

Clinical Management of
**Sexually Transmitted Infections
in Resource-Poor Settings**

*A Comprehensive Guide for
Clinicians*

Published in 2004

This document may be reproduced/quoted in part or fully. However, acknowledgement to the source will be appreciated.

Edited by Ms. Melissa Zebrowski.

The following individuals contributed to the writing and development of Volume II:

- Dr. T. L. N Prashad: MD DNB, Deputy Director – Andhra Pradesh State AIDS Control Society (APSACS), Hyderabad
- Dr. P. Somasekhar Reddy: Additional Project Director – Andhra Pradesh State AIDS Control Society (APSACS), Hyderabad
- Dr. Maryam Shahmanesh: Consultant – India HIV/AIDS Alliance
- Dr. P. Prameelamma: MBBS. DGO – Steps Health Clinic
- Dr. Ade Fakoya: Senior Programme Officer – Clinical Care, International HIV/AIDS Alliance, UK
- Dr. Sangeeta Kaul: Senior Programme Officer – Clinical Services, India HIV/AIDS Alliance, New Delhi
- Mr. Rajesh Divakaran: Project Officer – India HIV/AIDS Alliance, Andhra Pradesh
- Mr. Shumon Sengupta: Director – Andhra Pradesh, India HIV/AIDS Alliance
- Ms. Catherine Cook: Programme Assistant – Care and Impact Mitigation, International HIV/AIDS Alliance, UK

The guidelines in Volume II have been adapted from a variety of sources including:

- National AIDS Control Organisation (NACO). 2001. *Sexually Transmitted Infections: Treatment Guidelines*. Ministry of Health and Family Welfare, Government of India.
http://www.saathii.org/resources_materials/downloads/NACO_STI_treat.pdf
- National AIDS Control Organisation (NACO). 2004. *Flow Charts on the Syndromic Management of Sexually Transmitted Infections*. Ministry of Health and Family Welfare, Government of India.
http://www.saathii.org/resources_materials/downloads/NACO_STI_treat_flowchart.pdf
- World Health Organization. 2002. *Guidelines for the management of Sexually Transmitted Infections in Female Sex Workers*. WHO Regional Office for the Western Pacific.

The following materials have been included with permission from the Fellowship in HIV Medicine, Module 11 STI, RTI and HIV:

S1: Urethral Discharge case history, answers

S2: Genital Ulcer Syndrome, causes, case scenario, answers

S3: Vaginal discharge causes, case history, answers

S4: Scrotal swelling

S5: Lower abdominal pain in women, case history, answers

S6: Inguinal bubo, case history, answers

(Dr. Susanne A Pulimood: Professor, Department of Dermatology, Venereology & Leprosy – Christian Medical College, Vellore-632004)

Some of the case histories and the participatory exercise materials have been included from *Case Management for Sexually Transmitted Diseases A Training Handbook for Hospital Level Health Workers (1996)*. MoH/DoHS, National Centre for AIDS & STD Control, University of Heidelberg STD/HIV Project Kathmandu, Nepal. Funded by the Commission of the European Community.

Design, layout and printing

New Concept Information Systems Pvt. Ltd.

CONTENTS

Introduction	7
1. Sexual History Taking and Examination	9
1.1: Taking a Sexual History	9
1.2: Steps for Examining Female Patients	13
1.3: Steps for Examining Male Patients	15
1.4: Creating a Safe Clinical Environment for Men Who Have Sex With Men	16
2. Clinical Management	20
2.1: The Management of STIs in Female Sex Workers	20
2.2: The Management of STIs in MSM & Transgenders	22
Syndrome 1: Urethral Discharge	26
Syndrome 2: Genital Ulcer Syndrome	32
Syndrome 3: Vaginal Discharge	39
Syndrome 4: Scrotal Swelling	47
Syndrome 5: Lower Abdominal Pain in Women	52
Syndrome 6: Inguinal Bubo	56
Syndrome 7: Ophthalmia Neonatorum	60
Syndrome 8: Skin Infestations	62
Syndrome 9: Genital Warts	63
Syndrome 10: Molluscum Contagiosum	64
Syndrome 11: Anorectal Syndrome	64

3. Appendices	67
3.1: Client's Personal Identification Number	67
3.2: Clinical and Referral Codes	70
3.3: Client Referral Card	73
3.4: Formulary Essential Drug List	74
3.5: Male Clinic Attendance Form	80
3.6: Female Clinic Attendance Form	82
3.7: Client Identification Card	84
3.8: Universal Precautions	85
3.9: Safe Waste Disposal	92
4. Role Plays and Participatory Exercises	95

ABBREVIATIONS

AIDS	Acquired immuno-deficiency syndrome
APSACS	Andhra Pradesh State AIDS Control Society
BV	Bacterial vaginosis
CIC	Client identity card
CRC	Client referral card
CT	Chlamydia trachomatis
FPP	Frontiers Prevention Programme
FSW	Female sex workers
HbsAg	Hepatitis B antigen test
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
HSV	Herpes simplex virus
IAI-Avahan	India AIDS Initiative-Avahan
KP	Key Population groups
LGB	Lesbian, gay and bisexual
MSM	Men who have sex with men
NACO	National AIDS Control Organisation
ORW	Outreach worker
PID	Pelvic inflammatory disease
PIN	Personal identity number
RPR	Rapid plasma regain
STI	Sexually transmitted infection
TSS	Technical support staff
TV	Trichomonas vaginalis
VCT(C)	Voluntary counselling and testing (Centre)
VDRL	Venereal disease reference laboratory test
WHO	World Health Organization

INTRODUCTION

This manual has been developed to support the provision of clinical services to key populations (KPs) within the India AIDS Initiative-AVAHAN (IAI-Avahan) and Frontiers Prevention Programmes (FPP) implemented by India HIV/AIDS Alliance (Alliance India) in the Rayalseema and Telengana regions of Andhra Pradesh. Both of these projects are funded by the Bill and Melinda Gates Foundation. KPs have been defined as groups that are socially and economically marginalised and are therefore more vulnerable to acquiring STIs and HIV/AIDS. This vulnerability places KPs at the centre of comprehensive responses in these settings.

A key component of these programmes is to enhance the interface between clinical services and communities in order to increase the accessibility and acceptability of services. A comprehensive approach to service delivery, therefore, focuses on the referral pathways to services. For this reason, this manual contains tools to enhance this process and to enable community support services (those provided by outreach workers and specialised technical support staff) to effectively cooperate with the clinical services provided.

This manual is primarily intended for clinical staff who will examine and manage a variety of STIs within the specialised NGO clinics (Mythri Centres). As well as clinical staff, this manual is also useful to a wide range of individuals, including those involved in training on STI management, programme managers, community groups and other NGO staff.

Section 1 deals with taking a patient's sexual history and provides general details on the approaches to use. This initial section also covers the examination of a patient, specific information pertinent to male and female examinations, and useful consultation information when interacting with men who have sex with men (MSM) and female sex workers (FSW).

Section 2 focuses on the clinical syndromes based on NACO's Syndromic Management Guidelines. For each syndrome the text is divided into:

- Brief notes on the syndrome
- A flowchart for the syndromic management
- Recommended treatments and prepared treatment packs
- A case history scenario
- Answers to the case history

Section 3 (Appendix) contains tools which may be useful in implementing clinical services, including male and female clinical forms, and treatment pack compositions. Also included are the syndrome codes to aid in monitoring and data collection; information on generating patient-specific personal identification numbers (PIN).

Finally, Section 4 provides role plays and participatory exercises for those who wish to use this manual to assist in training. These tools aim to aid in the discussion on issues such as sexuality, sexual history taking, confidentiality and sexual health promotion.

1 SEXUAL HISTORY TAKING AND EXAMINATION

In order to deliver effective and accessible services, much attention should be paid to the layout and environment of the clinical and waiting area spaces. These spaces need to be relaxed, efficient, confidential, and should inspire feelings of confidence in patient-friendly and non-judgemental services. A successful sexual history and consultation is based on trust and it is important to convey to a patient that the information shared will not be known by anyone else. It is equally crucial to use language that is non-judgemental, understandable and reassuring.

1.1 Taking a Sexual History

In many instances it is helpful to use a standardised sexual history and clinical examination form. This ensures that all important and relevant information is collected and that adherence to specific protocols for clinical syndromes and treatment guidelines is maintained. The separate female and male clinical forms that are used at the Mythri Centres are given in Appendices 5 & 6.

General details should be obtained and entered into a standardised case report form. To maintain the anonymity of the patient, the patient's personal identification number (PIN) should be entered as opposed to their name (Refer to Appendix 1). This number should appear on all the patient's case sheets as well as on the specimen tubes and the laboratory request forms.

In order to obtain a truthful and accurate history from the patient it is important to:

- Explain what you are doing before you start.
- Ensure privacy and that the patient is seated comfortably.
- Convey that confidentiality will be maintained at all times.
- Remain non-judgmental and respectful.
- Avoid making assumptions about people, their sexual identity and sexual practices.

- Pay particular attention to your non-verbal communication
- Ensure that the patient remains dressed

When speaking to a patient, the choice of wording is crucial to their comfort and ability to comprehend the situation and its consequences. It is suggested to:

- Use vernacular or colloquial expressions rather than more technical expressions. Be careful, as patients may be less comfortable with the topic and may regard some colloquial terms as obscene.
- Adapt your language to the level of understanding of the patient.
- Utilise terms used by the patient, but be cautious as patients often struggle to express issues in medical terms and can confuse their meanings.

Asking questions is the basis for gathering a patient's sexual history. With this in mind, it is recommended to:

- Start with a general and less threatening question, such as "Tell me about your most recent sexual activity".
- Ask questions that are open-ended, not requiring simply a "yes" or "no" answer.
- To open a dialogue, avoid asking "why" questions and instead, ask "how," "what," "where" and "who" questions.
- Ask clear and specific questions.
- Do not hesitate to be direct in order to get clear information.
- Ask about sexual partners, as patients may be at risk of STIs because of their partner's sexual activity.
- Enquire about their knowledge and use of condoms, as it provides an opportunity for further information and education.

Sexual history checklist

Below are points that can be used to gather a comprehensive sexual history.

Physical symptoms



- Nature of problem
- Length of time
- General sexual concerns

Previous diagnosis of STIs



- ⇒ Previous sexual health issues
- ⇒ Perception of HIV and STI risk
- ⇒ Symptoms and diagnoses in recent sexual partners

Sexual behaviour

- ⇒ Contact with regular and/or casual sexual partners
- ⇒ Last sexual contact with partners
- ⇒ Number of sexual partners (using specific time periods, e.g. three months)
- ⇒ Gender of sexual partners
- ⇒ Type of sexual behaviour practised
- ⇒ Sex worker or client
- ⇒ Condom use and consistency of use



Relationship history



- ⇒ Regular partner
- ⇒ Regular partner's sexual activity
- ⇒ Casual partners

Drug and alcohol use

- ⇒ Patterns and frequency of use
- ⇒ Injecting drug use
- ⇒ Harm minimisation strategies



Medication and allergies



- ⇒ Current medications
- ⇒ History of allergic reactions

Symptomatology

It is important to determine if the patient has any symptoms and if so, to list these chronologically detailing the duration and the progression of the symptoms. Find out specifically, if this has not already come up, whether the patient has symptoms related to the genito-urinary system. Symptoms in men



and women differ, it is therefore necessary to differentiate your inquiry when speaking to men and women.



In men, enquire about:

- Urethral discharge, dysuria (pain on passing urine), urinary frequency, and urethral pain
- Swelling and/or pain in the groin
- Sores around the genitals and anus
- Skin rashes, warts or any swellings and/or lumps

In women, enquire about:

- Dysuria, urinary frequency, and vaginal discharge
- Swelling and/or pain in the groin
- Sores around the genitals and anus
- Lower abdominal pain, dyspareunia, skin rashes, warts or any swellings and/or lumps
- Menstrual cycle details, paying particular attention to irregularities in menstruation, dysmenorrhoea, menorrhagia and delay in menses



Determine if the patient has had any major illnesses or STIs in the past. Also, note whether the patient is currently taking any kind of medication and whether he/she is allergic to any medications.

When talking about sexuality, reassure the patient that the information being obtained is only to help in treating them and will not be divulged to anyone else. It is often helpful to begin questions regarding sexuality by saying, "I would now like to ask you some very personal questions. Please try to answer the questions as best you can. The answers to your questions will help me plan your treatment." Direct questioning should be used to obtain the sexual history of the patient and whether he/she uses condoms.

For all patients, ask whether they have ever had a sexual exchange for money or goods and whether this is/was a regular event.

- Determine the number of partners he/she has had sex with in a particular period of time. This may be 2 weeks, 3 months or longer depending on the assessment of the situation.
- For those engaged in transactional sex, find out if the person has a regular partner and whether they are using condoms with their regular partner.

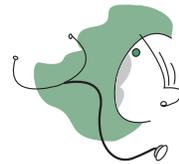


Non-prescribed drug use

Taking a client's sexual history is a useful point to enquire about the use of recreational and other non-prescribed medicines, including those obtained by traditional healers, pharmacists and other sources. Begin by asking about non-prescribed medicines and then ask about recreational drug use including alcohol and tobacco. Enquire about injecting drug use presently and in the past. If the client is concerned about confidentiality and legal issues, state that you do not have to document this information, but reiterate the confidential nature of the shared information.

1.2 Steps for Examining Female Patients

1. Ask the patient to remove her clothing from the waist down, and to then lie on the examination couch. To avoid embarrassment, use a sheet to cover the parts of her body that you are not examining. If the patient is wearing a skirt, a discreet examination can be conducted simply by removing the underwear.
2. Ask the patient to bend her knees and separate her legs, and then examine the vulva, anus and perineum.
3. Palpate the inguinal region in order to feel for the presence of enlarged lymph nodes.
4. Palpate the abdomen for pelvic masses and tenderness, taking care not to hurt the patient. Record the presence or absence of:
 - ulcers
 - vaginal discharge (noting the type, colour and amount)



Note: Gloves are required for genital, vaginal and bimanual examination.

Abdominal examination

Palpate the abdomen feeling for areas of tenderness and swelling. Particularly check for tenderness deep in the pelvis. Examine the pubic area and palpate for any inguinal lymph nodes.

Genital examination

Inspect the labia, urethral meatus, clitoris, introitus, and the perineum and perianal areas. Note any discharge, ulcers, warts or growths.

Speculum examination

Wear gloves to carry out a speculum and manual examination. In order to perform a speculum examination, the patient should lie with her legs bent at the knee and her feet and knees separated. A good, bright light source is necessary in order to inspect inside the vagina.

Separate the labia and insert a warm, well-lubricated bivalve speculum and inspect the vaginal walls and the cervix. Look carefully for ulcers, warts, and cervical and vaginal discharge. If you need to take specimens for laboratory tests, make sure that the speculum is lubricated with water only. Take the specimens while the speculum is inside the vagina and while inspecting the vagina and cervix directly.

Bimanual examination

When you have completed inspecting the vagina and cervix, remove the speculum, insert the index and middle fingers of your hand into the vagina and perform a digital bimanual examination. With the two fingers inside the vagina and the other hand placed on the lower abdomen, examine the pelvis for swellings and tenderness. Check for cervical motion tenderness by gently moving the cervix laterally. If a patient has extensive, painful genital ulcers, it may not be possible to perform a speculum examination. It is important to never cause additional pain to your patient.

Specimen collection

If it is necessary to take specimens, follow the laboratory protocol that has been developed for the clinic. Again, specimens should be collected while the speculum is inside the vagina. The procedure is as follows:

1. Take one swab from the vagina, behind the cervix (high vaginal swab); make a smear of this on a microscope slide and place the swab into the transport medium. Wipe the cervix with a cotton wool swab and discard the swab.
2. Take another swab and insert it into the cervix, roll it around inside the cervix for 30 seconds. Remove the swab, make a smear on a glass slide, placing the swab into the transport medium for the culture of *N. gonorrhoeae*.
3. Take a third swab and insert it into the cervix, roll it around inside the cervix for 30 seconds and then remove it, placing it in the transport medium for the detection of Chlamydia.

4. If there are genital ulcers, take an additional ulcer swab and place it in the transport medium for the detection of *Herpes simplex virus*.
5. After the examination is over, take 10 ml of venous blood from the arm, place it in a clotted blood tube and send it to the laboratory for syphilis tests.
6. If the patient has agreed, and would like to have an HIV test, take another specimen of blood for HIV antibody tests and refer the patient for pre-test counselling.

1.3 Steps for Examining Male Patients



1. Patients should initially be examined to exclude inguinal hernias. Ask the patient to pull down or remove his trousers and underwear.
2. Palpate the inguinal region to feel for the presence or absence of enlarged lymph nodes.
3. Inspect the external genitalia, the glans, the shaft of the penis and the surrounding areas, recording any abnormal features, including warts, ulcers or skin variations.
4. Examine the urethra for discharge. If none is apparent, gently milk the urethra and re-examine.
5. Examine the testicular sac and both testes for any abnormal tenderness, swelling or masses.
6. Palpate the epididymis for tenderness and masses.
7. Examine the external perineal area.

Specimen collection

If it is necessary to take specimens, follow the existing clinical laboratory protocol. It is advisable that the patient should not have passed urine more than 2 hours previously. The procedure for taking specimens from a male patient is as follows:

- Take a swab from the first part of the urethra (anterior urethra) passing the swab about 0.5 cm into the meatal opening. If there is no clear discharge, gently milk the urethra.
- Make a smear of this on a microscope slide and then place the swab in the transport medium for the culture of *N. Gonorrhoeae*.
- Take the specialised Chlamydia swab and insert it into the urethra to reach the posterior urethra (about 4 cm inside the meatus), warning the patient

that he may experience some discomfort. Rotate the swab for about 30 seconds to obtain an adequate specimen.

- Place the swab in the transport medium for the detection of Chlamydia.
- If there are ulcers on the external genitalia take a culture swab for the detection of *Herpes simplex virus*.
- After the examination is over, take 10 ml of venous blood from the arm and place it in a clotted blood tube and send it to the laboratory for syphilis tests.
- If the patient has agreed, and would like to have an HIV test, take another specimen of blood for HIV antibody tests and refer the patient for pre-test counselling.



1.4 Creating a Safe Clinical Environment for Men Who Have Sex with Men

The following are general guidance notes. While much of the information is not wholly applicable to the Indian context, the underlying principles are pertinent in creating a safe clinical setting. Current work is in progress to make this section more relevant to the Indian situation. In the absence of recognised gay organisations it is important that clinics liaise closely with the TSS and community-based outreach workers. (From the Gay and Lesbian Medical Association, 5/9/2002. Available at: <http://www.glma.org>).

Background

In medical practice, homophobia is a reality. A 1998 survey of nursing students showed that 8-12% “despised” lesbian, gay, and bisexual (LGB) people, 5-12% found them “disgusting,” and 40-43% thought LGB people should keep their sexuality private (2). Research conducted in 1999 in New Mexico showed that more than 8% of the male physicians surveyed could be described as homophobic. That percentage rose to more than 20% for male physicians in cities with populations between 25,000 and 50,000 people (3).

Disclosing information about sexual behaviour provokes anxiety in many individuals. Tailoring prevention messages to the individual patient requires that the patient feels comfortable in discussing these topics and revealing sensitive information. In a 1992 study, 44% of self-identified gay men had not told their primary care physician about their sexual orientation (2). MSM sometimes consciously avoid medical care out of the fear of discrimination (1). During initial visits with a clinician, MSM may still withhold sensitive, yet important information for the same reasons (4).

What Can Be Done?

Clinicians must consider every aspect of their practice when creating a gay-friendly environment and service.

The Environment: Providers can take multiple steps to create welcoming environments for MSM and/or gay-identified patients. Participating in provider referral programmes through gay organisations or advertising the practice in gay media can create a friendly environment even before a patient enters the door. Displaying posters or pamphlets with gay-friendly, positive messages, such as non-discrimination statements inclusive of sexual orientation, are ways to demonstrate a welcoming attitude. Subscribing to gay-oriented news and/or entertainment magazines, in addition to those with a general appeal, will provide information to the patients while they are in the office. Acknowledging relevant days of observance in your practice, such as World AIDS Day or Gay Pride Day will also help in promoting a safe and friendly clinical setting.

Patient Intake: Patients often form expectations of the patient-clinician interaction based on information requested in initial visit forms. Knowing this, forms should be written using appropriate language:

- Use the term “relationship status” instead of “marital status,” including options such as “partnered.”
- When asking for information about a patient’s significant other, use terms such as “partner” in addition to “spouse” and/or “husband/wife.”
- Offer the option of identifying with a particular sexual orientation.

The Patient Interview: Talking about issues related to patient sexuality is not easy, but by repeating the experience and applying the following recommendations, discussions will become more comfortable.

- As with all patient contacts, approach the interview showing empathy, open-mindedness, and without rendering judgment.
- Use gender-neutral language when inquiring about sexual partners or significant others.

When discussing sexual health:

- Begin by informing the patient that taking a sexual history is a standard practice.
- Avoid inquiring about sexual orientation, focusing instead on sexual behaviour.

- Assess their knowledge of the risk of STIs in relation to sexual behaviour. Some well-informed MSM may resent a discussion of HIV risk, assuming a clinician is equating homosexuality with HIV.
- Ask the patient to clarify terms and/or behaviours that you are unfamiliar with.
- Respect a patient's desire to withhold answers to sensitive questions, offering to discuss the issue at a later time.

Staff Sensitivity and Training: Sensitising administrative, nursing, and clinical staff members is critical to creating and maintaining practice environments that are considered safe by MSM. Topics to include in a staff training programme should include:

- Use of appropriate language when addressing or referring to patients and/or their significant others
- Basic familiarity with important MSM health issues such as substance abuse, partner violence, STIs/HIV, depression, and discrimination
- Mechanisms for the referral to gay-identified or gay-friendly providers

Developing resource lists and guidelines for patient interactions can reduce possible staff anxiety in dealing with MSM and/or gay-identified patients.

Confidentiality: Developing and distributing a written confidentiality statement will encourage MSM and other patients to disclose information pertinent to their sexual health. Such a policy should incorporate the following key elements :

- The information covered
- Who has access to the medical record
- How test results remain confidential
- Policy on sharing information with insurance companies
- Instances when maintaining confidentiality is not possible

Display the confidentiality statement prominently and provide a copy to every patient. It may also be beneficial if staff members agree to the statement in writing.

Key Resources and Relationships: An individual clinician or practice cannot meet every need of MSM and/or gay-identified patients. Developing a list of resources available in the local community will facilitate the comprehensive and quality care for all patients in your practice, which can include:

- Local community centres
- Counselling services including support groups, mental health services, and health education
- Identifying legal resources, specialists and other providers in the community who are gay-identified and/or gay-friendly

References and Additional Resources



1. Gay Men's Health. Small Effort, Big Change. <http://www.gmhp.demon.co.uk/guides/gp/smalleffort.html>. Accessed February 20, 2002.
2. Kaiser Permanente National Diversity Council and the Kaiser Permanente National Diversity Department. A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgendered Populations.
3. Telex, C. MD, et al. Journal of the Gay and Lesbian Medical Association. Attitudes of Physicians in New Mexico Toward Gay Men and Lesbians. Vol. 3, No. 3, 1999
4. Massachusetts Department of Health. The Gay, Lesbian, Bisexual, and Transgender Health Access Project. <http://www.glbthealth.org>. A source for consensus documents on LGBT health, standards of practice, and other resources, including three posters used in a public campaign.
5. Gay and Lesbian Medical Association. <http://www.glma.org>. GLMA works to maximise the quality of health and health services for lesbian, gay, bisexual, and transgender people.
6. Human Rights Campaign. <http://www.hrc.org>. Grassroots political organisation working for lesbian, gay, bisexual, and transgender equal rights.
7. Gay Men's Health Crisis. <http://www.gmhc.org>. Located in New York City, GMHC provides AIDS care, education and advocacy locally and worldwide.

2 CLINICAL MANAGEMENT

2.1 The Management of STIs in Female Sex Workers

(Adapted from the World Health Organization. 2002. Guidelines for the management of sexually transmitted infections in female sex workers. WHO Regional Office for the Western Pacific.)

First-time attendees

Upon their initial visit, all sex workers should be treated for cervicitis. In case laboratory facilities are available, venereal diseases research laboratories test (VDRL) or the rapid plasma regain (RPR) should be done to detect syphilis. Depending on the signs and symptoms presented, sex workers should also be treated for Vaginitis (caused by Candida) if there is a complaint of vaginal itching and white vaginal discharge. Sex workers should be treated for Bacterial vaginosis (BV) or Trichomonas vaginosis (TV) if there is a complaint of a frothy or offensive vaginal discharge. All clients who have not attended for more than 6 months should be considered new attendees and treated for cervicitis.

Follow-up cases

Clients re-attending within 6 months should be assessed according to facilities available:

- A. With laboratory and speculum
- B. Without laboratory, with speculum
- C. Without laboratory, without speculum

A. *With laboratory and speculum*



Risk assessment:

- Complaint of vaginal discharge
- Lower abdominal pain
- More than three clients per day
- Condom not used with clients
- Fever

Action: Treat for cervicitis if two or more are positive.

If the risk assessment is negative, determine if there is:

- Yellow discharge from cervix
- 20 white blood cells per high power field
- Cervical erosion/contact bleeding
- Pain on bimanual examination

Action: If any one sign is positive, treat for cervicitis.

In case laboratory facilities are available, perform tests for BV, TV and Candida, and treat accordingly.

B. *Without laboratory, with speculum*

Risk assessment:

- Complaint of vaginal discharge
- Lower abdominal pain
- More than three clients per day
- Condom not used with clients
- Fever

Action: Treat for cervicitis if two or more are positive. Ectopic pregnancy or other conditions requiring surgery should be excluded if suspected.

If the risk assessment is negative, determine if there is:

- Yellow discharge from cervix

- Cervical erosion/contact bleeding
- Pain on bimanual examination

Action: If any one sign is positive, treat for cervicitis.

If vaginitis is accompanied by a frothy discharge or a discharge with offensive smell, treat for BV or TV. If vaginal itching and white discharge is present, treat for Candida.

C. Without laboratory, without speculum

Risk assessment:

- Complaint of vaginal discharge
- Lower abdominal pain
- More than three clients per day
- Condom not used with clients
- Fever

Action: Treat for cervicitis if two or more are positive. Ectopic pregnancy or other conditions requiring surgery should be excluded if suspected.

If the vaginitis is accompanied by a frothy discharge or a discharge with offensive smell, treat for BV or TV. If vaginal itching and white discharge is present, treat for Candida.

Etiological diagnosis

This diagnosis requires a laboratory for the microbiological and serological testing of specimens. If the clinic has the minimum required equipment and the personnel are trained and experienced in performing tests, certain tests may be performed quickly and reliably on site. These include gram-staining, the microscopic examination of fresh wet mounts of secretions, and the RPR for syphilis.



2.2 Management of STIs in MSM and Transgenders

Many MSM and transgenders are at an increased risk of contracting STIs and HIV partly because of the high rates of partner change and low rates of condoms use. This situation is inevitably worse where there has been little intervention aimed at increasing condom use and improving their health-seeking behaviours and the quality of clinical STI services.

A high prevalence of STIs suggests that it is very likely that patients attending a clinic will already be infected with one or more STIs. The high incidence of STIs may also indicate that patients returning to a clinic may have acquired new and possibly different infections. Additionally, many infections remain asymptomatic. For example, gonococcal and chlamydial infections of the rectum are commonly asymptomatic and most syphilis remains undetected unless serological tests are performed. Ideally, syphilis patients should be treated with penicillin at the clinic as long as the clinic is equipped to handle the rare event of an anaphylactic reaction.



Routine referrals for MSM to clinical services

Many of the infections experienced by MSM and transgenders will be symptomatic and can be well managed by following the syndromic approach to STI case management (refer to the following section). However, an effective strategy for managing STIs among MSM and transgenders requires that both the asymptomatic and symptomatic infections are addressed. Within the FPP programme this means that outreach workers and other community groups should recommend routine referrals to the Mythri Centres.

Syndromic management of symptomatic infections in MSM and transgenders

The guidelines within this manual, which are based on the NACO syndromic treatment guidelines, should be applied to MSM displaying symptomatic STI symptoms seen within the Mythri Centres. To improve treatment adherence, the regimens recommended in the treatment packs are usually single doses, which should be administered under supervision whenever possible.

Pharyngeal infections

The prevalence of pharyngeal gonococcal and chlamydial infections among MSM and transgenders in Asia is not adequately documented. In the absence

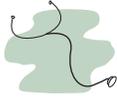
Treatment for presumptive pharyngeal gonococcal or chlamydial infections



Recommended Regime: GREY PACK

Cefixime: 400mg single oral dose

Azithromycin: 1g single oral dose



of etiological tests for gonorrhoea and chlamydia, it is very difficult to reliably diagnose these infections. Clinicians should also be aware that pharyngeal infections can be more difficult to clear than urethral infections. Other oropharyngeal STIs such as herpes and warts can often be detected by macroscopic examination and managed according to the national guidelines.

It is recommended that when a patient is suffering from significant pharyngitis and a history of unprotected oral sex makes pharyngeal gonococcal or chlamydial infection a likely risk, patients should be presumptively treated as follows:

Management of asymptomatic STIs

The following recommendations are for the clinical management strategy of the asymptomatic detection and treatment of STIs:

1. All MSM and transgenders should be recommended to attend an initial STI checkup that would include sexual history, an examination (external anogenital and, if indicated, proctoscopic), a pretest HIV discussion, a referral for voluntary counselling and testing (VCT), and serological testing for syphilis when available.
2. Symptomatic STI clients should be managed syndromically according to the FPP guidelines or following the protocol below for anorectal conditions according to their presenting complaint.
3. The subsequent development of symptoms would be managed by the syndromic approach.
4. The recommended frequency for repeat checkups is dependant on the reported sexual behaviours of the client and the assessment of the outreach worker. It is suggested that patients return every three to six months.

Anorectal STIs

STIs may be spread through anal sex when blood, semen or other body fluid is shared. STIs that affect the anorectal area include gonorrhoea, chlamydia, warts, syphilis, and herpes (*Herpes simplex virus infection*). Hepatitis B and HIV/AIDS, however, are two serious STIs whose lesions do not appear on the anus.

It is possible to acquire an STI without anal penetration. Oraltoanal contact, whether from kissing or from oral contact with fingers that touched the anus or genitals, can spread bacteria and cause infection. The sharing of unprotected or unclean sex toys may also transmit certain diseases. Using condoms is an excellent way to prevent STI transmission, although they might be less effective

against some STIs such as the human papilloma virus (HPV), which is transmitted by skin-to-skin contact.

Enteric and other pathogens that can be spread through anoral contact include Giardiasis, Shigellosis and infections with enteric pathogens such as Entamoeba and Hepatitis A.

Proctitis

Proctitis is the most common reaction to an anorectal STI such as gonorrhoea, syphilis, chlamydia, and herpes and is characterised by an inflammation of the rectal wall. An individual with an impaired immune system is also at an increased risk of developing proctitis, particularly from infections caused by the *Herpes simplex virus*, cytomegalovirus, or from the reactivation of an earlier infection.

Proctitis may be caused by *Salmonella* spp., *Shigella* spp. or *Entamoeba histolytica* as part of gastroenteritis, manifesting as diarrhoeal disease with systemic symptoms of fever, anorexia and abdominal cramps. Antibiotics that destroy normal intestinal bacteria and allow other bacteria to grow in their place may also cause proctitis. Proctitis can also be caused by radiation therapy directed at, or near, the rectum. Herpes proctitis may be mistaken for the rectal manifestation of ulcerative colitis or Crohn's disease.



Symptoms and diagnosis of proctitis

Proctitis typically causes bleeding or the passage of mucus (sometimes mistaken for diarrhoea) from the rectum. There also may be the ineffectual straining to defecate (tenesmus), sometimes described as constipation by patients. When the cause of proctitis is gonorrhoea, herpes or cytomegalovirus infection, the anus and rectum may be intensely painful, with external and internal ulcerations.

To diagnose proctitis, anoscopy or proctoscopy can be used to detect rectal pus, bleeding or ulcerations. Samples of pus and the ulcers may be sent to a laboratory for the diagnostic testing of bacteria, virus and fungi.

Treatment of Proctitis



The most effective treatment for proctitis caused by a specific bacterial infection is antibiotics. Most bacterial diarrhoeal diseases are immediately resolved with oral rehydration.

Management of anorectal infections in MSM and transgenders

The management of asymptomatic anorectal infections will not be undertaken within the Mythri Centres at the present time. This will be reviewed in the light of any new epidemiological data about the prevalence of these infections in MSM and transgenders.

Partner notification

Partner notification, also known as contact tracing, continues to be a problematic area. Many MSM may have female partners and are married. It is often difficult to pursue the tracing of partners, particularly in the case of spouses and regular female partners of clients found to be infected with STIs. The use of counselling services and community support by outreach workers and volunteers strongly facilitate the sensitive handling of these complex situations.

Please refer to Volume I for more information.

S1 Urethral Discharge

(Adapted from the World Health Organization. 2002. Guidelines for the management of sexually transmitted infections in female sex workers. WHO Regional Office for the Western Pacific)

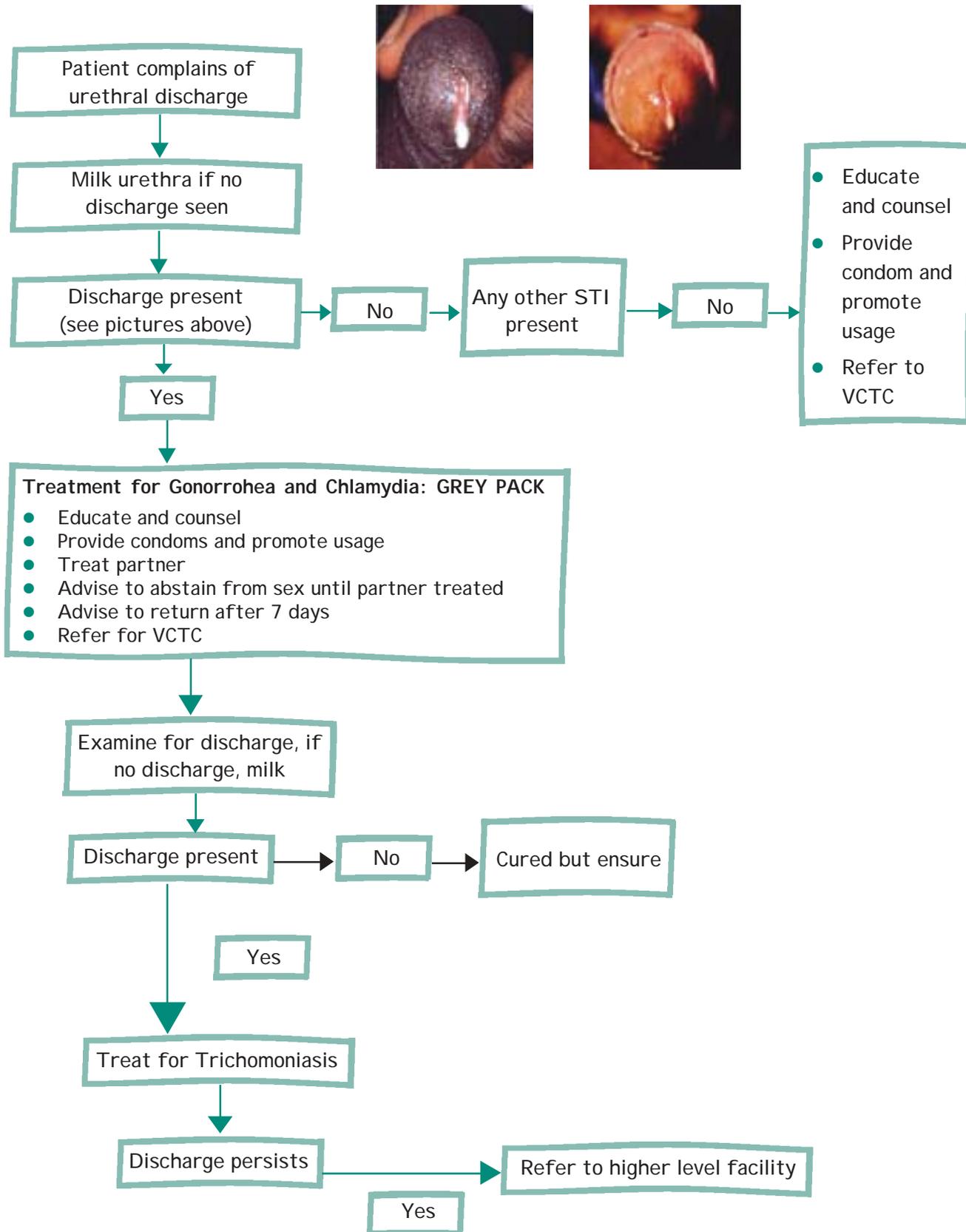
Male patients complaining of urethral discharge and/or dysuria should be examined for evidence of discharge. If none is seen, the urethra should be gently massaged from the ventral part of the penis towards the meatus. If microscopy is available, the examination of the urethral smear may show an increased number of polymorphonuclear (PMN) leukocytes and a gram stain may demonstrate the presence of Gonococci. In males, more than 5 PMN leukocytes per high power field (HPF) is indicative of Urethritis. If the patient complains of dysuria and there is no discharge on examination, a positive leukocyte esterase test or a smear showing more than 10 PMNs/HPF of the first voided urine or after holding the urine for 4 hours, also confirms the diagnosis of Urethritis. The major pathogens causing urethral discharge are *N. Gonorrhoeae* and *Chlamydia trachomatis*. In the syndromic management of urethral discharge, the treatment of a patient should effectively cover these two organisms.

Persistent or recurrent symptoms of Urethritis may be due to drug resistance, poor compliance or re-infection. In some cases there may be infection with *Trichomonas vaginalis* as new evidence in some geographic settings suggest a high prevalence of TV in men with urethral discharge. Where the symptoms

persist or recur after adequate treatment for Gonorrhoea and Chlamydia and the partner(s) have been treated, the patient should be treated for TV. If the symptoms are still present at the time of follow-up, the patient must be referred to a higher facility. Patients with Urethritis who are also infected with HIV should receive the same treatment regimen as those who are HIV-negative.

	Non-Gonococcal Urethritis	Gonococcal Urethritis
Etiology	C. trachomatis	N. gonorrhoeae
Clinical Features		
Onset	Gradual	Abrupt
Dysuria	Mild	Severe
Discharge Quality	Mucoid	Purulent
Quantity	Less	More
Microscopy	Urethral smear: > 5 PMNs/HPF	Gram stain negative: intra-cellular diplococci

S1 Syndromic management of urethral discharge



S1 Treatment of urethral discharge syndrome

Treatment for both Gonococcal and Chlamydial infections



Recommended regimen: GREY PACK

- Azithromycin: 1g single oral dose (to treat for Chlamydia)
- Cefixime: 400mg single oral dose, under supervision (to treat for Gonorrhoea)

Alternate regimen:

For Azithromycin sensitivity, use second line pack:

- Cefixime: 400mg single oral dose plus
- Doxycycline: 100mg, 2 times daily for 7 days.

Treatment for Trichomoniasis



Metronidazole: 2g oral single dose. Take after eating and avoid alcohol for 48 hours

S1 A case scenario of urethral discharge

Vickram is a 24 year-old married man who is complaining of urethral discharge for one day. He admits to having had unprotected oral sex five days ago with another man.

1. What further questions about his sexual history would you like to know?

2. Please list the likely pathogens that cause discharge per urethra in this patient.

3. What test would you do for presumptive diagnosis?

6. However, his symptoms of dysuria were persisting. What are the possibilities to consider?

Answers

1. What further questions about his sexual history would you like to know?

Ask further and detailed questions regarding his/her sexual history; history of anal sex use and use of condoms with each; whether each type of sex was “insertive” or “receptive”; number of partners in the last 3 months; and, sex with female partner.

2. Please list the likely pathogens that cause discharge per urethra in this patient.

N. gonorrhoeae
C. trachomatis

3. What test would you do for presumptive diagnosis?

Gram stain of discharge

4. The gram stain showed gram-negative intra-cellular diplococci. How would you manage the patient?

Azithromycin: 1g oral single dose (to treat for Chlamydia)
Cefixime: 400mg oral single dose (to treat for Gonorrhoea) under supervision

Advise:

- To abstain from sexual intercourse until 7 days after therapy is initiated
- To return for evaluation after 1 week
- To bring partner(s) for examination and treatment
- To use condoms usage during all sexual relationships

This patient is being treated for both gonorrhoea and chlamydia because of possible co-infection and the difficulty of excluding diagnosis of non-gonococcal urethritis. The same treatment could be administered if gram staining was not available.

5. On follow-up, his HIV-ELISA was positive. Do you have to change his treatment regime?

No, but he needs to undergo post-test discussion and counselling and provided with onward referrals.

6. However, his symptoms of dysuria were persisting. What are the possibilities to consider?

- Lack of treatment compliance, failure to abstain from sex, and partner (particularly wife) not treated
- Treatment failure/resistance
- Other etiologies such as Trichomoniasis
- Re-infection

Treatment Options:

- Retreat with initial regime if he did not comply with the initial regime or was re-exposed to untreated sexual partner(s).
- Prescribe 2g single oral dose of Metronidazole to treat for possible Trichomonas urethritis
- Alternative: Tinidazole 2g oral dose or Secnidazole 2g oral dose

S2 Genital Ulcer Syndrome

(Adapted from the World Health Organization. 2002. Guidelines for the management of sexually transmitted infections in female sex workers. WHO Regional Office for the Western Pacific)

The relative prevalence of causative organisms for genital ulcer syndrome varies in different parts of the world and may change over time. Clinical differential diagnosis of genital ulcers is inaccurate, particularly in settings where several aetiologies are common. Clinical manifestations and patterns of genital ulcer syndrome may be further altered in the presence of HIV/AIDS. After examining the patient to confirm the presence of genital ulceration, treatment appropriate to the local aetiologies and the antibiotic sensitivity patterns should be prescribed. For example, in areas where both Syphilis and Chancroid are prevalent, patients with genital ulcers should be treated for both conditions. In many parts of the world, genital herpes is the most frequent cause of genital ulcer syndrome. Where HIV infection is also detected, an increasing proportion of cases of genital ulcer syndrome are likely to harbour Herpes simplex virus.

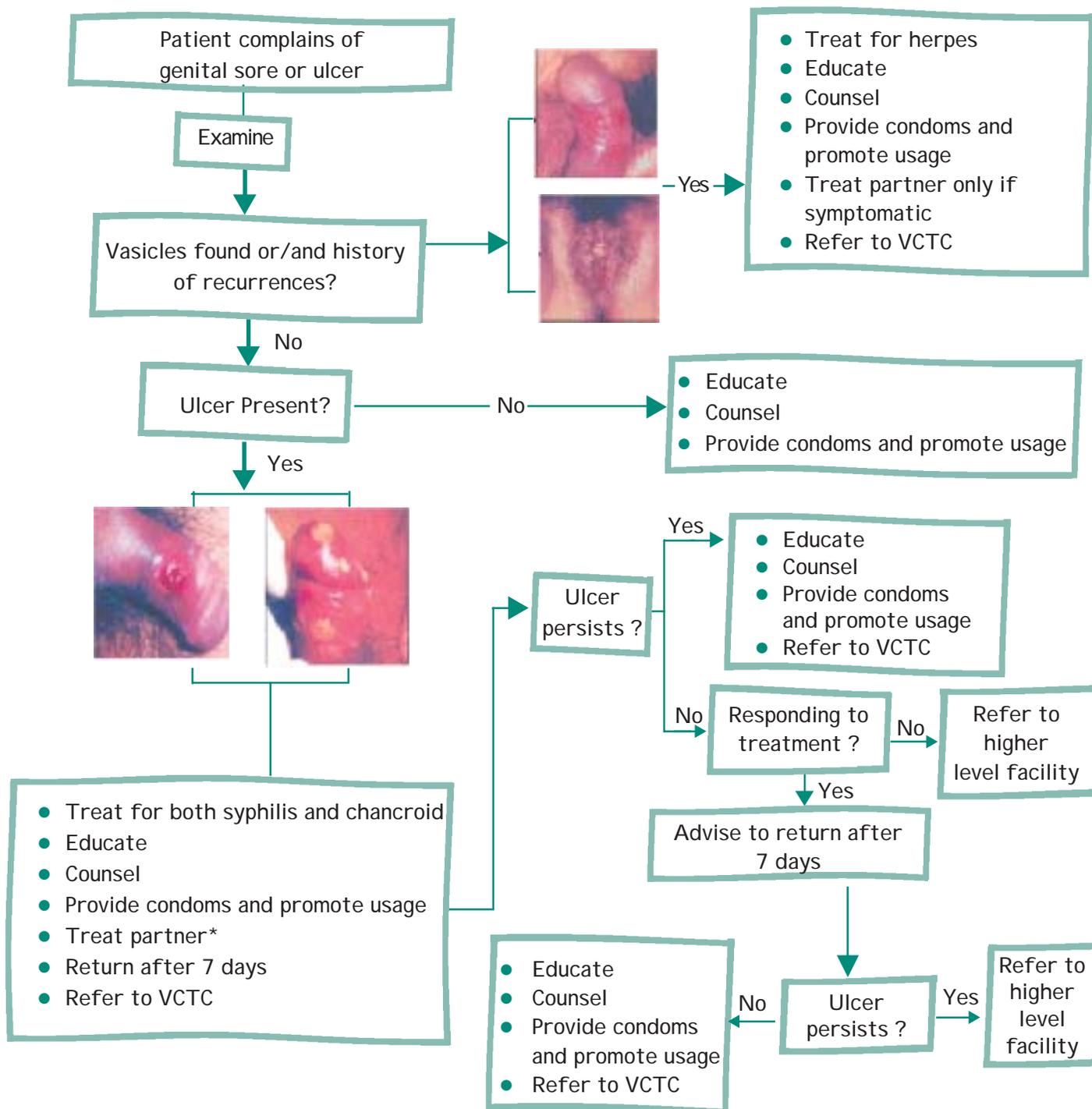
Laboratory assisted differential diagnosis is rarely helpful at the initial visit, as co-infections are common. In addition, in areas of high Syphilis prevalence, a reactive serological test may reflect a previous infection, giving a misleading picture of the patient's present condition. Not all genital ulcers are caused by STIs but may be a result of a traumatic and/or an Aphthous ulcer, Tuberculosis, Amoebiasis, Erythema multiforme or malignancy.

HIV testing and referral to a VCTC should be integrated into the management of patients who have genital ulcers as their presence increases both risk of acquiring and transmitting HIV infection. The clinical picture of ulcer syndromes may be particularly severe and prolonged when the patient is HIV positive, thus requiring longer courses of therapy. Recurrence rates after treatment may also be higher.

S2 Causes of genital ulcer syndrome

Disease	Chancroid	Granuloma Inguinale (Donovanosis)	Genital herpes	Lymphogranuloma venereum (LGV)	Syphilis
Agent	Haemophilus ducreyi	Calymatobacterium granulomatis	Herpes simplex type 1 and 2 (HSV-1 and HSV-2)	Chlamydia trachomatis serovars L1, L2 and L3	Treponema pallidum
Clinical features	<ul style="list-style-type: none"> Multiple, painful and irregular ulcers with undermined edges and not indurated (soft chancre) Unilateral, painful bubo (suppuration may occur) 	<ul style="list-style-type: none"> Painless, progressive ulcer (beefy red appearance) No regional lymphadenopathy 	<ul style="list-style-type: none"> Multiple, painful, and grouped vesicles; ulcerated and coalesced Bilateral adenopathy in primary infection Recurrent Herpes genitalis common 	<ul style="list-style-type: none"> Transient ulcer Unilateral, tender inguinal adenopathy Groove sign seen in 20% of patients 	<ul style="list-style-type: none"> Painless, single ulcer indurated with clean base. Firm bilateral Lymphadenopathy

S2 Syndromic management of genital ulcers



* Treat for syphilis, chancroid and counsel on herpes genitals.

S2 Treatment of genital ulcer syndrome

If vesicles are seen and/or history of recurrences

Considering the possible high prevalence rate of HIV infection:

Rx
Acyclovir: 400mg orally, 3 times a day for 7 days (recommended for first and recurrent episodes)

Note: There is no known cure of Herpes, but the course of the disease can be modified by *Acyclovir*.

If vesicles are not seen and no history of recurrences given Treat for both Syphilis and Chancroid

Rx
Recommended regimen: BLUE PACK

Injection of Benzathine penicillin: 2.4 million units IM, in 2 equally divided doses in each buttock (to treat Syphilis) *plus*

Azithromycin: 1g single oral dose, under supervision (to treat Chancroid)

Note: Sensitivity and/or allergy to penicillin of patients should be determined

Alternate regimens:

Option 1 for individuals allergic to penicillin: PINK PACK

Doxycycline: 100mg, 2 times daily for 15 days (to treat Syphilis) *plus*

Azithromycin: 1g single oral dose, under supervision (to treat Chancroid)

Option 2 for pregnant women allergic and/or intolerant to penicillin:

Erythromycin base/stearate: 500mg, 4 times daily for 15 days

Ask these women to bring their newborn baby for treatment within 7 days of birth.

The role of Azithromycin treatment of primary Syphilis

Please note, that the NACO guidelines do not advocate using Azithromycin 2g doses for the treatment of primary Syphilis. This has been highlighted as an alternative in the Center for Disease Control (2002) guidelines (<http://www.cdc.gov/std/treatment/default.htm>). There have been recent reported failures of this regimen (New England Journal of Medicine, June 2004) and its routine use, therefore, cannot be recommended.

S2 A case scenario of genital ulcer syndrome

Thirty-year-old Mr. Venkatappa comes with complaints of a painless ulcer of the penis over the past week. On examination, there were three mild and tender 0.5 cm non-indurated ulcers on the coronal sulcus. There was no past history of a genital ulcer and the ulcer did not start as vesicles.

1. List the STIs which can cause genital ulcers.

2. List the non-STI causes of genital ulceration

3. How would you manage this patient?

4. What serological tests to screen for STIs would you like to do on this patient? How will you raise these with him?

5. How would you follow-up with this patient? What would you do if the patient failed to respond to treatment? How should the patient's partner be screened?

Answers

1. List the STIs which can cause genital ulcers in this patient

1. *Herpes simplex*
 2. Syphilis
 3. Chancroid
 4. Donovanosis
 5. LGV

2. List the non-STI causes of genital ulceration

1. Trauma
 2. Tuberculosis
 3. Malignancies
 4. Drug-induced erythema multiforme/FDE
 5. Bullous disease
 6. Aphthous ulcers/Behcet's disease
 7. Dermatoses such as erosive lichen planus

3. How would you manage this patient?

Injection of Benzathine penicillin: 2.4 million units IM, in 2 equally divided doses in each buttock (to treat Syphilis) plus
Azithromycin: 1g single oral dose, under supervision (to treat Chancroid)

Note: Sensitivity and/or allergy to penicillin of patients should be determined

Alternate regimens:

Option 1 for individuals allergic to penicillin: **PINK PACK**

Doxycycline: 100mg, 2 times daily for 15 days (to treat Syphilis) plus
Azithromycin: 1g single oral dose, under supervision (to treat Chancroid)

Option 2 for pregnant women allergic and/or intolerant to penicillin:

Erythromycin base/stearate: 500mg, 4 times daily for 15 days

4. What serological tests, to screen for STIs, would you like to do on this patient? How will you raise these with him?

VDRL/RPR, HIV-ELISA, and HbsAg in conjunction with pre-test counselling. Explain to the patient the link between STIs and the link to HIV/AIDS with ulcerative and non-ulcerative STIs. Offer VCT referral.

5. How would you follow-up this patient? What would you do if the patient failed to respond to treatment? What should the patient's partner be screened for?

Follow-up with the patient after 7 days. If the ulcer has not healed, then you should assess compliance with medications. If the patient has been compliant, then he should be referred to a higher centre for further evaluation.

Follow-up on the RPR/VDRL results and other the serological tests.

The partner should be managed according to syndromic case management.

S3 Vaginal Discharge

(Adapted from the World Health Organization. 2002. Guidelines for the management of sexually transmitted infections in female sex workers. WHO Regional Office for the Western Pacific)

A complaint about abnormal vaginal discharge (abnormal in terms of quantity, colour or odour) is most commonly due to a vaginal infection. On rare occasions, it may be the result of a mucopurulent STI-related Cervicitis. *T. vaginalis*, *C. albicans* and bacterial vaginosis are the most common causes of vaginal infection, with *N. Gonorrhoeae* and *C. trachomatis* causing cervical infection. The clinical detection of cervical infection is difficult because a large proportion of women with gonococcal or chlamydial cervical infection are asymptomatic. The symptom of abnormal vaginal discharge is highly indicative of a vaginal infection, but poorly predictive for cervical infection. Thus, all women presenting with vaginal discharge should receive treatment for trichomoniasis and bacterial vaginosis. Among women presenting with discharge, one can attempt to identify those with an increased likelihood of infection with *N. Gonorrhoeae* and/or *C. trachomatis*.

Microscopy adds little to the diagnosis of cervical infection and is not recommended. To identify women at a greater risk of cervical infection, an assessment of risk status is useful, especially when risk factors are adapted to the local situation. Women who are positive on risk assessment have a higher likelihood of cervical infection than those who are risk negative. Women with vaginal discharge and a positive risk assessment could therefore be offered treatment for gonococcal infection and chlamydial cervicitis. Where resources permit, one could consider the use of laboratory tests such as a saline mount, gram staining and KOH preparation to screen women with vaginal discharge. Treatment does not differ in HIV-positive individuals.

S3 Causes of vaginal discharge

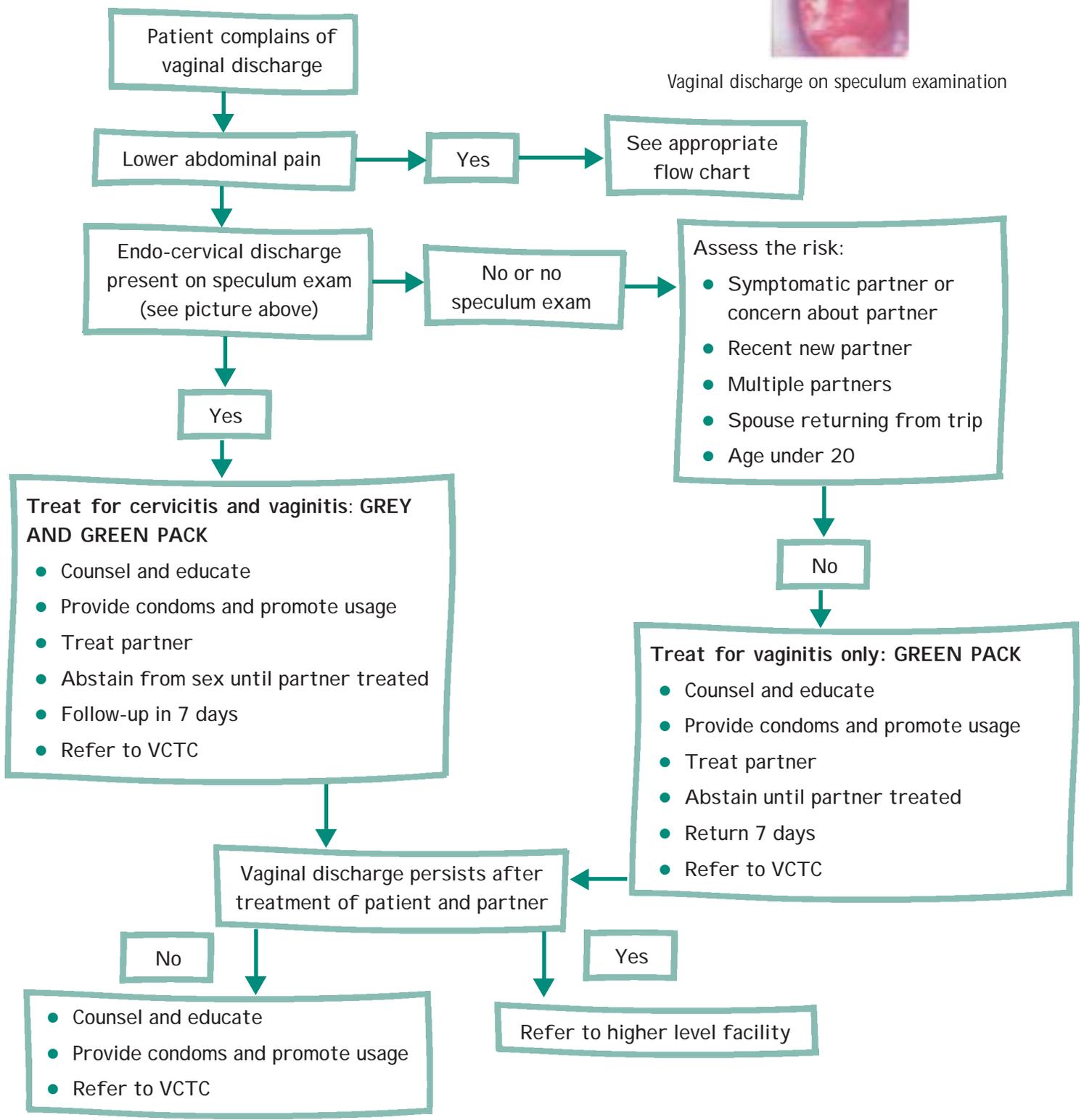
	<i>Candidial vaginitis</i>	<i>Trichomonas vaginitis</i>	<i>Bacterial vaginosis</i>
Etiology	<i>Candida albicans</i> and other <i>Candida sp.</i>	<i>Trichomonas vaginalis</i>	<i>Gardnerella vaginalis</i> , <i>anaerobic bacteria</i> , <i>Mycoplasma genitalium</i>
Clinical Features			
Symptoms	<ul style="list-style-type: none"> ● Vaginal discharge ● Vulval itching and burning 	<ul style="list-style-type: none"> ● Vaginal discharge 	<ul style="list-style-type: none"> ● Malodorous discharge
Discharge	<ul style="list-style-type: none"> ● White ● Curd-like 	<ul style="list-style-type: none"> ● Profuse ● Yellow, frothy 	<ul style="list-style-type: none"> ● White or grey ● Homogenous
Genital examination	<ul style="list-style-type: none"> ● Erythema of introitus and vaginal wall ● Vulvar dermatitis 	<ul style="list-style-type: none"> ● Erythema of vagina wall ● Strawberry cervix 	<ul style="list-style-type: none"> ● None
Microscopy	KOH: hyphae visible	Wet mount: motile <i>Trichomonas vaginalis</i>	Wet mount: Clue cells (squamous cells covered by bacterial rods)

S3 Syndromic management of vaginal discharge

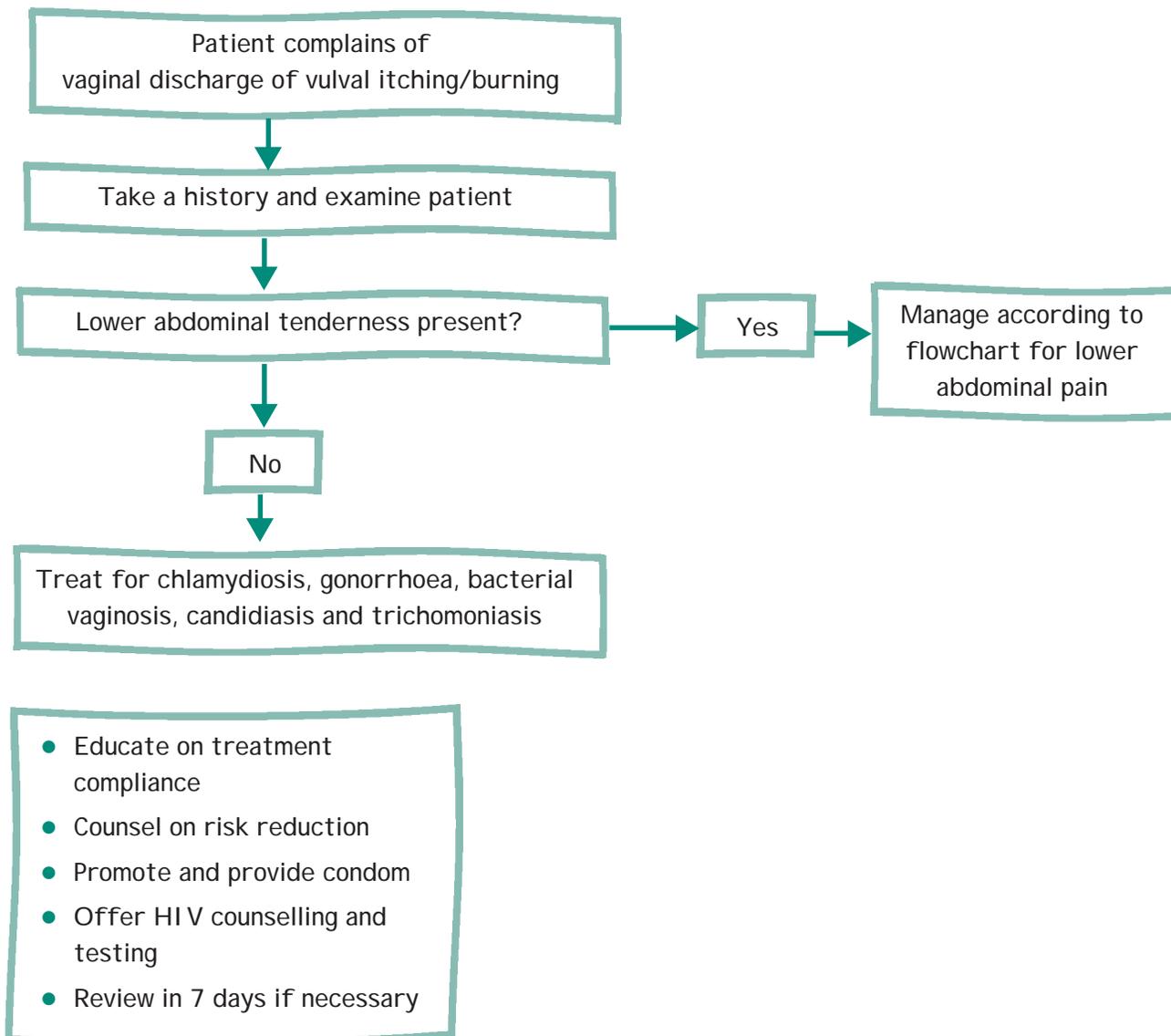
The following is for general female clients.



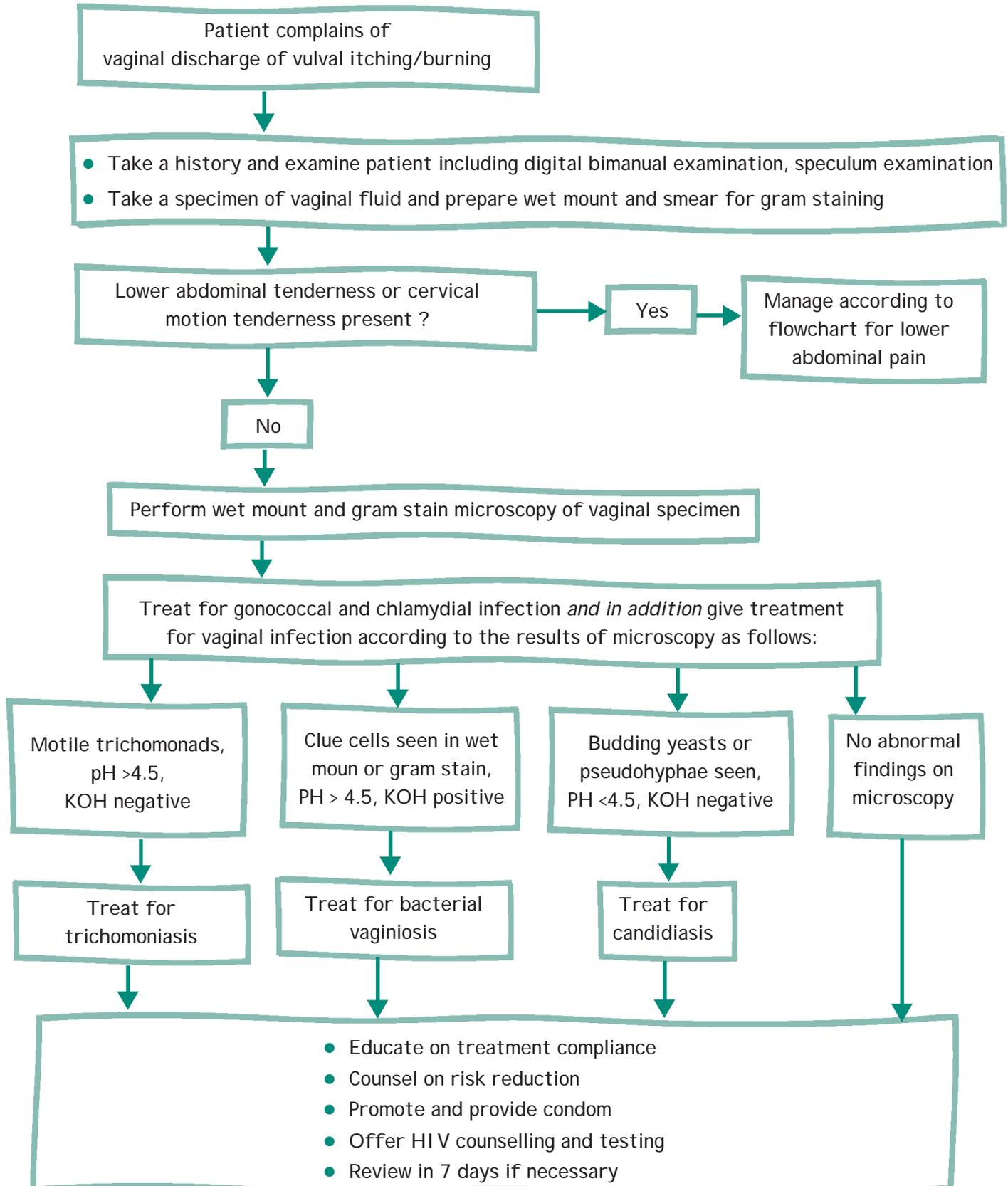
Vaginal discharge on speculum examination



S3 Management of vaginal discharge in female sex workers



S3 Management of vaginal discharge when speculum examination and laboratory facilities are available



S3 Treatment of vaginal discharge syndromes

Treatment for Cervicitis

Recommended regimen: GREY PACK

Azithromycin: 1g single oral dose *plus*

Cefixime: 400mg single dose under supervision (to treat both Gonococcal and Chlamydial infections).

Alternate regimens:

Option 1 for *Azithromycin* intolerance

Cefixime: 400mg single oral dose under supervision (to treat gonococcal infection) *plus*

Doxycycline*: 100mg oral dose, 2 times daily for 7 days (to treat chlamydial infection).

*In pregnant women give ***erythromycin stearate:*** 500mg oral dose, 4 times daily for 7 days instead of *Doxycycline*.

Treatment for Vaginitis

Recommended regimen: GREEN PACK

Metronidazole: 2g single oral dose under supervision (to treat trichomoniasis and bacterial vaginosis) *plus*

Fluconazole:** 150mg single oral dose (to treat candidiasis)

Alternate regimen:

Metronidazole*:** 400mg orally, 2 times a day, for 7 days (to treat trichomoniasis and bacterial vaginosis) *plus*

Fluconazole: 150mg single oral dose

Give pregnant women *clotrimazole pessary:*** 500mg intravaginally, one dose at night

***Do not give *Metronidazole* during the first trimester of pregnancy

S3 A case scenario of vaginal discharge

Shanti is a 23 year-old female sex worker who visits a clinic complaining of a vaginal discharge. She has no abdominal pain or pain during intercourse. This is her first visit to the clinic.

1. What other information would you require from her sexual history?

2. List the STIs that can cause vaginal discharge in this patient?

3. What laboratory tests could be done on the vaginal discharge?

4. How would you manage this patient?

5. What serological tests, to screen for STIs, would you offer to this patient?

6. What additional services would you offer?

Answers

1. What other information would you require from her sexual history?

A detailed sexual history including time of last sexual intercourse, barrier and non-barrier contraception usage, last menstrual period, etc.

2. List the STIs that can cause vaginal discharge in this patient.

1. Trichomoniasis
2. Vulvo-vaginal candidiasis
3. Bacterial vaginosis
4. Both gonorrhoea and chlamydia cause cervical discharge, which can present as vaginal discharge. Both need to be considered and treated in active female sex workers who present with vaginal discharge.

3. What laboratory tests could be done at the time of the vaginal examination?

KOH, saline mount, gram staining

4. How would you manage this patient?

If no speculum/laboratory facilities are available to treat gonorrhoea, chlamydia, bacterial vaginosis, trichomoniasis and candidiasis:
Cefixime: 400mg, Azithromycin: 1g, Metronidazole: 2g, Fluconazole: 150mg orally (or 500mg Clotrimazole pessary)

If lab facilities are available:
Azithromycin: 1g stat
Plus, treatment according to microscopy:

Motile trichomonads, pH >4.5, KOH negative: Trichomoniasis

Metronidazole: 2g single oral dose

Clue cells, pH > 4.5, KOH positive: Bacterial vaginosis

Metronidazole: 2g single oral dose

Budding yeasts or pseudohyphae, pH ≤4.5, KOH negative: Candidiasis

Fluconazole: 150mg or 500mg Clotrimazole pessary

Examine partners and prescribe treatment.

5. What serological test to screen for STIs would you offer to this patient?

Following discussion, VDRL/RPR, HIV-ELISA via referral for counselling and testing, and HbsAg would be recommended.

6. What additional services would you offer?

Education on treatment adherence, counselling on risk reduction, linkages to local groups, promotion and provision of condoms, offering referral for HIV testing and counselling, and follow-up review in 7 days, if necessary.

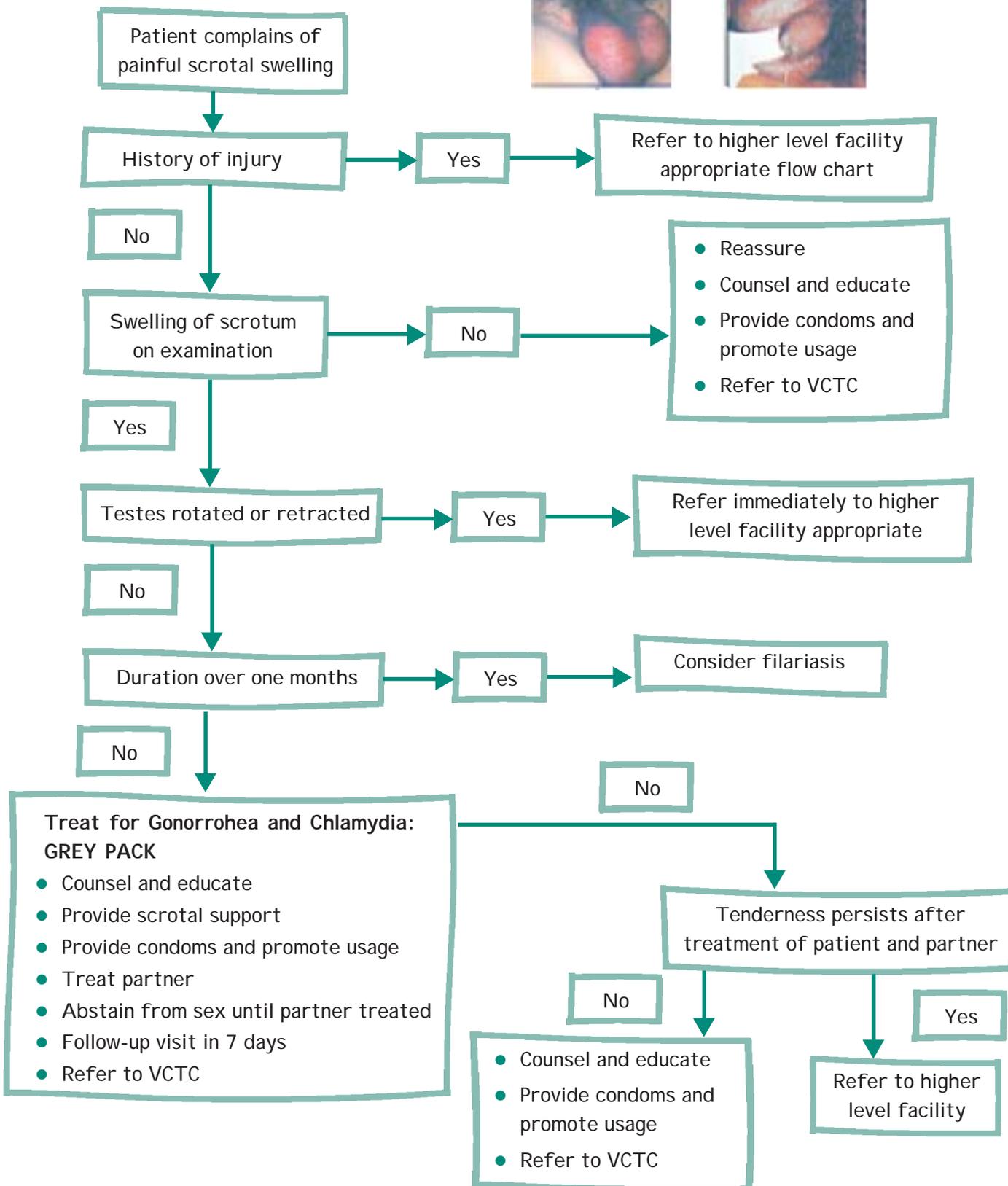
S4 Scrotal Swelling

(Adapted from the World Health Organization. 2002. Guidelines for the management of sexually transmitted infections in female sex workers. WHO Regional Office for the Western Pacific)

Inflammation of the epididymis (epididymitis) usually manifests itself by the acute onset of unilateral testicular pain and swelling. This is often accompanied with tenderness of the epididymis and vas deferens and occasionally with erythema and oedema of the overlying skin. In men under 35 years of age, this is more frequently due to STIs than in those over 35 years of age. When the epididymitis is accompanied by urethral discharge, it should be presumed to be of a sexually transmitted origin, commonly gonococcal and/or chlamydial. The adjacent testis may often be inflamed (Orchitis), giving rise to epididymo-orchitis.

In older men, where there may be no risk of STI, other general infections may be responsible, for example, *Escherichia coli*, *Klebsiella* sp., or *Pseudomonas aeruginosa*. A Tuberculous orchitis, generally accompanied by an epididymitis, is always secondary to lesions elsewhere, especially in the lungs or bones. It is important to consider other non-infectious causes of scrotal swelling such as trauma, testicular torsion and the presence of a tumour. Filial lymphadenitis is another prevalent cause of scrotal swelling. Testicular torsion, which should be suspected when the onset of scrotal pain is sudden, is a surgical emergency that requires urgent referral. If not effectively treated, STI-related epididymitis may lead to infertility.

S4 Scrotal swelling syndromic management



S4 Syndromic treatment of scrotal swelling

Treatment for Gonorrhoea and Chlamydia

Recommended regimen: GREY PACK

Azithromycin: 1g single oral dose ***plus***

Cefixime: 400mg single oral dose under supervision (to treat both Gonococcal and Chlamydial infections)

Alternative regimen:

Injection of Ceftriaxone: 250mg, IM stat (not in formulary) ***plus***

Doxycycline: 100mg, 2 times a day for 14 days or

Cefixime: 400mg oral dose, stat ***plus***

Doxycycline: 100mg, 2 times a day for 14 days

In addition to drug therapy:

Elevation of the scrotum with scrotal support.

Analgesia to be prescribed.

S4 A case scenario of scrotal swelling

A 25 year-old man presents to the clinic with symptoms of pain in the scrotum for 3 days. On examination, he has a tender and warm unilateral scrotal swelling. The epididymis was tender and thickened. There is no inguinal adenopathy.

1. What additional history and examination will you evaluate for?

2. What is the likely diagnosis? What differential diagnosis do you need to take into account?

3. What treatment will you initiate?

Answers

1. What additional history and examination will you evaluate for?

Additional history: History of trauma, onset of pain (acute onset may suggest torsion), loin to groin pain (may suggest testicular torsion), previous similar episodes (may suggest filarial epididymo-orchitis), recent urethral discharge, past history of tuberculosis, and history of high risk behaviour. Examination: Inspection (scrotal oedema), palpation (enlarged, tender testis - when elevated - having a transverse lie and the pain is not relieved, is suggestive of torsion testis), epididymal thickening and warmth.

2. What is the likely diagnosis? What differential diagnosis do you need to take into account?

Likely diagnosis: Epididymo-orchitis (due to *C. trachomatis* or *N. Gonorrhoeae*) since the onset is not acute and the scrotum is warm. Differential diagnosis: Epididymo-orchitis of other origin (bacterial, tuberculous, and filarial), trauma, testicular torsion, and testicular tumour.

3. What treatment will you initiate?

Recommended regimen:

Azithromycin: 1g single oral dose **plus**

Cefixime: 400mg single oral dose

Alternative regimen: if patient has intolerance to *Azithromycin*

Injection of Ceftriaxone: 250mg, IM stat (not in formulary) **plus**

Doxycycline: 100mg, 2 times a day for 14 days or

Cefixime: 400mg oral dose, stat **plus**

Doxycycline: 100mg, 2 times a day for 14 days

Elevation of the scrotum with scrotal support.

Analgesics

Advise patient to:

- Abstain from sexual intercourse until 7 days after therapy is initiated
- Return for follow-up after 1 week
- Bring partner for examination and treatment
- Use condoms with all sexual relationships

S5 Lower Abdominal Pain in Women

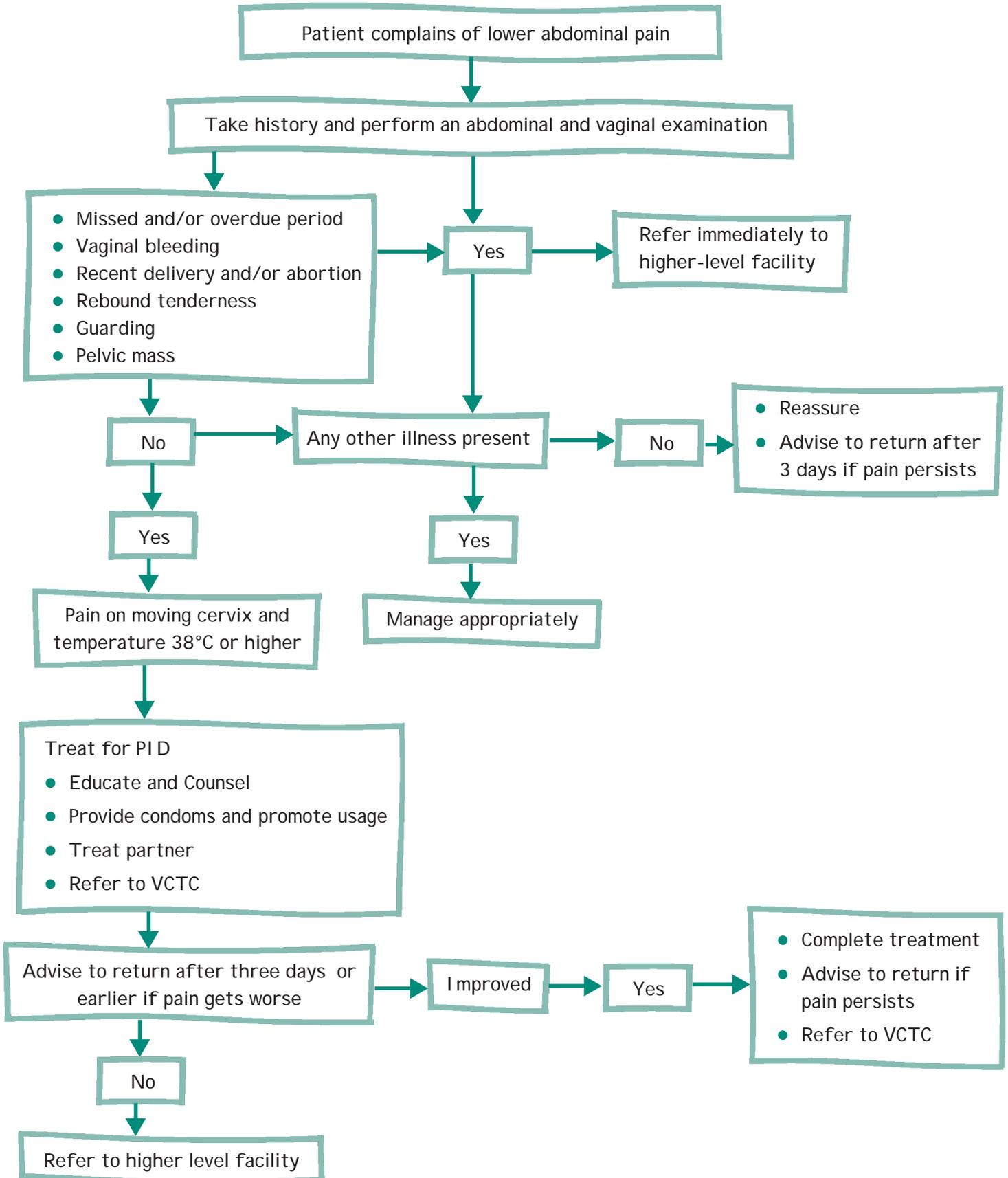
(Adapted from the World Health Organization. 2002. Guidelines for the management of sexually transmitted infections in female sex workers. WHO Regional Office for the Western Pacific)

All sexually active women presenting with lower abdominal pain should be carefully evaluated for the presence of Salpingitis (pelvic inflammatory disease, PID) and/or Endometritis. In addition, both routine bimanual and abdominal examinations should be carried out on all women with a suspected STI since some women with PID or Endometritis will not always complain of lower abdominal pain. Women with Endometritis may present with complaints of vaginal discharge, and/or bleeding, and/or uterine tenderness during the pelvic examination. The symptoms suggestive of PID include abdominal pain, dyspareunia, post coital bleeding, vaginal discharge, menorrhagia, dysuria, pain associated with menses, fever, nausea, and vomiting.

PID is difficult to diagnose because clinical manifestations are varied. PID becomes highly probable when one or more of the above symptoms are seen in a woman with adnexal tenderness, evidence of a lower genital tract infection, and cervical motion tenderness. The enlargement or induration of one or both of the fallopian tubes, a tender pelvic mass, and direct or rebound tenderness may also be present. The patient's temperature may be elevated, but is normal in many cases. Hospitalisation of patients with acute PID should seriously be considered when the diagnosis is uncertain; surgical emergencies such as Appendicitis and Ectopic pregnancy can not be excluded; a pelvic abscess is suspected; severe illness prevents management on an outpatient basis; the patient is pregnant; or, the patient is unable to follow, tolerate or has failed to respond to an outpatient regimen.

Etiological agents include *N. gonorrhoeae*, *C. trachomatis*, and anaerobic bacteria (*Bacteroides* spp. and gram-positive cocci). Facultative gram-negative rods and *Mycoplasma genitalium* have also been implicated as agents. As it is impossible to differentiate between these clinically, and a precise microbiological diagnosis is difficult, the treatment regimens must be effective against this broad range of pathogens.

Syndromic management of lower abdominal pain in women



S5 Syndromic treatment of lower abdominal pain in women

Treat patient for Gonococcal and Chlamydial infections as well as for anaerobic bacteria



Recommended regimen:

Cefixime: 400mg single oral dose under supervision (to treat Gonococcal infection) *plus*

Doxycycline*: 100mg orally, 2 times daily for 14 days (to treat Chlamydial infection) *plus*

Metronidazole:** 400mg orally, 2 times daily for 14 days (to treat anaerobic bacteria)

Alternate regimen: PURPLE PACK

Option 1

Azithromycin: 1g single oral dose *plus*

Cefixime: 400mg single oral dose under supervision (to treat both Gonococcal and Chlamydial infections) *plus*

Metronidazole:** 400mg orally, 2 times daily for 14 days (to treat anaerobic bacteria).

* In individuals with an allergic and/or intolerant reaction to *Doxycycline* and in all pregnant and/or lactating women use **Erythromycin base/ stearate:** 500mg orally, 4 times daily for 14 days instead of *Doxycycline*.

**Generally, *Metronidazole* is not recommended during the first trimester of pregnancy. However, it should not be withheld from a highly acute case of PID, which always represents an emergency. Pregnant women with abdominal pain should generally be referred to a specialist.

PID can be a serious condition. The treating doctor must refer the patient to the hospital if she does not respond to the treatment within 3 days and even earlier if condition is worsening.

S5 A case scenario of lower abdominal pain

A 22 year-old woman presented to the outpatient clinic with complaints of lower abdominal pain and fever for 4 days. On examination, her temperature was 101° F and Iliac fossa tenderness was present. The pelvic examination showed cervical motion tenderness. The speculum examination found a Copper-T in situ and a scanty mucopurulent discharge from the cervix was detected. No adnexal masses felt on bimanual examination.

1. What additional history will you ask for?

2. What additional findings will you look for on abdominal examination?

3. What treatment will you initiate?

Answers

1. What additional history will you ask for?

History of missed periods; recent delivery or abortion; menorrhagia or metorrhagia; history of sexual behaviour of patient and of partner; and, date of IUD insertion.

2. What findings will you look for on abdominal examination?

Rebound tenderness or guarding. The presence of these would suggest a surgical cause of abdominal pain such as acute appendicitis that requires immediate referral.

3. What treatment will you initiate?

Cefixime: 400mg single oral dose under supervision (to treat Gonococcal infection) plus

Doxycycline*: 100mg orally, 2 times daily for 14 days (to treat Chlamydial infection) plus

Metronidazole:** 400mg orally, 2 times daily for 14 days (to treat anaerobic bacteria)

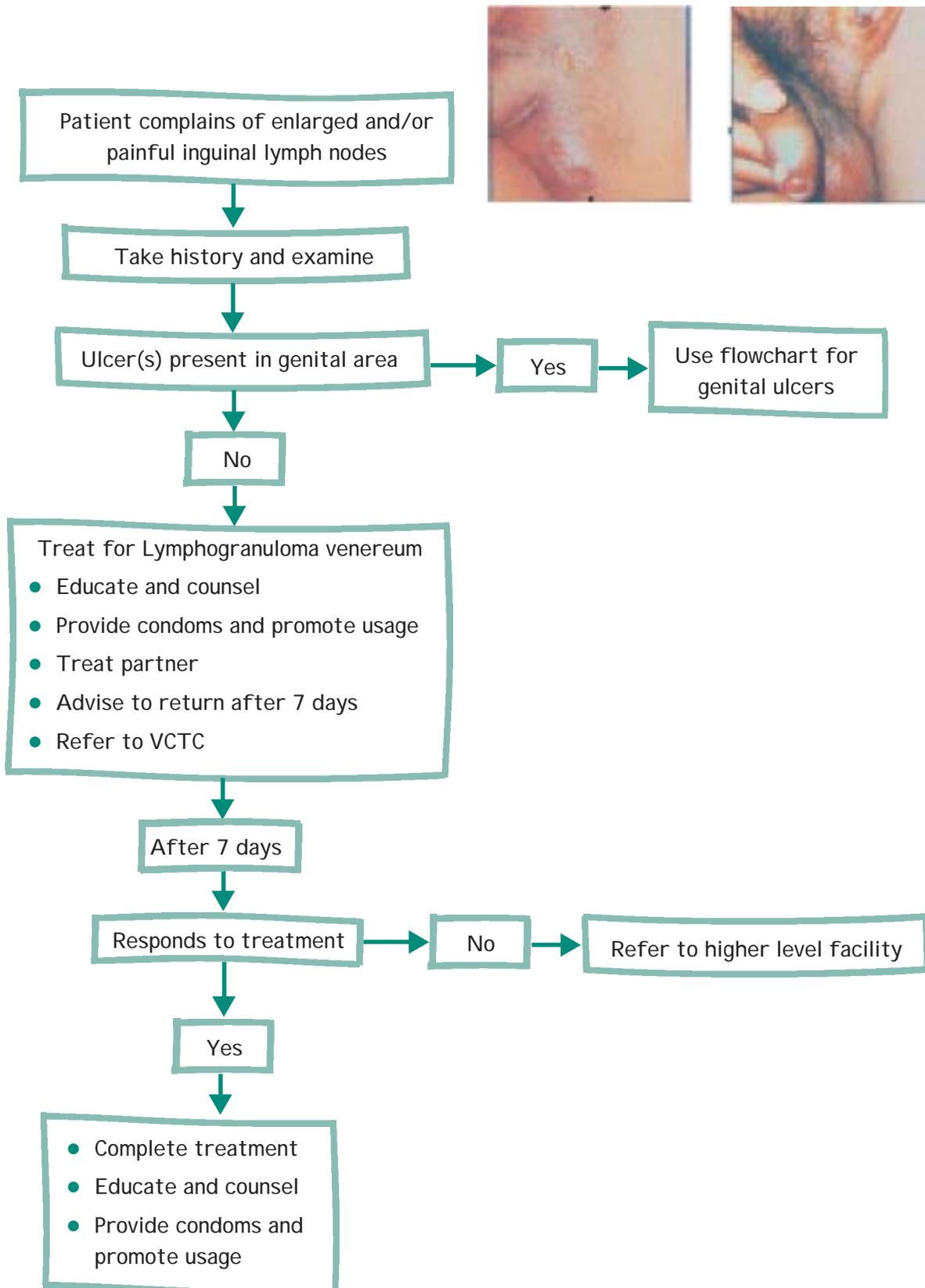
Patient should remove the copper-T on the first day of the next menstrual period, after 2-4 days of antibiotic coverage to prevent dissemination of infection.

S6 Inguinal Bubo

(Adapted from the World Health Organization. 2002. Guidelines for the management of sexually transmitted infections in female sex workers. WHO Regional Office for the Western Pacific)

Inguinal and femoral buboes are localised enlargements of the lymph nodes in the groin area, which are painful and may be fluctuant. They are frequently associated with *Lymphogranuloma venereum* and Chancroid. In many cases of Chancroid, an associated genital ulcer is visible. Non-sexually transmitted local and systemic infections (e.g. infections of a lower limb) can also cause swelling of the inguinal lymph nodes. Within India, it is particularly important to consider Tuberculosis and Filariasis as causes.

S6 Syndromic management of inguinal bubo



S6 Syndromic treatment of inguinal bubo

Rx

Recommended regimen:
YELLOW PACK

Doxycycline: 100mg orally,
2 times a day for 21 days.

Other options for management

If the bubo becomes fluctuant, the management requires aspiration of the pus with a wide bore needle and syringe. If the clinician is experienced, enter into the bubo through the adjacent healthy skin and over a non-dependent area. It is important to never incise and drain the bubo, as these should be referred onward to specialist centres.

S6 A case scenario of inguinal bubo

Thirty-five year old Mr. Ramachandran, a labourer, comes with a history of swelling in the left inguinal area for over 20 days. He was diagnosed with HIV 2 years ago. Upon examination, there were no lesions on the external genitalia. There was, however, a left-sided inguinal swelling with an overlying erythema.



(Photo courtesy of Dr. Beng Goh, St.Bart's & the London Hospital, UK)

1. What further questions would you ask and what general symptoms would you look for on examination?

2. List the STIs which can present as inguinal lymph node swelling.

3. What is the clinical sign in the picture?

4. How would you manage this patient?

Answers

1. What further questions would you ask and what general symptoms would you look for on examination?

Questions should focus on the constitutional symptoms such as fever, weight loss, and sexual history including history of ulcers. Particular attention in the general examination should be directed toward detecting a generalised lymphadenopathy of the lower limbs.

2. List the STIs which can present as inguinal lymph node swelling.

- | | |
|-----------------------------|------------------|
| 1. Lymphogranuloma venereum | 2. Chancroid |
| 3. Syphilis | 4. HIV infection |

3. What is the clinical sign in the picture?

A groove sign, which can only be seen in about 20% of cases with LGV.

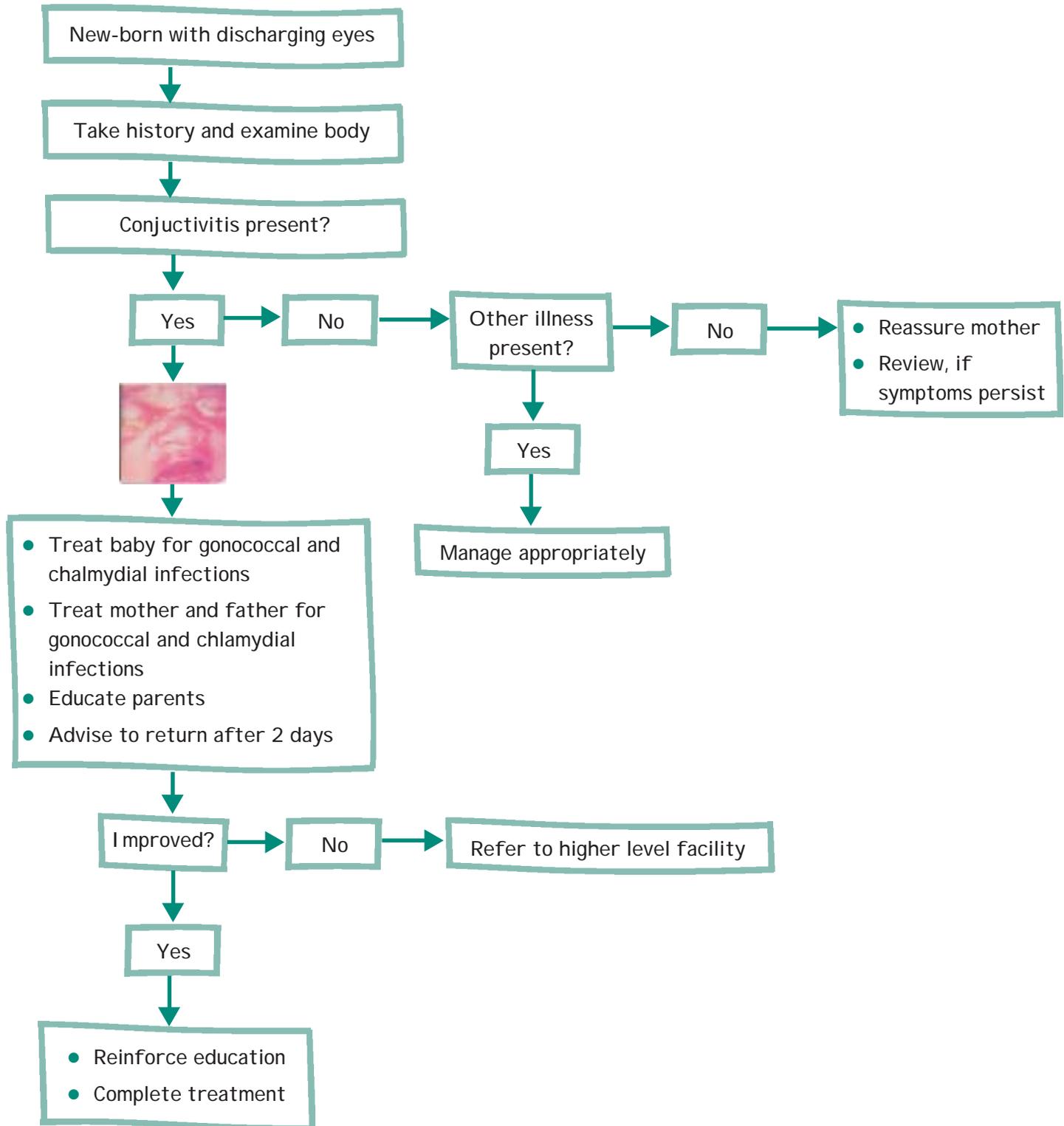
4. How would you manage this patient?

Doxycycline: 100mg, 2 times a day for 21 days. The bubo may have to be aspirated. Incision and drainage is not recommended. If the patient does not improve, refer for further investigation and management. Since the patient is HIV positive, the treatment may have to be prolonged.

S7 Ophthalmia Neonatorum

Ophthalmia neonatorum is the condition where the baby develops purulent conjunctivitis, an infection, in one or both eyes within four weeks of birth. It is a medical emergency and unless treatment is initiated within 24 hours there could be permanent damage to the eyes resulting in blindness. Neonates with Gonococcal ophthalmia neonatorum and those born to mothers with Gonococcal infections should be treated with the most effective antibiotics available. The discharge from the eyes may be caused by *N. gonorrhoeae*, *C. trachomatis* and less frequently by other bacteria. Persons caring for infected infants should always wash their hands carefully.

S7 Syndromic management of Ophthalmia neonatorum



S7 Treatment of Ophthalmia neonatorum

Treatment

Clean the eyes with distilled water or saline.

Recommended regimen:

Injection of Ceftriaxone: mg/kg body weight, I M single dose, up to a maximum of 125mg (to treat Gonococcal infection) **plus**

Erythromycin syrup: mg/kg body weight orally, daily in 4 divided doses for 14 days (to treat Chlamydial infection)

Alternate regimen:

Injection of Kanamycin: mg/kg body weight I.M single dose, up to a maximum of 75mg (to treat Gonococcal infection) **plus**

Erythromycin syrup: mg/kg body weight orally, daily in 4 divided doses for 14 days (to treat Chlamydial infection)

S8 Skin Infestations

Scabies

Permethrine, 5% cream: To be applied after a bath as a thin film over the entire body, beginning below the neck and washed off after 8-10 hours. All clothing and bed linen should be washed and dried under sunlight. A second course may be given after 7 days if required.

Special instructions

Sexual and household contacts should be treated simultaneously, even those who do not complain of any symptoms or signs.

Pruritus and/or itching may persist for a few weeks after adequate treatment and should be treated with antihistamines.

Pediculosis Pubis

Permethrine, 1% lotion: To be rubbed thoroughly into the pubic hair (near the root) and adjacent areas with fingers. The lotion is to be washed off after 10-30 minutes.



Special instructions

Re-treatment is recommended after 7 days if lice are found or eggs are observed at the hair-skin junction. Clothes and bed linen that may have been contaminated by the patient within the past two days should be washed and well dried.

Sexual partner(s) need to be treated regardless of symptoms.

S9 Treatment of Genital Warts

Chemical cauterisation:

Option 1, Applied by health care worker: Apply 20% *Podophyllin* in compounded tincture of benzoin to the wart, while carefully protecting the surrounding area with vaseline. This is to be washed off after 1-3 hours.

Treatment to be repeated once a week until lesions are completely resolved. *Podophyllin* should be applied only under medical supervision. Patients should be warned against self-medication.



Option 2, Applied by patient: Apply *Podophyllotoxin 0.5%* solution or gel to the warts twice daily for 3 days followed by 4 days of non-treatment. Repeat the cycle up to 4 times. No more than 0.5 ml of podophyllotoxin is to be applied per day.

Advise:

- Keep area dry and clean
- Salt-water bathing
- Recommend women to have cervical pap smears
- Warn patients of the possibility of recurrence

Both podophyllin and podophyllotoxin are contraindicated in pregnancy.

2.3: Sexual Health Promotion

A patient's visit to a clinic not only allows for the diagnosis and treatment of an STI, but provides an invaluable opportunity to convey information on sexual health and STI/HIV prevention. When handling a patient, it is important to communicate the three P's associated with sexual health:

Presenting an episode of STI

This step entails dealing with the presenting complaint, making a correct diagnosis, prescribing treatment, and providing information on the nature of the condition, medication compliance, preventing transmission to others, and the re-occurrence of the infection.

Prevention of other STIs and HIV

To prevent future STIs and their transmission, it is crucial to explain the link between one STI and another and the risk of contracting HIV. Discussions should focus on the patient's individual risk reduction strategies and the provision of proper support and onward referral.

Prophylaxis (condoms) use

Meeting with a patient allows for a staff member to encourage the use of condoms to prevent the spread of STIs and HIV. To help the patient understand the correct use of a condom, the attending staff member should demonstrate the application of a condom and provide condoms for the patient's use.

Specific health education and counselling advice for KPs

Clinical services should also be supported by staff members who are specifically devoted to providing counselling and support services for psychological and nutritional issues. If such services are not available, clinicians will need to provide a range of support services or offer appropriate referrals. All patients will need counselling on how to reduce their risk of acquiring STIs and how to reduce the risk of transmitting infections to their partners. Risk reduction counselling is necessary for both STI and non-STI patients.

Due to the nature of the FPP, the majority of the clients seen in clinics will be at a high-risk of acquiring a STI because of their vulnerability and/or sexual behaviour. Specialised health promotion messages are being developed by the Alliance and these will feed into the training programme for clinical staff.

3 APPENDICES

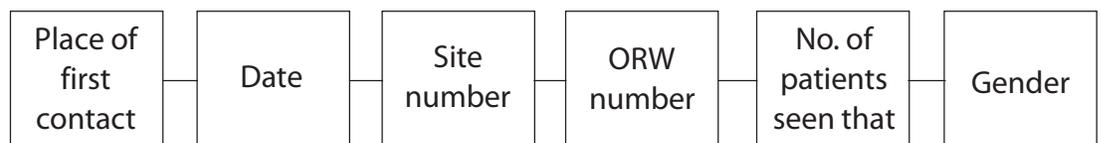
Appendix 3.1 Client Personal Identification Number (PIN)

Background

In order to manage and follow clients within the project clinics and to provide ongoing support and peer outreach, each client referred or seen in one of the **Mythri Centres** will have a unique number. This number will follow the client from the community to clinic and also from the clinic to the community, while maintaining their confidentiality.

Generation of number

The number consists of six fields, as shown below, and will consist of an alpha-numerical classification of 14 characters.



Field 1: Place of first contact

There are two options:

- R:** Denotes a client first seen and referred by an outreach worker (ORW) or a TSS.
- C:** Denotes a client who attends the clinic directly or without a referral by an ORW.

Field 2: Date

This is the date that the client is first seen and is a six digit number in the configuration of **dd-mm-yr** (e.g. 220704).

Field 3: Site number

Each Alliance project site in AP has been allocated a number. This is a double digit entry **XX** (e.g. 01, 02...15, 16 etc).

Field 4: ORW number

Each NGO will allocate the TSS and ORWs a number to complete this field. For clients who attend the clinic directly, a zero (0) is inserted.

Field 5: The number of that client seen that day

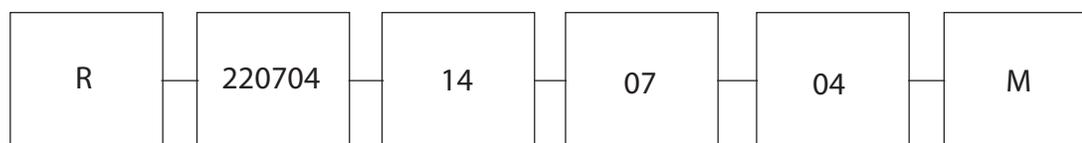
For clients referred from the community, each ORW should complete this field indicating the number of referrals each day starting from 1. For clients seen in the clinic, they should be numbered sequentially as they attend for consultation.

Field 6: Gender

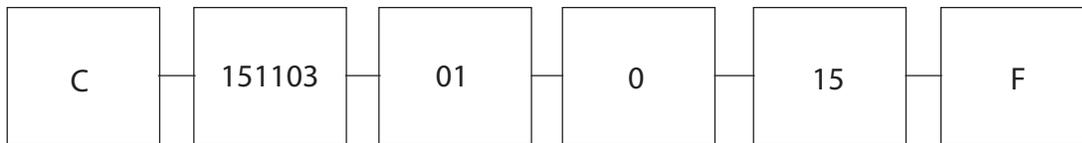
M: For male clients

F: For female clients

Examples:



This client's unique number is R220704-14-07-04-M. This client was referred to the clinic from an ORW on the 22nd July 2004 in site 14 from an ORW whose number is 07. This individual was the fourth clients seen that day and is a male. This will be the number that is used in the clinic and will remain the client's number when he accesses the clinic.



This client went directly to the clinic and is going to be referred to one of the ORWs for support and advice. What are the details of this client?

This PIN, unique to each client, is used on the client-held **treatment card** (refer to Appendix 3), the **clinical attendance form** (refer to Appendix 5 & 6), and also by the ORW within the NGO. A separate record of personal details will be kept confidentially in the NGO if the client consents to this.

Appendix 3.2 Project Clinical and Referral Codes

Main code	Subcodes	Corresponding NACO syndrome or other diagnosis	Notes
S1		Urethral discharge (undiagnosed cause)	Use if cause not known or not specified prior to referral
	S1a	Urethral discharge : treated for Gonorrhoea and Chlamydia	Requires partner/s management
	S1b	Urethral discharge treated for Trichomonas	Requires partner(s) management
	S1c	Urethral discharge : all other causes	Use for recording purposes only. Partner notification not required
S2		Genital ulcer syndrome (undiagnosed cause)	Use if cause not known or prior not specified to referral
	S2a	Genital ulcer; clinical diagnoses/ treated for Herpes simplex virus	Requires partner(s) management
	S2b	Genital ulcer: treatment for Syphilis and Chancroid	Requires partner(s) management
	S2c	Genital ulcer all other causes	Use for recording purposes only. Partner notification not required
S3		Vaginal discharge	Use if cause not known or not specified prior to referral
	S3a	Vaginal discharge; treated for Cervicitis and vaginitis	Requires partner(s) management
	S3b	Vaginal discharge; treatment for vaginitis only	Requires partner(s) management
	S3c	Vaginal discharge;	Use for recording purposes only. all other causes Partner notification not required
S4		Scrotal swelling	Use if cause not known or not specified prior to referral

Main code	Subcodes	Corresponding NACO syndrome or other diagnosis	Notes
	S4a	Scrotal swelling: Treatment for Gonorrhoea and Chlamydia	Requires partner(s) management
	S4b		Code not used
	S4c	Scrotal swelling: all other causes	Use for recording purposes only. Partner notification not required
	S4r	Scrotal swelling ; onward referral made	Use for causes which require onward referral to specialist
S5		Lower abdominal pain	Use if cause not known or not specified prior to referral
	S5a	Lower abdominal pain; treatment for PID	Requires partner(s) management
	S5b	Lower abdominal pain	Code not used
	S5c	Lower abdominal pain ;	Use for recording purposes only all other causes Partner(s) notification not required
	S5r	Lower abdominal pain ; onward referral	Use for causes which require onward referral to specialist Use for recording purposes only. Partner(s) notification not required
S6		Inguinal bubo	Use if cause not known or not specified prior to referral
	S6a	Inguinal bubo: LGV treatment	Requires partner(s) management
	S6b		Code not used
	S6c	Inguinal bubo: all other causes not referred onward	Use for recording purposes only. Partner(s) notification not required
	S6r	Inguinal bubo: onward referral	Use for causes which require onward referral to specialist
S7		Ophthalmia neonatorum	Use if cause not known or not specified prior to referral

Main code	Subcodes	Corresponding NACO syndrome or other diagnosis	Notes
	S7a	Ophthalmia neonatorum; child treated for Gonorrhoea and Chlamydia	Requires partner(s) management
	S7b/S7c S7r	Ophthalmia neonatorum: onward referral	Not used Use if onward referral to specialist is required
S8	S8a S8b	Skin Infestations Scabies Pediculosis pubis	
S9	S9a S9b	Warts/viral skin Genital warts Anal warts	
S10		Molluscum Contagiosum	
S11	S11a	Anal rectal syndrome Anal rectal syndrome: treated for Gonorrhoea and Chlamydia	Use if cause not known or not specified prior to referral
D	D1 D2 D3 D4	All other conditions seen in clinic All other conditions seen in clinic; that require any other treatment All other conditions seen in clinic: that don't require treatment Pre test discussions and counselling Pregnancy/Reproductive health problems	Use subcodes only Include counselling sessions by doctor healthcare staff and counsellor
E		HIV Diagnosis	
R		Referral codes	Use on referral slip from

Appendix 3.3 Client Referral Card

(For clients referred by outreach worker)

Card Number: Patient’s personal identification number (PIN)

--	--	--	--	--	--	--	--	--	--	--	--	--	--

Referred by:

Referred to:

Date of referral:

Name:

Place:

Age:

Gender:

Type of population:

Contact Type: New/Repeat Contact

Date of treatment:

Note: Referral will be made by the outreach worker based on the STI symptoms as reported by KP.

Next Follow up Date (if recommended):

_____ *Tear off slip to be retained by Outreach workers* _____

Card Number: Client’s personal identification number (PIN)

--	--	--	--	--	--	--	--	--	--	--	--	--	--

Referred by:

Referred to:

Date of referral:

Name:

Place:

Age:

Gender:

Type of Population:

Contact Type: New/Repeat Contact

Note: Referrals made based on the STI symptoms reported by the KP to the outreach worker

Appendix 3.4 Formulary Essential Drugs List

Drugs for the treatment of STIs

Drug	Prescription
<i>Acyclovir</i>	400mg tablets (3 times a day for 7 days)
<i>Azithromycin</i>	1g single oral dose
<i>Benzathine penicillin (Injection)</i>	2.4 MIU
<i>Cefixime</i>	400mg single oral dose
<i>Ceftriaxone (Injection)</i>	250mg
<i>Clotrimazole (pessary)</i>	500mg and 100mg
<i>Clotrimazole- hydrocortisone</i>	Cream
<i>Doxycycline</i>	100mg (2 times a day for 7 days)
<i>Erythromycin stearate</i>	500mg (4times day for 7 days)
<i>Fluconazole</i>	150mg and 50mg
<i>Metronidazole</i>	400mg (2 times a day for 7 days)
<i>Podophyllin resin</i>	20% compound tincture in benzoin
<i>Permethrin</i>	5% cream and 1% lotion
<i>Metronidazole</i>	2g single dose
<i>Trichloroacetic acid</i>	30% solution
Vaseline	Topical

Colour branded medicine packs

Each pack will contain:

- The appropriate drugs
- Condoms
- IEC material and information on side effects

- Warning to avoid the **YELLOW** and **GREEN** packs during pregnancy
- Warning to avoid the **BLUE PACK** if allergic to penicillin

The following is a checklist of specific information and details to be given to patients regarding the pack of medicine they have prescribed.

Syndrome	Drugs	Branding
<ul style="list-style-type: none"> ● Cervicitis and Urethritis ● Scrotal swelling ● Presumptive treatment of asymptomatic women ● Presumptive treatment of pharyngeal GC/Chlamydia 	<ul style="list-style-type: none"> ● <i>Azithromycin</i>: 1g ● <i>Cefixime</i>: 400mg 	GREY
<ul style="list-style-type: none"> ● Vaginal discharge 	<ul style="list-style-type: none"> ● <i>Metronidazole</i>: 2g ● <i>Fluconazole</i>: 150mg 	GREEN
<ul style="list-style-type: none"> ● Genital ulcer syndrome 	<ul style="list-style-type: none"> ● <i>Benzathine penicillin</i> 2.4 million units vial ● <i>Procaine penicillin</i> test dose ● <i>Azithromycin</i>: 1g ● Vial of water for injection ● Needles and syringe for injection 	BLUE
<ul style="list-style-type: none"> ● Herpes simplex 	<ul style="list-style-type: none"> ● <i>Acyclovir</i>: 400mg, 3 times a day for 7 days (21 tablets) 	RED
<ul style="list-style-type: none"> ● Inguinal bubo 	<ul style="list-style-type: none"> ● <i>Doxycycline</i>: 100mg 2 times a day for 21 days (42 tablets) 	YELLOW
<ul style="list-style-type: none"> ● Abdominal pain syndrome 	<ul style="list-style-type: none"> ● <i>Cefixime</i>: 400mg single oral dose under supervision ● <i>Doxycycline</i>*: 100mg orally, 2 times daily for 14 days ● <i>Metronidazole</i>** : 400mg orally, 2 times daily for 14 days 	PURPLE
<ul style="list-style-type: none"> ● Failed first line urethritis treatment 	<ul style="list-style-type: none"> ● <i>Metronidazole</i>: 2g 	ORANGE
<ul style="list-style-type: none"> ● Second-line GUS 	<ul style="list-style-type: none"> ● <i>Doxycycline</i>: 100mg, 2 times a day for 15 days (30 tablets) ● <i>Azithromycin</i>: 1g 	PINK
<ul style="list-style-type: none"> ● Vaginal discharge in pregnancy 	<ul style="list-style-type: none"> ● <i>Clotrimazole</i>: 500mg pessary ● <i>Metronidazole</i>: 400mg, 2 times a day for 7 days 	WHITE

GREY PACK

Advise to take on empty stomach

Offer water and a small biscuit to take them in front of you

Warn her that she may experience gastro-intestinal symptoms that are typically mild and short-lived. These include indigestion, cramps and loose stools and not every individual experiences these

Inform that all drugs may have unexpected side-effects such as a rash and to please come and report if concerned

GREEN and ORANGE PACKS

To be taken at night after eating their evening meal and before sleeping

Warn them that they must not drink alcohol for 48 hours or they may feel very sick

Warn them of a metallic taste in the mouth

Warn them of feeling nauseous

Inform that all drugs may have unexpected side effects such as a rash and to please come and report if concerned

PURPLE PACK

Advise to take *cefixime* on an empty stomach

Offer water and a small biscuit to take *azithromycin* in front of you

Warn her that she may experience gastro-intestinal symptoms that are typically mild and short-lived. These include indigestion, cramps and loose stools and not every individual experiences these

Take *metronidazole* after eating their morning and evening meals (before sleeping)

Warn them that they must not drink alcohol for 48 hours after the treatment course or they may feel very sick

Warn them of a metallic taste in the mouth

Warn them of feeling nauseous

Inform that all drugs may have unexpected side effects such as a rash and to please come and report if concerned

BLUE PACK

Check that they are not allergic to penicillin and have never had a rash after taking a tablet or injection

Warn that the injection site may be painful

Advise to take tablets on an empty stomach

Offer water and a small biscuit to take them in front of you

Warn her that she may experience gastro-intestinal symptoms that are typically mild and short-lived. These include indigestion, cramps and loose stools and not every individual experiences these

Inform that all drugs may have unexpected side effects such as a rash and to please come and report if concerned

RED PACK

Inform that all drugs may have unexpected side effects such as a rash and to please come and report if concerned

YELLOW PACK

Confirm they are not pregnant

Tablets to be taken 2 times a day on a full stomach and with plenty of water

Warn her that she may experience gastro-intestinal symptoms that are typically mild and short-lived. These include indigestion, cramps and loose stools and not every individual experiences these

Inform that all drugs may have unexpected side effects such as a rash and to please come and report if concerned

Emphasize the importance of adherence

PINK PACK

Confirm they are not pregnant

Advise to take the *Azithromycin* on empty stomach and offer water and a small biscuit to take them in front of you

Doxycycline to be taken 2 times a day on a full stomach and with plenty of water

Warn her that she may experience gastro-intestinal symptoms that are typically mild and short-lived. These include indigestion, cramps and loose stools and not every individual experiences these

Inform that all drugs may have unexpected side effects such as a rash and to please come and report if concerned

Emphasize the importance of adherence

WHITE PACK

Explain that the *Clotrimazole pessary* is vaginally inserted and NOT for oral consumption

Use before planning to sleep

Avoid using if planning to see clients as it may cause the condom to break

Drugs to be prescribed for side-effects

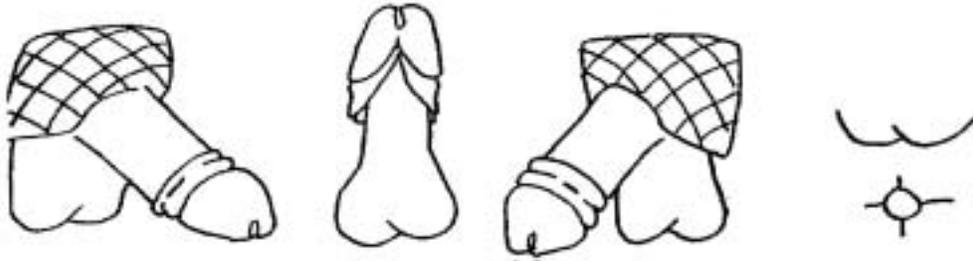
General	
Cetirizine	10mg
Dicyclomide	25mg
Domperidone	10mg
Ibuprofen	400mg, 3 times a day as required
Paracetamol	500mg, 4 times a day (max. 4g or 8 tablets in 24 hours)
Ranitidine	150mg, 2 times a day or 300mg
Emergency	
Adrenalin (injection)	1.1000
Atropine (injection)	0.5 mg of Atropine Sulphate to be administered I/M or I/V (5ml of 0.1 mg/ml solution)
Dextrose saline	1 Litre
Hydrocortisone (injection)	100mg
Other	
Ampicillin plus cloxacillin	1g
Cotrimoxazole	960mg

Male Examination ♂

General: Weight (Kgs) _____ PR/mt _____ Temperature (F) _____

Look For: Anaemia O Lymphnodes (glands) O Jaundice O Skin rashes O Mouth Ulcers O

Genital: (use diagram to record findings eg. Ulcers, warts, discharge)



Investigations/Results: _____

Diagnosis	Action plan/ Treatment
S1 S2 S4 S6 S7 S8 S9 S10 S11	PACK/S: _____
OTHER _____	OTHER DRUGS: _____

Counselling/Other Services

- Condom provision and demonstration yes no
- Partner management yes no
- HIV Counselling and testing referral yes no
- Onward referral yes no _____

Follow –up

(the client needs to return within two weeks to complete the follow up.)

Outcome:

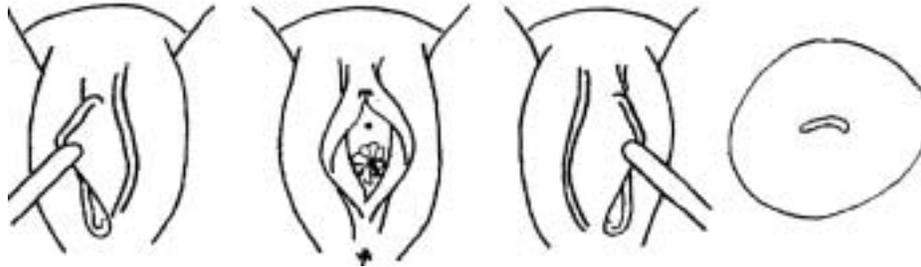
Unknown	Return symptoms improved	Did Not return Symptoms improved	Referred /second line treatment	Contact treated	Client did no return within two weeks

Female Examination ♀

General: (look for)

Anaemia Lymphadenopathy (glands) Jaundice Skin rashes Mouth

Genital: (use diagram to record findings eg. Ulcers, warts, discharge)



Vaginal discharge:

Amount _____ Odour _____

Colour _____ pH _____

Bi-manual examination:

Investigations

Diagnosis	Action plan/ Treatment

Counselling/Other Services

Condom provision and demonstration yes no

Partner management yes no

HIV Counselling and testing referral yes no

Onward referral yes no State type (e.g. KP Support)

Follow –up

(the client needs to return within two weeks to complete the follow up.)

Outcome:

Unknown treated	Return Symptoms improved	Not return Symptoms improved	Referred	Contact

List details of second line treatment

Appendix 3.7 Client Identification Card

This client identification card (CIC) will be carried as a record unique to a client's personal identification number (PIN). There is a section on the inside back cover where a record of attendances and diagnoses codes can be kept. There are several concerns about the willingness of some clients to carry a card with such details even in code, so the back section is detachable.

		Date	Diagnosis code
		If you do not wish to keep this part of the card you may detach it here	

Appendix 3.8: Universal Precautions

Universal precautions are the minimum level of infection prevention measures required to prevent the transmission of infection from one person to another. Universal precautions are based on the assumption that all blood and body fluids are potentially infectious, regardless of whether they are from any patient or health care worker.

Universal Precautions should be followed by all people (health workers, ancillary staff and laboratory staff) at all times

1. When exposed to blood and certain other body fluids such as
 - semen
 - vaginal secretions
 - synovial fluid
 - cerebrospinal fluid
 - pleural fluid
 - peritoneal fluid
 - pericardial fluid
 - amniotic fluid

2. When non intact skin and mucous membranes are exposed to blood or body fluids.

Universal precautions should be applied when exposed to all body fluids, when it is difficult to identify the specific body fluid or when body fluids are visibly contaminated with blood



Universal precautions are infection control guidelines that are designed to prevent transmission of human immunodeficiency virus (HIV), Hepatitis B and C and other blood borne pathogens encountered in health care institutions. The principles of Universal precaution are:

Use of protective barriers

Prevention of accidents

Proper use of disinfection and sterilization techniques

These barriers consist of:

- Personal protective equipment (PPE): Gloves, coats and gowns, masks and glasses with side shields. These equipments prevent blood or body fluids from reaching the workers skin, mucous membranes or personal clothing.
- Engineering controls:
- Work practice controls

Work Practice Controls – These are techniques that reduce the risk of infections with potential agents by changing the way the task is performed. These techniques include: hand washing, handling of used needles and other sharps and contaminated reusable sharps.

Personal Protective Equipment (PPE) - PPE includes gloves, lab coats, gowns, shoe covers, goggles, glasses with side shields, masks, and resuscitation bags. The purpose of PPE is to prevent blood and body fluids from reaching the workers' skin, mucous membranes, or personal clothing. It must create an effective barrier between the exposed worker and any blood or other body fluids.

Engineering Controls - Engineering controls refer to methods of isolating or removing hazards from the workplace. Example of engineering control includes: sharps disposal containers

Universal Precautions

1. Hand washing
 - a. After touching blood, body fluids, secretions, excretions and contaminated items
 - b. Immediately after removing gloves
 - c. Between patient examination
 - d. Wash for at least 10-15 seconds with soap and running water. Air dry with paper or personal towel. If running water is not available, a plastic container with a tap in the bottom of it can be used. A bowl of water for hand washing is not acceptable standard.

2. Gloves
 - a. For contact with blood, body fluids, secretions and contaminated items
 - b. For contact with mucous membranes and non intact skin
 - c. Gloves should be worn when;
 - i. Examination of mucous membranes or non intact skin (eg. Genital examination)
 - ii. Drawing of blood (phlebotomy) but not required for giving IM injections
 - iii. Handling of soiled instruments and equipment or linen (eg. Used speculum or anoscope)
 - iv. Disposing potentially contaminated medical waste (eg. Cotton, gauze and dressings)
 - d. Health staff should change gloves between patients and between procedures on same patient.
 - e. Gloves should be disposed in a biohazard disposal bag (Red Colour)
3. Gowns, Face Masks and Eye Goggles: These barriers are used to minimize the risk of transfer of body fluids and microorganisms from patient to staff member and from staff member to patient.
 - a. Masks& Eye Goggles should be worn to prevent exposure of mucous membranes of mouth, nose, and eyes during procedures that are likely to generate droplets of blood or body fluids.
 - b. Gowns or aprons should be worn during procedures that may generate splashes blood or body fluids- preferably during per-vaginal examination

Selection of Protective Barriers

Type of exposure	Protective barriers	Examples
Low risk Contact skin, no visible blood	<ul style="list-style-type: none"> ● Gloves helpful but not essential 	<ul style="list-style-type: none"> ● Injections, minor wound dressing
Medium risk Probable contact with blood, splashing unlikely	<ul style="list-style-type: none"> ● Gloves ● Gowns and apron may be necessary 	<ul style="list-style-type: none"> ● Vaginal examination, insertion ● Removal of intravenous cannula ● Handling of laboratory specimens ● Large open wounds dressing ● Venepuncture ● Spills of blood
High risk Probable contact with blood, splashing, uncontrolled bleeding	<ul style="list-style-type: none"> ● Gloves ● Waterproof gown or apron ● Eye wear ● Mask 	<ul style="list-style-type: none"> ● Major surgical procedures particularly in orthopaedic surgery and oral surgery ● Vaginal delivery

4. Safer Handling of needles and other sharp instruments: Health care staff is at risk of Hepatitis B virus and HIV infection though need stick injuries and cuts from sharp instruments. All health clinics should have system for safe use and needle disposal of sharp instruments including needles.
 - a. Disposable syringes and needles should be used in all occasions
 - b. Needles and syringes should only be used once
 - c. Needles should not be recapped after use
 - d. Puncture proof containers should be placed in all areas where needles are used. Used needles and along with syringes should be placed directly in these containers

- e. Needle destroyers or cutters can be used to cut needles and syringes can be placed in the puncture proof containers
 - f. If specially made containers are not available, use plastic puncture proof buckets with lids.
 - g. Container should be sealed and removed when it is $\frac{3}{4}$ full.
 - h. Containers should be disposed of by first autoclaving or incineration followed by burying in a secured landfill.
5. Linen
- a. Handle soiled linen carefully to avoid contact with skin/mucous membrane
 - b. Do not rinse soiled linen
6. Environmental Cleaning
- a. Routine care and cleaning with appropriate disinfectant is needed
 - b. All spills- blood or other potentially infectious material are to be cleaned immediately.
 - c. Wear gloves while cleaning the area of spill. Spills should be covered with paper towel or newspaper. Pour 1% bleach on and around the spill area. Leave it for about 10minutes. Remove the paper and discard it as infectious waste in Red Bag. Clean the area with disinfectant.

Proper use of Disinfection and Sterilization Techniques

The method of decontamination of instruments and equipment depends on what they are used for and the associated level of risk of transmission.

Selecting the Method of Decontamination

Level	Items	Decontamination
High risk	Instruments which penetrate the skin and the body	<ul style="list-style-type: none"> ● Sterilization ● Single use of a sterile disposable item
Moderate risk	Instruments which come into contact with mucous membranes or non intact skin	<ul style="list-style-type: none"> ● Sterilization ● Boiling ● Chemical disinfection
Low risk	Equipment which comes into contact with intact skin	<ul style="list-style-type: none"> ● Thorough washing

Efficient cleaning with detergent and warm water removes a high proportion of any micro organisms present.

Sterilization

All forms of sterilization destroy HIV, HBV and HCV. Sterilized instruments which are unwrapped can become re contaminated with micro organisms, so they should be wrapped carefully by appropriate material before Sterilization.

- Moist steam under pressure is the most effective method of sterilization. (Autoclave /Pressure Cooker autoclave)
- If sterilization by autoclaving is not possible, high level disinfection by boiling for 20 minutes is acceptable
- Dry heat sterilization can be used for powders/ glass ware and oils.(Electric or gas hot air oven)

Disinfection

The two common methods of disinfection are:

- Boiling (equipment which has already been cleaned should be boiled for 20 minutes)
- Chemical disinfection (Used for Heat sensitive equipment that is damaged by high temperatures)

- ➔ Chlorine –releasing compounds e.g. Bleach
- ➔ 2% glutaraldehyde
- ➔ 70% ethyl and Isopropyl Alcohol

References

1. Manual Control of Hospital Associated infection : Standard Operative Procedures,1999
2. Tietjen, L; Bossemeyer D and McIntosh, N“Infection Prevention Guidelines for Health Care Facilities with limited resources”. JHPIEGO. Johns Hopkins University,2002
3. Universal Precautions for Prevention of Transmission of HIV and Other Blood borne Infections. 1987 .CDC Atlanta Georgia USA
4. Universal Precautions. 2002. Canadian Centre for Occupational Health and Safety

Appendix 3.9: Safe Disposal of Hazardous Waste

Health institutions (hospitals, health centers, mobile clinics) produce waste – general waste (used paper etc) and hazardous waste (used needles and syringes, gloves, soiled dressings and linen etc). Infectious waste represents about 15 to 25 % of the total waste due to health care activities. This type of waste represents a higher risk to health in health care workers and waste handlers.

Categories of Hazardous Waste generated in health care institutions (Clinics, Hospitals etc):

1. **Sharp waste:** Single use disposable needles, needles from auto-disable syringes, scalpel blades, sharp instruments requiring disposal.
2. **Infectious Waste:** waste contaminated with blood and body fluids and other body fluids – gloves, masks, cotton, dressings, gauze etc
3. **Pharmaceutical Waste:** Expired, damaged or other wise unusable medicines

Waste should be categorized and segregated based on the above categories by the person responsible for producing the waste. For example, if sharp waste is produced after giving an injection by a nurse, she is responsible for proper disposal of used need and syringe as per the waste disposal protocol. No other staff member should try to sort waste or correct the appropriate disposal method.

Waste should be separated in color coded bags according to the Ministry of Environmental Guideline and labeled with biohazard symbol as follows:

Type of Waste	Color of Bag	Label
Infectious Waste	Red	Infectious Waste
Sharps	Blue/White	Danger contaminated sharps
Pharmaceutical Waste	Black	Toxic substances
General Waste	Yellow	Non hazardous waste

Appropriate containers with plastic bags(color coded) should be placed at all locations where a particular waste are generated. Bags are removed when three fourth is filled. Bags should be tightly tied at the neck with a cord or using self locking bag. Don't staple the bag. Replace similar plastic bag in the same container for further use.

All waste disposal bags should be stored in a secured place prior to final disposal either by burning or by incineration. It is the responsibility of the clinic to dispose the waste in a safe manner by either contacting local waste management service or linking with a hospital facility.

Sharps Waste

All health clinics should have system for safe use and needle disposal of sharp instruments including needles. Puncture proof containers when used correctly reduces the risk of needle injuries in health care staff

- Needles should not be recapped after use
- Needle destroyers or cutters can be used to cut needles and syringes can be placed in the puncture proof containers
- If specially made containers are not available, use plastic puncture proof buckets with lids.
- Container should be sealed and removed when it is $\frac{3}{4}$ full.
- Store the containers in safe and secure place prior to disposal

The used containers with needles and syringes should be disposed of by first autoclaving or by incineration and then buried in a secured land fill.

Other Infectious Medical Waste: (non useable)

Infectious waste should be incinerated or burned and then buried or disposed in a secured landfill.

Pharmaceutical Waste

Inappropriate disposal of expired drugs and other pharmaceutical products (antibiotic vials, adrenaline etc) may contaminate water supplies. These drugs may also release toxic pollutants in the air if incineration is incomplete and improperly conducted at the site.

Methods of Disposal

- a. Small quantities of pharmaceutical waste can be incinerated or burned and disposed in a secured landfill or buried away from any known water source

- b. Moderate quantities of liquid or semi liquid drugs such as IV fluids, cough syrup, vitamins etc may be disposed in municipal sewer system. Should never be disposed in slow moving water- lakes, rivers and canals.
- c. Antibiotics should be disposed by incineration.

References

1. WHO. Safe management of waste from health care activities 1999. http://www.who.int/water_sanitation_health/medical_waste/wastemanag/en/
2. NACO Manual for control of Hospital associated infections: Standard Operating Procedures. 1999. MOH and W. Government of India

4. Role Plays

1. Taking a sexual history of a gay identified man

Paul

Paul is a 26 year-old man who met another man while out drinking. You ended up having oral sex with him and now you are concerned. You have slight pain when you pass water, but it is not too bad. A friend has encouraged you to come to this clinic, ensuring you that it is a friendly and confidential setting. Your parents are very strict and are keen to get you married. You have seen a number of potential women for marriage but nothing is certain.

Healthcare worker

Take a sexual history from Paul and respond to his needs.

2. Taking a sexual history and negotiating investigations and management

Prem

Prem is a 56 year-old married lorry driver. He has been losing weight for about three months. He regularly visits brothels when he is away and doesn't always use condoms with the sex workers as it affects his sexual feeling. On his last visit to a brothel he was told by a community worker that it would be a good idea for him to have a check-up. About once or twice a year he develops small, painful ulcers on his penis which last about 5 days. Recently, he has had several of these attacks in quick succession.

Healthcare worker

Take a sexual history and suggest to Prem what steps you wish to take next, thoroughly explaining each.

3. Role play on sexual language

A. You are a male college student and are very shy. You suffer from anal warts and as there is no other doctor around, you have to go to the female doctor on campus. You are unfamiliar with the use of sexual words and cannot correctly name the parts of the body.

When you talk to her, look around shyly to make sure that nobody else hears you. Talk about your "back" or "backside" instead of anus. When asking about your sexual life, you do not understand the meaning of "sexual intercourse."

Upon her insistence, tell her that you have a very close boy friend for several months with whom you have "physical" contact with.

- B.** You are a female doctor and the only doctor on this college campus. You are very uncomfortable about seeing male patients. You only use medical words to talk about sex. When you discover that your patient has anal warts due to his homosexual relationship, you are even more embarrassed and rudely give him a prescription and send him away.

Use the following table to explore the appropriate use of language in a clinical setting to allow for a complete history taking and also enables good communication between the patient and the doctor.

Technical English	Acceptable local language Slan/colloquial terms
Sexual intercourse	
Semen	
Ejaculation	
Penis	
Vagina	
Clitoris	
Masturbation	
Orgasm	
Breasts	
Anal intercourse	
Kissing	
Oral sex	
Erection	
Buttocks	
Condom	
Homosexual	
Transgender	
Others	

Participatory Exercises

Exercise 1: Factors influencing patient-clinician interaction

Instructions

This exercise should create awareness and facilitate possible changes in how to approach STI patients beyond the focus of clinical treatment. The following questions should be written on flipchart paper and, if possible, individual answers should be collected using cards and/or post-it notes. If you have time constraints or lack the technical provisions, this exercise can be conducted as a plenary discussion. Each participant should contribute a minimum of one point, which the facilitator can directly ask each participant for.

Question: If you had an STI what would you expect from the clinician from whom you sought treatment?

Question: What do you think are the qualities of a good STI clinician?

Possible answers could be classified in three categories such as:

Setting

- Clean and professional appearance of the clinic and the doctor
- Doctor should be knowledgeable

Clinician's approach

- Should be empathic
- Should be non-judgmental
- Should be respectful

Communication skills

- Should use appropriate language
- Should be comfortable to talk about sex
- Should be positive
- Should listen well to the client

This exercise is a crucial step in the success of a session and is an opportunity for self reflection. In the summary of the exercise, the facilitator must stress that the majority of the contributions refer to the interaction between patient and clinician. Patients want to be respected by a clinician as adults with a specific problem and this same attitude should be shown towards their STI patients. Allow for group discussion and present the ideas exchanged as a summary using the overhead.

Exercise 2: Listening exercise

Being a good listener is one of the fundamental qualities of a good clinician and only a few people are aware that they are not good listeners. This exercise is often an eye-opener. Before beginning the exercise, make sure that the instructions are well understood.

Instructions

Invite two volunteers to sit in the centre of the group. Give them or ask them to name a controversial issue they would like to discuss. After determining the topic, the first participant should state his/her opinion. Before answering, the second participant has to repeat what the first one has said. Each time a statement has been made, the other participant has to repeat this statement before he/she develops a new argument. Stop the exercise after 5 minutes and ask each participant how they felt.

Normally, participants forget about the rules of the exercise in the heat of the discussion as they are thinking about their new arguments while the opponent is talking. As a result, they do not listen properly and are not able to repeat the statement the other has just given. Allow this to happen. Do not interrupt in the beginning and do not repeat the rules of the game.

Discuss with the plenary what they observed about the volunteers and their listening skills, asking them to relate this exercise to their own experiences and behaviours. If there is time remaining, discuss reasons for not listening well and what can be done to avoid it in their daily work.

Exercise 3: Diagnosis of STIs and approaches to history taking and examination

Instructions

This exercise is best done in a plenary discussion. Present the following two questions, which are already written on the flipchart paper. For each question,

it is recommended that the participants are broken into two work groups. Instruct the participants to write their answers on cards, which allows for a variety of contributions.

Question 1: Why is history taking important?

Possible answers:

- First step in providing health care
- Helps establish a relationship with the patient
- Gives the information needed to obtain a diagnosis

Question 2: What are the different steps in history taking?

Possible answers (including specific steps on how each is accomplished):

- Establish a relationship
- Assure confidentiality private setting
- Introduce yourself
- Explain that the questions asked are to better help the patient
- Be respectful and non-judgmental
- Begin the interview
- Reasons for attending the clinic
- How can you be of help

After collecting and categorising the cards, summarize the discussions by highlighting the most important points such as:

- Non-verbal communication is important
- Be aware of the language used, avoiding medical terms as much as possible
- Effective questioning helps in obtaining a good history, but allow the patients space to voice concerns and raise issues
- Active listening encourages the patient to tell about his/her problems

Patient examination

Instructions

Start this session with a plenary discussion, presenting the following questions and ensuring that every participant contributes.

Question 1: What will you say to a female/male patient when you are about to examine her/him in order to make her/him feel less embarrassed?

Question 2: Which steps do you have to consider during an examination?

For this question use cards to document the answers as you can rearrange the sequence after collecting the different contributions. Gather a consensus with the group and compare their contributions on the overhead or on the flipchart paper. When presenting the overheads, uncover one point at a time as this helps to focus discussions strictly on that point.

Exercise 4: Types of diagnosis

Instructions

This exercise introduces the different types of diagnosis. It is important that the participants have the same understanding of the terms presented. The following questions should be asked to the participants (written on flipchart paper) and their corresponding answers can be written down as well.

Question 1: What types of diagnoses do you know?

Question 2: What are the definitions of these types of diagnosis and what are their differences?

Answers

- Etiological diagnosis: based on specific diagnostic tests
- Clinical diagnosis: based on clinical criteria such as the clinical diagnosis of Herpes simplex virus infection
- Syndromic diagnosis: based on the differential diagnosis of the symptoms such as vaginal discharge

The facilitator should summarize and correct the contributions to ensure that there is a clear understanding on the types of diagnoses.