct and complete treatment to every STI/RTI patient across the country.

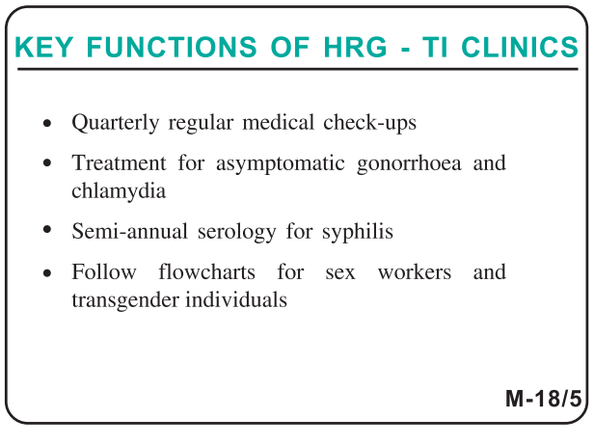
Where designated TI clinics, district hospitals and medical colleges have been recommended for performing laboratory tests, the treatment of patients must not be declined or delayed for want of the results of laboratory tests.

Impress upon the participants that counselling and partner management are essential components of STI/RTI control and prevention programmes.

Now, show Slide 5 and explain the following key issues that are relevant to service providers of HRG TI clinics:

1. A quarterly medical check up, sexual health history taking and physical examination are essential for sex workers.
2. Sex workers should be treated for asymptomatic gonorrhoea and chlamydia at the first visit. Repeat the asymptomatic treatment at 6 months if the patient has not attended the clinical services during this period.
3. Semi-annual serological screening for syphilis.
4. Follow the NACO recommended flowcharts for management of female and male/transgender sex workers, whether symptomatic or asymptomatic.

Slide 5



Ask the participants to refer to the flowcharts in Annexure X on Pages 66 and 67 of the "Operational Guidelines". Respond to their queries, if any.

Now ask them to open Page 13-14 of the "Operational Guidelines" and read Section 3.3 on 'Minimum laboratory tests at STI/RTI clinics'.

Clarify that the laboratory tests mentioned here are the minimum requirement for every designated STI/RTI clinic. The laboratory tests must be performed in accordance with the technical guidelines and recommendations provided in the "National Guidelines".

Module 19

Infection control system and waste disposal

MODULE 19

Infection control system and waste disposal

Learning Objectives:

At the end of this module, the participants will be able to:

1. Explain the importance of universal precautions in the context of STI/RTI clinics
2. Describe infection prevention/control and waste disposal measures for STI/RTI clinics

Materials:

- Overhead/LCD projector
- PowerPoint slides
- Flip charts
- Marker pens

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1.	Introduction to Module 19	Interactive Presentation
2.	Infection control and waste management in STI/RTI clinics	

SESSION 1

Introduction to Module 19

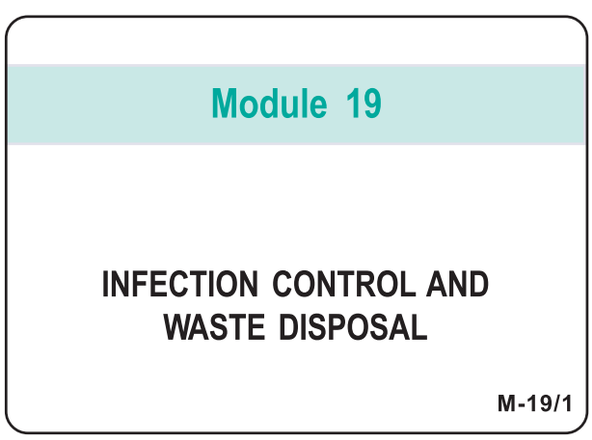
Objective:

At the end of this session, the participants will be able to:

- Provide an overview of this module including its objectives

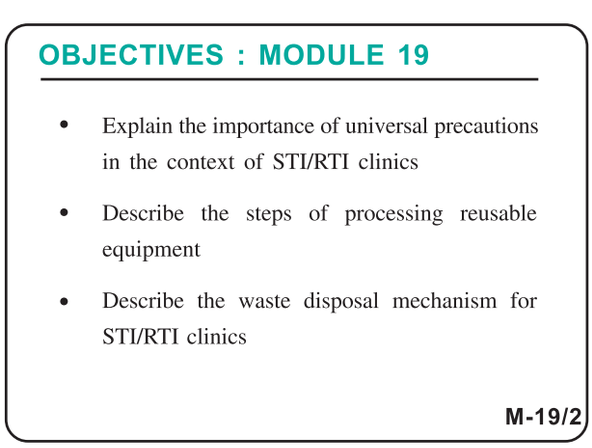
Show Slide 1 and tell the participants that in this module we are going to discuss infection control measures that are vital to every clinic.

Slide 1



Show Slide 2 and explain the objectives of the module.
State that infection control and waste disposal are essential components of quality health care services. Although not much importance is given to these services in many clinics, deficiencies in infection prevention and waste disposal can lead to dire consequences, even compromising people's lives.

Slide 2



SESSION 2

Infection control and waste management in STI/RTI clinics

Objectives:

At the end of this session, the participants will be able to:

- Explain the importance of universal precautions for controlling infection in STI/RTI clinics
- Describe the steps in processing reusable equipment
- Describe the waste disposal mechanism for STI/RTI clinics

Begin the session by showing Slide 3 and saying: "We all know that the purpose of following universal precautions and infection control measures are to:

Prevent transmission of infection to service providers

Prevent transmission of infection to other clinic staff such as instrument and trash-handlers

Prevent transmission of infection to other patients."

Slide 3

WHY INFECTION PREVENTION AND CONTROL

- To prevent transmission of infections to the service providers
- To prevent transmission of infections to other clinic staff such as the instrument and trash-handlers
- To prevent transmission of infections to other patients

M-19/3

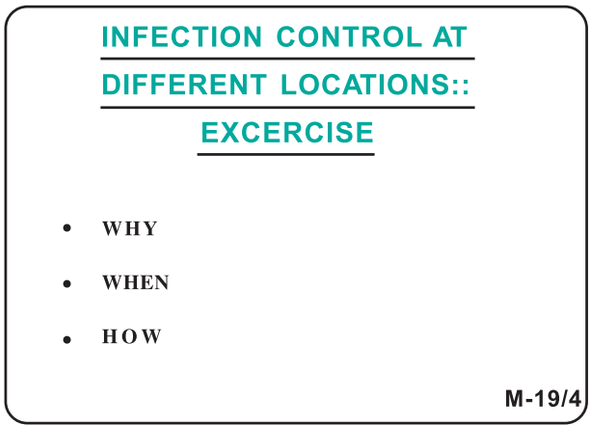
Now, tell the participants that we will discuss infection prevention measures through a game.

Divide them into 3 groups (or 2 groups, depending on the number of participants). Ask the participants to assume the role of doctors, nurses or laboratory technicians such that each group has at least one doctor, one nurse and one laboratory technician.

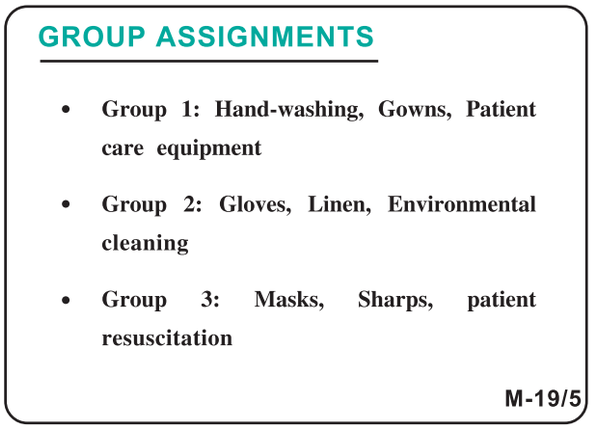
Show Slides 4 and 5 and explain the game. Say that each group will be assigned a topic on infection prevention/control. The groups are expected to respond to the 3 questions on Slide 4.

Allot 3-4 areas to each group as shown in Slide 5.

Slide 4



Slide 5



Allow the groups to discuss the issues for 5 minutes. Then go from group to group and let them share their findings on the allotted topics with the larger group.

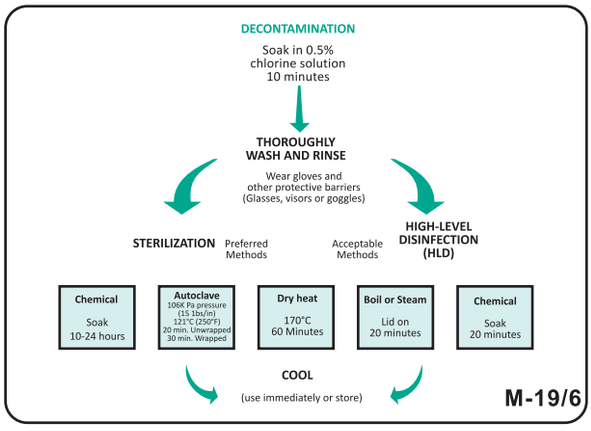
Encourage other groups to clap if any group provides a correct and complete response. If an important issue is missing from a group presentation, first give an opportunity to other groups to fill in the gap. If the groups are unable to list all the issues, the facilitator should add them and complete the discussion.

Finally, ask the participants to open Annexure VI on Page 61 of the "Operational Guidelines" and go through the 'Summary of universal precautions'.

Now ask the participants about the method followed for sterilization of instruments used in invasive procedures. Listen to their responses and appreciate correct and complete responses.

Show Slide 6 and explain the method recommended to process instruments and equipment in a stepwise manner (Annexure VII Page 62).

Slide 6



During the discussion on the first step – decontamination, ask the participants how 0.5 % chlorine is prepared?

Explain how chlorine solution is prepared. Now ask them: "Where should the chlorine solution be available?"

Expected responses include: the examination room, laboratory and other places where invasive procedures take place such as the injection room, first-aid room etc.

Clarify that every instrument/equipment that has come in contact with mucous membranes or body fluids of patients must be processed in a 0.5% chlorine solution, even if it is not to be re-used.

Emphasize that re-usable instruments soaked in chlorine solution must be thoroughly washed and rinsed to remove all the chlorine before they are further processed for sterilization or high-level disinfection (HLD).

Recommend that the participants note the processing time, temperature and pressure (where applicable) for each procedure of sterilization and HLD.

Now, ask the participants if they know how the waste materials in their clinics are disposed off.

Let 1-2 participants respond.

Ask them to open Page 23 of the "Operational Guidelines" and using Slide 7, clarify that in a clinic, the waste products should be segregated into 4 groups – sharps, infectious, pharmaceutical and general waste.

Waste materials from each of these groups need to be sorted on a day-to-day basis and collected in bags of the designated colour, bearing proper labels.

Show Slide 8 and explain each bullet point.

Re-emphasize that sharps must be decontaminated before disposal.

Recommend that the participants tie up with a good medical waste disposal agency or a nearby hospital for disposal of the waste generated in their clinics.

Slide 7

MANAGEMENT OF HAZARDOUS WASTE

- Sharps
- Infectious waste
- Pharmaceutical waste
- General waste

M-19/7

Slide 8

Clinic waste should be segregated as given below:		
Type of Waste	Colour of Bag	Label
Sharps waste	Blue /white	Danger,contaminated sharps
Infectious waste	Red	Infectious substances
Pharmaceutical waste	Black	**Toxic substances**
General Waste	-	

M-19/8

Post-exposure prophylaxis

Now, ask the participants if they are aware of the concept and management of post-exposure prophylaxis. If any of them know about it, allow her/him to explain it in 2-3 minutes. Appreciate correct and complete responses.

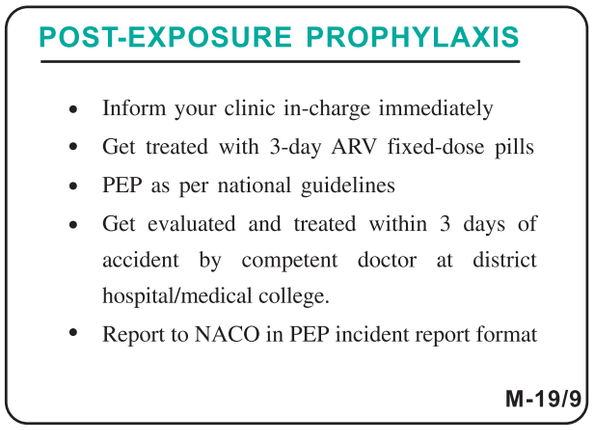
Show Slide 9 and state that if a staff member of the clinic is accidentally exposed to a patient's blood or body fluids, the staff member should receive prophylactic treatment for HIV according to the "National Guidelines".

Tell the participants that they should refer the exposed staff member to the nearest ICTC for further management. However, every clinic must have at least 3-day basic ARV fixed-dose pills containing Zidovudine and Lamivudine.

Say that it is absolutely essential to provide the exposed person with drugs as per the "National Guidelines" and refer her/him to experts at the district hospital or medical college for further management and counselling within 3 days of exposure.

NACO must be informed about accidental exposures in a prescribed PEP incident report format. Clarify that clinic staff must always be careful about accidental exposure to a patient's blood or body fluids, especially while dealing with sharps and laboratory specimens.

Slide 9



Emphasize: "Never take a chance, report the accidental exposure to your clinic in-charge immediately and get yourself treated promptly."

Module 20

Anaphylaxis Management and Referral Linkages

MODULE 20

Anaphylaxis Management and Referral Linkages

Learning objectives:

At the end of this module, the participants will be able to:

1. Explain the management of anaphylaxis
2. Explain the benefits of developing links with referral centres and field staff

Materials:

- Overhead / LCD projector
- PowerPoint slides for the session
- Flip charts
- Marker pens

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1.	Introduction to Module 20	Interactive Presentation
2.	Management of anaphylaxis	

SESSION 1

Introduction to Module 20

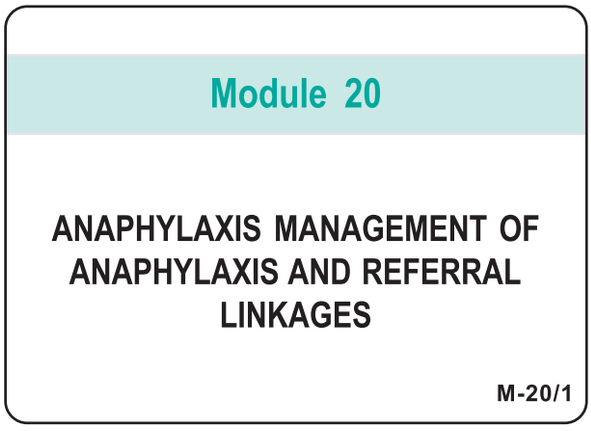
Objective:

At the end of this session, the participants will be able to:

- Provide an overview of this module including its objectives

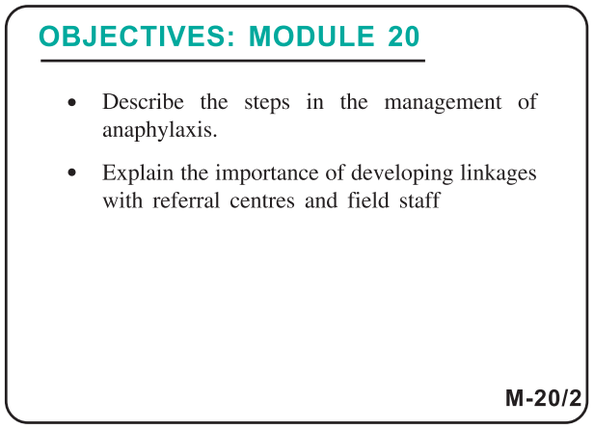
Show Slide 1 and introduce the topic of discussion of this module – the management of anaphylaxis including the development of linkages with referral centres.

Slide 1



Now, show Slide 2 and explain the objectives of the module.

Slide 2



SESSION 2

Management of anaphylaxis

Objectives:

At the end of this session, the participants will be able to:

- Describe the steps in the management of anaphylaxis
- Explain the importance of linking up with referral centres and field staff

Management of anaphylaxis

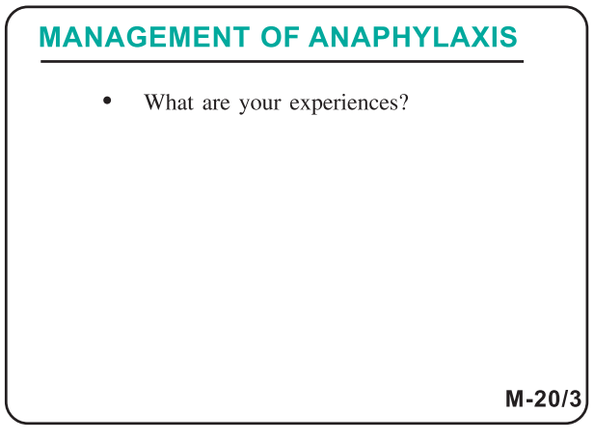
Ask the participants if they have seen or managed a patient who has had an anaphylactic reaction.

Show Slide 3.

If a participant has seen such a case, ask her/him to describe the symptoms and signs of anaphylaxis and how the case was managed.

It is possible that the participant/s will explain the entire process correctly and completely. If so, appreciate him/her.

Slide 3



Now, ask the participants about the symptoms and signs suggestive of anaphylaxis.

Show Slide 4 and clarify that it is not necessary for a patient to develop an anaphylactic shock and collapse every time. Often, patients just develop rashes and/or sometimes experience difficulty in breathing.

Nevertheless, an anaphylactic shock is an emergency situation wherein the provider needs to use her/his skills, knowledge and common sense to manage the situation.

Explain that a simple way to remember the steps to anaphylaxis management is to remember "ABC". If the service provider can maintain "ABC", the patient's life can be saved.

Show Slide 5 and explain the concept of "ABC".

Slide 4

SIGNS OF POSSIBLE ANAPHYLAXIS

- Shock
- Difficulty in breathing
- Itchy rash, hives

M-20/4

Slide 5

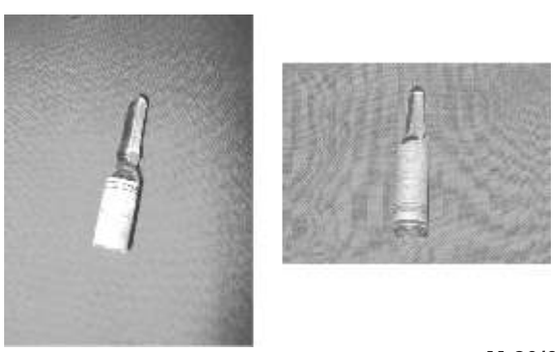
A-B-C OF ANAPHYLAXIS MANAGEMENT

- A – Airway
- B – Breathing
- C – Circulation

M-20/5

Now, show Slides 6 to 8 and ask the participants to see each figure and name the drug or instrument. In case it is a drug, say why it is given, in what dose and how frequently, and in case it is an equipment, describe how it is used.

Slide 6

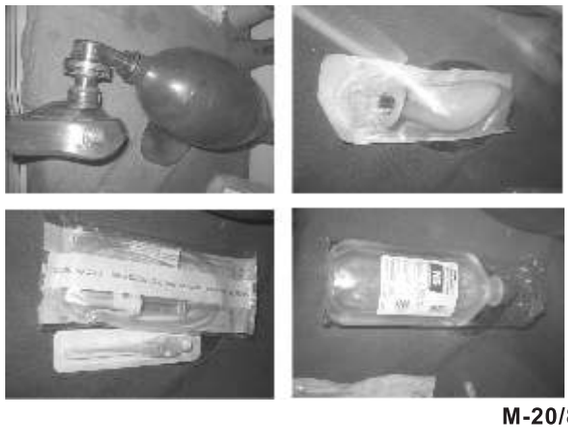


M-20/6

Slide 7

M-20/7

Slide 8



M-20/8

Now, show Slides 9 and 10, and explain each step in the clinical management of anaphylaxis.

Emphasize that if the clinic is not equipped with appropriate equipment and trained persons for handling anaphylactic shock, it is better to stabilize the patient using the basic emergency steps mentioned on Slides 9 and 10 and, in the meantime, make immediate arrangements to transport her/him to a competent clinic where facilities for handling such cases are available.

Slide 9

STEPS IN ANAPHYLAXIS MANAGEMENT

- Place patient in supine position with feet elevated.
- Monitor vital signs frequently (every five to ten minutes) and stay with the patient.
- Give cardiopulmonary resuscitation if appropriate, with securing of airway with oropharyngeal airway device.
- Give intramuscular aqueous adrenaline (epinephrine) 1:1,000 dilution 0.5 ml (0.5 mg). Usual site of injection is the upper arm. The site may be gently massaged to facilitate absorption. The dose may be repeated two or three times at 5 to 10 minute intervals. If anaphylaxis is caused by an injection, administer aqueous adrenaline, 0.15 ml, into injection site to inhibit further absorption of the injected substance.

M-20/9

Slide 10

STEPS IN ANAPHYLAXIS MANAGEMENT
Contd...

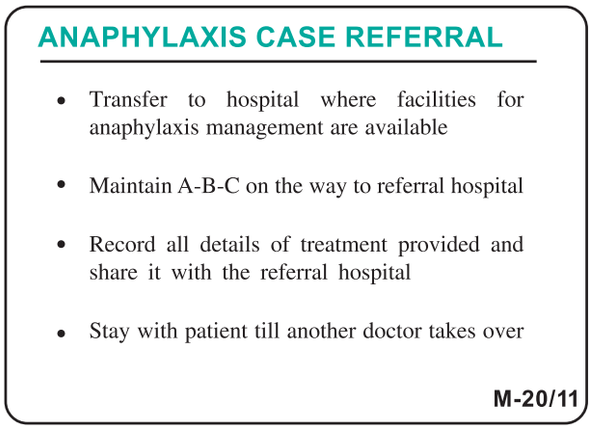
- Administer high flow oxygen if possible (8-10 L per minute).
- Start IV and give normal saline 1-2 L run at rapid rate.
- Antihistamine can be given by slow intravenous or intramuscular route: Diphenhydramine 25-50 mg or
- Chlorphenamine (chlorpheniramine) 10-20 mg.
- Give Hydrocortisone 250 mg by intravenous or intramuscular route. The benefit is not realized for 6-12 hours after administration; their primary role is in the prevention of recurrent or protracted anaphylaxis.
- Transfer to hospital immediately for continued emergency management. Ideally, the doctor should accompany the patient to the hospital to ensure immediate care on arrival.

M-20/10

Instruct the participants to be systematic and prompt when making referrals using the steps mentioned on Slide 11.

State that the doctor should accompany the patient to the referral hospital and keep the patient stable on the way. It is essential to provide a detailed referral form to such clients.

Slide 11

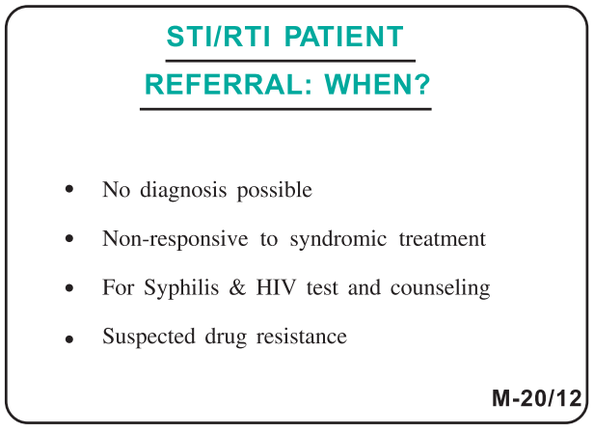


Finally, ask the participants to open Annexure V on 'Anaphylaxis Wall Chart' on Page 60 of the "Operational Guidelines".
State: "NACO has provided a simple wall chart as a reminder for management of anaphylaxis in your clinic in the form of a job aid. You may want to keep this wall chart in your clinic room for ready reference.

Linkages and referrals

Show the caption of Slide 12 and explain that there will be times when the clinic will have to refer patients to higher centres or referral hospitals.
Ask the participants to list such situations. Show the entire content of Slide 12, compare the participants' list with it, and complete the list.

Slide 12

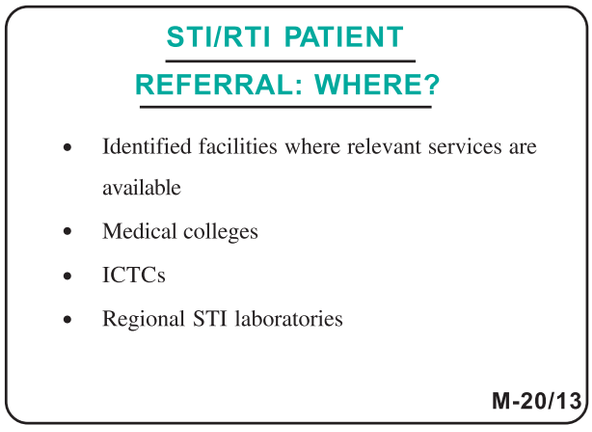


Show Slide 13 and clarify that the doctors at the Primary Health Centre or sub-district hospitals should not feel hesitant about patient referrals.

Although many STIs are not immediately life-threatening, providers must not keep experimenting with patients for a long time.

Patients must be referred to an appropriate facility depending on the type of service/s s/he needs.

Slide 13

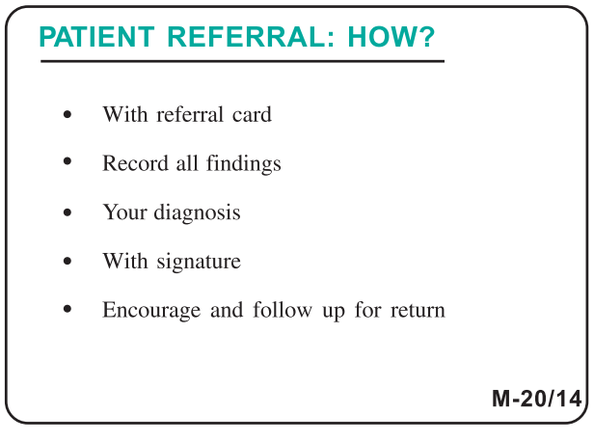


Further explain that the patients must be provided with a proper and prescribed referral card with all essential information noted on it.

Show Slide 14 and ask the participants to see Annexure XIV on 'Referral Form' on Page 74 of the "Operational Guidelines".

Give them 2 minutes to go through the format.

Slide 14



Finally, tell the participants that they should encourage the referred patient to come back to your clinic after availing the services at the referral centre/hospital. This will help you to know the diagnosis of the patient and to provide follow-up services, if needed.

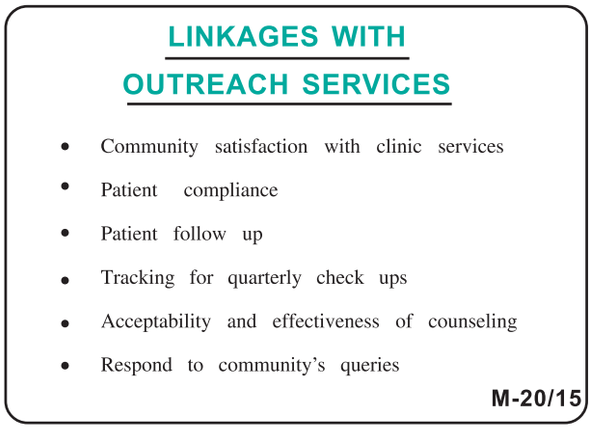
Also tell them that service providers in STI clinics must try to maintain at least the minimum quality standards recommended by NACO.

Further, they should also try to assess the community's perceptions in respect of service quality and the behaviour of service providers. A simple way of doing this is to keep in touch with the field staff on a regular basis.

Show Slide 15 and explain that maintaining linkages with the field staff has many advantages. It not only helps us to know the community's opinions about our staff and clinic but also helps in field follow-up of STI clients and their sexual partners. Thus, linkages with the field team can increase the overall effectiveness of the STI/RTI control and prevention programme.

The clinic in-charge should organize periodic meetings of the clinic staff and field staff for achieving better coordination and mutual support.

Slide 15



Module 21

Recording and reporting

MODULE 21

Recording and Reporting

Learning Objectives:

At the end of this module, the participants will be able to:

1. Explain the importance and process of managing STI/RTI clinic data
2. Discuss and practice the use of prescribed recording and reporting tools for STI/RTI services

Materials:

- Overhead / LCD projector
- PowerPoint slides for the session
- Flip charts
- Marker pens
- For distribution to participants:
- Copies of blank individual patient cards for STIs/RTIs
- Copies of blank monthly reporting formats for STIs/RTIs
- Copies of 5 case studies

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1.	Introduction to Module 21	Interactive Presentation
2.	Management of STI/RTI clinic data	

SESSION 1

Introduction to Module 21

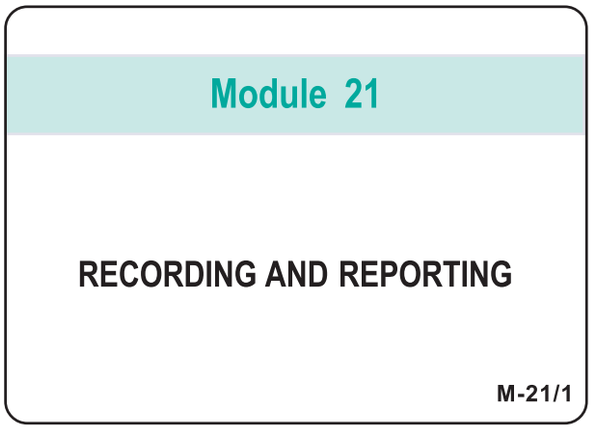
Objective:

At the end of this session, the participants will be able to:

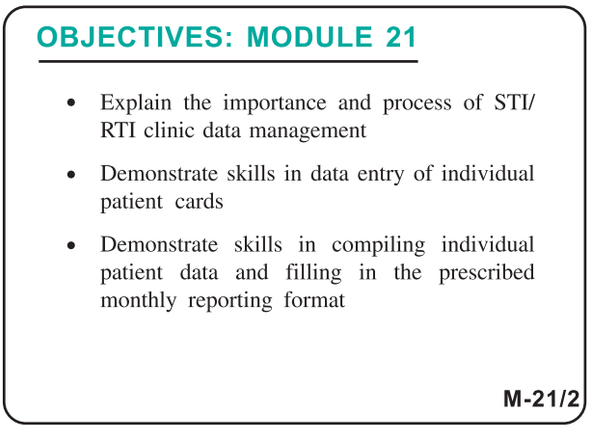
- Provide an overview of this module including its objectives

Show Slides 1 and 2 and say: "Recording and reporting of STI/RTI case management-related data is an essential function of every STI/RTI clinic. Let us discuss some important aspects of recording and reporting."
Explain each objective of the module on Slide 2, mentioning that we will do some hands-on practice of filling out reporting formats.

Slide 1



Slide 2



SESSION 2

Management of STI/RTI clinic data

Objectives:

At the end of this session, the participants will be able to:

- Explain the importance and process of STI/RTI clinic data management
- Demonstrate skills in data entry of individual patient cards
- Demonstrate skills in compiling individual patient data and filling in the prescribed monthly reporting format

Begin the session by asking the participants why data recording and reporting are important.

Let 2-3 participants respond.

Listen to their responses carefully. Many providers/staff seem to think that data are collected only for reporting to the higher authorities. If this point comes up in any of the responses, ensure that you clarify it during the discussion.

Show Slides 3 and 4 and explain that the different data sets that will be generated will help the clinic staff to track the overall progress of their clinic's STI control programme. For example, it will provide information about the spectrum of clients reporting to the clinic, what services were provided, how many patients got cured, etc.

The reports generated will also be useful for sharing details of the STI/RTI activities of your clinic with higher monitoring agencies such as SACS, NRHM and NACO.

Slide 3

RECORDS AND REPORTS

- WHY?
- WHAT?
- WHO?

M-21/3

Slide 4

WHY?

- To record and review overall progress of the program
- To report the status and progress to relevant agencies (SACS, NACO, NRHM etc)
- To celebrate the achievements as well as make plans for sustaining high performance or improving low performance.

Remember, you should be the first user of your data. So, use data at the local level to track progress and making improvements. Do not wait for feedback from others.

M-21/4

Now, say: "It is possible that the higher agencies such as SACS/NACO/NRHM might send you some feedback on your clinic performance. However, it is most essential for the clinic-in-charge and his team to compile and analyze their data and monitor their own performance by using certain key indicators.

"Thus, if the team at the local STI/RTI clinic level, starts using its own data to identify the strengths of and gaps in its programme, it will not have to depend on feedback from any other authority. Instead, the clinic in-charge and his team themselves will be able to plan and fill the gaps to improve the quality of their services.

"Now, let us find out what different sets of data a clinic team will have to gather and compile on a day-to-day basis from various level of health facilities."

Show Slide 5 and explain that what data and different format that we need to keep & collect from different levels of health facilities, what are the record keeping formats at various level of health facilities. It also explains about detailed information for every STI/RTI client daily.

Information generated from the individual patient cards, registers are compiled as monthly report.

Slide 5

Minimum records to be maintained at NRHM facility*	Minimum records to be maintained at Designated STI/RTI clinic	Minimum records to be maintained at Targetted Intervention Projects (Static/Preferred Provider clinics)
OPD register	Patient Wise Card	Patient Wise Card
Referral form	STI register	Patient register
Drug register	Counselors Patient Diary	Patient wise STI/RTI drug distribution
Laboratory Register	Indent form	Weekly/Daily Drug Record
NRHM Monthly Reporting Format	Stock Register	Indent Register
	Referral form	Referral form
	STI/RTI Monthly Reporting Format	STI/RTI Monthly Reporting Format

M-21/5

WHAT?

- **Individual patient record**
- **Monthly report – formats**
  - No. of patients who availed services
  - STI syndrome diagnosed and treated
  - Details of counseling, condom, lab tests, partner treatment etc.
  - Service provision to HRG
  - ANC syphilis screening
  - Lab diagnosis
  - Human resources details

M-21/5

Now, show Slide 6 and clarify that collection, compilation and analysis of patient data on a routine basis is a shared responsibility of the clinic staff. However, information regarding the specific activities of different sections of the clinic will come from their respective personnel. For example, the doctors will be responsible for completing the individual patient cards, the laboratory technicians will report the results of the prescribed laboratory tests and the status of consumables, the nurse will report on drug consumption, counselling etc.

Finally, emphasize that data compilation and reporting is "team work" and every staff member must proactively contribute to these efforts.

Slide 6

WHO?

- It is a "team work" under the leadership of the clinic in-charge.
- To be filled up at all STI/RTI clinics – Designated clinics, NRHM sub district health facilities and HRG – TI clinics

M-21/6

Now, tell the participants that we will discuss individual formats in small groups and actually practice data entry in some of the formats prescribed in the "Operational Guidelines" on page 49 & at Annexure XV page 76. Records & reports to be maintened by following STI/RTI health care facilities :

1. Designated STI/RTI clinic - Page 77 to 88 & monthly report on page 97 to 108.
2. Targeted Intervention project- page 89 to 96 & monthly report on page 97 to 108.
3. NRHM sub district health facilities- page 109 to 110 & monthly report on page 111 to 115.

Show Slides 20 and 21 and explain the instructions for small group work. Ensure that there is at least one facilitator for each small group of about 5 participants.

SESSION 3

Recording and Reporting Formats at Designated STI/RTI Clinic

Objectives:

By the end of the session, participant will be able to:

- Understand the process of filling the STI/RTI records and STI/RTI Monthly Report to be filled at Designated STI/RTI clinic.
- The trainer should explain to the participants about all the STI/RTI records which need to be maintained at the designated clinic .The trainer should also ask the participants to fill each of the formats.
- The trainer should explain about filling of Monthly STI/RTI reporting format for the designated STI clinic. The Trainer should also ask the participant to fill monthly report manually.

Note: The trainer should explain ONLY Designated STI/RTI clinic recording and reporting format while training the trainees of Designated STI/RTI clinic.

Recording and Reporting Formats for Designated STI/RTI Clinic

Slide 7

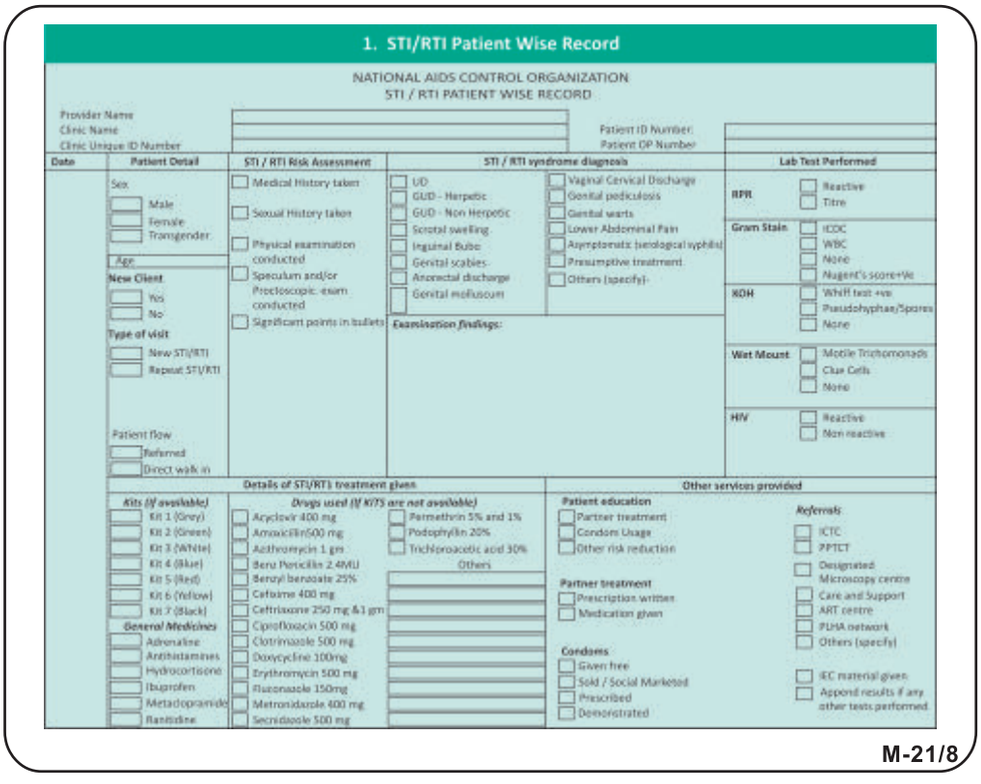
Records and Reports of Designated STI/RTI Clinic.

1 Patient Wise Card
2 STI/RTI Register
3 Counsellors Diary
4 Indent Form
5 Stock Register
6 Referral Form
7 STI/RTI Monthly Reporting Format

M-21/7

- The trainer should explain about all the record and reports that are to be maintained at Designated STI/RTI clinic these includes Patient wise card, STI Register, Counsellors Diary, Indent Form, Stock Register, Referral Form and STI/RTI Monthly Reporting Format.
- The trainer should explain to the participants how to fill these formats.

Slide 8



1. STI/RTI Patient Wise Record

NATIONAL AIDS CONTROL ORGANIZATION
STI / RTI PATIENT WISE RECORD

Provider Name
Clinic Name
Clinic Unique ID Number
Patient ID Number
Patient OP Number

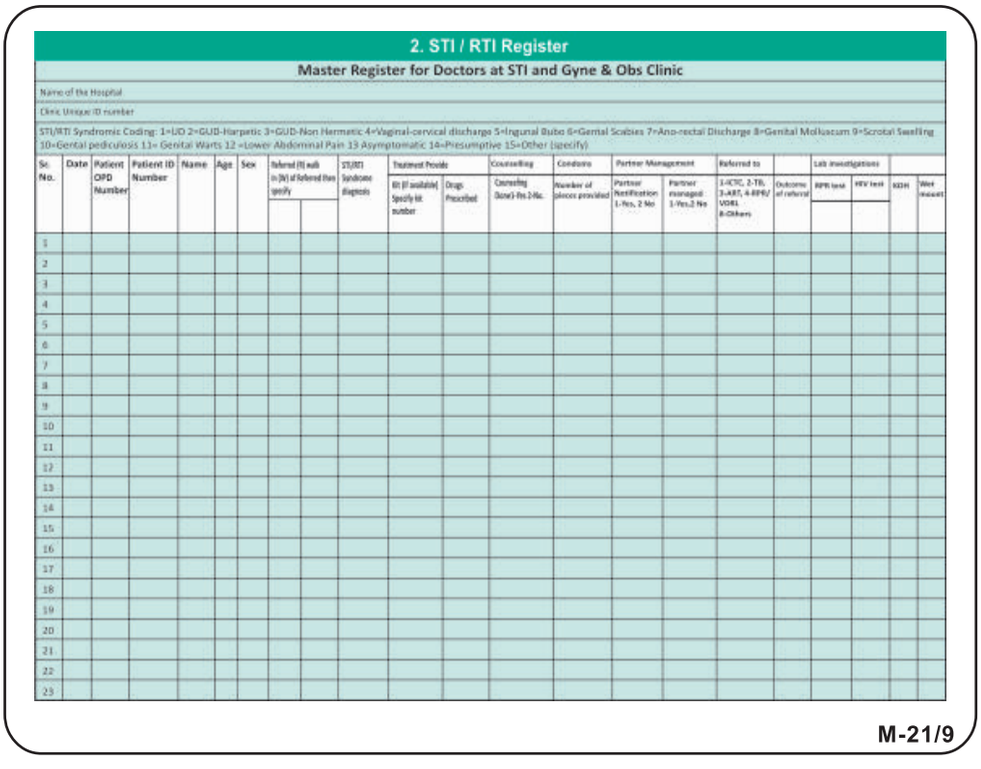
Date	Patient Detail	STI / RTI Risk Assessment	STI / RTI syndrome diagnosis	Lab Test Performed
	Sex: Male, Female, Transgender Age New Client: Yes, No Type of visit: New STI/RTI, Repeat STI/RTI Patient flow: Referred, Direct walk in	Medical History taken Sexual History taken Physical examination conducted Speculum and/or Proctoscopic exam conducted Significant points in bullets	UD GUD - Herpetic GUD - Non Herpetic Scrotal swelling Inguinal Bubo Genital scabies Anorectal discharge Genital molluscum Vaginal Cervical Discharge Genital pediculosis Genital warts Lower Abdominal Pain Asymptomatic (serological syphilis) Presumptive treatment Others (specify)- Examination findings:	RPR: Reactive, Titre Gram Stain: ICOC, WBC, None, Nugent's score+ve KOH: Whiff test +ve, Pseudohyphae/Spores, None Wet Mount: Motile Trichomonads, Clue Cells, None HIV: Reactive, Non reactive

Details of STI/RTI treatment given			Other services provided	
Kits (If available)	Drugs used (If KITS are not available)		Patient education	Referrals
Kit 1 (Grey)	Acyclovir 400 mg	Permethrin 5% and 1%	Partner treatment	ICTC
Kit 2 (Green)	Amoxicillin500 mg	Podophyllin 20%	Condom Usage	PPTCT
Kit 3 (White)	Azithromycin 1 gm	Trichloroacetic acid 30%	Other risk reduction	Designated Microscopy centre
Kit 4 (Blue)	Beru Penicillin 2.4MU	Others	Partner treatment	Care and Support
Kit 5 (Red)	Benzyl benzoate 25%		Prescription written	ART centre
Kit 6 (Yellow)	Cefixime 400 mg		Medication given	PLHA network
Kit 7 (Black)	Ceftriaxone 250 mg &1 gm		Condoms	Others (specify)
General Medicines	Ciprofloxacin 500 mg		Given free	IEC material given
Adrenaline	Clotrimazole 500 mg		Sold / Social Marketed	Append results if any other tests performed
Antihistamines	Doxycycline 100mg		Prescribed	
Hydrocortisone	Erythromycin 500 mg		Demonstrated	
Ibuprofen	Fluconazole 150mg			
Metaclopramide	Metronidazole 400 mg			
Ranitidine	Secnidazole 500 mg			

M-21/8

- The guidelines for filling of patient wise card can be obtained from Operational Guidelines for Programme Managers and Service Providers for Strengthening STI/RTI services May 2011 from page 78-83. The guidelines should be read out.

Slide 9



2. STI / RTI Register

Master Register for Doctors at STI and Gyne & Obs Clinic

Name of the Hospital
Clinic Unique ID number

STI/RTI Syndromic Coding: 1=UD 2=GUD-Herpatic 3=GUD-Non Hermetic 4=Vaginal-cervical discharge 5=Inguinal Bubo 6=Genital Scabies 7=Ano-rectal Discharge 8=Genital Molluscum 9=Scrotal Swelling 10=Genital pediculosis 11= Genital Warts 12 =Lower Abdominal Pain 13 Asymptomatic 14=Presumptive 15=Other (specify)

Sr. No.	Date	Patient OPD Number	Patient ID Number	Name	Age	Sex	Referred (R) walk in (W) if Referred then specify		STI/RTI Syndrome diagnosis	Treatment Provide: Kit (If available) Specify kit number	Treatment Provide: Drugs Prescribed	Counselling: Counselling Done(1-Yes,2-No.	Condoms: Number of pieces provided	Partner Management: Partner Notification 1-Yes, 2 No	Partner Management: Partner managed 1-Yes,2 No	Referred to: 1-ICTC, 2-TBL, 3-ART, 4-RPR/ VDRL 8-Others	Outcome of referral	Lab investigations: RPR test	Lab investigations: HIV test	KOH	Wet mount
1																					
2																					
3																					
4																					
5																					
6																					
7																					
8																					
9																					
10																					
11																					
12																					
13																					
14																					
15																					
16																					
17																					
18																					
19																					
20																					
21																					
22																					
23																					

M-21/9

Slide 10

3. Counselors Patient Dairy

S. No.	Date	STI-PID No.	New / Repeat	Age	Sex	Occupation	Education	Patient Complaints	Important points in sexual & Personal history	Interventions by Counselors	Other Remarks
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											

M-21/10

Slide 11

4. Indent Form

Name of the Hospital :

Clinic Unique ID number:

Sl No.	Name of the Drug	Balance on the day of indent	Amount to be indented (Date)	Amount received (Date)	Remark
1	Kit 1				
2	Kit 2				
3	Kit 3				
4	Kit 4				
5	Kit 5				
6	Kit 6				
7	Kit 7				
8	RPR Test kits				

Note:

1. The clinic must have supply of drug for at least three months.
2. There should be a critical level of stock for each STI/RTI drugs & kits.
   Whenever supply reaches less than one quarter of supply the drug should be indented.
3. The Clinic should follow the policy of FEFO (First Expiry First Out).

Signature
Counsellor

Signature
STI Clinic Incharge

Signature
Issuing authority at SACS

M-21/11

Slide 12

5. Stock Register

_____ STATE AIDS CONTROL SOCIETY

Format for Stock Register for STI Clinic

Name of Test/Drugs/Consumable _____

Date	Opening Stock	Number received this month	Number of tests performed	Wastage if any	Closing Stock	Number requested	Date of placing request

M-21/10

Slide 13

STI/RTI Referral Form

(To be filled and handed to the client by STI/RTI Counselor/Nurse)

Referral to

ICTC/Chest & TB/Laboratory_____

The patient with the following details is being referred to your center.

Name:_____ Age_____ Sex:_____

STI/RTI-PID No:_____

Kindly do the needful

Referring Provider

Name:_____ Designation:_____

Contact Phone:_____Date of referral:_____

(To be filled and retained at referral site so as to be collected by STI/RTI counselor/Nurse weekly)

The above patient referred has been provided ICTC/TB/RPR/VDRL/_____ services and the patient has been tested/diagnosed/treated for_____

The test/results of RPR/VDRL/is/are_____

Signature of the Medical Officer/Counselor/Lab In-charge

M-21/13

- The trainer should explain how to fill format from Flipchart IX-2-7; all these formats are self explanatory.

Slide 14A

Monthly STI/RTI

Unique ID. No. of STI/RTI Clinic /Gynae OPD /TI NGO	

MONTHLY REPORT FORMAT FOR STI/RTI CLINICS

Name of STI/RTI Clinic/ Hospital to which the Gynecology OPD is Attached/ TI NGO					
Sub Type		Category		Location	
Address :					
District :		Block :		City :	
Reporting Period :	Month(MM) :		Year(YYYY) :		
Name of Officer In - charge :					
Phone no. of Officer In - charge :					

Section 1 : No. of Patients Availed STI/RTI services in this month

Type of Patients	Age Group & Sex												Total		
	<20			20-24			25-44			>44					
	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG
Clinic visit with STI/RTI complaint and were diagnosed with an STI/RTI															
Clinic visit with STI/RTI complaint but were NOT diagnosed with an STI/RTI. • Clinic visit for Syphilis Screening (Excluding ANC) • For TI-NGOs-RMC, PT, Syphilis Screening (whichever applicable)															
Follow up visit for the index STI/RTI complaint															
Total No of visits															

Section 2 : STI/RTI syndromic diagnosis

(Should be filled by all STI/RTI service providers for clinic visit for STI/RTI complaint only)

Diagnosis (Age Group & Sex)	Male	Female	TS/TG	Total
1. Vaginal/ Cervical Discharge(VCD)				
2. Genital Ulcer (GUD) - non herpetic				
3. Genital ulcer(GUD) – herpetic				
4. Lower abdominal pain (LAP)				
5. Urethral discharge (UD)				
6. Ano-rectal discharge (ARD)				
7. Inguinal Bubo (IB)				
8. Painful scrotal swelling (SS)				
9. Genital warts				
10. Other STIs				
11. Serologically + ve for syphilis				
Total No of episodes				
No of people living with HIV/AIDS (PLHAs) who attended with STI/RTI complain during the month				

Section 3. Details of other services provided to patients attending STI/RTI clinics in this month

To be filled in by all STI/RTI Service Providers

Service	Male	Female	TS/TG	Total
1. Number of patients counseled				
2. Number of condoms provided				
3. Number of RPR/VDRL tests conducted				
4. Number of patients found reactive				
5. Number of partner notification undertaken				
6. Number of partners managed				
7. Number of patients referred to ICTC				
8. Number of patients found HIV-infected (of above)				
9. Number of patients referred to other services				

Section 4 : STI/RTI service for HRGs in the month (To be filled in by TI NGO)

	Male	Female	TS/TG	Total
Number of new individuals visited the clinic				
Number of Presumptive Treatments (PT) provided for gonococcus and Chlamydia				
Number of regular STI check-ups (RMC) conducted (check-up including internal examination of HRGs once in a quarter)				

M-21/14A

Slide 14B

Section 5 : ANC syphilis screening in this month	
Should be filled by all service providers with ANC service provision	**Total**
Number of ANC first visits in the month (Registration)	
Number of rapid plasma reagin RPR/VDRL tests performed	
Number of RPR/VDRL tests reactive (Qualitative)	
Number of RPR/VDRL tests reactive above >=1:8 (Quantitative)	
Number of pregnant women treated for syphilis	

Section 6 : Laboratory diagnosis of STI/RTI				
Laboratory diagnosis/Tests	**Male**	**Female**	**TS/TG**	**Total**
1. Total RPR/VDRL tests performed				
RPR tests reactive >= 1:8				
2. Total Gram stain performed				
Gonococcus + (gram negative intracellular diplococci +)				
Non-Gonococcus urethritis (NGU)-Pus cells +ve				
Non-Gonococcus cervicitis (NGC)-Pus cells +ve				
None				
Nugents score +ve				
3. Wet mount test performed				
Motile Trichomonads +ve				
Whiff test +ve				
Clues cells +				
None				
4. KOH test performed				
Candidiasis				
None				
5. Availability of consumables (Yes=1, No=2)				
Do you have STI pre-packed kits?				
Functional Computer				
AMC of Computer				

Section 7 : Drugs & Consumables								
Drugs & Consumables	Opening stock	Number received this month	Consumed	Damage/ Wastage	Closing stock	Stock Sufficient for approx months	Earliest Expiry Date (Month/Year)	Quantity
RPR tests								
Pre-packed STI Kit 1								
Pre-packed STI Kit 2								
Pre-packed STI Kit 3								
Pre-packed STI Kit 4								
Pre-packed STI Kit 5								
Pre-packed STI Kit 6								
Pre-packed STI Kit 7								
Condom Pieces								
Reagent for gram stain								
Reagents for wet mount and KOH test								
Others								

Section 8 : Details of Staff at the STI/RTI clinics					
Human resource details at STI/RTI and /or Gynaecology clinics (Should be filled by all STI/RTI clinics)					
Staff	**Number Sanctioned**	**Number in place**	**Number of Person Trained during month**		
			Induction	**Refresher**	**Others**
Medical Officer					
Staff Nurse					
Laboratory Technicians					
Counsellor					

M-21/14B

- The guidelines for filling of STI/RTI Monthly Report can be obtained from Operational Guidelines for Programme Managers and Service Providers for Strengthening STI/RTI Services, May 2011 from page 99-108. The guidelines should be read out.
- The trainer should ensure that each of the participant has filled the monthly STI/RTI format manually and should ensure each of the participant have understood filling of format correctly.

SESSION 4

Recording and Reporting Formats at Sub-District Health Facilities

(PHC/CHC/Block PHC, Sub-divisional hospital, urban Health centre etc.)

Objectives:

By the end of the session, participant will be able to:

- Understand the prototype and process of filling the STI/RTI records and STI/RTI Monthly Report to be filled at Sub-district Health Facilities (PHC/CHC/Block PHC, Sub-divisional hospital, urban Health centre etc)
- The trainer should explain to the participants about all the STI/RTI records which need to be maintained at the Sub-district health facilities (PHC/CHC/Block PHC, Sub-divisional hospital, urban Health centre etc).
- It should be emphasised that no new recording formats are required to be created. The Nursing Staff will maintain the records in existing registers of the facility by adding columns/pages. The prototype of the STI/RTI record keeping is explained in the next session. The trainer should also ask the participants to fill each of the formats.
- The trainer should explain about filling of Monthly STI/RTI reporting format from NRHM facilities. The Trainer should also ask the participant to fill monthly report manually.

  NOTE: The trainer should explain ONLY Sub-district the health facility (PHC/CHC/Block PHC, Sub-divisional Hospital, Urban Health etc) recording and monthly reporting format to the trainee of sub-district health facility.

Recording and Reporting Formats for Sub-district Health Facilities (PHC/CHC/Block PHC/Sub-divisional hospital, Urban Health Centre etc):

Slide 15

Records to be maintained at NRHM facility (PHC/CHC/Block PHC, Sub-divisional Hospital, Urban Health etc).

1 OPD register
2 Referral Form
3 Drug Register
4 Laboratory Register
5 Monthly STI/RTI NRHM Report

M-21/15

- The trainer should explain about all the record and reports that are to be maintained at Sub-district health facility (PHC/CHC/Block PHC, Sub-divisional Hospital, Urban Health etc), these includes OPD Register, Referral Form, Drug Register, Laboratory Register and Monthly STI/RTI NRHM Reporting format.
- The trainer should explain to the participants how to fill these formats.

Slide 16

Patient Register for STI/RTI Services

S. No.	Date	Name	Age	Sex	Diagnosis
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

M-21/16

- The OPD register and other existing record maintained in PHC/CHC/Block PHC etc should be utilised for maintaining records pertaining to STI/RTI. The physician should indicate the syndromic diagnosis in the OPD register.

Slide 17

Drug Stock record format				
Drugs	Opening stock (1st of every month)	Number received this month	Consumed	Closing stock (last day of every month)
Prepacked sTi Kit 1				
Prepacked sTi Kit 2				
Prepacked sTi Kit 3				
Prepacked sTi Kit 4				
Prepacked sTi Kit 5				
Prepacked sTi Kit 6				
Prepacked sTi Kit 7				

M-21/17

Slide 18

Syphilis screening of pregnant women or STI/RTI patients							
S.No.	Date	Name	Age	Sex	Patient details (STI patient or ANC Mother)	Syphilis test: RPR/VDRL	Test results for syphilis
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

M-21/18

- The existing drug maintenance register and laboratory register used in the PHC/CHC/Block PHC etc should be used for recording purpose. Only relevant column/page should be added to the pharmacy and laboratory records so as to collect data pertaining to drug stock and laboratory testing.

Slide 19

Unique ID. No. of District					
STI/RTI MONTHLY REPORTING FORMAT FROM NRHM FACILITIES IN DISTRICT					
Name of District /CHC/PHC/Others					
Number of NRHM facilities to report in the district					
Number of Units reported in this month					
Reporting Period :	Month (MM) :		Year (YYYY) :		
Name of Officer In - charge :					
Phone no. of Officer In – Charge :					

Section 1 : No. of Patients Availed STI/RTI services in this month			
	Total		
	Male	Female	Total
No. of patients diagnosed and treated for various STI/RTI			

Section 2 : Syndromic diagnosis and investigation details (Should be filled by Officer in-charge)			
Diagnosis	Male	Female	Total
1.Vaginal/Cervical Discharge			
2.Genital Ulcer (GUD)-non Herpetic			
3.Genital Ulcer (GUD) – Herpetic			
4.Lower Abdominal Pain(LAP)			
5.Urethral Discharge (UD)			
6.Ano-rectal discharge (ARD)			
7.Inguinal Bubo (IB)			
8.Painful Scrotal Swelling (SS)			
9.Genital warts			
10.Other STIs			
11. Serologically +ve for syphilis			
Investigations			
12. Number of STI/RTI patients tested for syphilis (RPR/VDRL)			
13. Of Above, Number of STI/RTI patients found reactive for syphilis			
14. Number of STI/RTI patients referred for HIV testing			
15. Of above, Number of STI/RTI patients found HIV reactive			
16. Number of STI/RTI patient tested for wet mount			

Section 3. Details of syphilis screening of Pregnant women			
Service	Male	Female	Total
1. Number of Pregnant women screened for syphilis (VDRL/RPR test)			
2. Of above, Number of Pregnant women found reactive			

Section 4 : Status of Drugs & test kits	
Drugs & test kits	No. of kits Available
Prepacked STI Kit 1	
Prepacked STI Kit 2	
Prepacked STI Kit 3	
Prepacked STI Kit 4	
Prepacked STI Kit 5	
Prepacked STI Kit 6	
Prepacked STI Kit 8	
RPR/VDRL Tests Kit	

M-21/19

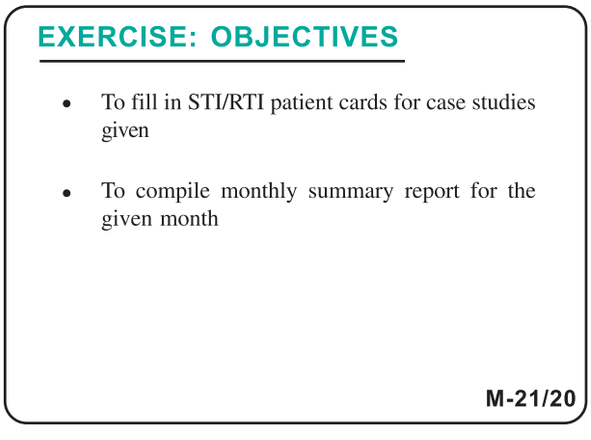
- The process of STI/RTI monthly report collection and further transmission should be discussed:
  - The monthly reports should be generated at PHC by ANM/Staff nurse/Medical officer with the help of computer operator/lower division clerk and transmitted to CHC and compiled at the district level by the district RCH Officer with the help of data entry operator.
  - District RCH Officer will consolidate the data in the monthly HMIS/NACO SIMS reporting format and forward the same to SACS and SPMU by 5th of every month.

- The guidelines of filling of STI/RTI monthly reporting format from NRHM facilities can be obtained from Operational Guidelines for Programme Managers and Service Providers for Strengthening STI/RTI services May 2011 from page 112-115. The guidelines should be read out.
- The trainer should ensure that each of the participant has filled the monthly STI/RTI format manually and should ensure each of the participant have understood filling of format correctly.

Explain that each group will be given 5 case studies of 5 STI clients (Slides 22 to 26) along with 5 blank individual patient cards. Each group has to fill up a patient card for each case/STI client, based on the information provided in the case studies, and reading through the instructions/guidelines for filling up the individual patient cards.

Clarify that the groups must proceed systematically and in a stepwise manner while entering the information in the patient card because even one small mistake would mean revisiting the cases again and having to spend more time. So, it is all right if they are a little slow but they should be accurate and methodical.

Slide 20



Slide 21

STI/RTI PATIENT CARD – SMALL GROUP WORK

- Divide into 4 groups, each with a facilitator
- Each of the participants will be given copies of the STI/RTI patient card along with guidelines for filling in
- Please read the guidelines carefully
- Please fill in the patient cards for the 5 case studies given
- Group facilitators will conduct a group discussion
- Time for the small group work: 60 minutes

M-21/21

Suggest that one of the participants loudly read the case description and guidelines for filling up the format and the remaining participants enter the data for at least one case. This will help all the participants to practice data entry of the individual patient card. The group as a whole must fill up individual patient cards for all 5 cases.

Slide 22

CASE NO. 1

Ramu is a 20 year-old bachelor who has come to a STI clinic for the first time. He has a complaint of a penile discharge and dysuria. He denies H/O exposure. Examination shows clear urethral discharge, no other findings. Gram stain of discharge shows 8 PMN/hpf but no intracellular diplococci. He is given treatment, demonstrated correct condom use and given free condoms.

M-21/22

Slide 23

CASE NO. 2

Ramu comes back after a week, saying that his symptoms have not been relieved. He says he has taken the drugs you gave him and has not had sex in the last week. Examination confirms presence of urethral discharge. He is given treatment and advised to get his sexual partners treated. Consistent condom use is reiterated.

M-21/23

Slide 24

CASE NO. 3

Rani, a 28 year old street-based sex worker comes to a TI clinic complaining of vaginal discharge. She had similar complaints 3 months ago for which she was treated. Examination shows white-colored vaginal discharge, fishy odor, cervix is normal, not tender. On site laboratory is not available. She is treated and given free condoms. She is advised to get her regular partner for treatment. She is also referred to the ICTC.

M-21/24

Slide 25

CASE NO. 4

Lakshmi, an 18 year-old transgender comes to a TI clinic for a routine check up, accompanied by a peer educator. This is her third visit to the clinic over a period of 6 months. At her first visit, she was given presumptive treatment. She complains of a mild cough for 3 days, examination including proctoscopy is normal. RPR screening is advised (no onsite laboratory), she is given treatment and free condoms.

M-21/35

Slide 26

CASE NO. 5

Pushpa, a 32 year-old housewife, a 2nd **gravida is** referred from the ANC to the STI clinic because her blood test showed a VDRL reactive in 1:16 titre, TPHA test is not available. She is accompanied by her husband who admits to having a casual sexual encounter about a year ago. Pushpa and her husband have no symptoms or signs. They are treated, demonstrated correct condom use and given free condoms. She is also referred to the ICTC.

M-21/26

When all the participants and groups have completed the data entry, suggest that they exchange the completed cards with other members of their group and check the accuracy of each other's entries.

The facilitator/s should try to follow the above-mentioned method for group work and provide need-based guidance and clarification during the group exercise.

When all the groups are ready with all 5 individual patient cards, ask them their reactions about the ease in filling up the patient cards. Ask them how much time it takes for completing one card?

Clarify that while dealing with actual clients, the data will be directly entered in the patient cards, and with a little practice, it will not take extra time to fill up the cards.

Emphasize that it is extremely important to enter every service provided to the client. This is because these cards will ultimately establish the quality of services provided by the clinic.

Ask the participants to stay in the group and move on to the next activity.

Next, tell the participants that the data from the individual patient cards will be compiled in a monthly reporting format and these reports will be submitted to SACS every month.

Distribute copies of blank monthly report formats to the participants. Ask them to open Page 97 & 108 of the "Operational Guidelines" which gives instructions for filling up the monthly format.

Show Slide 14 and explain that within the next 30 minutes, the groups will have to transfer the data from the individual patient cards to the monthly reporting format using the instructions provided in the "Operational Guidelines".

Let the group work begin. The facilitator/s should assist the groups in data compilation.

After 30 minutes when all the groups have completed the exercise, ask for participant reactions about the process of data compilation. Respond to their queries and concerns, if any.

Slide 27

MONTHLY SUMMARY REPORT

- Please stay in your small groups
- Each participant will be given a copy of the monthly summary report along with guidelines for filling it in
- Please read the guidelines carefully
- Please fill in the monthly summary report for the 5 cases given earlier
- Group facilitators will conduct a group discussion
- Time for the small group work: 30 minutes

M-21/27

Module 22

Monitoring and Supervision

MODULE 22

Monitoring and Supervision

Learning Objective:

At the end of this module, the participants will be able to:

1. Appreciate the importance of supportive supervision and monitoring in the STI/RTI programme

Materials:

- Overhead/LCD projector
- PowerPoint slides for the session
- Flip charts
- Marker pens
- Copies of the supervisory checklist.

Preparation by facilitator:

- Read through the content of the session, PowerPoint slides and reference materials thoroughly.
- Become familiar with the content and its flow.
- Discuss the session beforehand with your co-facilitator and ensure her/his readiness to assist you during the session.

Module outline

Session No.	Topic	Methodology
1	Introduction to Module 22	Interactive Presentation and Group work
2	Importance of supervision and monitoring	
3	Supervisory tools and their use	
4	Monitoring and use of STI/RTI clinic data	

SESSION 1

Introduction to Module 22

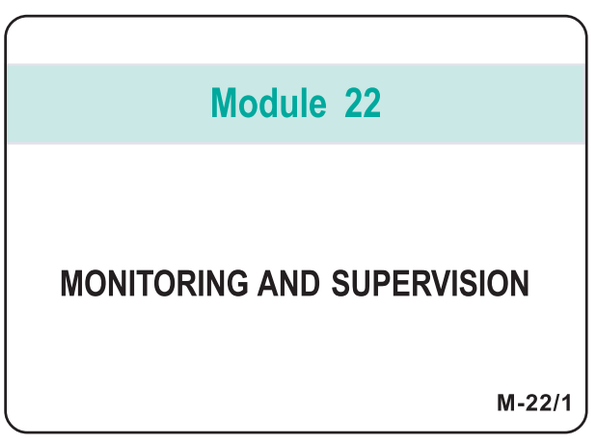
Objective:

At the end of this session, the participants will be able to:

- Provide an overview of this module including its objectives

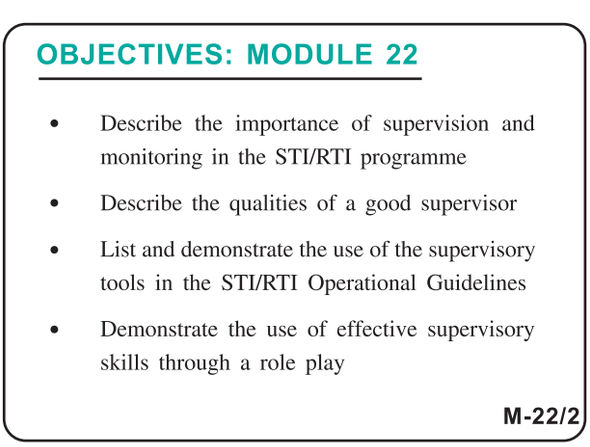
Begin the session by saying that monitoring and supervision are the pillars of a successful programme. Show Slide 1 and state that we will now discuss monitoring and supervision mechanisms related to STI/RTI control and prevention.

Slide 1



Now, show Slide 2 and explain the objectives of the module by saying: "The discussion on monitoring and supervision will include some basic facts about the supervision process, the qualities and prerequisites of a good supervisor, and the tools and indicators recommended by NACO-NRHM for monitoring the STI/RTI prevention, management and control programme."

Slide 2



SESSION 2

Importance of supervision and monitoring

Objectives:

At the end of this session, the participants will be able to:

- Describe the importance of supervision and monitoring in the STI/RTI program
- List the tools for monitoring and supervision

Ask the participants to open Page 29 of the "Operational Guidelines" and also share Slide 4. Explain that simple tools are available for monitoring programmes. Clarify that every piece of data available in the STI/RTI clinic is useful for monitoring purposes.

Take the example of the individual patient record card. Tell the participants that a mere close observation of 4-5 random patient data cards will provide valuable information about the quality of services. Or, taking a look at even one small piece of information such as "diagnosis and treatment", can throw light on the quality of treatment provided by the clinic.

Therefore, it is important for the supervisor to ensure that data entry is done on a regular basis and in a correct and complete manner. Incomplete and/or insufficient data will lead to incorrect conclusions and actions.

Thus, the more data we have and the more accurate is the data, the better will be our decision-making.

Say: "Now, let us see who is responsible for monitoring and supervision."

Show Slide 3 and continue: "Monitoring is done at the local, district, state and national levels. The clinic in-charge is responsible for local-level monitoring. The supervisors in SACS, NRHM and NACO do the monitoring at the state and national levels."

Slide 3

WHO? - PERSONS RESPONSIBLE

- District agency supported by DPMU, DMO, DAPCU, RCH Officer, SACS and TSU will visit all STI/RTI facilities each quarter
- SACS will compile consolidated STI/RTI monthly report
- DAPCU, SACS and NACO will use CMIS/SMIS for monitoring services

M-22/3

Inform the participants that supervisory tools for capturing both quantitative and qualitative information about management and STI/RTI service delivery have been prepared. All of us need to be well acquainted with the content and use of these tools.
Show Slide 4 and share the list of supervisory tools.

Also ask the participants to open Page 63-64, Annexure VII of the "Operational Guidelines".

Slide 4

TOOLS FOR MONITORING AND SUPERVISION

STI facilities

- STI/RTI patient card
- Monthly summary report
- Supervisory checklist

Training and support team

- Pre and post test
- Participant feedback
- Mentoring checklists

M-22/4

Emphasize that the supervisory checklists for designated STI/RTI clinic and sub-district health facilities clinic are made in a simple format wherein the supervisor only needs to mark " Yes" or "No", or write some numbers. Thus, they are simple and user-friendly tools. Show Slide 5 and share the list of issues captured in the supervisory checklist.

Clarify that the checklist includes both quantitative information such as physical verification of items as well as qualitative information such as "services provided by the providers".

Now, show Slide 6 and share examples of quality of care indicators

Slide 5

WHAT? - SUPERVISORY CHECKLIST- SERVICE QUALITY INDICATORS

- Appropriate signage
- Privacy for consultations
- Equipment
- Consumables available
- Documentation up to date
- Prescription audit
- Infection control
- PEP drugs: 3 days supply
- Staff requiring training/reorientation
- Referrals to and from

M-22/5

Slide 6

SERVICE QUALITY INDICATORS

Contd...

- % medical history taken
- % sexual history taken
- % physical examination done
- % given correct drug/s for STI syndrome/s
- % partner treatment discussed
- % risk reduction discussed
- % condom use discussed

M-22/6

SESSION 3

Supervisory tools and their use

Objectives:

At the end of this session, the participants will be able to:

- Describe the qualities of a good supervisor
- List and demonstrate the use of the supervisory tools in the Operational Guidelines
- Demonstrate the use of effective supervisory skills through a role play

Now, ask the participants how many of them have experience of working as supervisors?

Ask those with such experience to give the meaning of the word "supervision". Encourage them, saying that they need not give the technical definition of the term but just a brief and general description.

Let 2-3 participants attempt to define the term.

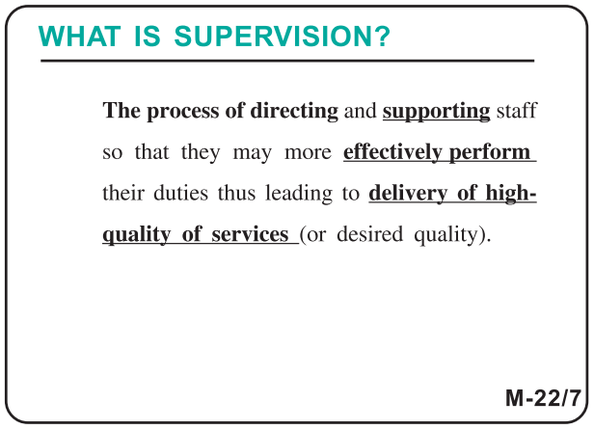
Now show Slide 7 and clarify the key words in the definition of "supervision".

Emphasize that providing direction is important but providing support for achieving the task is more important. Mere preaching is not enough.

Further, draw the participants' attention to "performance" and "high-quality services". Clarify that the focus of a supervisor is "performance" and not the person; "quality services" not just "service delivery".

Supervision is a process aimed at enhancing performance and outcome. It is not just about finding the gaps and criticizing people for their poor performance. It is a process meant for helping people to achieve high-level and high-quality performance.

Slide 7



Next, show Slide 8 and state that a comparison of two different and extreme styles shows that the "traditional" style is more person-focused and fault-finding, and largely, a static process.
As against the "traditional" style, the "supportive style" focuses on work and performance, collaborative problem-solving, and is a continuous process.

Slide 8

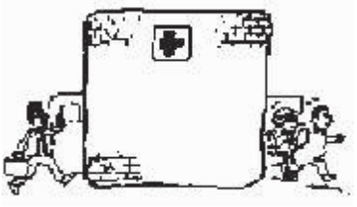
SUPERVISION STYLES

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

M-22/8

State that some supervisors who have adopted the supportive style after practicing the traditional style for a long time, have found it very effective. It has also been appreciated by the clinic staff.
Show the quote on Slide 9.

Slide 9



Before supportive supervision, the staff were angry when we came to supervise them. Now they get angry when we don't come.

– A regional supervisor

M-22/9

Assure the participants that the supportive style allows you to improve the performance of individuals and teams, maintaining a congenial atmosphere and transparency. It allows the individual's professional growth and increases motivation for work.

Tell them that so far, we have been talking about someone else's style of supervision. Now, let us see what we ourselves believe in and practice when it comes to supervising someone.

Show Slide 10 and complete the exercise. Ask the participants to use the questionnaire in Annexure 1 at the end of this module.

Slide 10

SELF ASSESSMENT

- Fill out form based on your experience so far
- No names
- Be honest!
- Measure against a high standard
- Turn it face down when you are done

If you answered "no" to two or more of these questions, you may be ready to try a different approach

M-22/10

Next, show Slide 11 and ask the participants to close their eyes and think of any one of their supervisors in the past whom they liked and admired most and whose supervisory style they appreciated.

Ask them to list some of the specific characteristics of that supervisor which they think made her/him a better and different supervisor.

Allow 2-3 minutes for listing the characteristics.

Now, ask 2-3 participants to read out their lists loudly and simultaneously list the characteristics on a flip chart.

Slide 11

TRAITS OF A GOOD SUPERVISOR

Think of someone who supervised you in the past, someone whom you admired and whose efforts you appreciated.

What personal characteristics did that person exhibit?

M-22/11

Show Slide 12 and compare the listed traits of a good supervisor with the participants' responses. There will definitely be some similarities.

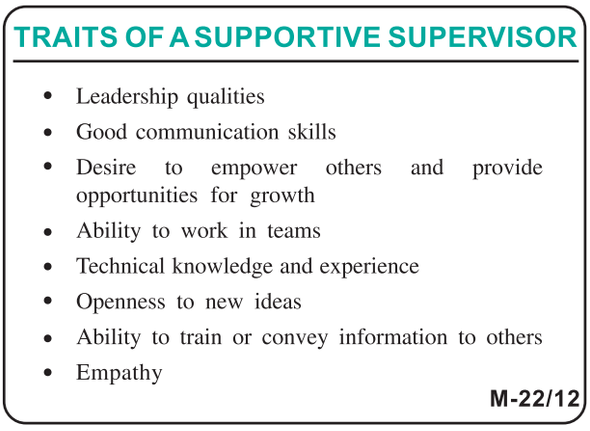
Explain that a good supervisor is also a good leader and will have excellent communication skills. Unlike the traditional supervision style where the supervisor believes in directing people, the supportive supervisor practices collaborative effort for problem identification, analysis and solving.

Emphasize that it is absolutely mandatory for the supervisor to be a master of the technical or managerial skills which s/he supervises and expects from others.

Please remember, you have no right to supervise someone if you cannot effectively perform the skills that you expect your supervisee to perform.

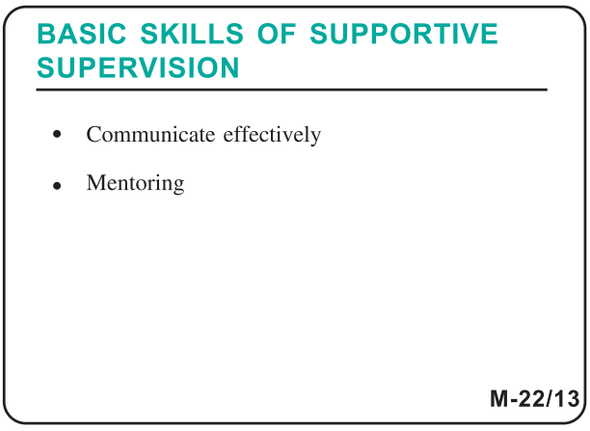
Also state that a good supervisor must share her/his emotions with the staff being supervised and should be able to model the behaviour that s/he expects from others.

Slide 12



Now, show Slide 13 and state that the most important tools for a successful supervisor are effective communication and mentoring skills.

Slide 13



Let us first talk about communication skills.

Ask the participants to guess the different components of communication skills.

Show Slide 14 and clarify that active listening is very essential for a supervisor.

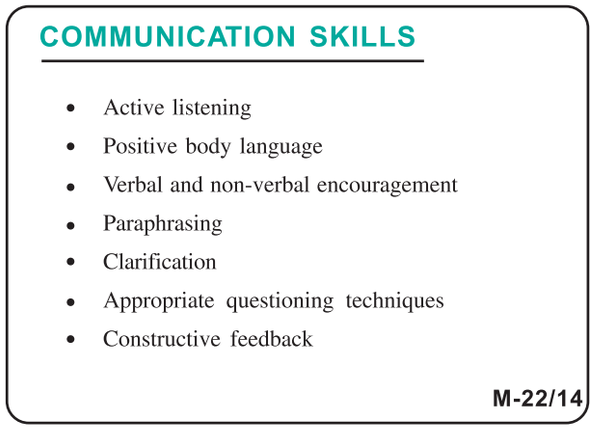
Ask them what they understand by active listening. Explain that active listening goes beyond passive listening to the words of another person. It is about deciphering the real feelings behind the conversation, making the other person feel that you are paying full attention to her/him.

Say: "Using encouraging verbal and non-verbal movements to facilitate the discussion is an essential component of active listening.

"A good supervisor makes appropriate use of paraphrasing to ensure a clear understanding of what the other person is saying.

"Finally, the use of good, open-ended questions is vital for a supervisor in order to allow or compel the other person to provide a detailed response, and not just one limited to 'yes' or 'no'."

Slide 14



State that one more key skill needed for becoming an effective supervisor is "feedback skill".

Say: "You must have heard terms such as 'positive feedback', 'negative feedback' or 'constructive feedback'. Can someone explain these terms?"

Listen to the responses carefully so that you can use suitable parts of these responses during the subsequent discussion on feedback skills.

Now, show Slide 15 and explain that feedback could be of 4 types.

- Negative feedback involves extreme criticism using harsh words. It definitely results in hurt feelings.
- Positive feedback focuses mainly on selecting positive things and making the other person feel good.
- Punitive feedback, as the name suggests, is aimed at punishing the other person by assigning the entire blame to her/him.
- Constructive feedback focuses on the solution of the problem.

Slide 15

TYPES OF FEEDBACK

- Negative – overly critical, causes hurt feelings
- Positive – supportive, causes good feelings
- Punitive – focuses on assigning blame
- Constructive – focuses on solutions to problems

M-22/15

Tell the participants that now we will see a role play.

Show only the caption of Slide 16 during the role play.

Use the role play situation provided in Annexure 2 at the end of this module.

Instruct the participants to see the role play carefully and note the finer aspects related to the supervisor's behaviour and actions. Tell them that we will have a discussion about it at the end of the role play.

Slide 16

ROLE PLAY: RAJNI AND HER SUPERVISOR

- **Type of feedback**
  - Negative
- **Mistakes made by supervisor**
  - Emotional
  - Didn't listen to Rajni's's side
  - Attacked the individual ("you", you always waste time)
  - Didn't make a plan for solving the problem

M-22/16

Provide specific guidance to the participants when they are observing the role play.

Ask them to look at the traits and qualities expected of a good supervisor and observe her/his behaviour based on these criteria. Clarify that you expect very specific comments from them and not generalized ones.

The two facilitators playing the roles must ensure that the roles are played with full vigour and intensity. The emphasis on blaming the person should emerge automatically. However, the language should be more sarcastic and rude rather than cheap.

While processing the role play, take the participants' reactions first. Remind them to be very specific and compare the 'supervisor's' behaviour with the traits listed and discussed earlier.

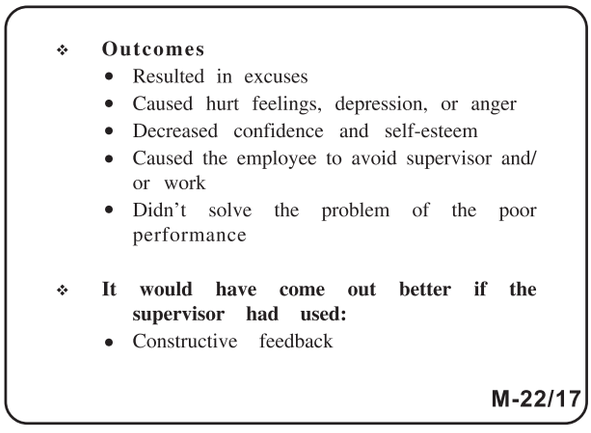
Now, show the entire Slide 16 and discuss the mistakes made by the 'supervisor' and how Rajni reacted to this situation.

Clarify that whenever the supervisor follows a negative or punitive style, the employee also accommodates to the situation and makes suitable excuses for the low or non-performance. This ultimately leads to loss of confidence in the employee and low self-esteem too. The employees later try to avoid such supervisors. There might also be the possibility of a burst of anger and further complications.

While analyzing the role play, whenever a participant points to something wrong done by the 'supervisor' (in the role play), the facilitator/s must ask her/him what s/he (the participant) would have done differently in such a situation. Ask this question to the participants for every comment they make on the role playing 'supervisor'.

Show Slide 17 and explain the outcomes of poor supervision.

Slide 17



Clarify that the supervisor has to walk on a thin line or a sharp-edged sword when s/he has ro make the employee realize that mistakes have been made and could be rectified. At the same time, s/he has to ensure a congenial atmosphere wherein the employee takes the feedback in the right spirit, without taking it personally or as an insult.

Providing constructive feedback is an art which one can learn through observation and practice.

Tell the participants that there are 6 major steps in providing constructive feedback.

Show Slide 18 and initiate a discussion on the first two steps.

Slide 18

CONSTRUCTIVE FEEDBACK IN SIX STEPS

Step One: Choose appropriate timing.

- Don't give feedback in public.
- Avoid times when the person is busy, tired, or upset.
- The longer you wait, the weaker the impact will be.

Step Two: 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. "Maria, we need to get our statistical reports on time so we can use them to assess how well we're serving the community."

M-22/18

Explain the following issues:

- Provide positive feedback or comments in public. However, constructive feedback which might include a discussion of mistakes and gaps should be provided in private.
- It is better to set a time for the feedback session. Avoid giving it when the person is tense or tired.
- The more immediate the feedback given, the better will be the impact.
- It is important to be neutral but it is equally important that your verbal and non-verbal communication support the same intent.
- Remember, constructive feedback is not about becoming unduly polite or goody-goody. You need to be candid but also polished and friendly at the same time.

Show Slide 19 and explain the following points:

- Ensure that the focus during feedback is on work and action and definitely not on the person. Therefore, avoid "you" as much as possible.
- The more specific you are in pointing to the issue/s, the better will be the chance of improvement. Therefore, specify the instance, time, place, reports etc. Do not generalize.
- Be unbiased and non-judgmental during feedback. Do not let your emotions get involved in your feedback. Do not get excited even if the issue or performance is good or the worst.

Slide 19

Step Three : Describe specifically what you've observed

- Focus on the behavior or action, not on the person
  - Avoid labeling (e.g. "You are lazy.")
  - Avoid "you" statements. (e.g. "You were late with your reports."
- Be specific, brief, and to the point. (e.g. "The reports weren't submitted on time.")
- Limit feedback to one behavior or action, whenever possible
- Remain calm and unemotional

M-22/19

Now, show Slide 20 and explain the following:

Always focus on programmatic outcomes and not personal actions or effects. Explain this using the example of MIS reports provided on the Slide.

Slide 20

Step Four : State the impact of the behavior or action

- Link the behavior to program goals.

  Example: "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."

M-22/20

Now, show Slide 21 and clarify the following:

- As mentioned earlier, a constructive feedback session is a two-way process wherein both the provider and receiver identify and agree on the problem issues, identify the reasons for the problem and generate a mutually agreeable solution.
- Therefore, you must involve the receiver of the feedback in the discussion. Encourage her/him to respond, to ask questions. Ask open-ended questions which compel the other person to respond elaborately.
- And, of course, active listening is the cornerstone of constructive feedback and good communication.

Slide 21

Step Five: Ask the other person to respond

- **Ask :**
  - "What do you think?"
  - "What is your view of the situation?"
  - "How do you see things?"
- Listen attentively, with encouragement

M-22/21

Lastly, showing Slide 22, explain the following:

- Constructive feedback being an inclusive process, the receiver of the feedback must be part of the solution. This will ensure accountability on the part of the receiver; the solution will be feasible and implementable by the receiver.
- In situations where the other person is short of creative ideas, you may want to suggest various options and help her/him adopt a suitable solution.

Slide 22

Step Six: Focus the discussion on solutions (this is the constructive part)

- Explore solutions jointly – try to avoid imposing the solution. (However, you should suggest a solution if the person cannot.)
- Guide the staff toward solutions that are practical to implement.

M-22/22

Now, show Slide 23 and summarize the discussion on constructive feedback stating that supportive supervisors make the best use of available opportunities and choose the positive and constructive feedback process on appropriate occasions.

Slide 23

Supportive supervisors use:

- Positive feedback – when performance is good.
- Constructive feedback – when performance needs improvement.

M-22/23

Now, say: "Besides effective communication skills, another desired quality of a good supervisor is 'mentoring'". Ask the participants if they know the meaning of "mentoring".

Let 1-2 participants respond.

Show Slide 24 and explain the concept of mentoring, using the following points:

- Mentoring is usually a long-term relationship in which one person almost acts as a "guru" of the other.
- Mentoring includes business as well as personal relationships. This is because the objective of the mentor is to create an enabling environment for a person to learn and grow.
- The mentor has a hard role to play all the time to model the desired behaviour. Thus, mentoring is not about preaching but a way of living and leading, and helping others to grow.
- Mentoring involves the transfer of skills through experience and hands-on assistance, and the effective use of constructive feedback to ensure that growth is not a directed process but an inclusive and consultative process.

Slide 24

MENTORING

Seeks to achieve continuous improvement through:

- Motivation
- Modeling
- Practice
- Constructive feedback
- Skills transfer

M-22/24

State that we expect all the participants to be supportive supervisors using constructive feedback and mentoring for developing the capabilities of individuals in the system, in the long run.

Show Slide 25 and clarify that we expect you to follow the supportive supervision style and pledge to uphold certain essentials of being supportive and to believe in the facts mentioned on Slide 26.

Mention the quotes below in addition to those mentioned on Slide 27.

- "The more you assign responsibilities to people, the more responsibly they will behave and perform".
- "If the decision-making is not consultative, only you are accountable for the outcomes, not the other person".
- "Everyone errs. The best supervisors provide opportunity and atmosphere to make corrections, other just struggle and fail".
- "Anyone will feel committed to the job when they are aware of what to do, if they have the necessary skills and environment, and if they are informed from time to time, how they are doing".
- "Nobody goes to work to do a bad job".

Slide 25

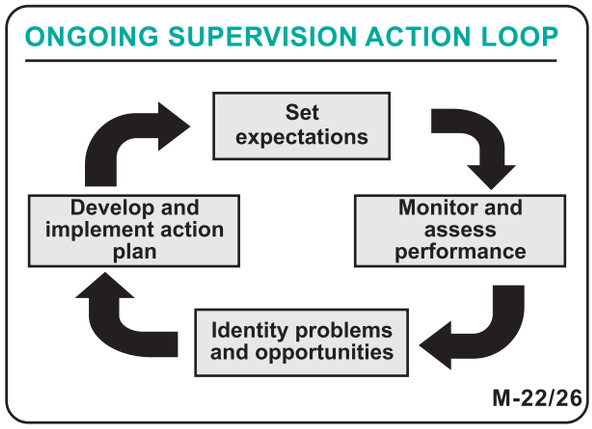
SUPPORTIVE SUPERVISION REQUIRES YOU TO SUBSCRIBE TO THESE BELIEFS

- People want to do a good job and improve when encouraged
- Supervisors can improve performance by giving them:
- Responsibility
- Involve in decision making
- Opportunity to improve on mistakes
- Staff become committed when:
- They understand their jobs
- They have the requisite skills
- They receive positive feedback

M-22/25

Now, show Slide 26 and explain the performance and supervision continuum.
Say: "Performance improvement is a continuous process and supervision is an essential component of it. Thus, we keep developing new plans, implementing and supervising them and achieving the goals. During the process, some new learning occurs and small problems crop up. Again, we go back to the drawing-board to develop a new plan, set new objectives, eliminate the obstacles experienced in the last cycle, and add new dimensions based on the latest research findings. This cycle goes on forever."

Slide 26



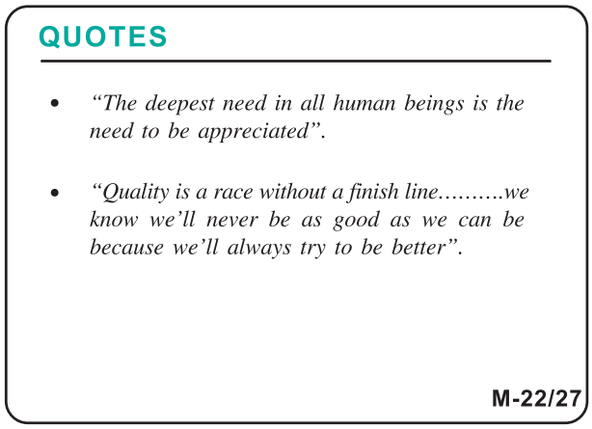
Next, show Slide 27 and say: "These are some interesting quotes regarding quality and supervision. I am sure all of us like to be appreciated and acknowledged for doing a good job."

Explain that quality is a continuous process, a never-ending process. New dimensions of quality get added with the times and the system tries to achieve the highest level of standards. However, the major challenge is to sustain this quality forever.

The supervision system and supervisors play a key role in keeping the system on track. The better and more acceptable the supervision system and its individual supervisors, the better and quicker and sustainable will be the improvements.

Many of you will play the key role of a supervisor in the future. Hence, it is important for all of us to quickly learn the art of mentoring and supportive supervision.

Slide 27



SESSION 4

Monitoring and use of STI/RTI clinic data

Objective:

At the end of this session, the participants will be able to:

- Discuss the importance of collecting STI/RTI clinic data
- Understand the use of STI/RTI clinic data

Say: “Based on the discussion so far, I hope by now, all of us will be able to appreciate the importance of supervision and the role of the supervisor.

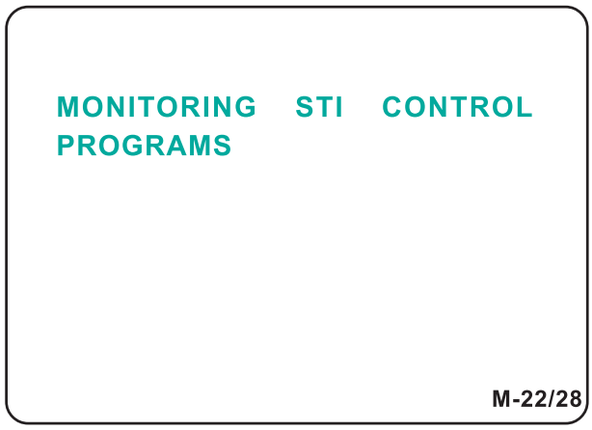
"However, we must recognize that the key tools which make the supervision or supervisor effective are: data analysis and data interpretation. Unless the supervisor has real data in hand and has the ability to draw meaningful conclusions from the data, s/he may not be able to provide effective and specific feedback and thereby, supportive supervision.

Now, let us take some examples and see how the data can provide us with important clues about clinic performance."

Show Slide 28.

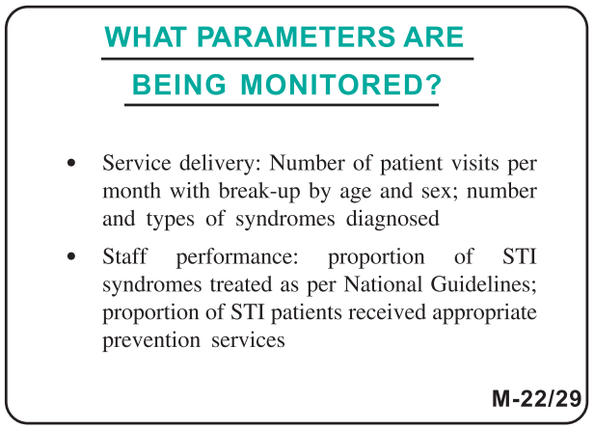
State that monitoring of STI clinic data can provide the real picture of the level and quality of service delivery at the clinic and/or region or state level.

Slide 28



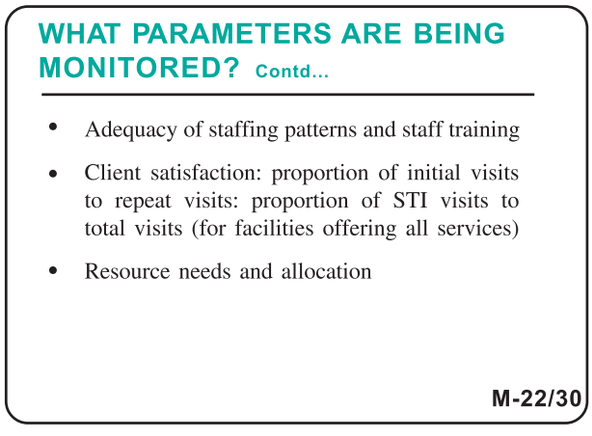
Now, show Slide 29 and explain that the data will not only provide us with quantitative information such as the number of patients attending the clinic, their average age etc but also information on the quality of services such as “the number of patients treated correctly” or “the number of patients receiving patient education”.

Slide 29



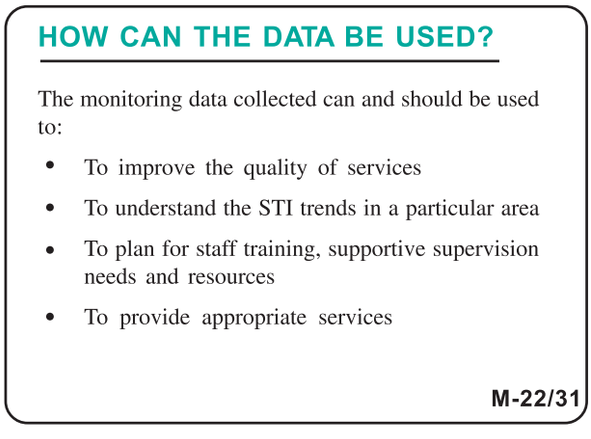
Next, show Slide 30, and tell the participants that staff-related information such as adequacy of staff, their training status, availability of resources etc., can also be monitored through compilation and careful analysis of monthly data from STI clinics.

Slide 30



Now, show the caption of Slide 31 and ask the participants about the importance of collecting and making the best use of STI data.

Slide 31



Next, show the entire Slide 31 and clarify that –

- Data compilation, analysis and careful and critical interpretation can assist supervisors to know the field situation both in terms of quantity and quality of services.
- The data can provide important epidemiological information such as geographic and time patterns of different STIs or syndromes.
- Staff-related data can help supervisors to plan new postings of staff, their reorganization and requirements of staff training and resources.

Now, ask the participants if they have attempted the analysis and interpretation of clinic data at their level. Encourage them to share concrete examples of what data was analyzed, what were the findings and what specific information they could derive from it.

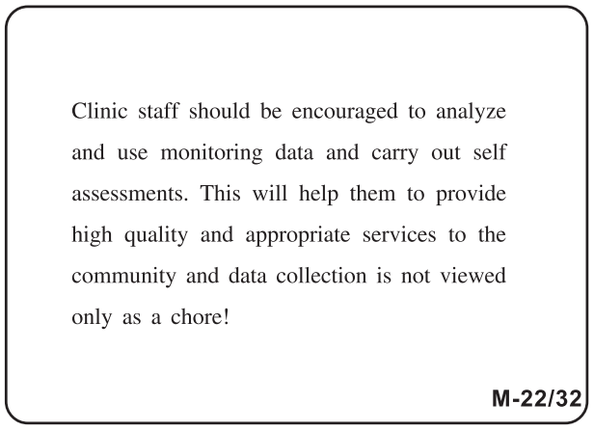
Clarify and suggest that the STI clinic team which compiles and reports all the data should be the "first beneficiary" of this data.

The clinic team must analyze and interpret its own service delivery data regularly, and evaluate progress. If any shortcomings are observed, they should take timely corrective action without waiting for someone higher-up in the supervision chain to point these out. This will ensure that shortcomings, if any, are rectified without loss of valuable time.

Now, show Slide 32. Explain that similar to data collection responsibilities, data compilation and analysis also involves "team work" wherein the entire clinic team is involved.

It must not be considered as the "responsibility of the supervisor" alone. The prompt services provided by using the data at the local level will benefit the entire clinic team and their patients.

Slide 32



Show Slide 33 and giving some examples, tell the participants that we will read the data and try to figure out the meaning of the data or "interpret the data".

Slide 33

How would you interpret the following monitoring data?

M-22/33

Now, show Slide 34.

Allow the participants to read the data for a minute and ask one of them her/his reactions.

Expected responses could be:

- Overall, the number of patients has gone down in the past 3 months.
- There is a small decline in the "number of male patients"

The "number of female patients" has drastically declined in the last 3 months

Slide 34

'Mana' STI Clinic Attendance

2007	Jan	Feb	Mar	Apr	May	June
Male	80	75	80	110	90	88
Female	84	100	80	40	20	10
Total	164	175	160	150	110	98

M-22/32

Once you get the above responses, ask the participants which additional issues they would like to examine in light of the fact that the "number of female clients" has significantly decreased in the past 3 months.

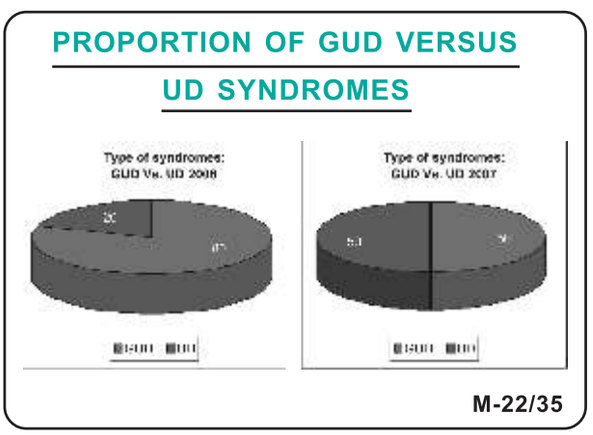
What could have happened 3 months ago to affect the flow of female clients?

Possible answers could be:

- No female doctor since the last 3 months,
- No privacy arrangements since the last 3 months.
- Some untoward incident happened with a female client.

Clarify that the supervisor might want to explore the above possibilities to find out the reason/s for the low attendance of female patients at the clinic.
Now, show Slide 35 and ask one of the participants to take a close look at the two pie diagrams and share her/his observations and interpretation of the data presented in the diagrams.

Slide 35



Expected responses could be:

- The pattern of STI syndromes UD and GUD has significantly changed in the past one year.
- Among the total cases of UD and GUD, the proportion of GUD has declined from 80% to 50 %.
- The share of UD has increased from 20% to 50%.

Ask: "What could be the reason/s?"

Possible responses could be:

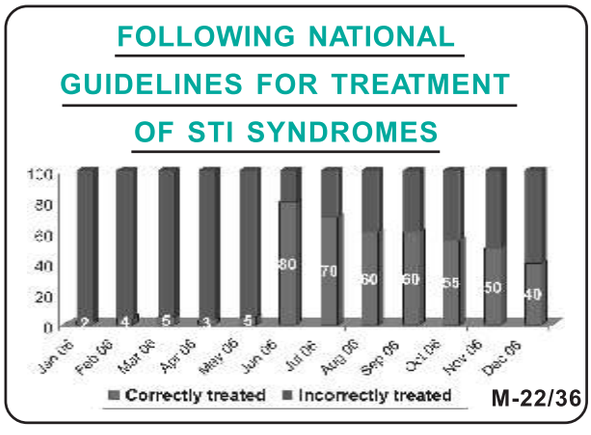
- The STI program was focussing on managing treatable causes of GUD. GUDs have the highest correlation with HIV infection.
- To further analyze the data, we would also need the absolute number of STI cases.

Now, show Slide 36 and take another example of data which can be derived from individual patient cards.

Show the graph to the participants, allow 1-2 minutes to read and compose their thoughts.

Ask one of the participants to share her/his observations and interpretation.

Slide 36



A possible response could be:

The proportion of patients receiving STI treatment as per national protocols suddenly increased in the month of June and again declined by 50% over the next 6 months.

Ask them what additional information they would like in order to examine the reason/s for this sudden rise in the quality of treatment services.

Possible responses could be:

- A training programme of service providers was organized in June 2010
- Change of clinic in-charge, the new one being a strict supervisor who believes in high-quality treatment.
- The quality has steadily declined every month since June.

Ask: "What could be the probable reason/s?"

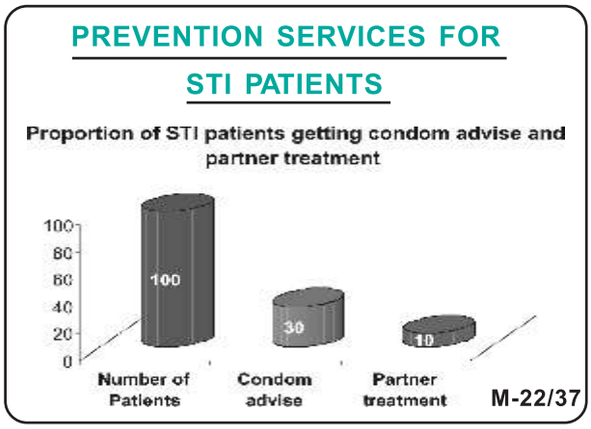
Possible responses could be:

- There was no on-site supportive supervision and follow up after the training.
- Soon after training, the providers were motivated to change their practices, but after some time they went back to their old ways.

During these exercises, provide an opportunity to different participants to respond to the data sets presented.

Now, show Slide 37 and ask one of the participants to share her/his findings as a supervisor.

Slide 37



Possible responses could be:

- STI patients are not receiving comprehensive care.
- Condom advice is given to only 30% of the patients when it is expected to be provided to 100% patients.
- Partner treatment is very low. Only 10%.

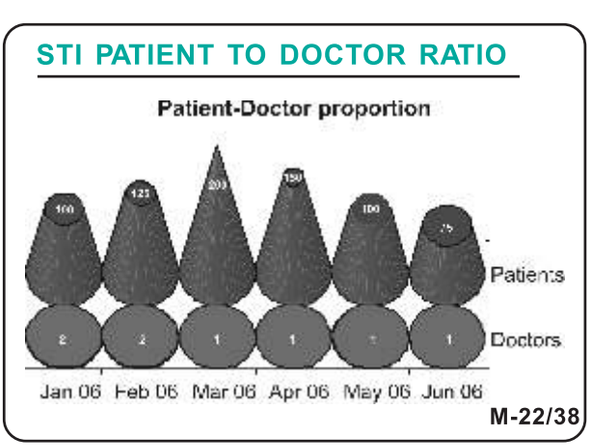
Ask the participants what other issues they would like to explore further to reach the root cause/s of this performance.

Now show Slide 38 and ask another participant to read the slide and share the findings. State that this slide is for the managers at SACS/NRHM or NACO. The graph shows that the number of doctors in a given clinic dropped from two to one in the month of March and, thereafter, the number of patients declined steadily. What could be the probable reason?

Possible responses could be:

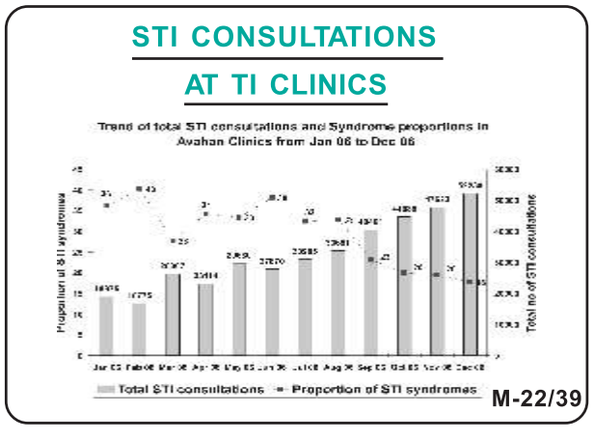
This decline could be the inability of only one doctor to serve a high client load or this could have resulted in increased waiting time for patients, resulting in low patient reporting at the clinic.

Slide 38



Next, explain the ways of approaching such a situation by appropriately interpreting available data. Show Slide 39 and ask the next participant to look at the graph and share her/his findings.

Slide 39



Note: STI consultations at TI clinics (particularly sex worker clinics) include those who have STI symptoms, and others who are asymptomatic for STIs and attend the clinic for regular STI check ups.

Possible responses could include:

- At the beginning of the year, although the number of total STI consultations were relatively few (compared to subsequent months), a high proportion of syndromic case identification has happened.
- In the second half of the year, although the number of STI consultations has gone up, the proportion of symptomatic patients has reduced. This may mean that the interventions have led to improved health care seeking behaviour among sex workers as regards regular STI check ups and taking presumptive/asymptomatic treatment.

Clarify that such information and graphs would be useful for regional or state level supervisors because the volume of data they receive would be significantly higher and suitable for deriving meaningful conclusions.

State that these are just illustrative examples of data presentation in different formats and how supervisors can derive important information and conclusions from given data sets.

Ask the participants how they felt about this experience. Also ask them if they practice data analysis and local use of data routinely.

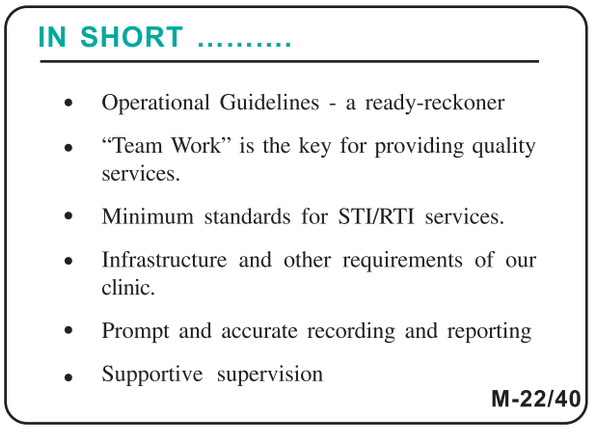
Encourage them to closely monitor the data in their own work-areas (clinic, hospital, district, region, state or national), try to decipher the meaning of data sets and take corrective action in a timely manner. Also suggest that participants (especially supervisors) motivate supervisors at the next level to analyze and make the best use of data at their own level as well as to take corrective action immediately, rather than depending on feedback from higher-level supervisors.

Finally, show Slide 40 and summarize the entire discussion on operational guidelines by emphasizing the following:

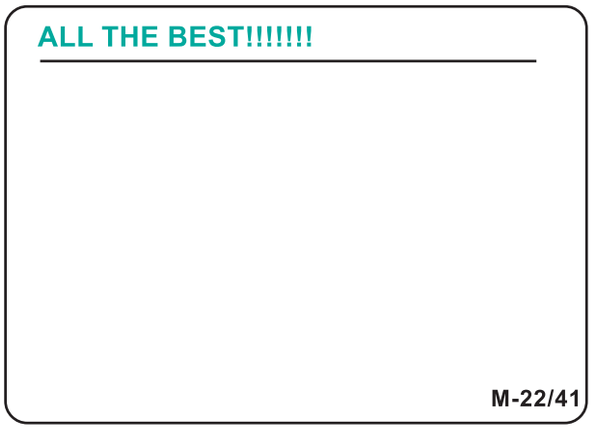
- The "Operational Guidelines" document is a ready-reckoner for the effective operationalization of STI/RTI clinics.
- We all agree that "Team Work" is the key to providing quality services.
- We are aware of the minimum standards of STI/RTI services.
- We know the infrastructure and other requirements of our clinic. We have reviewed the current status of our clinic and identified some of the deficiencies in terms of space, instruments etc.
- Prompt and accurate recording and reporting is a tool available to us for self-assessment as well as showing our performance to the external world.
- Supportive supervision is essential for helping the team perform well and sustain the performance.

Suggest that participants refer to the "Operational Guidelines" as and when needed. Respond to their queries, if any.

Slide 40



Slide 41



Annexure 1

Self - Assessment : Do you Need to Change Your Approach ?

Please take a few minutes to assess how you approach your suprvisory visits.

- I visit the sites under my jurisdiction frequently. ❑ Yes ❑ No
- I see myself as part of their team. ❑ Yes ❑ No
- My Primary objective is to improve service quality, not to collect data. ❑ Yes ❑ No
- I believe in empowerment rather than criticism. ❑ Yes ❑ No
- I take enough time to understand the site's problems. ❑ Yes ❑ No
- I speak to all levels of staff during my visits. ❑ Yes ❑ No
- I regularly observe the day - to - day operations of the clinic. ❑ Yes ❑ No
- I try to help the staff identify and solve their problems. ❑ Yes ❑ No
- I practice active listening and other communication skills when supervising. ❑ Yes ❑ No
- I provide the staff with the Information they need to perform their jobs well. ❑ Yes ❑ No
- I provide or arrange training that staff need to provide high-quality services. ❑ Yes ❑ No
- I try to create partnerships between the staff and outside resources to help improve service quality. ❑ Yes ❑ No

If you answered "no" to two or more of these questions, you may be ready to try a different approach.

Exercise

Supervisor's Self - Assessment

Please take a moment to answer the following questions about how you think.

- Site staff are willing to organize my visit for me. ❑ Yes ❑ No
- Site staff give me the time I need during my visit. ❑ Yes ❑ No
- Site staff willingly provide me with information. ❑ Yes ❑ No
- Site staff willing give me access to the facility and its activities. ❑ Yes ❑ No
- Site staff are eager to discuss their problems with me. ❑ Yes ❑ No
- Site staff are co-operative and open. ❑ Yes ❑ No

Annexure 2

Role Play: Rajni and her supervisor

Supervisor : (in an angry tone)	Rajni, you did a poor job of preparing those reports yesterday and I'm veryannoyed.
Rajni:	It was Prem's fault. She didn't get me the statistics on time.
Supervisor:	Nevertheless, it was your responsibility to make sure that the reports were submitted in good order.
Rajni:	But I've been so busy with other things that I didn't have enough time to devote to those reports. Really, I'm overworked here.
Supervisor:	I often see you wasting time around the clinic. I think you had enough notice to prepare better. Please don't make the same mistake next time.
Supervisor leaves.	
Rajni looks down at the floor and talks to herself:	I've got a meeting with that guy tomorrow and there's no way I'm going to listen to more of him. I'll just call in sick. Someone else can do those reports from here on out.

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