Training of
Nursing Personnel
to Deliver STI/RTI Services

Participant's Handout

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
2005 - 2012

सत्यमेव जयते

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

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May 2011

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MESSAGE

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

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

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

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

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

(Sayan Chatterjee)

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सत्यमेव जयते

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PREFACE

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

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

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

(P.K. Pradhan)

सत्यमेव जयते

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FOREWORD

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

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

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

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

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ACKNOWLEDGMENT

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

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

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

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

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

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

(Dr. Sunil D. Khaparde)

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Care
ART	Anti Retroviral Therapy
ANMs	Auxiliary Nurse Midwives
BV	Bacterial Vaginosis
CA	Candidiasis, yeast infection
CHCs	Community Health Centres
CMV	Cyto Megalo Virus
CDC	Centre for Disease Control
DNA	Deoxy Ribonucleic Acid
EC	Emergency Contraception
ESR	Erythrocyte Sedimentation Rate
EIA	Enzyme Immuno Assay
ELISA	Enzyme Linked Immuno Sorbent Assay
Endo	Endogenous
FP	Family Planning
FHI	Family Health International
FTA-Abs	Fluorescent Treponema Antibody Absorption Test
GUD	Genital Ulcer Disease
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
Iatro	Iatrogenic
IPHS	Indian Public Health Standards
ICTC	Integrated Counselling and Testing Centre
IDUs	Intravenous Drug Users
IM	Intramuscular
IU	International Units
IUD	Intra Uterine Device
IV	Intravenous
KOH	Potassium Hydroxide
LCR	Ligase Chain Reaction
LGV	Lympho Granuloma Venereum

LHV	Lady Health Visitor
MOHFW	Ministry of Health and Family Welfare
MSMs	Men having Sex with Men
MCH	Maternal and Child Health
MHA-TP	Micro Haemagglutination Assay for antibodies to Treponema Pallidum
MTCT	Mother-To-Child Transmission
MVA	Manual Vacuum Aspiration
NACP	National AIDS Control Program
NRHM	National Rural Health Mission
NPCP-III	National AIDS Control Program-Phase III
NIRRH	National Institute for Research in Reproductive Health
NACO	National AIDS Control Organization
NGO	Non Governmental Organization
NGU	Non Gonococcal Urethritis
PHC	Primary Health Centre
PLHAs	Persons Living with HIV/AIDS
PAP Test	Papanicolaou Test
PPTCT	Prevention of Parent-To-Child Transmission of HIV
PSI	Population Services International
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PID	Pelvic Inflammatory Disease
ROM	Rupture of Membrane
RPR	Rapid Plasma Reagin
RTI	Reproductive Tract Infection(s)
RCH	Reproductive and Child Health Program
RCH-II	Reproductive and Child Health Program-Phase II
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease
SACS	State AIDS Control Society
TPHA	Treponema Pallidum Haemagglutination Test
TI	Targetted Intervention
TV	Trichomonas Vaginalis
UTI	Urinary Tract Infection
UNFPA	United Nations Population Funds
VCT	Voluntary Counseling and Testing
VDRL	Venereal Disease Research Laboratory
WBC	White Blood Cells
WHO	World Health Organization

Contents

HANDOUT NO. 1

PROGRAMME OBJECTIVES AND SCHEDULE

1. Objectives of the training programme

By the end of this programme, Nursing Personnel will be:

- More knowledgeable and aware about the magnitude of STI/RTI problem in the country;
- Able to understand the seriousness of complications of common STI/RTI, if left untreated and its long term implications on health including reproductive health;
- Aware about the approaches to STI/RTI management;
- Able to define risk assessment and describe the steps for patient referral;
- Educate and counsel STI/RTI clients about prevention, successful treatment of STI/RTI and partner treatment;
- Understand their role in promoting community awareness and prevention of STI/RTI.

Training Workshop on STI/RTI for Nursing Personnel

Duration: 2 days		
Days/Timings	**Module: Topic and duration**	**Contents**
Day 1 (Morning)		
09 00 hrs	**Module 1:** Introductory module (1 hr. 30 min)	Getting to know each other Program objectives and schedule Pre-test
10 30 hrs	**Module 2:** Understanding common STI/RTI (1 hr 45 min)	Basic information on common STI/RTI Signs and symptoms of common STI/RTI Complications of STI/RTI Challenges in prevention and management
12 00 hrs	**Module 3:** Approaches and important considerations for STI/RTI case management (1 hr)	STI/RTI case management Action points for management of STI/RTI in men and women
13 00 hrs	LUNCH BREAK	
Day 1 (Afternoon)		
14 00 hrs	**Module 4:** Risk assessment, prompt referral and Partner management in STI/RTI (2 hrs)	History taking and risk assessment in STI/RTI Referral of patients Partner management Checklist for history taking
16 00 hrs	**Module 6:** Preventing STI/RTI among special populations (1 hr 30 min)	• Men • Adolescents • High Risk Group Population

Day 2 (Morning)		
9 00 hrs	**Module 5:** Client education and counseling (2 hrs)	Communication Client education on STI/RTI Counseling ICTC
11 00 hrs	**Module 7:** Community education for prevention of STI/RTI (45 min)	Importance of STI/RTI in the community STI/RTI prevention and control in the community Developing strategies for BCC in the community
11 45 hrs	Risk assessment, referral skills (1 hr 15 min)	Demonstration and Practical
13 00 hrs	**LUNCH BREAK**	
Day 2 (Afternoon)		
14 00 hrs	Counseling skills (1 hr)	Demonstration and Practical
15 00 hrs	**Module 8:** Condom use (45 min)	Demonstration and Practical
15 45 hrs	**Module 9:** Recording and Reporting	Format Filling
17 45 hrs	Post Test (30 min)	

HANDOUT NO. 2

HANDOUT NO. 2

UNDERSTANDING COMMON STI/RTI

1. What are STI/RTI and their routes for transmission

What are reproductive tract infections (RTI)?

The term RTI refers to any infection of the reproductive tract. In women, this includes infections of the outer genitals, vagina, cervix, uterus, tubes, or ovaries. In men, RTI involve the penis, testes, scrotum, or prostate.

What are sexually transmitted infections (STI)?

STI are infections caused by germs such as bacteria, viruses, or protozoa that are passed from one person to another through sexual contact. Sexually transmitted organisms may be sometimes transmitted by nonsexual modes of transmission.

What is HIV and AIDS?

HIV stands for Human Immunodeficiency Virus, a retrovirus transmitted from an infected person through unprotected sexual intercourse, or by exchange of body fluids such as blood, or from an infected mother to her infant. AIDS stands for Acquired Immunodeficiency Syndrome. AIDS is the stage of HIV infection that develops some years after a person is infected with HIV. Since HIV is a STI and is transmitted through the same behavior that transmits other STI, whenever there is risk of STI, there is risk of HIV infection as well.

Note: I*n India almost all HIV is sexually transmitted (85%), HIV and AIDS are always included when we speak of STI in the training.*

Sexually transmissible infections (STI) are also known as **sexually transmitted diseases (STDs).** These are the infections caused by germs such as bacteria, viruses, or protozoa that are passed from one person to another through sexual contact.

STDs versus STI

Historically, the terminology used to describe infections and diseases acquired through sexual contact has demonstrated the social stigma attached to these infections. As these terms became laden with moral judgments and as medical and public health professionals began to see the need for a more accurate, technical description, the term STI was approved by WHO and hence became the standardized term.

Routes of transmission of STI/RTI

RTI include both sexually transmitted infections (STI) and non-sexually transmitted infections. STI caused by bacteria, viruses, or protozoa that are passed from one person to another through sexual contact. While RTI, which are not sexually transmitted, can be caused by disturbances of the normal endogenous flora and by medical interventions that may provoke iatrogenic infection.

1. Through unsafe sex
2. Through unsafe procedures like unsafe abortions, unsafe delivery, etc.
3. Through unsafe blood transfusions.

In men, sexually transmitted infections are much more common than endogenous or iatrogenic infections. While in women RTI include mainly sexually transmitted diseases (STI), as well as infections caused by disturbances of the normal vaginal flora containing bacteria and fungi and due to infections caused while doing medical procedures related to pregnancy, birth, or abortion under unsafe conditions.

In women, overgrowth of endogenous microorganisms normally found in the vagina may cause RTI such as fungal infection and bacterial vaginosis. Medical procedures may provoke iatrogenic infection in several ways—endogenous organisms from the vagina or sexually transmitted organisms in the cervix may be pushed upwards during a transcervical procedure into the upper genital tract and cause serious infection of the uterus, fallopian tubes and other pelvic organs. Organisms from outside, not normally present in the body, can also be introduced into the upper genital tract during medical procedures, if infection control measures are poorly followed.

RTI in both men and women include:

STI; and they are transmitted sexually mainly due to unsafe sexual practices.

While RTI in women also include:

- Break in normal vaginal flora (candida and bacterial vaginosis)
- Postpartum and post abortion infections
- Following procedures (e.g. IUD insertion)

They are transmitted mainly due to unsafe deliveries, abortions and procedures.

Some RTI can be easily cured by using antibiotics or other drugs, while few others are incurable. HIV, which causes AIDS, is a viral STI that is a leading cause of death in many countries. An understanding of these differences is essential in order to provide effective care and to give good advice to patients with reproductive tract complaints.

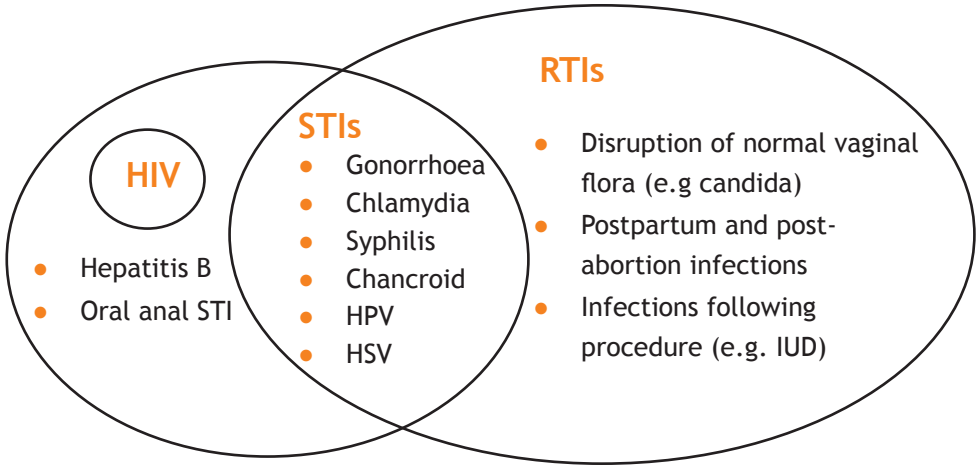


Figure 1: Reproductive tract Infections (RTI); Sexually Transmitted Infections (STI); and HIV Infection

2. Reasons for occurrence of STI/RTI in men and women

Reproductive tract infections (RTI) including sexually transmitted infections (STI) present a huge burden of disease and adversely affects on reproductive health of people. They not only cause huge sufferings for both men and women around the world, their consequences are far more devastating and widespread among women than among men. RTI often go undiagnosed and untreated, and when left untreated, they lead to complications such as infertility; ectopic pregnancy and cervical cancer. Pelvic inflammatory disease arising from STI poses a major public health problem and adversely affects the reproductive health of untreated women. Due to the emergence of HIV/AIDS problem and identification of STI as a co-factor for its causation, STI/RTI has become one of important public health problem in the world, letting a sense of urgency for formulating a programmatic response to address it.

Each new STI/RTI infection can cause serious complications for the infected person, and it increases the risk of HIV transmission for his/her partner(s). Each untreated infection also increases the chances of further transmission in the community. Doctors and health workers working in the Primary Health Care system have an important role to play in correctly managing STI/RTI for those who use their services. Control of STI/RTI, however, requires more than just treatment. People in the community and not just those using the health facility, must be made aware of STI/RTI and the importance of early treatment. Most importantly, in order to control STI/RTI, quality services for their prevention and treatment must be available and that is to be used by persons at the highest risk of infection.

Factors contributing to the spread of STI/RTI

There are many reasons for high prevalence of STI/RTI, which include lack of access to health care and medicines, lack of awareness of STI, and in-out migration.

- Iatrogenic infections are more commonly seen where the STI/RTI in high prevalence, and where health care providers do not have the training or supplies to perform procedures safely. Postpartum and post abortion infections are more common where medical services and follow-up care are not provided safely.
- Endogenous infections, such as yeast infection and bacterial vaginosis, are common worldwide and are influenced by environmental, hygienic, hormonal and other factors like co existent diabetes and immune compromised states like AIDS.
- Sexually transmitted infections (STI) such as syphilis, gonorrhoea and chancroid spread more rapidly in places where communities are disrupted, migrant labour is common and commercial sex networks are active. Though the STI are infectious diseases, however, more than with other infectious diseases, STI transmission depends mainly on human behavior. A person with many sexual partners is much more likely to acquire a STI than a person with one partner. A person with many partners also has more opportunity to infect others. In fact, most STI transmission occurs within a small part of the population that has multiple sex partners. This does not mean, however, that the rest of the community is not at risk for STI infection.
- For these reasons, control of STI in any community requires effective strategies that reach those with the greatest number of sex partners. Clinical services can contribute to STI control, but they are not enough. Often, those at highest risk of STI infection are least likely to use services.

So remember: 

Factors that increase the risk of RTI

- Poor general health
- Poor genital hygiene
- Poor menstrual hygiene
- Unhygienic practices by service providers during delivery, abortion, and IUCD insertion in women

Factors that increase the risk of STI

- Unprotected sex
- Multiple Partners
- Sex with Partner having sore on the genital region, urethral discharge or infected vaginal discharge
- Previous STI infection(s) in the past year

Special concerns for STI/RTI in women

Although STI affect both women and men, women are more susceptible to infection and are less likely to seek treatment than are men. The potential complications of untreated STI/RTI are more serious in women and infections can be transmitted to the offspring of pregnant women as well.

Risk groups

In most communities there are certain people who may be more vulnerable to STI. These may vary in different communities, but they usually include:

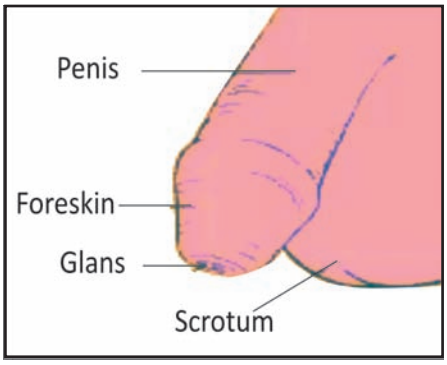
- Adolescent girls and boys who are sexually active and indulging in unsafe sex
- Women who have several partners for earning money.
- Female and male sex workers and their clients
- Men and women whose jobs force them to be away from their families or regular sexual partners are away for long periods of time.
- Men having sex with men including transgenders.
- Street children, prison inmates, etc.

3. Body sites where STI/RTI could occur in men and women

An understanding of sexual and reproductive anatomy and physiology helps providers to educate clients about their bodies and helps both clients and providers in a better way to discuss the sexual and reproductive health issues.

Male sexual and reproductive organs

External male genitals

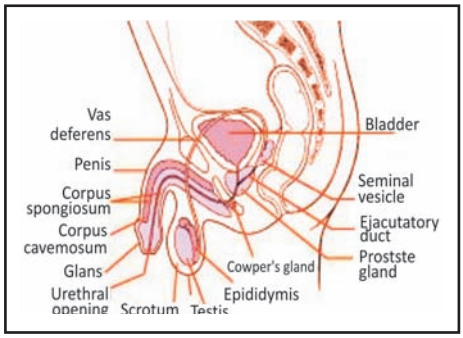


The external male genitals consist of the **penis** and the scrotum. The penis is a cylindrical structure with the capacity to be flaccid or erect. The penis provides passage for both urine and semen. It can be a source of pleasure in response to sexual stimulation and is the organ that penetrates the mouth, vagina, or anus during penetrative sex. The head of the penis, the ***glans (glans penis)***, is the part of the penis that is most sensitive and has the most nerve endings. The glans is covered by the foreskin, or ***prepuce***, in men who are not circumcised. The **scrotum** is a pouch of skin hanging directly under the penis that contains the testes. The scrotum protects the testes and maintains the temperature necessary for the production of sperm.

Internal male genitals

The internal male genitals are: the testes, the epididymis, the vas deferens, the seminal vesicles, the prostate gland, and the Cowper's glands. The **testes,** the paired, oval- shaped organs that produce sperm and male sex hormones, are located in the scrotum. They are highly innervated and sensitive to touch and pressure. The testes produce ***testosterone***, which is responsible for the development of male sexual characteristics and sex drive ***(libido)***.

The **epididymis** are the two highly coiled tubes against the backside of the testes where sperm mature and are stored until they are released during ejaculation. The vas deferens are the paired tubes that carry the mature sperm from the epididymis to the urethra.



The **seminal vesicles** are a pair of glandular sacs that secrete about 60% of the fluid that makes up the semen in which sperm are transported. Seminal fluid provides nourishment for sperm.

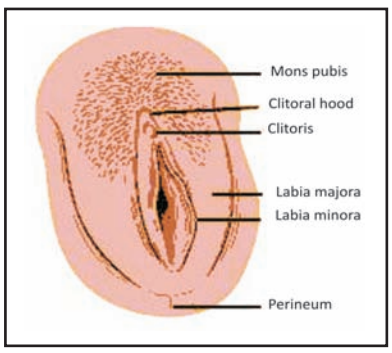
The **prostate gland** is a walnut-sized, glandular structure that secretes about 30% of the fluid that makes up semen. The alkaline quality of the fluid neutralizes the acidic environment of the male and female reproductive tracts. A muscle at the bottom of the prostate gland keeps the sperm out of the urethra until ejaculation begins. The prostate gland is very sensitive to stimulation and can be a source of sexual pleasure for some men.

The **Cowper's glands** are two pea-sized glands at the base of the penis under the prostate gland that secrete a clear alkaline fluid into the urethra during sexual arousal and before orgasm and ejaculation. These glands produce mucus-like, pre-ejaculatory fluid in the urethra that acts as a lubricant for the sperm and the urethra as semen flows out of the penis.

Female sexual and reproductive organs

External female genitals

The external female genitals are: the mons pubis, the clitoris, the labia majora, and the labia minora. Together, along with the opening of vagina, they are known as the **vulva.** The **mons pubis** is a pad of fatty tissue over the pubic bone. This structure, which becomes covered with hair during puberty, protects the internal sexual and reproductive organs.



The **clitoris** is an erectile, hooded organ at the upper joining of the labia that contains a high concentration of nerve endings and is very sensitive to stimulation. The clitoris is the only anatomical organ whose sole function is providing sexual pleasure.

The **labia majora** are two spongy folds of skin, one on either side of the vaginal opening, that cover and protect the genital structures. The labia minora are the two erectile folds of skin between the labia majora that extend from the clitoris on both sides of the urethral and vaginal openings. (The area covered by the labia minora that

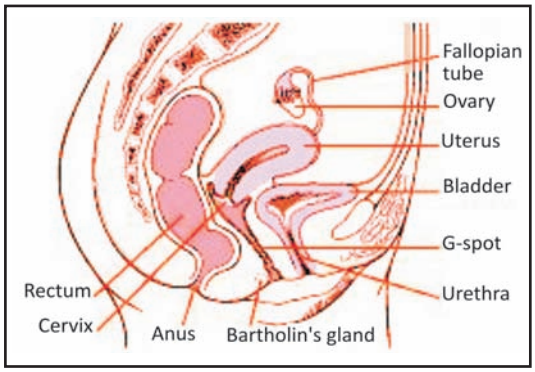
includes the openings to the vagina and urethra, as well as the Bartholin's and Skene's glands, is called the vestibule.)

The **perineum** is a network of muscles located between and surrounding the vagina and the anus that support the pelvic cavity and help keep pelvic organs in place.

Internal female genitals

The internal female genitals are: the vagina, the cervix, the uterus, the fallopian tubes, and the ovaries.

The **vagina** is a muscular, highly expandable, tubular cavity leading from the vestibule to the uterus. The cervix (the lower part of the uterus that protrudes into the vaginal canal) has an orifice that allows passage for menstrual flow from the uterus and passage of sperm into the uterus.



The **uterus** is a hollow, thick-walled, pear-shaped, muscular organ located between the bladder and rectum. It is the site for implantation of the fertilized ovum (egg), the location where the fetus develops during pregnancy, and the structure that sheds its lining monthly during menstruation. The upper portion of the uterus contracts during orgasm.

The **fallopian tubes *(oviducts)*** are a pair of tubes that extend from the upper uterus, extending out toward the ovaries (but not touching them), through which ova (eggs) travel from the ovaries toward the uterus and in which fertilization of the ovum takes place. The fallopian tubes contract during orgasm.

The **ovaries** are two organs located at the end of each fallopian tube that produce ova (releasing one per month from puberty to menopause). The ovaries produce ***estrogen*** and ***progesterone*****,** the hormones responsible for the development of sex characteristics. These hormones are also responsible for elasticity of the genitalia, integrity of the vaginal lining and lubrication of the genitalia. ***Testosterone*** is also produced – although in smaller amounts than is produced in men – and is responsible for sexual desire.

Where STI/RTI occur in females?

In women, RTI involve the outer genitals, vagina and cervix are referred to as lower reproductive tract infections. Infections in the uterus, fallopian tubes, and ovaries are considered upper reproductive tract infections.

It also leads to

- Disruption of normal vaginal flora (candida and bacterial vaginosis)
- Postpartum and postabortion infections
- Following procedures (e.g. IUD insertion)

Note: Infections of the cervix are considered more severe than vaginitis because they much more commonly result in upper reproductive tract infection with its serious consequences. Unfortunately they are also more difficult to detect, as they are frequently asymptomatic.

Where STI/RTI occur in males?

RTI generally begin in the lower reproductive tract (the urethra). If untreated, they may ascend through the vas deferens (sperm tube) to the upper reproductive tract (which includes the epididymis and testes). It also leads to prostatitis and epididymitis

Note: In general, RTI in men are easier to identify and treat, as they are more likely to be symptomatic.

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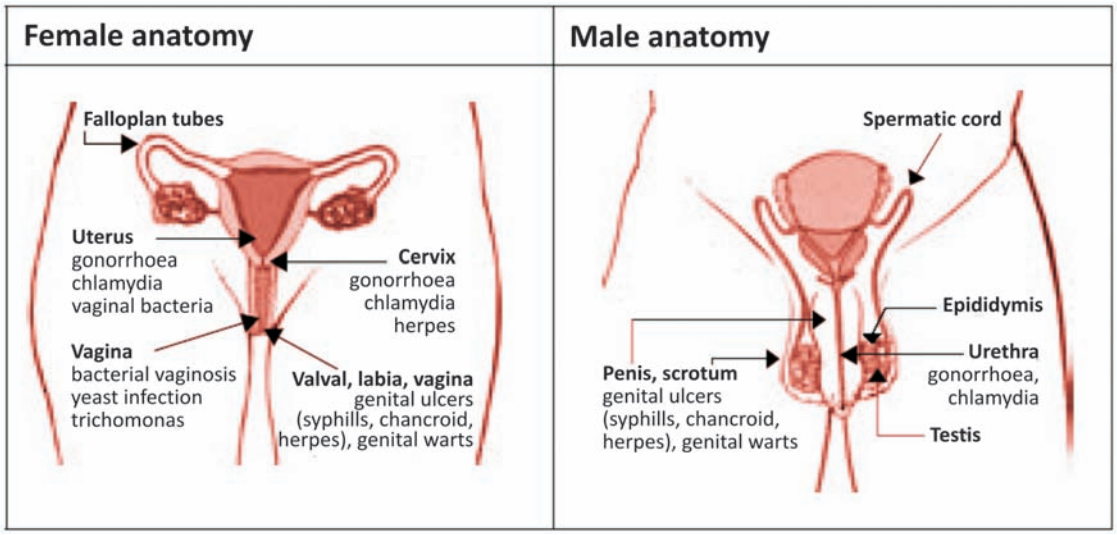
Different body sites where STI/RTI occur in females and males



***Source**: Adopted from "In tegrating STI/RTI care for reproductive health, sexually transmitted and other reproductive tract infections, A guide to essential practice-2005 WHO"*

4. Common STI/RTI and Causative Organisms

Any individual can become infected with a **sexually transmitted infection (STI)** or **reproductive tract infection (RTI),** regardless of age, background, or socioeconomic class.

RTI that are most common but may not always be sexually transmitted are:

1. **Bacterial Vaginosis** (BV) - A RTI in women that is caused by an imbalance in the vagina's normal environment and overgrowth of bacteria in the vagina.
2. **Vaginal yeast infection-** A RTI in women that occurs when the normal environment in the vagina changes and there is overgrowth of yeast, commonly candida albicans.

There are over 20 STI. But the most common are:

1. **Syphilis-** A STI due to infection by Treponema Pallidum that initially causes sores that will heal on their own but, if left untreated, can cause serious complications or even death.
2. **Gonorrhoea-** A STI due to infection by *Neisseria gonorrhoea* that can cause infertility in both men and women. It includes ophthalmia neonatarum.
3. **Chlamydial infection-** A STI due to infection by *Chlamydia trachomatis* in both men and women. It is often asymptomatic.
4. **Trichomonas infection-** A STI due to infection by *Trichomonas vaginalis* in both men and women. It is often asymptomatic.
5. **Chancroid-** A STI due to infection by *Haemophilus ducreyi,* that causes lymph node swelling and painful ulcers in the genital area.
6. **Genital herpes-** A STI due to *Herpes simplex* virus that causes painful genital ulcers.
7. **Genital and cervical warts due to** *Human papilloma virus* (HPV) -Growth or warts in the genital area caused by some forms of HPV. Other forms of HPVs can lead to cervical cancer.
8. **HIV infection** - is caused by (Human immunodeficiency virus) a retrovirus that weakens the immune system and causes AIDS.
9. **Hepatitis B and Hepatitis C infection-** A virus that can cause liver damage, and possibly even liver failure.
10. **Donovanosis -** A STI due to infection by *Calymmatobacterium granulomatis* or *Kleibsella granulomatis* that can cause serious ulcers at the site of infection. These ulcers can grow together and cause permanent scarring and genital destruction.
11. **Lymphogranuloma venereum (LGV) -** A STI due to a subtype of *Chlamydia trachomatis* that causes inflammation of and prevents drainage of the lymph nodes in the genital area. LGV can cause destruction and scarring of surrounding tissue.

12. **Molluscum contagiosum -** A STI due to a virus that causes relatively benign skin infections. Molluscum contagiosum infection can lead to secondary bacterial infections.
13. **Genital scabies-** A STI in both men and women caused by itch mite, *sarcoptis scabiei*.
14. **Pubic lice-** A STI in both men and women caused by pubic lice *(phthirus pubis)*.

5. Signs and Symptoms of STI/RTI

The following list identifies signs and symptoms of the most common RTI and STI:

In men:

- *Urethral discharge:* chlamydia, gonorrhoea and trichomonas infection
- *Genital ulcer:* T. Pallidum, H. Ducreyi.
- *Genital itching:* chlamydia, gonorrhoea and trichomonas infection
- *Swollen and/or painful testicles:* chlamydia, gonorrhoea

In women:

- *Unusual vaginal discharge:* BV, Chlamydia, gonorrhoea, trichomonas infection, vaginal yeast infection
- *Genital itching:* BV, trichomonas infection, vaginal yeast infection
- *Abnormal and/or heavy vaginal bleeding:* chlamydia, gonorrhoea *(Note: This symptom is often caused by factors other than STI.)*
- *Bleeding after intercourse:* chlamydia, gonorrhoea, chancroid and genital herpes
- *Lower abdominal pain (pain below the belly button; pelvic pain):* chlamydia, gonorrhoea
- *Persistent vaginal candidiasis:* HIV/AIDS
- *Dyspareunia*

In men or women:

- *Blisters or ulcers (sores) on the mouth, lips, genitals, anus, or surrounding areas:* chancroid, genital herpes, and syphilis
- *Burning or pain during urination:* chlamydia, genital herpes, trichomonas infection and gonorrhoea
- *Itching or tingling in the genital area:* genital herpes, candidiasis
- *Jaundice (yellowing of the eyes and skin) and/or fever, headache, muscle ache, dark urine:* hepatitis B, hepatitis C
- *Warts or bumps on the genitals, anus, or surrounding areas:* HPV (genital warts)

- *Flu-like syndromes (fever, fatigue, headaches, muscle aches), mild liver inflammation:* CMV
- *Small, dimpled bumps or lesions on the skin that usually do not hurt or itch and are flesh colored, but can vary from white to yellow to pink:* molluscum contagiosum
- *Small, red lesions or ulcers in the genital or anal area; lymph node swelling in the genital area; chronic ulcers on the genitals or anus:* LGV (Lympho Granuloma Venereum)
- *Red nodules or bumps under the skin on the mouth, genitals, or anus that ulcerate, become tender, and often bleed easily:* donovanosis

6. Complications of STI/RTI

STI/RTI if left untreated can cause serious complications in males, females and neonates. Millions of men, women, and children all over the world are affected by the long-term complications of RTI and STI.

These infections can lead to numerous serious, long-term, and sometimes deadly complications, particularly in women. Some STI/RTI can also cause pregnancy-related complications or congenital infections. Unfortunately, symptoms and signs of many infections may not appear until it is too late to prevent serious consequences and damage to the reproductive organs.

In addition, the complications of RTI and STI affect even more than an individual's health. The sufferings associated with them has a profoundly adverse effect on the quality of life and economic productivity of many women and men, their families, and, consequently, entire communities.

Some of the common complications of STI/RTI in men, women and children include:

Complications of STI/RTI in males

1. Phimosis, paraphimosis and urethral stricture

2. Inflammation of testes

3. Infertility

Infection of the upper reproductive tract can occasionally result in partial or complete blockage of the sperm ducts, and disorders in sperm production. This can cause low sperm counts in semen or abnormal sperm, which contribute to male infertility.

4. Carcinoma of the penis

Infection with Human papilloma virus (HPV) is associated with the development of penile cancer.

Complications of STI/RTI in Females

1. Pelvic inflammatory disease

Some of the most serious consequences of RTI in women occur when an infection of the lower genital tract (cervix or vagina) or outside organisms reach the upper genital tract (uterus, fallopian tubes, ovaries and surrounding structures). Infection may become generalized and life threatening, and resulting tissue damage and scarring may cause infertility, chronic pelvic pain and increased risk of ectopic pregnancy.

Untreated gonococcal and chlamydial infection in women results in pelvic inflammatory disease in upto 40% of cases. One in 4 of these will result in infertility.

2. Adverse outcomes of pregnancy

RTI such as chlamydia, gonorrhoea, syphilis, genital herpes etc. are responsible for the adverse outcomes of pregnancy. In addition to ectopic pregnancy, other poor pregnancy outcomes that are linked to RTI include:

- Fetal wastage - spontaneous abortion or stillbirth.
- Low birth weight due to premature delivery or intra-uterine growth retardation.
- Congenital or perinatal infections - eye infections causing blindness, infant pneumonias and mental retardation.

3. Infertility

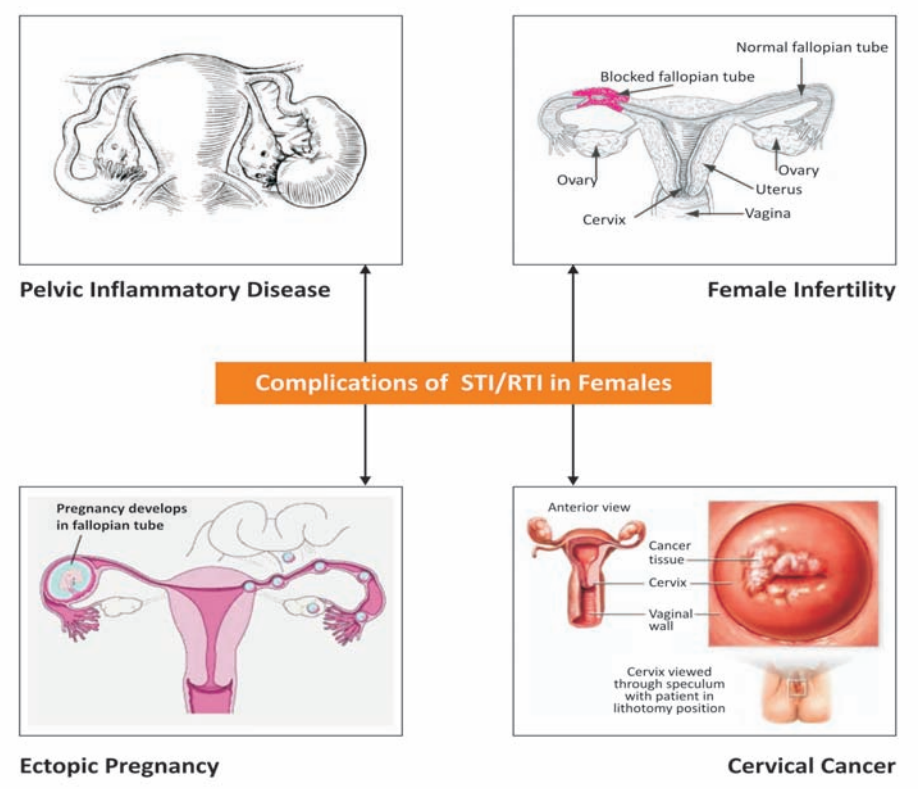
Infertility often follows after untreated pelvic inflammatory disease in women, and epididymitis and urethral scarring in men. In fact, complications of RTI are the most important preventable causes of infertility in regions where childlessness is most common. Repeated spontaneous abortion and stillbirth often due to STI such as syphilis are other important reasons why couples are unable to have children.

4. Ectopic pregnancy

The tubal scarring and blockage that often follows PID may be total or partial. Fertilization can still occur with partial tubal blockage but risk of implantation in the fallopian tubes or other site outside the uterus (ectopic pregnancy) is high. Ruptured ectopic pregnancy, along with complications of abortion and postpartum infection, is a common preventable cause of maternal death in places with high prevalence of STI/RTI and PID.

5. Cervical cancer

Infection with Human papilloma virus (HPV) appears to be strongly associated with the development of cervical cancer. HPV causes about 5,00,000 cases of cervical cancer resulting in 2,40,000 deaths mainly in the resource poor countries. It is the most common genital cancer among women in India. Cervical cytological screening (Papanicolaou smears) facilities are still not available in the primary health care facilities and therefore majority of diagnosed cases are detected in advanced stages when treatment has lower successful outcome.



Complications of STI/RTI in newborn babies

1. Perinatal and neo-natal infections

(i) Congenital syphilis

Congenital syphilis results from the transmission of treponema pallidum infection from an infected pregnant woman to her fetus. Maximum transmission (up to 100%) occurs if the mother herself is in the primary or secondary stages of the disease and this transmission rate drops to 10% to 30% if the mother is in the late latent stage. The symptoms and signs of the congenital infection may not be evident till the infant is about 3 months old when hepato-splenomegaly, conjugated hyperbilirubinemia, skeletal lesions, skin and mucus membrane lesions and other features are detectable. If untreated, late manifestations appear in the second year of life.

(ii) Gonorrhoea

An untreated Neisseria gonorrhoea infection in pregnant woman results in its transmission to her neonate. The neonate may present with only conjunctivitis, which usually appears within the first four days of life and may progress to panophthalmitis unless treated. The newborn may also have systemic disease, which may present as sepsis, arthritis or meningitis.

(iii) Chlamydia

Chlamydia trachomatis can be vertically transmitted from an infected pregnant woman to her neonate and may cause only conjunctivitis or have systemic infection like pneumonitis.

Worldwide upto 4000 newborn babies become blind every year because of eye infection attributable to untreated maternal gonorrhea and chlamydial infections.

(iv) Human immunodeficiency virus (HIV)

Most of the HIV transmission takes place during delivery but it must be remembered that HIV is also transmitted through breast milk (14%).

(v) Herpes simplex viruses 1 & 2 (HSV1 & HSV2)

The herpes simplex virus has a very high intrapartum transmission rate (75% to 90%) and can lead to localized or central nervous system or disseminated disease in the affected neonates with a very high rate of long-term residual sequelae.

(vi) Hepatitis B virus

Hepatitis B virus infection in the mother can be transmitted to the neonate. Neonatal infections result in higher carrier rates with more chances of long-term sequel. There are a number of other infections like cytomegalovirus, candida, trichomonas and other organisms that are transmitted from the mother to the neonate and can cause serious morbidity.

2. Prematurity

STI/RTI in pregnancy especially bacterial vaginosis and trichomoniasis may result in preterm delivery, which can lead to prematurity and associated complications in the neonate.

3. Low birth weight

Low birth weight can be a result of prematurity or intrauterine growth retardation caused due to associated STI/RTI in pregnancy.

Systemic complications

Systemic complications are common to all & include renal, cardiac, gastrointestinal, neurological, complications of skin and Septicaemia.

Why reproductive health services should focus on STI/RTI?

The STI/RTI are becoming a rapidly growing problem throughout the world as well in our country and the impact of STI is serious. Transmission and prevalence of STI/RTI are influenced by social and economic factors as well as by biological and behavior pattern. Therefore the burden of STI/RTI varies greatly in our country from region to region, and from community to community. Where STI/RTI are common, their complications are also common.

RTI often go undiagnosed and untreated, and they lead to serious complications. If left untreated or if not diagnosed and treated in time, even curable STI can cause serious complications such as Pelvic inflammatory disease, premature labor and delivery, spontaneous abortion, ectopic pregnancy, infertility, inflammation of the testes, cardiovascular or neurological complications, cervical cancer or even death. Some undetected and untreated infections can also lead to pneumonia, respiratory infections, and eye infections in infants. Pelvic inflammatory disease arising from STI poses a major public health problem and adversely affects the reproductive health of poor and untreated women. In women of childbearing age, STI are second only to maternal factors as causes of disease and death. By far, the greatest burden of STI is borne by women and adolescents.

7. The impact of STI/RTI and the need for its prevention and management

Situation in India

Many studies have been conducted to estimate the prevalence of STI/RTI in men and women in India, which reveal that there is a huge burden of STI/RTI and they adversely impact reproductive health of people.

It is estimated that the prevalence of symptoms suggestive of STI/RTI in women was in the range of 23% to 43%, while in men, it is in the range of 4% to 9%. The STI clinic based data indicates syphilis as the major prevalent STI among men (31%-57%). This is followed by chlamydia (20%-30%), chancroid (10%-35%), and gonnorhoea (8%-26%). The hospital based studies report a varied prevalence for HSV (3%-15%) and HPV (5%-14%) among men in India. Awareness of STI/RTI in men is 53% while in women is only 44%.

Links to HIV/AIDS

Studies have shown that the spread of HIV and other STI are closely related, STI are identified as a co-factor for the causation of HIV infection and promiscuous behavior puts people at risk for any sexually transmitted infections as well as HIV infection (90%). A person with an STI has a much higher risk of *acquiring* HIV from an infected partner. A person infected with both HIV and another STI has a much higher risk of *transmitting* HIV to an uninfected partner.

For example, a person who has chancroid, chlamydia, gonorrhoea, syphilis, or trichomonas infection can have as much as four times the risk of getting HIV from a sexual partner as a person who is not infected with one of these STI. An ulcerative STI (such as genital herpes, syphilis, or chancroid) increases the risk of HIV transmission per exposure significantly more than a nonulcerative STI (such as gonorrhoea or chlamydia) since HIV can pass more easily through genital ulcers. But STI that do not cause ulcers also increase risk because they increase the number of white blood cells (which have receptor sites for HIV) in the genital tract, and because genital inflammation may result in damage that can allow HIV to enter the body more easily.

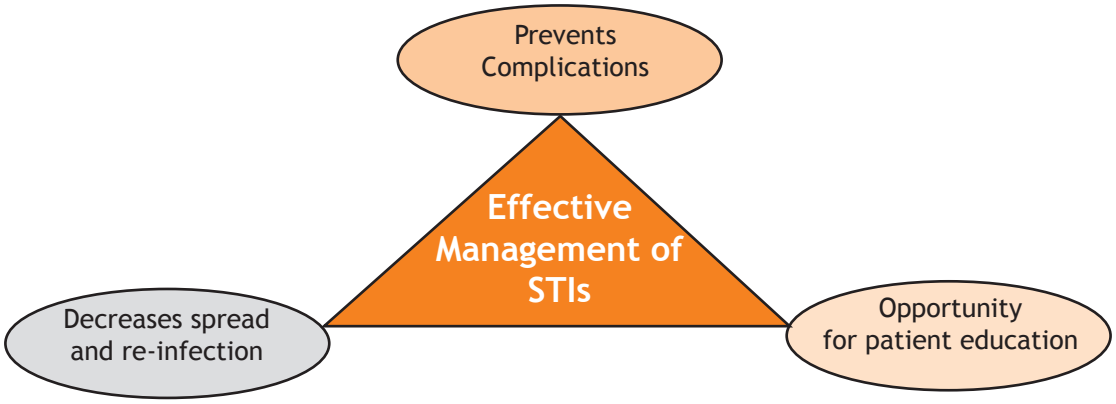
Fortunately, prevention of STI involves much the same behavior as prevention of HIV, and prevention works. In addition, since HIV spreads more easily when other STI are present, HIV transmission can be reduced by improving the recognition and management of curable STI at the Primary Health Care level. Therefore in prevention campaigns to educate people about the link between behavior and infection with STI and HIV are needed.

So, STI treatment and prevention can be an important tool in limiting the spread of HIV infection.

STI/RTI control strategies

There are two main elements of STI/RTI control:

- **Prevention** is the primary strategy for controlling STI/RTI and HIV/AIDS. Prevention means using community education and other strategies to prevent infection from occurring. In order to raise community awareness, messages should be included about STI/RTI and their consequences, reducing the number of sex Partners, using condoms, and having safer sex. As a strategy, prevention works.
- **Effective case management** means correctly diagnosing and treating symptomatic patients, and providing patient education and partner management to prevent reinfection and transmission to others.



Effective case management

Control strategies are often different for those who are at high risk and those at lower risk of contracting and transmitting infection. Reaching those at high risk will provide the greatest overall reduction of STI/RTI in the community.

8. Prevention of STI/RTI

Primary prevention	Secondary prevention	Tertiary prevention
• Creating awareness and imparting knowledge about safer sex and STI/RTI • Advising on practicing safe sex • Use of condom-Correct and consistent use of condom • Having single partner, avoiding multiple partners • Maintaining sexual hygiene • Removing stigma and bias in community and health care provider for improving the treatment seeking behavior • Improving access to safe delivery and safe abortion services • Screening of each and every pregnant women for syphilis	• Early diagnosis and prompt treatment by trained health care personnel prevents spread of infection • Correct and adequate treatment • Treatment of both the partners simultaneously • Strengthening the referral system • Accessible and affordable STI/RTI services in locality	• Prevention of late complications, complications of infertility and children

9. Challenges in Prevention and Control of STI/RTI

However, people are often too embarrassed or frightened to ask for help and information. Social stigma, misinformation, fear, shame, cultural barriers, gender inequities, and other factors can keep individuals from practicing safer sex behaviors, notifying partners, or receiving adequate treatment.

In our country, women find it particularly difficult to talk about STI and seek services for a variety of reasons. Because of cultural and social factors, a woman may be more likely to blame herself for her infections, fear abuse by a Partner, deny the presence of symptoms, or feel too embarrassed to ask for care. Young people may also have particular difficulty in accessing health care facilities because they may lack independent financial resources or fear that they will be denied services or judged by health care workers and others. In some countries, men who have sex with men – particularly those who do not consider themselves bisexual or homosexual – may fail to seek treatment out of embarrassment, fear, or stigmatization.

Prevention and control of STI/RTI in India is difficult because of:

- Very few cases are symptomatic; mostly they are asymptomatic, chronic or vaguely symptomatic. People do not seek treatment easily but they can transmit infection even when not having symptoms
- Sex is a taboo subject. So people, especially women do not discuss problems they think are related to sexual activity and avoid seeking treatment
- Often treatment is taken from quacks
- Treatment, even when taken, is often inadequate, incomplete, left halfway
- Partners often do not take treatment which results in reinfection
- Overburdened and under-trained health care workers.
- Stigmatizing attitudes of health care workers towards marginalized high risk groups i.e. Most at Risk Population (MARP).
- Inadequate referral systems.
- Limited preventive strategies.
- Inadequate preventive educational efforts, especially for youth.

It is important for health care providers to remember that STI affect men and women of all ages, backgrounds, and socioeconomic levels. Providers of STI services and counseling must avoid judgmental and moralistic attitudes that can deter clients from seeking treatment, especially in the case of clients (who might be particularly susceptible to social stigma and bias, such as adolescents, sex workers, unmarried women, and homosexuals).

The Piot and Fransen model of STI/RTI management graphically sums up the problems in the treatment of RTI. The model shows that about 40 percent of women have STI/RTI at any given time but only 1 percent complete full treatment of both partners.

The Piot - Fransen model illustrates some obstacles to STI/RTI control. The bottom bar represents all women with STI/RTI in a community. The bars above show how many people are identified at each step and the differences between the bars illustrate lost opportunities for stopping STI/RTI transmission. Comparison of the small top bar with the bottom one shows the proportion of all people with STI/RTI in the community who are identified and correctly managed at health facilities. In the typical clinical approach to the control of STI/RTI, the contribution of clinical services is small.

For example, suppose that 10 percent of the women in your community have STI/RTI. Of these women, less than half are likely to have symptoms. Even among symptomatic women, however, perhaps only half will seek or have access to care from a clinic. In this example, already less than one-quarter of the women with STI/RTI are seeking care from a qualified health worker.

There are other obstacles. How many of the symptomatic women who come to your clinic are accurately diagnosed? Even when diagnosed correctly, do the women leave with effective medications and take all of them? Finally, do women treated for STI/RTI have their partners treated successfully at the same time to ensure that they are not reinfected? These can be difficult steps to achieve and are some of the things to consider when deciding whether your STI/RTI services will make a difference in your community.

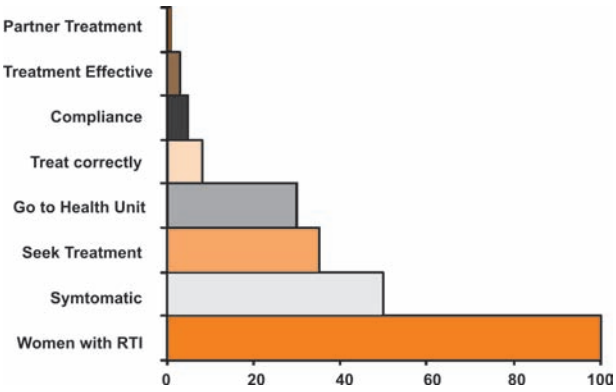


Figure 1: Problems in management of RTI (Piot - Fransen Model)

Improving STI/RTI case management at health centers expands the smallest bar, resulting in higher cure rates among those who seek care. Still, it is apparent that improving services has its limits. Clients do not usually come to health centers unless they have symptoms, and many don't. Even among people with symptoms, some choose to seek care from places other than clinics and hospitals. Self-treatment, direct purchase of antibiotics from pharmacists or drug peddlers, and consultation with traditional healers are among the many options available to someone with STI/RTI symptoms.

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

HANDOUT NO. 3

HANDOUT NO. 3

APPROACHES AND IMPORTANT CONSIDERATIONS FOR CASE MANAGEMENT

1. STI/RTI Case management

The main objectives of STI/RTI management at sub-centre level is to assess the risk of clients attending sub-centre facilities for STI/RTI and send them to PHC facilities for diagnosing the infection and availing appropriate treatment. The provider at sub-center level should encourage the clients for change in sexual behaviors and other risk-reduction strategies. They should ensure the client that sexual partners are also appropriately treated at PHC.

High quality management of STI/RTI is important because it:

1. Prevents the development of long-term complications.
2. Reduces the length of time a person is infected and therefore, the further spread of STI/RTI.
3. Reduces the level of STI/RTI in the population that present an increased risk for sexual transmission of HIV.
4. Allows for education and counseling on risk reduction and health-seeking behaviors.
5. Generally improves the quality of people's lives.
6. Management of STI/RTI involves more than simply diagnosis and treatment of the infection.

The 7 steps of comprehensive STI/RTI case management are:

1. Take history
2. Conduct physical examination
3. Provide treatment
4. Provide health education on prevention
5. Provide condoms and demonstrate use
6. Offer Partner treatment
7. Follow up or refer as needed

From the above the following critical components are to be addressed by Nursing Personnel:

Counseling and education: Client centered counseling helps prevent the spread of infection and reduce clients risk for infection and reinfection. Counseling and education also provide clients with information on potential complications, as well as strategies to change risky sexual behaviors.

Condom promotion: Demonstration/instruction in the correct use of condoms and access to an adequate supply of condoms are essential parts of STI management. Programs should help clients understand the importance of consistent and correct use and the steps of proper condom use, as well as help them develop skills for negotiating condom use.

Adherence with treatment: Providers must educate clients about the importance of following and completing treatment regimens, even after all symptoms have disappeared. Providers should explore ways that clients can successfully adhere to treatment regimens by identifying potential barriers to adherence (e.g. costs, schedule, family or partner finding out) and strategize ways to overcome these barriers.

Partner notification: When feasible, sexual Partners of clients with STI should be notified and encouraged to seek appropriate care however, strict confidentiality is critical, and issues of domestic violence or potential harm to the client must also be addressed). Treating Partners prevents the further spread of the infection and reinfection of the client. There are three options for notifying Partners: 1) Clients can be counseled about talking to their Partners on their own, 2) providers can tell Partners in conjunction with Clients and 3) if resources permit, providers or public health workers can inform Partners.

2. Diagnosis and management of STI/RTI by syndromic approach

The syndromic case management approach to STI/RTI

Syndromic management: The patient is diagnosed and treated based on groups of symptoms or syndromes, rather than for specific STI/RTI. All possible STI/RTI that can cause those symptoms are treated at the same time.

Advantages:

- Fast—the patient is diagnosed and treated in one visit.
- Highly effective for selected STI/RTI syndromes.
- Relatively inexpensive since it avoids use of laboratory.
- No need for patient to return for lab results.
- Avoids the wrong treatment since all possible STI/RTI causing signs and symptoms are treated at once.
- Can be used by providers at all levels.

Whenever any case suggestive of STI/RTI comes to doctor working at PHC, the provider at sub-center should know how does doctor manage a case of STI/RTI so that provider at sub-center who wants to send any client having risk of STI/RTI they can convince the client and help doctors in case management.

How does doctor manage a case of STI/RTI at PHC level?

- By taking a history and doing a physical examination, he arrives at a diagnosis of STI/RTI. If laboratory facility is available, he makes use of that by asking specific laboratory test to confirm his diagnosis.
- He treats STI/RTI case by providing medicines/drugs and information on how to take them.
- He tries to prevent another STI/RTI by educating the patient about disease and transmission and promotes and provides condoms.
- He ensures the patient cured by offering partner/s treatment and asks them to follow up.
- If patient is not responding he asks them to follow up and refers to higher center.

How ANMs/Other Nursing Personnel can help doctors in case management?

They can help doctors by:

1. Referring patients whose clinical history suggests symptoms of STI/RTI
2. Referring patients or Clients who are having risk of STI/RTI but are not having any symptoms suggestive of STI/RTI or screening asymptomatic Clients
3. In Client education for treatment compliance and follow up
4. In Partner management by motivating them for treatment and follow up and in community awareness

Action points for management of STI/RTI in men and women

ANMs/Other Nursing Personnel should consider following important factors when managing men and women with STI/RTI:

- Men and women are unaware of the consequences of STI/RTI problem
- They are shy and do not come out with their problem especially adolescent and youth.
- It is difficult to elicit the sexual health related information from them
- They believe in privacy and confidentiality

HANDOUT NO. 4

HANDOUT NO. 4

RISK ASSESSMENT, PROMPT REFERRAL AND PARTNER MANAGEMENT

1. Importance of history taking

A client history is taken to get the information needed to make an accurate assessment of the problem so that the providers working at sub-center level can refer the patients to the higher services such as PHC, ICTC, Rural hospital or District hospital. It is one of the most important and sensitive parts of the patient encounter, since we ask and probe about private sexual behaviors and concerns. Risk assessment involves asking how likely it is that someone has been or will be exposed to a STI/RTI. The elements of history taking and risk assessment required to counsel patients on STI/RTI prevention, and to refer the patients to the higher services for syndromic management of STI/RTI.

How history taking helps in STI/RTI case management

A patient history is taken to get the information needed to make an accurate assessment of the problem and to provide appropriate treatment. It is one of the most important and sensitive parts of the patient encounter, since we ask and probe about private sexual behaviors and concerns. Risk assessment involves asking how likely it is that someone has been or will be exposed to a STI/RTI. In this module we will cover the elements of history taking and risk assessment required to counsel patients on STI/RTI prevention, and for syndromic management of STI/RTI. Counseling and communication skills will be covered in further module on Patient Education.

What are the goals of taking history?

- To efficiently collect essential information that will help in diagnosis, treatment and prevention of STI/RTI.
- To establish the patient’s risk of contracting or transmitting a STI/RTI.
- To determine if the patient has had any Partners who may have been infected.

2. Knowledge and skills necessary for accurate history taking

The most important part of history taking is to maintain its confidentiality, develop good rapport with patient and to apply good interpersonal communication skills. While taking a history, the provider must reassure the patient that confidentiality will be maintained and explain the reason for asking certain questions. Patients are often embarrassed and may withhold important information if they think that others will know what they say. The provider needs to establish good rapport with the patient from the start. An effective provider

is able to apply good interpersonal communication skills when taking a history, during an examination, and while providing information and counseling. An effective provider:

- Empathizes with the patient
- Listens actively
- Poses questions clearly
- Has a non-judgmental attitude
- Recognizes and correctly interprets nonverbal clues and body language
- Paraphrases, interprets, and summarizes patient's comments and concerns
- Offers praise and encouragement
- Uses language the patient understands

General tips for taking a history are:

- History must be taken in a language, which the client understands well. Clients are often reluctant to talk about these conditions due to shyness or fear of stigmatization. Hence health care providers should ensure privacy, confidentiality, be sympathetic, understanding, and non-judgmental.
- Ensure privacy by having a separate room for history taking and examination, which is not stigmatized with a nameplate for STI. There should be auditory as well as visual privacy for history taking as well as examination.
- Start the conversation by welcoming your client, taking them into confidence and encouraging him/her to talk about their complaints. If a couple comes together, each of them also needs to be interviewed and examined separately.
- Often, because the client feels uncomfortable talking about STI/RTI, individuals may come to the clinic with other non-specific complaints or requesting a check-up, assuming that the health care provider will notice anything abnormal that needs treatment. Therefore, health care workers should maintain a high index of suspicion about STI/RTI.
- Clients seeking antenatal care and family planning services should be viewed as opportunities to provide general information about STI/RTI and should be asked about STI/RTI symptoms and contraception.
- One of the reasons why service providers hesitate to discuss STI/RTI with clients is that they don’t want to start partner suspicion and partner conflict. One may assure that STI are not necessarily acquired through sexual contact but they can also be acquired through unhygienic conditions. For example, there is some evidence that HPV could be transmitted vertically from mother to child and gonorrhoea could also spread through swimming pools. Hence whilst emphasizing that they should not suspect only the partners, clearly indicate the possibility of sexual transmission and the need for both partners to be treated simultaneously. This is absolutely essential to get partner confidence and co-operation.

- The health care personnel should be aware of the commonly used culturally appropriate STI/RTI related terminology as well as those used for high-risk behavior.

Information to be collected in history taking

- **General information:** age, sex, address, marital status-married or single, number of children, employment, contraceptive method if any, date of last menstrual period and information of partner/s.
- **Present illness:** signs, symptoms, and their duration previous treatment and response to therapy.
- **Medical history:** STI/RTI in the past, other illnesses, and drug allergies.
- **Sexual history:** Currently sexually active, age at first intercourse, new Partner, risky sexual behaviors, sexual preference (homosexual, heterosexual or bisexual) and use of condoms with each partner)

Good rapport in history taking

In history taking, the provider needs to establish good rapport with the patient from the start. This means:

- Providing the patient with privacy
- Establishing eye contact
- Being attentive

Good interpersonal skills

An effective provider is able to apply good interpersonal communication skills when taking a history and while providing information and counseling. An effective provider:

- Empathizes with the patient
- Listens actively
- Poses questions clearly
- Has a non-judgmental and compassionate attitude
- Recognizes and correctly interprets nonverbal cues and body language
- Paraphrases, interprets, and summarizes patient's comments and concerns
- Uses language the patient understands

Common problems encountered when taking history related to STI/RTI:

- Not enough time is available
- The provider is uncomfortable talking about sex
- The patient is uncomfortable talking about sex, especially if s/he knows that the provider feels uncomfortable about a difference in social status between them and the provider and when the provider is of opposite gender

3. Risk assessment and its use for STI/RTI prevention

Risk assessment is a process of confidentially asking a patient particular questions to determine his or her chance of contracting or transmitting a STI/RTI (e.g. many women may be at risk due to the behavior of their husbands or partners). For example: A 30-year old woman comes to you complaining of vaginal discharge. She occasionally picks up casual partners in a local bar to supplement her small income. Her last sexual contact was with a truck driver one week ago. The provider assumes STI risk.

It is important to assess men and women's risk equally. Risk assessment is most effective when the questions are developed in local language and according to local needs and conditions. Assessing risk may be improved by tailoring questions to reflect local STI prevalence, making questions more culturally appropriate and devising ways to help clients assess their own risk (self-assessment). There is some evidence that self risk assessment can provide information that is more accurate because it avoids the difficulties of face-to-face questioning on sexual behavior. Self-assessment of risk requires the health care worker to provide the client with sufficient information to allow the client to decide whether s/he is at risk. Often people suspect they are at risk but are reluctant to discuss their situations; and they need encouragement to ask any questions they may have.

Situations that might put a woman at greater risk:

- Her husband is a migrant worker
- Her husband has other partners
- She is a street child
- She is a sex worker
- Her partner has had STI/RTI

Risk assessment in men:

It is equally important to assess men's risk (or to help them assess their own risk) for the same reasons: STI/RTI prevention, treatment, and Partner management. Some of the situations are:

- He has many or casual partners
- He works as a truck driver
- He is a migrant worker
- His partner has a STI

Limitations of risk assessment:

- It requires asking difficult, sensitive questions
- Clients may feel embarrassed about answering such questions, especially if the provider is of opposite sex Clients may not understand the questions being asked since some of the scientific words or sentences cannot be translated in local language
- Information given may be inaccurate, poorly recalled, or untruthful

Assessing risk may be improved by:

- Ensuring the client that the confidentiality will be maintained
- Risk assessment is most effective when the questions are developed according to local needs and conditions
- Tailoring questions to reflect local STI/RTI prevalence
- Making questions more culturally appropriate
- ways to help clients assess their own risk (self-assessment)

There is some evidence that self-risk assessment can provide information that is more accurate because it avoids the difficulties of face-to-face questioning on sexual behavior. Self-assessment of risk requires the health care worker to provide the client with sufficient information to allow the client to decide whether s/he is at risk. Often people suspect they are at risk but are reluctant to discuss their situations; and they need encouragement to ask any questions they may have. The provider at sub-center should know the procedures for client referral from sub-center to higher facilities.

4. Referral of Patients

When to refer a patient:

1. If history suggests symptoms of STI/RTI including HIV/AIDS
2. Patient is a known case of STI/RTI and gives symptoms suggestive of reinfection
3. If there is Partner history of STI/RTI
4. If there is history of risky sexual behavior
5. ANC cases having symptoms
6. History of recent abortion and symptoms like fever or pain abdomen
7. Post natal women with symptoms of infection

Where to refer a patient:

- Patient should be referred to the nearest center where facilities for managing STI/RTI are available i.e. to PHC or Rural hospital, District hospital
- Voluntary testing for HIV/AIDS is done at ICTC centers

How to refer a patient:

- Patient record to be maintained properly along with history, symptoms, diagnosis and referral history
- Patient to be advised properly where and how to go
- Referral slip to be given with clear directions of where
- Partner should ideally accompany the patient
- Patient should be advised for follow up visit
- Patient should carry the old records with them

Framing statement

"In order to provide the best care for you and to understand your risk for certain infections, it is necessary for us to talk about your sexual behavior."

Screening questions

- Have you recently developed any of these symptoms?

STI (Genital infections) symptoms checklist

For men

1. Discharge or pus (drip) from the penis
2. Urinary burning or frequency
3. Genital sores (ulcers) or rash or itching
4. Scrotal swelling
5. Swelling in the groin
6. Infertility

For women

1. Abnormal vaginal discharge (increased amount, abnormal odor, abnormal color, consistency)
2. Genital sores (ulcers), rash or itching
3. Urinary burning or frequency
4. Pain in lower abdomen
5. Dysmenorrhoea, menorrhagia, irregular menstrual cycles?
6. Infertility

High risk sexual behavior

- For all adolescents: Have you begun having any kind of sex yet?
- If sexually active do you use condom consistently?
- Do you have any reason to think you might have a sexually transmitted disease? If so, what reason?

- Have you had sex with any man, woman, with a gay or a bisexual?
- Have you or your Partner had sex with more than one Partner?
- Has your sex Partner(s) had any genital infections? If so, which ones?
- Do you indulge in high risk sexual activity like anal sex
- Do you practice correct and consistent condom usage while having sex? If yes, whether every time or sometimes?

STI history

- In the past have you ever had any genital infections, which could have been sexually transmitted? If so, can you describe?

STI treatment history

- Have you been treated in the past for any genital symptoms? By whom? (qualified or unqualified person)
- Did your Partner receive treatment for the same at that time?
- Has your Partner been treated in the past for any genital symptoms? By whom? (qualified or unqualified person)

Injection drug use

- Have you had substance abuse? (If yes, have you ever shared needles or injection equipment?)
- Have you ever had sex with anyone who had ever indulged in any form of substance abuse?

Menstrual and obstetric history in women and contraceptive history in both sexes should be asked

5. Partner Management

What is Partner management?

Partner management is an activity in which the Partners of those identified as having STI/RTI are located, informed of their potential risk of infection, motivate and offer them treatment and counseling services.

Timely Partner management serves following purpose:

- Prevention of re-infection
- Prevention of transmission from infected Partners and
- Help in detection of asymptomatic individuals, who do not seek treatment

Important issues in Partner management

Confidentiality: Partners should be assured of confidentiality. Many times Partners do not seek services, as they perceive confidentiality as a serious problem. Respecting dignity of client and ensuring confidentiality will promote Partner management.

Voluntary reporting: Providers must not impose any pre-conditions giving treatment to the index client. Providers may need to counsel client several times to emphasize the importance of client-initiated referral of the partners.

Client initiated Partner management: Providers should understand that because of prevailing gender inequities, woman may not be in position always to communicate adequately to her husband/partner regarding need for partner management. Such client initiated partner management may not work in some relationships and may also put women at the risk of violence. Hence alternative approaches should be considered in such situations.

Availability of services: STI/RTI diagnostic and treatment services should be available to all Partners.

Approaches for Partner management

There are two approaches

1. Referral by Index Client

In this approach, index Client informs the Partner/s of possible infection. This appears to be a feasible approach, because it does not involve extra personnel, is inexpensive and does not require any identification of Partners. This approach may also include use of Client-initiated therapy for all contacts.

2. Referral by Providers

In this approach service provider contacts Client's Partners through issuing appropriate Partner notification card. The information provided by Client is used confidentially to trace and contact Partners directly. This approach needs extra staff and is expensive.

General principles for Partner Management

- The Partners of patients having STI/RTI must be referred even if they do not have symptoms suggestive of STI/RTI.
- It is important to explain to the couple that some of these infections are acquired through unhygienic conditions like unclean toilets, fomites, swimming pools etc. However if one of them has acquired the infection, it cannot be treated fully unless the Partner is also treated, as there is a definite chance of reinfection through sexual transmission. This ensures compliance from both Partners.
- A two-step strategy can be used where Clients are first asked to contact Partners themselves. If no response till one or two weeks, clinic or health department staff can attempt to trace the contact for treatment.

Note: Efforts needed to trace the Partner but whether the Partner should be treated, the choice to be rested with the patient.

HANDOUT NO. 5

HANDOUT NO. 5

CLIENT EDUCATION AND COUNSELING

1. Communicating with Clients on STI/RTI

Health care providers working at the sub-centre for family planning and maternal child health need to talk about issues of sexuality and sexual health in their work every day. The way they talk about these issues with clients determines the quality of the interaction and to a large degree, the quality of care the clients receive. Good communication of information on prevention, especially on behavior change, linked with effective treatment is key to the control of STI/RTI. Even when treatment is not available at the sub center level, prevention information and condoms can be provided.

Adult education principles

Acknowledge that adults learn:

- 20% of what they hear.
- 40% of what they hear and see.
- 80% of what they do or discover for themselves.

Therefore, teaching clients to increase their awareness of STI/RTI, risk reduction, behavior change, etc. must involve three things to be effective: action, feelings, and ideas. These correspond to the areas of skills, attitudes, and knowledge in this training.

Types of communication

a. Interpersonal communication

b. Verbal communication

c. Non-verbal communication

d. Behavior change communication

a. Interpersonal communication

The face-to-face process of giving and receiving information between two or more people, involves both verbal and non-verbal communication.

b. Non-verbal communication

- Refers to actions, gestures, behaviors, and facial expressions that express how we feel in addition to speaking.
- Is often complex and largely unconscious.

- Often reveals the real feelings or messages being conveyed.
- Can involve all of the senses.

c. Verbal communication

- Refers to words and their meanings.
- Begins and ends with what we say and how we say it.
- Is largely conscious and controlled by the speaker.

d. Behavior change communication

The process of developing and providing simple messages based on proven information that suggests realistic ways to change risky behavior. This includes exploration of life situation and risk, consideration of options, and skill building, practice, and support to implement and sustain the behavior change.

How to communicate with clients having STI/RTI

We all attach strong emotions, values and attitudes to sex. Sometimes we are judgmental or disrespectful toward clients who do not share our views. This leads to a client feeling attacked or judged a situation that makes learning difficult, and to poor understanding and compliance with treatment.

Talking about sex

Most of us, including health care providers, respond emotionally to words that relate to the sexual organs and sexual activity. Such words often make us uncomfortable. This is communicated to clients who then feel even more uncomfortable bringing up their problems. Providers often use medical terms that clients do not understand to cover up their own embarrassment about sex. Be comfortable with the real words your clients use to communicate about sexual matters and use them yourself when appropriate in order to:

- Put clients at ease.
- Make what you are saying understandable.
- Make compliance with treatment and behavior change more likely.

2. Client Education on STI/RTI

Client education on public health needs. This includes information on infections, transmission, recommended treatment, prevention, risk reduction, behavior change, and Partner referral. This information can be communicated one-on-one, in group settings in the clinic; and via posters, videos, and brochures. It should involve all possible staff. Client education requires teaching and group facilitation skills.

Goals of client education and counseling

- Primary prevention or preventing infection in uninfected clients. This is the most effective strategy to reduce the spread of STI/RTI and can be easily integrated into all health care settings.
- Curing the current infection.
- Secondary prevention, which prevents further transmission of that infection in the community and prevents complications and re-infection in the client.

Where you will find the opportunities for client education

Client education does not happen only one-to-one. A friendly and supportive atmosphere clinic-wide promotes client confidence and use of services. Important messages on prevention and treatment can be reinforced everywhere in the center. Centre may contribute significantly to the success of a STI/RTI prevention and management program.

Client education on STI/RTI at the sub-centre can be done through, educational posters on the wall, condom demonstration by provider, pictorial list of where to get STI/RTI and HIV testing and services.

What the client needs to know

Prevention of STI/RTI

- Risk reduction
- Using condoms, correctly and consistently, availability of condoms
- Limiting the number of partners
- Alternatives to penetrative sex
- Negotiating skills

Information about STI/RTI

- How they are spread between people
- Consequences of STI/RTI
- Links between STI/RTI and HIV

STI/RTI treatment

- How to take medications
- Symptoms that call for a return visit to the clinic
- Importance of Partner referral and treatment

Principles of effective client education

- Shows respect and concern for the safety of clients through body language, telling clients you are concerned, being attentive to and acknowledging clients feelings, and taking sufficient time with them.
- Is client-centered. Provides messages that are tailored for each individual-different message for married men, women, and adolescents.
- Involves 3 kinds of learning: through ideas, actions, and feelings (cognitive, psycho-motor, and affective).
- Uses multiple channels (eyes, ears and face-to-face/visual, auditory, interpersonal).
- Delivers messages via the eyes, ears, and face-to-face communication.

Risky behaviors

We know that certain behaviors increase the risk of STI/RTI transmission. Most of these behaviors involve sexual activity and are called unsafe sex.

What is safer sex?

Safer sex is sex with a partner who is uninfected or any sexual activity that reduces the risk of passing STI and HIV from one person to another.

Some safer sex practices

- Mutually faithful relationship between two uninfected partners.
- Reducing the number of sex partners.
- Using a barrier such as a condom for all types of intercourse.

- Non-penetrative sexual practices such as kissing, hugging, rubbing, and masturbating.
- Avoiding sex when either partner has signs of a STI.
- Abstinence.

Some practices that make sex risky

- Unprotected vaginal sex if you don't know whether your partner is infected.
- Sex with a partner who has signs of a STI.
- Sex with a partner who has other partners.
- Unprotected anal sex.
- Unprotected oral sex.
- Use of alcohol or drugs with sex.
- Sex with an intravenous drug user.
- Multiple partners.
- Casual sex or sex with strangers.
- Frequent change of partners.
- Douching.
- Use of vaginal drying agents.

Therefore, behavior change communication is required for prevention of STI/RTI

Principles of behavior change for prevention

- **Give good information.** Give clients clear and accurate information on risky behaviors, the dangers of STI, and specific ways to protect themselves. Identify behaviors that put particular clients at risk.
- **People need motivation to change a behavior.** People change behavior as a result of a personal experience or crisis. Meeting someone who has HIV/AIDS, hearing statistics about HIV/AIDS, hearing about a family member or friend who is infertile due to a STI, hearing about the children of someone who died of AIDS, or learning that a partner is HIV-positive are all experiences that might motivate someone to change.
- **Identify barriers to behavior change.** What keeps someone from changing behavior? Is it personal views, lack of information, or social restraints such as the need to please a husband?
- **Establish goals for behavior change.** Set up short- and long-term goals that client and provider can agree upon.
- **Offer real skills.** Teach negotiation skills for women, demonstrate how to use a condom, and conduct role- playing conversations.

- **Offer choices.** Clients need to feel that they have choices and can make their own decisions. Offer substitute behaviors that are less risky.
- **Plan for setbacks.** Rehearse how the client can deal with a situation that temporarily worsens (for example, the husband becomes angry, or refuses to use condoms).

Guidelines for communicating with clients on safer sex methods

- Use protection (condom or other barriers) every time you have sex unless you have sex with only one faithful Partner who is uninfected.
- Keep away from unsafe practices like "dry sex" that may break the skin—the vagina should be wet inside when you have intercourse.
- Do not have sex in the anus, but if you must, always use a condom with lubrication because the skin there can tear easily and allow HIV to pass.
- Try massage, rubbing, touching, dry kissing, hugging, or masturbation instead of intercourse.
- Have oral sex with a male or female condom if this is acceptable to you.
- DO NOT have sex when either Partner has sores on the genitals or when there is a discharge from the penis.

Guidelines for communicating with clients on negotiating safer sex

- **Negotiating for safer sex**

  Negotiating for safer sex is similar to bargaining for other things that we need. Thinking about how to negotiate successfully in other areas will help. A way to begin is for someone to decide what s/he wants, and what s/he is willing to offer in return.

- **Focus on safety**

  In negotiating for safer sex, the focus should be on safety, not lack of trust or blame or punishment. It is easier to reach agreement around safety because both people benefit from it.

- **Use other people as examples**

  Knowledge that others are practicing safer sex can make it easier to start.

- **Ask for help if you need it**

  Inviting another trusted person to help discuss safer sex with a Partner may make it easier.

3. Counseling on STI/RTI

Counseling: It is face-to-face communication between two or more people in which one person helps the other to make a decision and then act upon it.

It is two way communication and the counselor listens patiently to the clients thoughts, fears, misconceptions and problems without being judgmental. It takes into account psychosocial, emotional and spiritual needs of the client. It is strictly confidential. Information given to the client is full and accurate. It helps the client to make decisions for himself or herself.

Guidelines for counseling

Counseling often has 6 elements, or steps. Each letter in the word GATHER stands for one of these elements. Good counseling is more than covering the GATHER elements, however. A good counselor also understands the feelings and needs of persons having STI/RTI. With this understanding, the counselor adapts counseling to suit each person. Good counseling need not take a lot of time. Respect, attention to each person's concerns, and sometimes just a few more minutes make difference.

G = Greet the person

A = Ask how can I help you?

T = Tell them any relevant information

H = Help them to make decisions

E = Explain any misunderstanding

R = Return for follow up or Referral

Barriers to good counseling

- Lack of privacy.
- Not greeting or not looking at the client.
- Appearing to be distracted (for example, by looking at your watch or reading papers while s/he is talking).
- Using a harsh tone of voice or making angry gestures.
- Sitting while the client stands or sitting far away from the client.
- Allowing interruptions during the consultation.
- Being critical, judgmental, sarcastic, or rude.
- Interrupting the client.
- Making the client wait for a long time.
- Not allowing enough time for the visit.

Client counseling on STI/RTI: During counseling session, provider should talk about causation, transmission, recommended treatment, prevention, risk reduction, behavior change, and Partner referral. Clinics can have take away information brochures in simple local languages with illustrations to reinforce messages.

4. Integrated counseling and testing centers (ICTCs) and their role in STI prevention and management

Clients with STI have shown high-risk sexual behaviour. Based on this high-risk behavior, the health care worker should inform the client about the links between STI and HIV and should encourage all clients to undergo an HIV test, as the risk of HIV among STI is upto 10 times higher. In order to get HIV test, Integrated Counseling and Testing Centers (ICTC) have been established. Each ICTC has counselor(s) and a laboratory technician.

In Integrated Counseling and Testing Centers, the STI client will receive comprehensive and accurate information on HIV/AIDS and HIV counseling to facilitate an informed choice regarding an HIV test. The integrated centers serve as single window system by pooling all counselors and laboratory technicians working in ICTC, PPTCT, blood safety, STI, ART/ OIs and HIV - TB together to offer round the clock counseling and testing services. This common facility will remove fear, stigma and discrimination among the clients, PLHAs and the referrals.

The ICTC have common television and video based health education materials that are screened continuously in the clients waiting area. The information related to preventive, promotive and curative health care along with information regarding HIV/AIDS, and various services provided by the hospital is provided to all the clients.

Opt-out strategy – In this, the counselor assumes that the client has come to get an HIV test (implied consent). The HIV test will be done unless the client actively denies the test.

Opt-in strategy – In this, the counselor specifically asks the client, whether s/he would like to undergo the HIV test. The client has to actively agree to the HIV test.

As per the National AIDS Prevention and Control Policy, all HIV tests are voluntary, based on clients consent, accompanied by counseling and confidentiality of the results.

Aims of pre-test counseling

- To ensure that any decision to take the test is fully informed & voluntary
- To prepare the client for any type of result, whether negative or positive or indeterminate
- To provide client risk reduction information & strategies irrespective of whether testing proceeds

The clients are advised about preventive measures and use of condoms.

If the client declines to take the test, he/she leaves the ICTC. Some clients return to the ICTC after a few days for the test. If the client agrees to undergo the test, he/she proceeds to the attached laboratory for blood collection. After the blood sample is taken, the client either waits for the results or is asked to return on assigned date with Patient Identification Digit (PID) number.

The tests are performed by using the rapid test kits. If the test is negative and the client has history of high risk factors, s/he is advised to repeat the test after 3 months as he/she may be in the window period. If the result is positive the test is repeated with kits using a different method of antibody detection. The result is considered positive if all three tests are positive. Before the results are revealed to the client, post counseling is done.

Aims of post-test counseling aims to

- Help client understand and cope with the HIV test results.
- Provide the client with any further information required.
- Help clients decide what to do about disclosing their test result to partners and others.
- Help clients reduce their risk of HIV/AIDS and take action to prevent infection to others including condom, avoiding multiple partners and other high-risk behavior (positive prevention).
- Help clients access the medical and social care and support they need.
- Establish link with PLHA groups, if needed.

In STI settings, the following is recommended

- HIV testing should be recommended for all STI clients after pre-test counseling and informed consent. There should be guarantee for confidentiality. HIV counseling and testing can either be performed in the STI clinic (if counselor is available) or clients can be referred to the nearest ICTC.
- In some cases of STI in the presence of HIV infection, larger doses and longer treatment duration of the drugs listed under the different STI may be required. These clients should be followed up regularly for longer duration.
- Excessive use of anti-microbial should be avoided, as it is likely to lead to more rapid development of antibiotic resistance.

Although counseling of individual clients on risk reduction, and prevention of STI transmission to the partners should be done in all clients of STI, this is of vital importance for those infected with HIV.

Glossary of STI/RTI Related Terminology

S. No.	Terms	Meaning
1.	Sexual Aberration	A sexual activity, which differs from those generally, practiced, or considered 'right' or 'moral'; also called deviation, paraphilia or perversion
2.	Adultery	Sexual intercourse between a married person and an individual other than his or her legal spouse
3.	AIDS	Acquired Immune Deficiency Syndrome; a fatal viral disease that impairs the body's ability to fight infections and cancers; while the disease may be treated, the underlying immune deficiency cannot up to now be cured by any means.
4.	AIDS test	Usually refers to laboratory tests, ELISA or Western Blot, done to detect the absence or presence of HIV antibodies which indicates whether the person has been exposed to the Human Immunodeficiency virus (HIV)
5.	Anal intercourse	Sexual intercourse in which the penis is inserted into the Partner's anus; sometimes termed sodomy or buggery
6.	Anilingus	The act of using the mouth or tongue in erotic stimulation of the anus (the rim)
7.	Aphrodisiac or Zoophilia	Anything, such as drug or perfume, that is believed to stimulate sexual desire
8.	Bestiality	Sexual relations between a human and an animal
9.	Celibacy	a. The state of being unmarried, usually implying sexual abstinence b. Abstaining from sexual intercourse
10.	Clap	A layman's expression for gonorrhoea
11.	Coitus/Copulation (To engage in coitus, to bang, to fuck, to lay, to screw, to climb on)	Sexual intercourse between a male and a female, in which the penis is inserted into the vagina
12.	Coitus interruptus (premature withdrawal, pulling out)	The practice of withdrawing the penis from the vagina just before ejaculation;
13.	Condom (French letter or FL, rubber sheath, Nirodh) In females the condom is placed in the vagina.	A contraceptive commonly used by males and recently introduced for females. For males it consists of a rubber or gut sheath that is drawn over the erect penis before sexual intercourse

S. No.	Terms	Meaning
14.	Fellatio (penilingus) (a blow job; to blow, to go down on, to eat, to suck)	The act of taking the penis into the mouth and sucking it for sexual pleasure
15.	Fidelity	Being faithful to one's chosen or given sexual Partner(s) and having sexual intercourse only with that/those Partner(s)
16.	Fondling	Touching or stroking lovingly; caressing
17.	Foreskin (Prepuce)	The skin covering the tip of the penis or the clitoris
18.	French kissing (deep kissing or wet kissing)	Use of the tongue in kissing; thrusting of the tongue into the Partner's mouth during a kiss
19.	Gay	Another term for male homosexual
20.	Glans	The head of the clitoris or the penis; comes from the Latin term for acorn
21.	High-risk behaviour	Term used to describe certain activities which increase the risk of transmitting an STI; includes frequent change of sex Partners, anal and vaginal intercourse without using a condom, oral-anal contact, semen or urine in the mouth, sharing intravenous needles or syringes, intimate blood contact and sharing of sex toys contaminated by body fluids; often referred to as 'unsafe 'activities
22.	HIV	Human Immunodeficiency virus which renders the human immune (defence) system deficient and unable to resist opportunistic infections and the development of specific cancers
23.	HIV – negative	When HIV antibodies are not detected in the body
24.	HIV- positive	When HIV antibodies are detected in the body
25.	IDU	Injecting drug users
26.	Impotence (Erectile dysfunction)	Inability of a man to have sexual intercourse; usually refers to inadequacy of penile erection
27.	Incest	Sexual intercourse between close relatives, such as father and daughter, mother and son, or brother and sister
28.	Labia majora	The major or outer lips of the vulva
29.	Labia minora	The minor or inner lips of the vulva
30.	Lecherous	Being very lustful
31.	Lesbian	A female homosexual
32.	Libido	Sexual drive, interest or urge
33.	Masturbation (Hand practice, playing with oneself)	Self stimulation of the genitals through manipulation; autoeroticism; self gratification

S. No.	Terms	Meaning
34.	Monogamy	A marital arrangement in which a person has only one spouse
35.	Nymphomania	The constant, extreme and irrepressible desire of a woman for sexual satisfaction
36.	Oral-genital sex	Application of the mouth or tongue of one Partner to the genitals of the other
37.	Oral-sex (head job, come down on, eat each other)	Sexual activity which involves mouth contact with another person's genitals or anus; contact may include kissing, sucking or licking of the sexual organs
38	Orgasm (The big O, to experience orgasm, to come)	The peak or climax of sexual excitement in sexual activity
39.	Paedophile	An adult who engage in or desires sexual activity with a child
40.	Partner exchange (Swinging, swapping)	The planned exchange of sexual Partners between four or more individuals
41.	Pederasty	1. Male sexual relations with boy, often-anal intercourse 2. Sexual relations via the anus
42.	Petting (Making out, necking, dry fuck, dry lay)	Sexual contact that excludes coitus
43.	Polyandry	The form of marriage in which a woman has several husbands
44.	Polygamy	A marital arrangement in which a person has more than one spouse
45.	Polygyny	The form of marriage in which a man has several wives
46.	Pornography	The explicit description or exhibition of sexual activity in literature, photographs, films, etc, intended to stimulate erotic rather than emotional feelings
47.	Promiscuous	Engaging in sexual intercourse with many persons; engaging in causal sexual relations
48.	Prostitute	A person who engages in sexual relationships for payment (hooker, streetwalker, whore, pros); nowadays referred to as a commercial sex worker to avoid a negative bias
49.	Prostitution	Engaging in sexual activity for money
50.	Sadism	The achievement of sexual gratification by inflicting physical or psychological pain upon the sexual Partner
51.	Sado-masochism	A form of behaviour in which sex and pain become pathologically attached bondage, discipline

S. No.	Terms	Meaning
52.	Safe- sex	Term used currently to describe sexual activities mostly to reduce the risk of transmission of STD; includes always using a condom during sexual intercourse, mutual masturbation, dry kissing, massage, fantasy, touching; opposed to unsafe sex practices
53.	Vaginal lubrication	A clear fluid (like sweat) that appears on the walls of the vagina within a few seconds after the onset of sexual stimulation
54.	Virgin	A woman or girl who has never had sexual intercourse

HANDOUT NO. 6

HANDOUT NO. 6

PREVENTING STI/RTI AMONG SPECIAL POPULATIONS

1. Male Participation in Prevention and Control of STI/RTI

Strategies for involving men in STI/RTI prevention

Often men are the bridging group who acquire infection from and transmit STI/RTI to high-risk Partners such as sex workers and who then carry it home to their regular Partners. In this way, STI/RTI spread even to women who have only one Partner. Reaching men with prevention messages and condoms and treating their STI/RTI early and correctly are very effective ways to prevent the spread of STI/RTI in their regular Partners. A key strategy is getting men with STI/RTI to refer or bring their regular Partners for treatment, thus reaching the many women who may appear to be low risk and have no symptoms.

Why should family planning and STI/RTI services include men?

Men may have access to services for STI/RTI treatment through STI clinics and PHCs, but they are mostly less informed than women about basic issues of sexual health and disease prevention. It is clear from new research studies that men are eager for more information about their own reproductive health and than that of their Partners. Men and women alike suffer from the fear of shame and embarrassment attached to seeking treatment for STI/RTI and need sensitive treatment from providers. Family planning and STI/RTI services should include men for the following purpose:

- To provide opportunities for increased access to information.
- To enable men to support their partners.
- To increase effectiveness of partner referral for STI/RTI treatment.
- To improve partner communication skills.
- To increase the use of condoms with casual partners.
- To increase the use of condoms with regular partner if any one of the partner is infected or has unprotected sex outside of it.

Two important reasons why men should be involved in STI/RTI prevention program

1. To encourage men with STI/RTI to bring or refer their partners for treatment. Since STI/RTI are more often symptomatic in men than in women, partner management is an important way to identify asymptomatic women who need treatment.
2. To reach men with information about prevention, especially use of condoms in casual and commercial sex encounters. This will reduce the chance that they will take STI/RTI home.

Ways to Involve Men in Awareness, Prevention, and Treatment

There are many ways to involve men in the awareness, prevention, and treatment of STI/RTI. The following are only a few examples:

- Public information campaign on STI/RTI directed to men receiving early treatment and informing their partners of the need for treatment.
- Condom promotion for men with casual partners in addition to primary partners if not practicing safer sex outside of the primary relationships.
- Posters in local bars, pan shops where men gather that address STI/RTI and the need for men to protect their families.
- Drug treatment packets/kits with information on STI/RTI for female partners.
- Partner referral cards for a man to give to his primary partner.
- Linking FP/MCH services with STI/RTI services for partner referral.
- Public information campaign on syphilis and HIV that addresses how men can protect both their wives and newborns by decreasing the number of casual partners and using condoms.
- Adverting ANC services that promote male partnership in pregnancy and birth.
- Trained peer educators in the workplace.

Men may be more receptive to STI prevention messages if they understand that STI threaten their health and fertility, and may endanger the lives of their wives, girlfriends and children.

The challenge of reaching Men and how to address these challenges

Challenges	How to address
• Men may not feel comfortable using services mainly used by women.	• Establish men only clinic or have dedicated hours for men services • Ensure privacy and confidentiality
• Men may feel shame or embarrassment about seeking information or treatment for STI/ RTI.	• Create general public awareness • Provide better experiences to those attending the clinic so they recommend others to seek services • Provide adequate information to those attending the clinic which might help in spreading the word in the peers and community
• There is a lack of confidentiality for men if their partners are with them.	• Have proper arrangements for privacy to men and women in the clinic • Assure then and maintain • Try couple counseling rather than individuals
• Treating men may take time and resources away from women.	• Assign adequate time to men as well as women • Make available enough resources and manpower for handling the load of STI/RTI clinic/RH clinics
• Treating men requires new skills from providers.	• Train providers to respond to STI/RTI management needs of both men as well as women
• Treating men may require different facilities and more male providers	• Establish men only clinic or have dedicated hours for men services

2. Preventing STI/RTI in Adolescents

WHO has defined adolescents as those between the age group of 10 to 19 whereas youth between the age group of 15-24 years. Many PHCs do not offer services to unmarried adolescents. Services such as family planning for women under age 18 or for those who are unmarried are many a time denied. At the same time pregnancy, abortion, and STI rates in young women are high, accounting for a large part of maternal ill health and deaths.

Adolescent girls are particularly vulnerable to STI since they are less likely to have access to health services and to recognize symptoms. Health services for adolescent boys are also extremely limited. Lack of education about sexual health for both boys and girls leaves them ill equipped to make important choices to protect themselves against unwanted sex, pregnancy, and STI. The AIDS epidemic gives a new urgency to STI prevention and is also an opportunity to protect new generations from the devastating effects of AIDS by making information and services available.

This section gives us information on Adolescent Reproductive and Sexual Health Strategy in STI/RTI prevention.

Adolescent and youth at risk

- Adolescents and youth in the age group 10-24 years contribute to about 30% of our population. According to Census 2001, there are 225 million adolescents comprising nearly one fifth (22%) of India's total population.
- The data from various Indian studies reveal that adolescents indulge in pre-marital sex more frequently and at an early age.
- More than half of the currently married illiterate females are married below the legal age of marriage. Nearly 20% of the 1.5 million girls married under the age of 15 are already mothers. Nearly 27% of married females adolescents have reported unmet need for contraception.
- STI, including HIV, are most common among young people aged 15-24 years and more so in young women. Over 35% of all reported HIV infections in India occur among young people in the age group of 15-24 yrs indicating that young people are highly vulnerable. The majority of them are infected through unprotected sex.
- Deaths due to pregnancy and its outcomes in married female adolescents of 15-19 yrs are higher than adult females who are in the reproductive age group.
- These statistics document the extent of unprotected sexual activity among youth and the clear need to protect young women against both STI/RTI and pregnancy. We have to seek the opportunity to educate, prevent, and treat STI/RTI, when young women already come for abortion and care of pregnancy, in PHC setting.
- Protection against infection and pregnancy involve the same strategies and services used for adults.

- Young men can be involved in both family planning and STI/RTI prevention if their need for information and treatment is addressed.

Why adolescent and youth are at risk for STI/RTI?

- Youth lack accurate knowledge about the body, sexuality, sexual health and STI.
- Changing partners is more common among youth than among older men or women who may be in stable relationships.

Vulnerability of Young Women-

- The female genital tract is not mature and is more susceptible to infection.
- Females have submissive attitudes towards men.
- Young women may have their first sexual experiences with older men.

Vulnerability of Young Men-

- Young men often have a need to prove sexual powers.
- Young men may have their first sexual experiences with sex workers.

Therefore there is an urgent need for improving the accessibility of adolescents to preventive and curative services including information and counseling.

Barriers to information and services for youth

- Lack of services: little access to family planning or services for treatment or prevention of STI.
- Lack of access to condoms.
- Provider, parent, teacher, and community attitudes about youth and sexuality.
- False belief that young people are not sexually active, and that information will increase sexual activity.
- Lack of messages targeted to youth.
- Lack of providers trained to deal with youth.

Overview of the adolescent reproductive and sexual health strategy

The Govt. of India has realized that the health situation of adolescent and youth will be central in determining India's health, mortality, morbidity and population growth scenario. Investment in adolescent reproductive and sexual health will yield dividends in terms of delaying age at marriage, reducing incidence of STI and reducing the proportion of HIV positive cases in 10-19 age group. This will also help India in realizing its demographic bonus, as healthy adolescents are an important resource for the economy.

Accordingly a National Strategy for Adolescent Reproductive and Sexual Health (ARSH) has been developed and in the National Rural Health Mission (NRHM) ARSH strategy has been approved as a part of the Reproductive and Child Health Phase II (RCH II). Various States as a part of their State and District RCH II plans have adopted this national strategy. This strategy is now to be implemented in the districts in the Primary Health Care setting.

ARSH strategy in National RCH II PIP

The goals of the Govt. of India's RCH II are reduction in IMR, MMR and TFR. In order to achieve these goals the RCH lists out four technical strategies. One of the technical strategies is for adolescent health.

A strategy for ARSH has been approved as part of the National RCH II Programme Implementation Plan (PIP). This strategy focuses on reorgansing the existing public health system in order to meet the service needs of adolescent. Steps are to be taken to ensure improved service delivery to adolescent during routine check ups at sub centers clinics and to ensure service availability on fixed days and timings at the PHC and CHC levels. This is to being tune with the out reach activities.

A core package of services would include preventive, promotive, curative and counseling services. The framework of services in the RCH II ARSH strategy in the National PIP is presented below. This describes the intended beneficiaries of the adolescent friendly reproductive and sexual health services (target group) the health problems/issues to be addressed (service package) and the health facilities and service providers to be involved.

Such friendly services are to be made available for all adolescent married and unmarried girls and boys during the clinic sessions but not denied services during routine hours. Focus is to be given to vulnerable and marginalized sub groups. A plan of service provision as per level of care may be developed based on the RCH II service delivery plan.

The ANM should give information on STI/RTI prevention to adolescents as follows:

- Delay the onset of sexual activity.
- Abstain from sexual activity until married.
- Learn how to use condoms.

- Use condoms. These may be discontinued when pregnancy is desired.
- Avoid multiple partners and stick with one partner.
- Avoid high-risk partners.
- Recognize symptoms of STI/RTI. If burning with urination and/or discharge from the penis, or there are genital sores, young men and their partners should not have sex, but both should come to the clinic for treatment.

Key issues to be communicated are:

A - Abstinence

B - Be faithful to your partner

C - Use condoms

D - Early diagnosis

E - Ensure cure

3. Preventing STI/RTI among High Risk Group Population (HRG)

Who are the people whom we can say as "High Risk Group Population" (HRG) ?

High risk group population comprises the people who sell sex for money or favors, the sex workers, men having sex with men (MSMs), transgender and intravenous drug users (IDUs).

What all HRG have in common is that their work puts them at high risk for STI/RTI. As health workers, it is important to be able to identify these men and women at risk and give them the care they need in a non- judgmental and compassionate way.

Preventing transmission of STI/RTI among people, who have multiple partners, is the single most effective strategy to reduce the number of new infections within the general population. HRG population can transmit infections at a higher rate than others in the population. Providers need skills to help these women and men who are at high risk, to welcome them non-judgmentally, and to treat them with the same care like their other clients. Due to their high potential to transmit infections to others, the high risk group population especially sex worker needs effective treatment whenever and wherever they present for care, as well as knowledge and skills to promote condom use with their regular partners and customers.

HRG and STI/RTI

Not everyone in the population has the same probability of becoming infected with STI/RTI or transmitting them to others. Female sex workers, MSMs, IDUs have the highest rates of transmission of HIV. The reasons for the high rates of infection and transmission for sex workers include their high number of sexual contacts, as well as co-factors such as the presence of other STI, concurrent substance abuse and/or poor health status and lack of access to health services.

Providing services to sex workers such as distributing free condoms, STI treatment and enabling them to adopt safer behavior can have the greatest impact on slowing STI transmission in the larger community.

Barriers for service access to HRG

- Because of the mindset of community, there is a stigma for HRG and therefore they are not always welcome by general population.
- Though women and transgenders who trade sex are often at the highest risk for STI/RTI, they are often the least likely to seek STI/RTI services.
- The female sex workers also has the same kind of barriers to care for themselves that affect all women.
- HRG often find that services may be highly stigmatized. The providers may judge them harshly as immoral and may treat them badly.

Providing care for HRG

- You can make a big difference in the life of HRG by helping them get the care they needs and prevent transmission of STI to the wider population.
- Give the same respectful care to HRG as you give to others.

HANDOUT NO. 7

HANDOUT NO. 7

COMMUNITY EDUCATION FOR PREVENTION OF STI/RTI

1. STI/RTI Prevention and Control in the Community

Good management of STI/RTI in the clinic is necessary, but it alone will not prevent the spread of STI/RTI. An urgent need to increase community awareness of STI/RTI and AIDS exists because of the general lack of knowledge and motivation for behavior change and the stigma associated with STI/RTI, particularly HIV.

Health workers have an important role to play in disseminating health messages and promoting community involvement in the fight against STI/RTI and HIV. Providers can support the prevention efforts of groups outside the clinic (peer educators, CBDs, religious groups, schools, and others) by providing consistent messages that contain accurate information.

Much of health care providers work involves providing information, skills, and motivation that Clients need for making decisions to improve their health. Viral STI/RTI, including HIV, cannot be cured—prevention is our only hope. And even when STI/RTI are curable, working to prevent infection in the first place is of utmost importance because reproductive health services are not accessible to all and, in the best of circumstances, cannot reach everyone at risk in the community.

Need for community education on prevention and control of STI/RTI

a. To increase awareness of the symptoms and consequences of STI/RTI:

Awareness of the signs of STI/RTI, knowledge about STI/RTI transmission and the serious consequences of STI/RTI, and perception of risk is low in many communities, especially among certain populations. Increasing knowledge and awareness is the first step toward changing behavior.

b. To counter myths and misconceptions:

Myths and misconceptions about AIDS and STI/RTI abound, often causing stigmatization of people known to be infected. Negative community attitudes based on misunderstandings prevent people from openly seeking information and health care and using condoms to protect themselves.

c. To encourage risk-reducing behaviors:

People need to know which behaviors are safe and how to reduce unsafe behavior. Awareness of the consequences of unsafe behavior can lead to motivation for change.

Various ways through which community education on STI/RTI can be done:

a. Increase use of available health services:

Adverting availability of services at the health centers with clear messages about services offered and populations served can increase the use of available services. The quality of an individual's experience can be greatly improved by creating a welcoming, supportive, educational atmosphere.

b. Start a process of social change:

Many women are at risk for STI/RTI or HIV/AIDS because of social norms, such as taboos on sexuality, male behavior, double standards, and economic dependency. Social and cultural norms can change, and this change may be essential for STI/RTI prevention. Organize community groups to talk about health problems, including STI/RTI and AIDS and explain hoe early detection and treatment of STI/RTI help prevent HIV infection.

c. Gain public support for STI/RTI services:

In order to familiarize people with health centre services, links between the community and the health center should be created through outreach activities. If community members see that prevention efforts are backed up by quality health services, they will be more willing to support such services. Make sure condoms are available in your community and at the health centers.

d. Increase community leaders' support for STI/RTI services:

Active engagement of the community in STI/RTI prevention that yields positive results can make it easier for leaders to support STI/RTI control efforts publicly, continuing a positive cycle of prevention activities. Involving various stakeholders at the local level such as NGOs, community leaders,community groups, community-based health workers and others who are working on reproductive and sexual health issues can have an impact and make change happen.

2. Developing Strategies for BCC in the Community

Changing behavior is difficult. Especially at the community level, social norms are deeply embedded in institutions such as schools, mandir, masjid and churches. Going against the norms may be objectionable to certain groups. Putting messages out into the community requires thoughtful planning. These are the steps toward bringing about behavior change in a community.

a. Define target groups:

Think about targeting groups at highest risk or in greatest need. Who needs information most urgently? Who can be reached using available resources you have? What links can be made with other organizations already targeting groups in need? Understand that different messages are required to reach different groups. Sex workers, youth, men, rural and urban women, community leaders, and religious leaders—all need messages and information tailored to their different situations.

b. Understand community beliefs and practices:

To understand what messages will reach people, one needs to understand why they behave the way they do.

c. Set communication objectives and activities:

What do people already know about STI/RTI? What do they need to know? What are their attitudes and prejudices about STI/RTI? Who are their leaders or who has influence over them? What cultural and language barriers exist?

d. Develop strategies to reach target groups:

Can you use peer educators to reach marginal groups? Can you attract people by offering clinical services?

e. Evaluate the strategies impact:

How well did the strategies work? Can you monitor condom use in your clinic? Can you track numbers of condoms dispensed in a given period of time?

HANDOUT NO. 8

HANDOUT NO. 8

CONDOM AND ITS PROPER USAGE TECHNIQUE

1. Condoms for STI/RTI Prevention

Condom is one of the barrier methods of contraception. They are made by using either latex or polyurethane, which cannot be penetrated by sperm, STI or HIV, so it provides dual protection, helps in avoiding unwanted pregnancies and gives protection against STI. Therefore promotion of the use of condoms and ready accessibility of condoms is important for the control of STI and HIV. Management of STI includes counseling on preventive measures and use of condoms. All health facilities providing STI services must always have in stock the essential drugs and condoms. The necessity of using condoms must be explained to the Clients along with the advice on the treatment schedule and important for compliance of the full course of medicines prescribed.

General instructions for condom use

Remember:

- The condom does not include spermicide. If you want additional protection, you must add your own spermicide.
- Because it is made from polyurethane, you can use oil-based lubricants with the condom.
- Use a new condom each time you have sex.
- Use a condom only once.
- For best results, store condoms in a cool, dry place.
- Do not use a condom that may be old or damaged.

Do not use a condom if:

- The package is broken.
- The condom is brittle or dried out.
- The color is uneven or has changed.
- The condom is unusually sticky.

Male condom

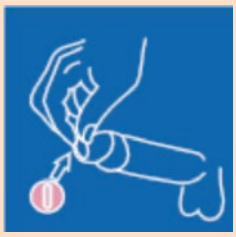
Most male condoms are made of latex, while some are made of polyurethane. Male condoms are of two types: Non lubricated and lubricated.

Female condom

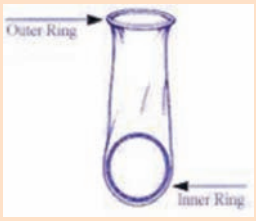
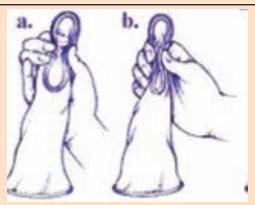
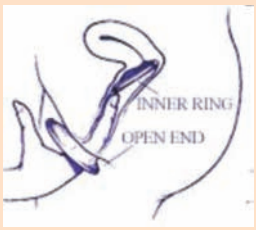
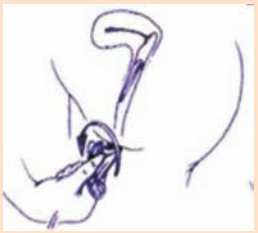
Female condoms are made of polyurethane. One advantage of it over the male condom is that its size and shape enable it to cover the wider surface area including some of the external genitalia, thus it may offer additional protection against infections that can be transmitted by contact with skin normally not covered by a male condom. However, the female condom is expensive. It is freely available in open market but not yet included in the National family Welfare program.

2. How to use a condom

How to use a male condom

	**Step 1: Open package** • Use a new condom each time you have sex • Check that it has not expired and that the packaging has no holes by pressing the pack between your fingers • Push condom to one side of package to allow room to tear open other side • Remove condom carefully • DO NOT use finger nails, teeth or sharp objects to open package or remove condom
	**Step 2: Put it on** • Squeeze closed top end of condom to make sure no air is inside (can make it break) • Place condom over top of erect penis • With other hand, unroll condom gently down the full length of your penis (one hand still squeezing top end)
	**Step 3: During sex** • Make sure condom stays in place • If it comes off, withdraw your penis and put on a new condom before intercourse continues • Once sperm has been released into condom (ejaculation), withdraw the erect penis and HOLD the condom in place on penis
	**Step 4: Dispose of condom** • Remove condom ONLY when penis is fully withdrawn • Keep both penis and condom clear from contact with your Partners body • Knot the end of the used condom
	• Place in tissue or bag before throwing it in dustbin • DO NOT flush condoms down the toilet. It will block the system.

How to use a female condom

<table>
<tr><td> 
</td><td>Before intercourse
Step 1 : Open package
• Remove the female condom from the package, and rub it between two fingers to be sure the lubricant is evenly spread inside the sheath. If you need more lubrication, squeeze two drops of the extra lubricant included in the package into the condom sheath.</td></tr>
<tr><td> 
</td><td>Step 2 : Put it in
• The closed end of the female condom will go inside your vagina. Squeeze the inner ring between your thumb and middle finger.</td></tr>
<tr><td> 
</td><td>Step 3 : Assure right position
• Insert the ring into your vagina. Using your index finger, push the sheath all the way into your vagina as far as it will go. It is in the right place when you cannot feel it. Do not worry, it can't go too far.
Note: The lubrication on the female condom will make it slippery, so take your time to insert it.</td></tr>
<tr><td>  </td><td>During sex
Step 4 :
• The ring at the open end of the female condom should stay outside your vagina and rest against your labia (the outer lip of the vagina). Be sure the condom is not twisted.
• Once you begin to engage in intercourse, you may have to guide the penis into the female condom. If you do not, be aware that the penis could enter the vagina outside of the condom's sheath. If this happens, you will not be protected.</td></tr>
<tr><td>  </td><td>After intercourse
Step 5: Dispose of condom
• You can safely remove the female condom at any time after intercourse. If you are lying down, remove the condom before you stand to avoid spillage.
• Throw the female condom away. Do not reuse it.</td></tr>
</table>

During intercourse remember to remove and insert a new female condom if: Condom rips or tears during insertion or tears during insertion or use, the outer ring is pushed inside, the penis enters outside the pouch, the condom bunches inside the vagina, or you have sex again.

HANDOUT NO. 9

HANDOUT NO. 9

RECORDING AND REPORTING

1. Recording and Reporting Formats for Designated clinic

Good reporting practices help clinics monitor their services and permit meaningful data generation to enable regular evaluation of the programmes. Minimal reporting records that should be maintained by each of the designated STI/RTI clinic are given in table below:

Records and Reports of Designated STI/RTI clinic.

1 Patient Wise Card

2 STI Register

3 Counsellors Diary

4 Indent Form

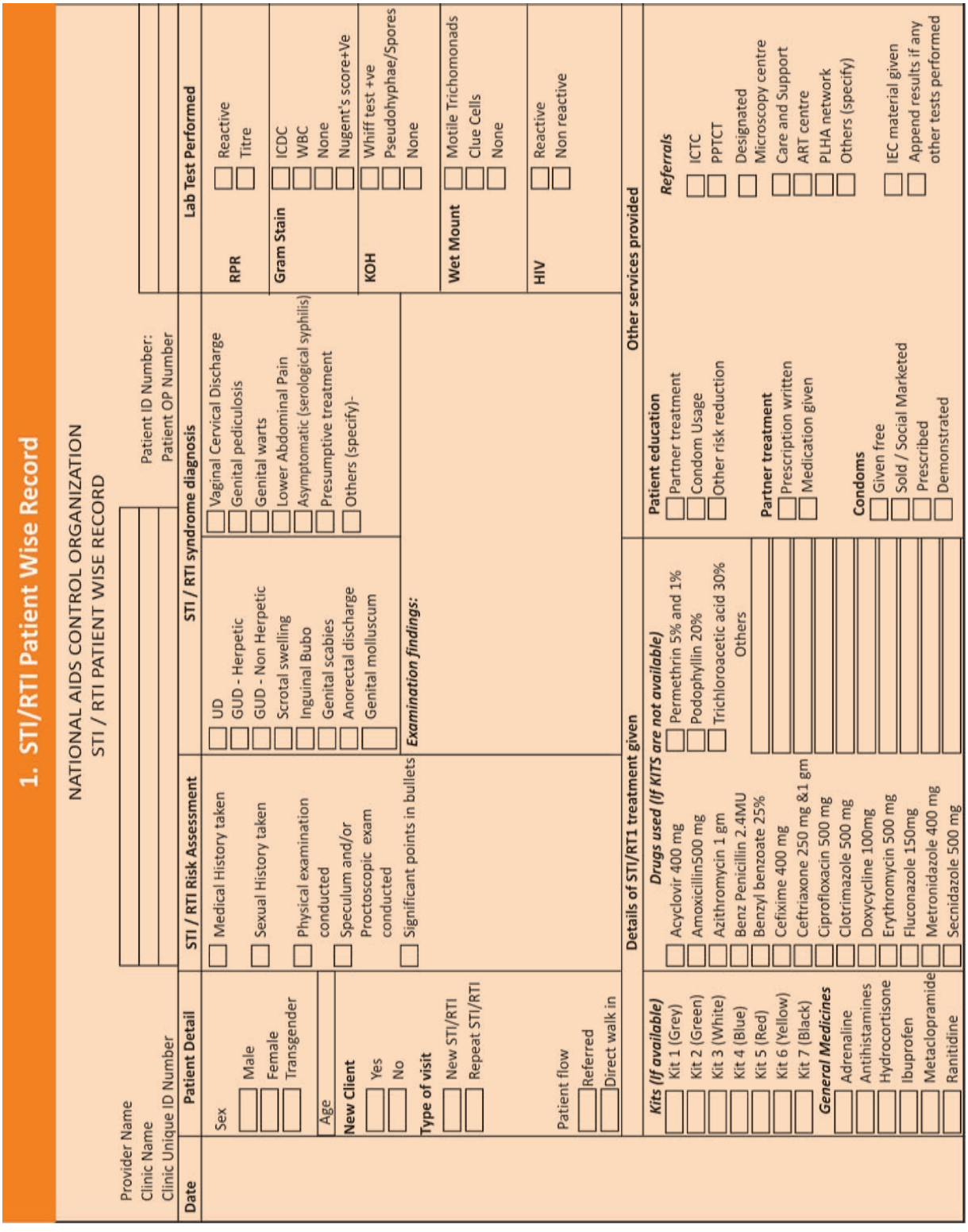
5 Stock Register

6 Referral Form

7 STI/RTI Monthly Reporting Format

The details of filling of these formats is described

1. Patient Wise Card:



Guidelines for Filling the STI/RTI Patient Wise Card

(To be used by all STI/RTI service providers)

General Instructions

Write the name of the service provider, Name and unique ID number of clinic (list of unique ID numbers allotted to each STI/RTI clinic is available with M&E division of SACS)

1. SACS may print the name and unique ID number of STI/RTI clinic on cards before dispatching them to individual clinics.
2. Write the name of service provider.
3. Write the patient ID number.
    a. Write the patient ID number starting from 00001 and write consecutive numbers from April to March.
    b. Repeat the same for each financial year.
4. Write the patient general outpatient number (wherever applicable/available).

Who should fill the cards?

The STI/RTI patient wise card should be filled by STI/RTI service providers for each new STI/RTI episode treated. The cards should be stored securely. All the cards of individual clients should be kept stapled.

The monthly reporting format should be filled by using the consolidated data from these cards. The filled cards should be available at clinic during supervisory visits.

The STI/RTI service providers include.

a) Providers at all designated STI/RTI and ObGyn clinics (health care facilities located at area/district hospitals, teaching hospitals attached to medical colleges etc).

b) Providers with targeted interventions providing STI/RTI services for high risk groups.

Specific instructions

What should be written?

1. Write the date of visit under date column
2. Check the patient details -
    a. Check the box for - Male or Female or Transgender accordingly.
    b. Age - Write the completed years as told by patient.
    c. Check "**yes**" if the patient is a New client i.e. attending that particular STI/RTI clinic for first time or with fresh episode.
    d. Check "**No**" if the patient has visited that particular STI/RTI clinic previously.

Type of visit

e. Check the type of visit **ONLY** after examination is completed.

f. Check type of visit as "**New STI/RTI**" if the patient is attending with a fresh episode of STI/RTI.

- Patients present with STI/RTI symptoms, and confirmed to have STI/RTI on physical and internal examination.
- STI/RTI signs are elicited by internal examinations, and/or
- STI/RTI etiology diagnosed using laboratory method, and/or
- If a known herpes patients visits with recurrent infection, check this box

g. Check type of visit as "Repeat visit" if the patient repeated the visit for the previously documented complaints. This includes STI/RTI follow up (when the visit happens within 14 days following treatment).

3. **a.** Check the "**Referred by**" if the patient is referred by some other facility (such as ICTC/PPTCT/ART centre/other OPDs in the institute where the clinic is located/NGOs/ STI clinic with targeted interventions/Peer Educator/Outreach worker etc).

   b. Check the "**Direct walk in**" if the patient attended the clinic directly.

4. STI/RTI risk assessment

a) Check the box after taking detailed "**Medical history**" from the patient.

b) Check the box after taking detailed "**Sexual history**" from the patient

c) Check the box after conducting detailed "**Physical examination**" of the patient

d) Check the box after conducting detailed "**Internal examination**" of the patient

e) Write the key points of significance from history in the box provided.

5. STI/RTI syndrome diagnosis

a. Check the appropriate box as per the diagnosis made.

b. While making the syndrome diagnosis, the standardized definitions given ONLY to be followed.

c. Should be filled in even if the diagnosis is made on clinical or etiological basis.

d. If the patients have more than one syndrome or condition, check all the appropriate syndromes and/or conditions diagnos ed.

1. **Vaginal/Cervical Discharge (VCD):** Includes a) Woman with symptomatic vaginal discharge b) Asymptomatic patient with vaginal discharge seen on speculum examination.
   c) Cervical discharge seen on speculum examination (All syndromic, etiological and clinical STI/RTI diagnosis relating to vaginal or cervical discharge should be included here).

2. **Genital ulcer disease-non-herpetic (GUD-NH):** Female or male or transgender with genital or ano- rectal ulceration and with NO blisters (vesicles). (All STI syndromic, clinical or etiological diagnosis relating to genial ulcers caused by Treponema Pallidum (syphilis), Haemophilus Ducreyi (Chancroid), Granuloma Inguinale and Lymphogranuloma Venereum (LGV) except herpes simplex virus type 2 should be included here).
3. **Genital ulcer disease-herpetic (GUD-H):** Female or male or transgender with genital or ano- rectal blisters (vesicles) with ulcers or recurrence primarily caused by herpes simplex virus type 2.

   Note: If both ulcers and blisters are present, tick on both GUD and GUD herpetic or when the provider is not able to differentiate between the two.
4. **Lower abdominal pain (LAP):** Female with Lower Abdominal Pain or tenderness, or Cervical motion tenderness.
5. **Urethral discharge (UD):** Male or transgender with intact genitalia with Urethral Discharge with or without dysuria or other symptoms with a history of unprotected sexual intercourse in recent past.
6. **Ano-rectal discharge (ARD):** Male, female or transgender with symptoms of tenesmus or if ano-rectal discharge seen on examination.
7. **Inguinal bubo (IB):** Individuals with inguinal bubo and NO genital ulcer. (Syndromic or Clinical diagnosis of LGV should be included here).
8. **Painful scrotal swelling (PSS):** Male or transgender (with intact genitalia) with painful scrotal swelling (primarily caused by infection of Gonococci and Chlamydia).
9. **Genital warts:** Individuals with anal or genital warts.
10. **Genital scabies:** Tick if patient is diagnosed as having genital scabies.
11. **Genital Pediculosis:** Tick if patient is diagnosed as having genital pediculosis.
12. **Genital molluscum:** Check the box if the patient is suffering with molluscum lesions over the genitalia.
13. **Asymptomatic (Serological Syphilis)** - this box to be checked if the patient is found serological syphilis.
14. **Presumptive Treatment (PT)** - All asymptomatic sex workers (male and female) attending the clinic for the first time should be provided with presumptive treatment. Presumptive treatment is also to be provided in case the sex worker presents asymptomatically after not attending any clinical service for six consecutive months or more.
15. **Other (specify):** Individuals attending with any other STI/RTI related condition.

5. Examination findings

Summarize the salient findings of physical including internal examination in the box provided.

6. Laboratory Tests Performed

RPR/VDRL test

a) Check if Rapid Plasma Reagin (RPR)/VDRL test is conducted and found reactive.

b) Write the highest titers reactive.

Gram stain

a) Check the box for "ICDC" if urethral and endo cervical smears demonstrates >5 PMN/hpf and intracellular gram-negative diplococci inside polymorph nuclear cells.

b) Check the box for "WBC" if urethral and endo cervical smears demonstrates >5 PMN/hpf and no intracellular gram-negative diplococci inside polymorph nuclear cells.

c) Check the box for "None" if urethral smears demonstrates <5 PMN/hpf and no intracellular gram-negative diplococci inside polymorph nuclear cells.

d) Check the box for "None" if endo cervical smears demonstrates <10 PMN/hpf and no intracellular gram-negative diplococci inside polymorph nuclear cells.

e) Check the box for "Nugent's score Positive" - if the score is between 7 and 10 of vaginal discharge smear (refer the National guidelines for managing reproductive tract infections including sexually transmitted infections, August 2007).

KOH

a) Check the box for "Whiff test" - If a drop of 10% potassium hydroxide on vaginal secretion on a glass slide releases fishy odours of amines.

b) Check the box for "Pseudohyphae" - If budding yeast/hyphae is seen under light microscope

c) Check the box "None" - if negative for whiff test and pseudohyphae.

Wet mount

a) Check the box for "Trichomonads" - if Motile trichomonads seen under light microscope (10x).

b) Check the box for "Clue cells" - if Clue cells comprise more than 20% of all epithelial cells in any view under light microscope.

HIV

a) Check the box for "Reactive" - if an HIV test is performed as per national HIV testing guidelines and declared as reactive

b) Check the box for "Non Reactive" - if an HIV test is performed as per national HIV testing guidelines and declared as non reactive

Details of STI/RTI Treatment Given

This section has 'four' components

- Pre specified colour coded kits starting from No 1 to 7
- Check the box against the kit administered to the patient
- If more than one kit is given to same patient due to multiple syndromes then check the relevant boxes
- General medicines administered to the patient
- Check the relevant box, if any of these medicines were administered
- If drugs for anaphylaxis are checked, detail the entire management of anaphylaxis including the outcome on a separate sheet and append to the card.
- All drug allergies, idiosyncratic reactions to be marked with "red ink" on the card
- If kits are not in supply or in addition to kits loose drugs were prescribed/administered then check the relevant boxes. Treatment regimens should be in accordance to National Technical Guidelines for Managing RTI including STI, August 2007.
- Write any other drug administered or prescribed to patient which doesn't fall in any of the above mentioned categories.

Other Services Provided

This section has four components and basically concerned with what additional value added services provided to patient.

Patient education: check the relevant box if individual patient is provided with STI counseling on

- Partner/s treatment
- Condom usage and disposal
- Other risk reduction communication

Partner treatment: check the relevant box if individual patient is provided with

- Prescription written
- Medications given

Condoms: check the relevant box if individual patient is provided with

- Condom given free
- Sold (Social marketed)
- Prescribed
- Demonstrated (all clinics should have a penis model for demonstration purpose)

Referrals: check all the relevant boxes

- **ICTC:** check the box if STI/RTI patient referred to the ICTC.
- **PPTCT:** check the box if a pregnant STI/RTI patient referred to PPTCT.
- **DMC:** check the box if STI/RTI patient who has suspected to be chest symptomatic referred to DMC.
- **Care and support centre:** check this box if a referral is done (List of care and support centres with contact details should be available at all clinics and displayed at waiting hall).
- **ART centre:** check this box if a referral is done (List of ART centres with contact details should be available at all clinics and displayed at waiting hall. All individuals who are tested reactive for HIV are to be referred for nearest ART centre, for registration and subsequent follow up. This ART registration number should be written over the card for future references).
- **PLHA networks:** check this box if a referral is done (List of PLHA net works with contact details should be available at all clinics and displayed at waiting hall).
- **Others (specify):** if a referral other than those mentioned above is done then specify the place/centre to which patient is referred.
- All ways provider should get the feedback of referral and document them in the card. As there is no name over the card, the information will remain confidential and this fact should be emphasized to PLHAs and HRG individuals.
- **IEC material given:** check this box if take home IEC material is provided to attendee (the clinic should keep a stock of simple hand bills on STI/RTIs for patient self education. SACS should ensure availability of such IEC material at all STI/RTI clinics).
- **Append with results if any other tests performed:** check this box if any other additional tests performed. Append the copies of test/s performed along with their results .

2. STI / RTI Register

Master Register for Doctors at STI and Gyne & Obs Clinic

Name of the Hospital

Clinic Unique ID number

STI/RTI Syndromic Coding: 1=UD 2=GUD-Harpetic 3=GUD-Non Hermetic 4=Vaginal-cervical discharge 5=Ingunal Bubo 6=Gental Scabies 7=Ano-rectal Discharge 8=Genital Molluscum 9=Scrotal Swelling 10=Gental pediculosis 11= Genital Warts 12 =Lower Abdominal Pain 13 Asymptomatic 14=Presumptive 15=Other (specify)

Sr. No.	Date	Patient OPD Number	Patient ID Number	Name	Age	Sex	Referred (R) walk in (W) of Referred then specify		STI/RTI Syndrome diagnosis	Treatment Provide		Counselling	Condoms	Partner Management		Referred to		Lab investigations			
										Kit (if available) Specify kit number	Drugs Prescribed	Counseling Done1-Yes 2-No.	Number of pieces provided	Partner Notification 1-Yes, 2 No	Partner managed 1-Yes,2 No	1-ICTC, 2-TB, 3-ART, 4-RPR/ VDRL 8-Others	Outcome of referral	RPR test	HIV test	KOH	Wet mount
1																					
2																					
3																					
4																					
5																					
6																					
7																					
8																					
9																					
10																					
11																					
12																					
13																					
14																					
15																					
16																					
17																					
18																					
19																					
20																					
21																					
22																					
23																					

3. Counselors Patient Dairy

S. No.	Date	STI-PID No.	New / Repeat	Age	Sex	Occupation	Education	Patient Complaints	Important points in sexual & Personal history	Interventions by Counselors	Other Remarks
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											

4. Indent Form

Name of the Hospital :					
Clinic Unique ID number:					
Sl No.	**Name of the Drug**	**Balance on the day of indent**	**Amount to be indented (Date)**	**Amount received (Date)**	**Remark**
1	Kit 1				
2	Kit 2				
3	Kit 3				
4	Kit 4				
5	Kit 5				
6	Kit 6				
7	Kit 7				
8	RPR Test kits				

Note:

1. The clinic must have supply of drug for at least three months.
2. There should be a critical level of stock for each STI/RTI drugs & kits.
   Whenever supply reaches less than one quarter of supply the drug should be indented.
3. The Clinic should follow the policy of FEFO (First Expiry First Out).

Signature
Counsellor

Signature
STI Clinic Incharge

Signature
Issuing authority at SACS

5. Stock Register

_____ STATE AIDS CONTROL SOCIETY

Format for Stock Register for STI Clinic

Name of Test/Drugs/Consumable _____

Date	Opening Stock	Number received this month	Number of tests performed	Wastage if any	Closing Stock	Number requested	Date of placing request

6. STI/RTI Referral Form

STI/RTI Referral Form

(To be filled and handed to the client by STI/RTI Counselor/Nurse)

Referral to

ICTC/Chest & TB/Laboratory_____

The patient with the following details is being referred to your center.

Name:_____ Age_____ Sex:_____

STI/RTI-PID No:_____

Kindly do the needful

Referring Provider

Name:_____ Designation:_____

Contact Phone:_____Date of referral:_____

(To be filled and retained at referral site so as to be collected by STI/RTI counselor/Nurse weekly)

The above patient referred has been provided ICTC/TB/RPR/VDRL/_____ services and the patient has been tested/diagnosed/treated for_____

The test/results of RPR/VDRL/is/are_____

Signature of the Medical Officer/Counselor/Lab In-charge

7. STI/RTI Monthly Report

Monthly STI/RTI

Unique ID. No. of STI/RTI Clinic /Gynae OPD /TI NGO	

MONTHLY REPORT FORMAT FOR STI/RTI CLINICS

Name of STI/RTI Clinic/ Hospital to which the Gynecology OPD is Attached/ TI NGO					
Sub Type		Category		Location	
Address :					
District :		Block :		City :	
Reporting Period :	Month(MM) :		Year(YYYY) :		
Name of Officer In - charge :					
Phone no. of Officer In - charge :					

Section 1 : No. of Patients Availed STI/RTI services in this month

Type of Patients	Age Group & Sex												Total		
	<20			20-24			25-44			>44					
	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG
Clinic visit with STI/RTI complaint and were diagnosed with an STI/RTI															
Clinic visit with STI/RTI complaint but were NOT diagnosed with an STI/RTI. • Clinic visit for Syphilis Screening (Excluding ANC) • For TI-NGOs-RMC, PT, Syphilis Screening (whichever applicable)															
Follow up visit for the index STI/RTI complaint															
Total No of visits															

Section 2 : STI/RTI syndromic diagnosis

(Should be filled by all STI/RTI service providers for clinic visit for STI/RTI complaint only)

Diagnosis	Age Group & Sex			
	Male	Female	TS/TG	Total
1. Vaginal/ Cervical Discharge(VCD)				
2. Genital Ulcer (GUD) - non herpetic				
3. Genital ulcer(GUD) – herpetic				
4. Lower abdominal pain (LAP)				
5. Urethral discharge (UD)				
6. Ano-rectal discharge (ARD)				
7. Inguinal Bubo (IB)				
8. Painful scrotal swelling (SS)				
9. Genital warts				
10. Other STIs				
11. Serologically + ve for syphilis				
Total No of episodes				
No of people living with HIV/AIDS (PLHAs) who attended with STI/RTI complain during the month				

Section 3. Details of other services provided to patients attending STI/RTI clinics in this month

To be filled in by all STI/RTI Service Providers

Service	Male	Female	TS/TG	Total
1. Number of patients counseled				
2. Number of condoms provided				
3. Number of RPR/VDRL tests conducted				
4. Number of patients found reactive				
5. Number of partner notification undertaken				
6. Number of partners managed				
7. Number of patients referred to ICTC				
8. Number of patients found HIV-infected (of above)				
9. Number of patients referred to other services				

Section 4 : STI/RTI service for HRGs in the month (To be filled in by TI NGO)

	Male	Female	TS/TG	Total
Number of new individuals visited the clinic				
Number of Presumptive Treatments (PT) provided for gonococcus and Chlamydia				
Number of regular STI check-ups (RMC) conducted (check-up including internal examination of HRGs once in a quarter)				

Section 5 : ANC syphilis screening in this month	
Should be filled by all service providers with ANC service provision	**Total**
Number of ANC first visits in the month (Registration)	
Number of rapid plasma reagin RPR/VDRL tests performed	
Number of RPR/VDRL tests reactive (Qualitative)	
Number of RPR/VDRL tests reactive above >=1:8 (Quantitative)	
Number of pregnant women treated for syphilis	

Section 6 : Laboratory diagnosis of STI/RTI				
Laboratory diagnosis/Tests	**Male**	**Female**	**TS/TG**	**Total**
1. Total RPR/VDRL tests performed				
RPR tests reactive >= 1:8				
2. Total Gram stain performed				
Gonococcus + (gram negative intracellular diplococci +)				
Non-Gonococcus urethritis (NGU)-Pus cells +ve				
Non-Gonococcus cervicitis (NGC)-Pus cells +ve				
None				
Nugents score +ve				
3. Wet mount test performed				
Motile Trichomonads +ve				
Whiff test +ve				
Clues cells +				
None				
4. KOH test performed				
Candidiasis				
None				
5. Availability of consumables (Yes=1, No=2)				
Do you have STI pre-packed kits?				
Functional Computer				
AMC of Computer				

Section 7 : Drugs & Consumables								
Drugs & Consumables	Opening stock	Number received this month	Consumed	Damage/ Wastage	Closing stock	Stock Sufficient for approx months	Earliest Expiry Date (Month/Year)	Quantity
RPR tests								
Pre-packed STI Kit 1								
Pre-packed STI Kit 2								
Pre-packed STI Kit 3								
Pre-packed STI Kit 4								
Pre-packed STI Kit 5								
Pre-packed STI Kit 6								
Pre-packed STI Kit 7								
Condom Pieces								
Reagent for gram stain								
Reagents for wet mount and KOH test								
Others								

Section 8 : Details of Staff at the STI/RTI clinics					
Human resource details at STI/RTI and /or Gynaecology clinics (Should be filled by all STI/RTI clinics)					
Staff	**Number Sanctioned**	**Number in place**	**Number of Person Trained during month**		
			Induction	**Refresher**	**Others**
Medical Officer					
Staff Nurse					
Laboratory Technicians					
Counsellor					

NOTE: The medical officer in-charge, staff nurse and STI counselor at designated STI/RTI clinic should ensure maintenance of all records and generate the monthly report which should be submitted to SACS by the 5th of every month.

Guidelines for filling Monthly Report Format for STI/RTI Clinics (all public health facilities supported by NACO and TI NGOs)

Who should fill this?

This reporting format should be filled by all ***STI/RTI service providers*** and sent to the corresponding reporting authority by the 5th of next month through SIMS. The STI/RTI service providers include:

- Providers at all ***designated STI/RTI clinics*** (located in area/district hospitals, teaching hospitals attached to medical colleges etc)
- ***Targeted Interventions*** providing STI/RTI services for High Risk Behaviour Groups

What are the different sections of STI format?

The format is divided into eight sections as follows.

Section 1: Number of Patients availed STI/RTI services in this month

Section 2: STI/RTI syndrome and other STI/RTI diagnosed

Section 3: Details of other services provided to patients attending STI/RTI clinics in this month

Section 4: STI/RTI service for HRGs in this month

Section 5: ANC Syphilis screening in this month

Section 6: Laboratory diagnosis of STI/RTI

Section 7: Drugs & Consumables

Section 8: Details of Staff at the STI/RTI clinics

What should be reported?

- Section 1, 2, 3, 5, 7 and 8 should be reported by all NACO ***designated STI/RTI clinics***
- Section 1, 2, 3, 4 and 7 should be filled by all ***Targeted Interventions***
- Additional Section 6 should be filled up by NACO ***designated STI/RTI clinics*** also having laboratory services (Laboratory may be located in the STI/RTI clinic or through linkage with existing laboratory in the hospital).

General information

Sl No.	Indicators	Explanation
1	Unique ID	Unique ID provided to STI/RTI Clinic/ Gynaecology OPD/TI NGO by respective SACS
2	Name of the STI/RTI Clinic/Gynae OPD/TI NGO	Name of the institution where STI/RTI Clinic/ Gynaecology OPD is located Name of the TI NGO
3	Address of STI/Gynae	Address of STI clinic including state, city, district, Block/Mandal and pin code
4	Reporting period	Reporting month and year in the form of MM and YYYY. Example: the data for the month January, 2011 would be reported in February 2011. So the reporting month is 01 and year is 2011.
5	Name and phone number of the Officer in-charge	Name of the medical officer who is in charge of STI Clinic
6	Phone number of the Officer in-charge	Phone number of the officer who is in charge of STI Clinic

Section 1: No. of Patients availed STI/RTI services in this month

- Should be reported by **all STI/RTI service providers**
- **One individual should be entered once in a month in this section in any row**
- Fill the number of individuals who have availed STI/RTI services under appropriate age and sex category
- Fill in the total number of STI/RTI visits under the specific category as per description below

Sl No.	Indicator	Definition/Explanation
1	Clinic visit with STI/RTI complaints and were diagnosed with STI/RTI	Fill the number of individuals visited with any STI/RTI complaints as per STI/RTI patient wise card and was treated for the same. This indicates fresh STI/RTI episodes.
2	Clinic visit with STI/RTI complaint but were NOT diagnosed with an STI/RTI Clinic visit for syphilis screening (Exclude ANC) For TI-NGOs-RMC, PT, Syphilis Screening (whichever applicable)	Fill the number of individuals visited for complaints of STI/RTI, but were not diagnosed with STI/RTI as per patient wise card. Include the patients who came for syphilis screening to Designated STI/RTI clinics. ***Do not include ANC attendees***. Only for TI-NGOs, fill all those HRG (without diagnosed STI/RTI) attending the STI clinic for Regular Medical Check-up, Presumptive Treatment and Syphilis screening * *1. If any HRG attending for RMC or syphilis screening or PT is found to be having STI/RTI, they should be entered in row 1 only. 2. If any HRG availing more than 1 service (eg RMC + Syphilis screening, PT + syphilis screening, Symptomatic STI + Syphilis screening) should be entered only once in one row based on his/her having an STI/RTI or not.
3	Follow up visits for the STI/RTI complaint	Fill the number of patients who have come for a follow up visit (within 14 days of availing treatment) out of patients counted in row 1 (clinic visit with STI/RTI and were diagnosed with STI/RTI)
4	Age group and Sex	Fill the number of individual availed STI/RTI services under appropriate age (<20, 20-24, 25-44, >44) and sex category.
5	Total no. of visits	This is auto calculated in software. The total gives total attendance of individuals at STI/RTI clinic.

Section 2: STI/RTI Syndromic Diagnosis

- Should be reported by **all STI/RTI service providers**
- Should be filled for clinic visit with STI/RTI complaints and were diagnosed with STI/RTI only (Section 1 Row 1)
- Diagnosis could be reached on syndromic/clinical/etiological basis
- Fill up consolidated number of STI/RTI patients diagnosed with following syndromes

Sl No	Indicator	Definition/Explanation
1	Vaginal/Cervical discharge (VCD)	a) Woman with symptomatic vaginal discharge b) Asymptomatic patient with vaginal discharge seen on speculum examination c) Cervical discharge seen on speculum examination (All syndromic, etiological and clinical STI/RTI diagnosis relating to vaginal or cervical discharge should be included here)
2	Genital Ulcer Disease (GUD)-Non Herpetic	Female or male or transgender with genital or ano-rectal ulceration and with NO blisters (vesicles). (All STI syndromic, clinical or etiological diagnosis relating to genial ulcers caused by Treponema Pallidum (syphilis), Haemophilus Ducreyi (Chancroid), Granuloma Inguinale and Lymphogranuloma Venereum (LGV) except herpes simplex virus type 2 should be included here)
3	Genital Ulcer Disease (GUD)-Herpetic	Female or male or transgender with genital or ano-rectal blisters (vesicles) with ulcers or recurrence primarily caused by herpes simplex virus type 2.
4	Lower Abdominal Pain (LAP)	Female with Lower Abdominal Pain or tenderness, or Cervical motion tenderness
5	Urethral Discharge (UD)	Male or transgender with intact genitalia with Urethral Discharge with or without dysuria or other symptoms
6	Ano-rectal Discharge (ARD)	Male, female or transgender with symptoms of tenesmus or if ano-rectal discharge seen on exam
7	Inguinal Bubo (IB)	Individuals with inguinal bubo and NO genital ulcer. (Syndromic or Clinical diagnosis of LGV should be included here)
8	Painful Scrotal Swelling (SS)	Male or transgender (with intact genitalia) with painful scrotal swelling (primarily caused by infection of Gonococci and Chlamydia)
9	Genital warts	Individuals with anal or genital warts.

Sl No	Indicator	Definition/Explanation
10	Other STIs	Individuals attending with any other STI/RTI related condition (e.g. Genital Scabies, pubic lice, and Genital Molluscum Contagiosum etc).
11	Serologically +ve for syphilis	Individuals treated for serological reactive for Syphilis.
Total number of episodes		These counts the total number of episodes of STI/RTI diagnosis made during the month. This is auto calculated in the software.
People living with HIV attended with STI/RTI complaints		People living with HIV attended/treated for STI/RTI

Section 3: Details of Other Services provided to patients attending STI/RTI clinics in this month

- Should be reported by **all STI/RTI service providers**
- Should be filled with details of other services like counselling, condom distribution, referrals provided to STI/RTI clinic attendees as per Section 1.

Sl No	Indicator	Definition/Explanation
1	Number of patients counseled	Fill total number of STI/RTI clinic attendees provided with STI/RTI counseling.
2	Number of condoms provided	Fill total number of condoms provided to all STI/RTI clinic attendees.
3	Number of RPR/VDRL tests conducted	Fill total number of RPR/VDRL tests conducted for STI/RTI clinic attendees.
4	Number of patients found reactive	Fill the number detected reactive for RPR/VDRL test of the above.
5	Number of partner notification undertaken	Fill the total number of partner notifications undertaken of index STI/RTI patients treated.
6	Number of partners managed	Fill the total number of partners of index STI/RTI patients attended the clinic and managed.
7	Number of patients referred to ICTC	Fill the number of STI/RTI clinic attendees referred to ICTC.
8	Number of patients found HIV-infected (of above)	Fill the number detected as HIV reactive, of the above.
9	Number of patients referred to other services	Fill in the number of STI/RTI clinic attendees referred for any other services like care and support, tuberculosis screening etc.

Section 4: STI/RTI Service for HRGs

- Should be filled by **TI-NGO** providing services to high risk behavior group(HRG).

Sl No.	Indicator	Definition/Explanation
1	Number of new individuals visited the clinic	Fill in total number of new High Risk Behaviour Group individuals visiting the clinic for the first time for any clinical services. This would include both symptomatic and asymptomatic HRGs. It has no relationship with what package of services is being availed. This number can be arrived by summing up "new clients" checked as "Yes" in patient wise card. Definition of "new" HRG individual is as per TI guidelines
2	Number of presumptive treatment (PT) provided for Gonococcus and Chlamydia	Fill in total number of HRG individuals (FSW, MSM including TS/TG) who attended the clinic for STI/RTI services without being symptomatic and were provided with treatment for Gonococcus and Chlamydia as per NACO STI/RTI technical guidelines August 2007.
3	Number of regular STI check-ups (RMC) conducted	Fill in the number of HRG individuals (FSW, MSM including TS/TG) who attended the clinic for STI/RTI services without being symptomatic and received RMC. RMC means medical check up including internal examination of HRG to be done once in a quarter, which may include speculum or proctoscope examination; and found to be not having STI/RTI. Exclude the numbers of HRG receiving presumptive treatment in this row.

Section 5: ANC Syphilis Screening in this Month

- Should be filled by all NACO ***designated STI/RTI clinics***
- Data should be drawn from the records of ANC clinic in the hospital
- Should fill information for women making first visit for ANC only

Sl No.	Indicator	Definition/Explanation
1	Number of ANC first visits in the month (Registration)	Write the number of pregnant women registered for first time with the ANC clinic during the month.
2	Number of RPR/VDRL tests performed	Write the number of registered pregnant women undergone RPR/VDRL test during the month*
3	Number of RPR/VDRL tests reactive (qualitative)	Write the number of pregnant women found reactive for RPR/VDRL test*, of the above
4	Number of RPR/VDRL tests reactive >= 1:8 (quantitative)	Write the number of pregnant women whose RPR/VDRL test* titre is >=1:8, of the above
5	Number of pregnant women treated for syphilis	Write the number of pregnant women diagnosed having syphilis undergone treatment

Section 6: Laboratory Diagnosis of STI/RTI

- Should be filled by all NACO ***designated STI/RTI clinics***
- ***Do not include ANC syphilis screening data in this section***

Sl No.	Indicator	Definition/Explanation
1	**Total RPR/VDRL test performed**	Fill in the total number of RPR or VDRL qualitative tests conducted among men, women, and others during the reporting month (write the same number as recorded in row 3 under section 3)
	RPR test reactive >= 1:8	Fill in the number of RPR/VDRL tests reactive at or above 1:8 titres among men, women and others*, of the above
2	**Total Gram stain performed**	Fill in total number of gram stain performed among men (urethral smear) and women (endo-cervical smear and vaginal discharge smear)*
	Number of Smears +ve for Gonococcus	Fill in number of gram stained smears positive for gonococcus
	Criteria for urethral smear	>5 PMN/hpf and intracellular gram negative diplococci inside poly morphonuclear cells
	Criteria for endocervical smear	Numerous PMN/hpf and intracellular gram negative diplococci inside poly morphonuclear cells

Sl No.	Indicator	Definition/Explanation
	Non Gonococcal Urethritis/cervicitis-Pus cells +	Fill in number of gram stained smears positive for non gonococcal urethritis/cervicitis
	Criteria for urethral smear	> 5 PMN/hpf and NO intracellular gram negative diplococci inside poly morphonuclear cells
	Criteria for endocervical smears	>10 PMN/hpf and NO gram negative diplococci inside poly morphonuclear cells
	None	Fill in number of gram stained smears negative for both
	Criteria for urethral smear	< 5PMN/hpf and NO intracellular gram negative diplococci inside poly morphonuclear cells
	Criteria for endocervical smear	<10 PMN/hpf and NO gram negative diplococci inside poly morphonuclear cells
	Number of smears +ve for Nugent's score	Fill in the number of smears +ve for Nugent's score. Nugent's score is +ve when the score is between 7 to 10
3	**Wet mount tests performed**	Fill in the total number of wet mounts performed among women
	Motile trichomonads +	Fill in the number of wet mounts demonstrated Motile trichomonads seen under light microscope (10x)
	Clues cells +	Fill in the number of wet mounts demonstrated Clue cells in more than 20% of all epithelial cells in any view under light microscope
	Whiff test +	Fill in the number of wet mounts released fishy odours of amines, when a drop of 10% potassium hydroxide is placed on vaginal secretion on a glass slide
	None	None of the above tests are positive
4	**KOH test performed**	Fill in total number of KOH tests performed among women
	Candidiasis+	Fill in the number of KOH slides demonstrated budding yeast/hyphae under light microscope
	None	Fill in the number of KOH slides not demonstrated budding yeast/hype under light microscope
5	**Availability of consumables, functional computers and AMC of Computers**	Check yes or no for availability of the STI/RTI colour coded drug kits, functional computers and its AMC.
**** The information on number of test conducted and/or results may or may not be available with facility providing clinical services. The providers are to ensure collection of the laboratory data from the concerned providers/departments/or facilities (microbiology/pathology/general lab).***		

Section 7: Drugs and Consumables

- Should be filled by all service providers at STI/RTI clinic
- Provide details of stock of RPR test, TPHA tests kits, Per-packed STI kit 1, kit 2, kit 3, kit 4, kit 5, kit 6 and kit 7, condom pieces, reagents for gram stain, wet mount and KOH test and others if any

Sl No.	Indicator	Definition/Explanation
1	Opening Stock	This is auto calculated in software. This gives number of STI/RTI drug kits/reagent/RPR, TPHA test kits available on the first day of the month.
2	Number received in this month	Write the number of STI/RTI drug kits/reagent/RPR, TPHA test kits received during the month.
3	Number consumed	Write the number of STI/RTI drug kits/reagent/ RPR, TPHA test kits utilised or distributed during the month.
4	Damage/Wastage	Write the number of STI/RTI drug kits/reagent/RPR, TPHA test kits wasted or damaged during the month.
5	Closing stock	This is auto calculated in software. This gives the number of STI/RTI drug kits/reagent/RPR, TPHA test kits available on the last day of the month.
6	Stock sufficient for approximate month	This is auto calculated in software. (Closing stock/ drugs consumed plus damaged/wasted) Every clinic to ensure one quarter (3 months) drug/ testing kits/reagent supply for the clinic.
7	Earliest expiry date	Write the expiry date of the drug kit, condom or reagent in a lot of the closing stock having the earliest expiry date in MM/YEAR
8	Quantity	Write the quantity of the drug kit, condom and reagent kit having earliest expiry date

Section 8: Details of Staff at the STI/RTI clinics

- Should be filled by all STI/RTI clinics
- Contains human resource details at STI/RTI clinics

Sl No.	Indicator	Definition/Explanation
1	Medical Officer/s	Number of doctors posts sanctioned, Number in place Number of the doctors trained in STI as per National guidelines (Induction/Refresher/Other) during the month
2	Staff Nurse	Number of Staff Nurse posts sanctioned, Number in place Number of the staff nurse trained in STI as per National guidelines (Induction/Refresher/Other) during the month
3	Lab Technician	Number of Lab Technician posts sanctioned, Number in place Number of the Lab Technician trained in STI as per National guidelines (Induction/Refresher/Other) during the month
4	Counsellor	Number of Counsellor posts sanctioned, Number in place Number of the Counsellor trained in STI as per National guidelines (Induction/Refresher/Other) during the month

2. RECORDING AND REPORTING FORMATS AT SUB-DISTRICT HEALTH FACILITIES (PHC/CHC/Block PHC, Sub-divisional hospital, urban Health centre etc)

Minimal reporting records that should be maintained by each of the sub-district health facilities (PHC/CHC/Block PHC/Sub-divisional Hospital/urban Health centre) are given in below in table:

Records to be maintained at NRHM facility (PHC/CHC/Block PHC, Sub-divisional Hospital, Urban Health etc).

1 OPD Register

2 Drug Register

3 Laboratory Register

4 Referral Form

5 Monthly STI/RTI Monthly Reporting Format for NRHM

1. Patient OPD Register:

Patient Register for STI/RTI Services					
S. No.	Date	Name	Age	Sex	Diagnosis
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

The OPD register and other existing record maintained in PHC/CHC/Block PHC etc should be utilised for maintaining records pertaining to STI/RTI. The physician should indicate the syndromic diagnosis in the OPD register.

2. Drug Stock Register:

Drug Stock Record Format				
Drugs	**Opening stock (1st of every month)**	**Number received this month**	**Consumed**	**Closing stock (last day of every month)**
Prepacked STI Kit 1				
Prepacked STI Kit 2				
Prepacked STI Kit 3				
Prepacked STI Kit 4				
Prepacked STI Kit 5				
Prepacked STI Kit 6				
Prepacked STI Kit 7				

3. Laboratory Register:

Syphilis screening of pregnant women or STI/RTI patients							
S. No.	**Date**	**Name**	**Age**	**Sex**	**Patient details (STI patient or ANC Mother)**	**Syphilis test: RPR/VDRL**	**Test results for syphilis**
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

The existing drug maintenance register and laboratory register used in the PHC/CHC/Block PHC etc should be used for recording purpose. Only relevant column/page should be added to the pharmacy and laboratory records so as to collect data pertaining to drug stock and laboratory testing.

4. STI/RTI Referral Form

STI/RTI Referral Form

(To be filled and handed to the client by STI/RTI Counselor/Nurse)

Referral to

ICTC/Chest & TB/Laboratory_____

The patient with the following details is being referred to your center.

Name:_____ Age_____ Sex:_____

STI/RTI-PID No:_____

Kindly do the needful

Referring Provider

Name:_____ Designation:_____

Contact Phone:_____Date of referral:_____

(To be filled and retained at referral site so as to be collected by STI/RTI counselor/Nurse weekly)

The above patient referred has been provided ICTC/TB/RPR/VDRL/_____ services and the patient has been tested/diagnosed/treated for_____

The test/results of RPR/VDRL/is/are_____

Signature of the Medical Officer/Counselor/Lab In-charge

5. Monthly STI/RTI Monthly Reporting Format for NRHM:

Unique ID. No. of District					
STI/RTI MONTHLY REPORTING FORMAT FROM NRHM FACILITIES IN DISTRICT					
Name of District /CHC/PHC/Others					
Number of NRHM facilities to report in the district					
Number of Units reported in this month					
Reporting Period :	**Month (MM) :**		**Year (YYYY) :**		
Name of Officer In - charge :					
Phone no. of Officer In – Charge :					

Section 1 : No. of Patients Availed STI/RTI services in this month			
	Total		
	Male	**Female**	**Total**
No. of patients diagnosed and treated for various STI/RTI			

Section 2 : Syndromic diagnosis and investigation details			
(Should be filled by Officer in-charge)			
Diagnosis	**Male**	**Female**	**Total**
1.Vaginal/Cervical Discharge			
2.Genital Ulcer (GUD)-non Herpetic			
3.Genital Ulcer (GUD) – Herpetic			
4.Lower Abdominal Pain(LAP)			
5.Urethral Discharge (UD)			
6.Ano-rectal discharge (ARD)			
7.Inguinal Bubo (IB)			
8.Painful Scrotal Swelling (SS)			
9.Genital warts			
10.Other STIs			
11. Serologically +ve for syphilis			
Investigations			
12. Number of STI/RTI patients tested for syphilis (RPR/VDRL)			
13. Of Above, Number of STI/RTI patients found reactive for syphilis			
14. Number of STI/RTI patients referred for HIV testing			
15. Of above, Number of STI/RTI patients found HIV reactive			
16. Number of STI/RTI patient tested for wet mount			

Section 3. Details of syphilis screening of Pregnant women			
Service	**Male**	**Female**	**Total**
1. Number of Pregnant women screened for syphilis (VDRL/RPR test)			
2. Of above, Number of Pregnant women found reactive			

Section 4 : Status of Drugs & test kits	
Drugs & test kits	No. of kits Available
Prepacked STI Kit 1	
Prepacked STI Kit 2	
Prepacked STI Kit 3	
Prepacked STI Kit 4	
Prepacked STI Kit 5	
Prepacked STI Kit 6	
Prepacked STI Kit 8	
RPR/VDRL Tests Kit	

Guidelines for filling Monthly Reporting Format from NRHM facilities (all public health facilities not supported by NACO)

Who should fill this?

Hard copies of this reporting format should be filled and submitted to the corresponding reporting authority (District RCH officer or any other corresponding reporting authority) by the 5th of next month by all NRHM facilities NOT supported by NACO (PHC/CHC/Urban Health Posts and Other sub-district health facilities) under STI/RTI control and prevention program. These individual reports are to be consolidated at district level and submitted as one report to SACS and State Mission Director every month by the 7th of the month.

Note: All facilities supported by NACO need to report on the three page STI/RTI format only

What are the different sections of STI format?

The STI format is divided into 4 sections as follows:

Section 1: Number of Patients availed STI/RTI services in this month

Section 2: Syndromic diagnosis and investigation details

Section 3: Details of syphilis screening of pregnant women

Section 4: Status of Drugs & test kits

General Information

Sl No.	Indicators	Explanation
1	Unique ID of District	Write the Unique ID of District which will be provided to District by respective SACS
2	Name of the District/ CHC/PHC/Other facilities	Write the Name of the District or CHC or PHC or other facilities sending the report.
3	Number of NRHM facilities to report in the district*	Write the number of NRHM facilities to report in the district.
4	Number of Units reported in this month*	Write the number of NRHM facilities reported in this month, of the above
5	Reporting period	Reporting month and year in the form of MM and YYYY. Example: the data for the month January, 2010 would be reported in Feb 2010. So the reporting month is 01 and year is 2010.
6	Name of the Officer in-charge	Name of the medical officer who is in charge of STI Clinic
7	Phone number of the Officer in-charge	Phone number of the officer who is in charge of STI Clinic

** This information is only to be provided by the District.*

Section 1: No. of Patients Availed STI/RTI services in this month

- Fill the number of individuals who have availed STI/RTI services under appropriate sex category

Sl No.	Indicator	Definition/Explanation
1	No. of patients diagnosed and treated for various STI/RTI	Fill the number of individuals visited with any STI/ RTI complaints and was treated for the same.

Section 2: Syndromic diagnosis and investigation details

- Diagnosis could be reached on syndromic/clinical/etiological basis

Sl No.	Indicator	Definition/Explanation
	Diagnosis	Fill up consolidated number of STI/RTI patients diagnosed with following syndromes
1	VCD - Vaginal/Cervical Discharge	a) Woman with symptomatic vaginal discharge b) Asymptomatic patient with vaginal discharge seen on speculum examination c) Cervical discharge seen on speculum examination (All syndromic, etiological and clinical STI/RTI diagnosis relating to vaginal or cervical discharge should be included here)
2	GUD - Non Herpetic - Genital ulcer disease- Non Herpetic	Female or male or transgender with genital or ano-rectal ulceration and with NO blisters (vesicles). (All STI syndromic, clinical or etiological diagnosis relating to genial ulcers caused by Treponema Pallidum (syphilis), Haemophilus Ducreyi (Chancroid), Granuloma Inguinale and Lymphogranuloma Venereum (LGV) except herpes simplex virus type 2 should be included here)
3	GUD - Herpetic - Genital Ulcer Disease – Herpetic	Female or male or transgender with genital or ano-rectal blisters (vesicles) with ulcers or recurrence primarily caused by herpes simplex virus type 2.
4	LAP - Lower Abdominal Pain	Female with Lower Abdominal Pain or tenderness, or Cervical motion tenderness
5.	UD - Urethral Discharge	Male or transgender with intact genitalia with Urethral Discharge with or without dysuria or other symptoms
6	ARD - Ano-Rectal Discharge	Male, female or transgender with symptoms of tenesmus or if ano-rectal discharge seen on exam
7	IB - Inguinal Bubo	Individuals with inguinal bubo and NO genital ulcer. (Syndromic or Clinical diagnosis of LGV should be included here)
8	SS - Painful Scrotal Swelling	Male or transgender (with intact genitalia) with painful scrotal swelling (primarily caused by infection of Gonococci and Chlamydia)
9	Genital Warts	Individuals with anal or genital warts.
10	Other STI's	Individuals attending with any other STI/RTI related condition (e.g. Genital Scabies, pubic lice, and Genital Molluscum Contagiosum etc).
11	Serologically Positive for Syphilis	Individuals treated for serological reactive for Syphilis.

Sl No.	Indicator	Definition/Explanation
	Investigation details	
12	Number of STI/RTI patients tested for syphilis (RPR/VDRL)	Fill total number of RPR/VDRL tests conducted
13	Of Above, Number of STI/RTI patients found reactive for syphilis	Fill the number found reactive for RPR/VDRL test
14	Number of STI/RTI patients referred for HIV testing	Fill the number of STI/RTI clinic attendees referred to ICTC
15	Of above, Number of STI/RTI patients found HIV-infected	Fill the number detected as HIV reactive, of the referred individuals
16	Number of STI/RTI patient tested for wet mount	Fill in the number of STI/RTI clinic attendees tested with wet mount

Section 3: Details of syphilis screening of Pregnant women

- Data should be drawn from the records of ANC clinic in the facility

Sl No.	Indicator	Definition/Explanation
1	Number of Pregnant women screened for syphilis(VRDL/RPR)	Write the number of pregnant women undergone RPR/ VDRL test for syphilis during the month
2	Of above, Number of Pregnant women found reactive	Write the number of pregnant women found reactive for RPR/VDRL test

Section 4: Status of Drugs & test kits

- Provide details of stock status of RPR/VDRL test kits and Pre-packed STI kit 1 to 7

Sl No.	Indicator	Definition/Explanation
1	Drugs & test kits available	Fill in the numbers of RPR/VDRL test kits and Per-packed STI kit 1, kit 2, kit 3, kit 4, kit 5, kit 6 and kit 7 kits available

Process of Submitting Monthly Report:

- The monthly reports should be generated at PHC by ANM/Staff nurse/Medical officer with the help of computer operator/lower division clerk and transmitted to CHC and compiled at the district level by the district RCH Officer with the help of data entry operator.
- District RCH Officer will consolidate the data in the monthly HMIS/NACO SIMS reporting format and forward the same to SACS and SPMU by 5th of every month.

ANNEXURE-I

REFERENCES AND SOURCE

We gratefully acknowledge the use of material that has been adapted from the following sources:

Source	Publication	Year
AVSC International	Sexually Transmitted and Other Reproductive Tract Infections	2000
Pathfinder International	Comprehensive Reproductive Health and Family Planning Training Curriculum (Module 12)	2000
World Health Organisation	Guidelines for the Management of Sexually Transmitted Infections	2003
World Health Organisation	Sexually Transmitted and Other Reproductive Tract Infections - A Guide to essential Practice	2005
World Health Organisation	Draft Global Strategy for the Prevention and Control of Sexually Transmitted infections	2005
Engender Health	Sexually Transmitted Infections - Online minicourse	2006
Government of India	National Guidelines on Prevention, Management and Control of Reproductive Tract Infections including Sexually Transmitted Infections	2006

ANNEXURE II

ANNEXURE-II

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ANNEXURE III

ANNEXURE-III

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Ministry of Health & Family Welfare, Government of India

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