

# **Refresher Training Programme for Counsellors in STI/RTI Services**

## **Trainee's Handouts**

2012



---

**National AIDS Control Organisation**

India's voice against AIDS

Department of AIDS Control

Ministry of Health & Family Welfare, Government of India

[www.nacoonline.org](http://www.nacoonline.org)





**Sayan Chatterjee**

*Secretary & Director General*

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

15<sup>th</sup> October 2012

### **FOREWORD**

People with Sexually Transmitted Infections are at risk of infection from HIV also. They require support for behaviour change to avoid re-infection as well as guidance for taking the full course of medication. People with High Risk Behaviours are especially vulnerable to STI. The National AIDS Control Organisation delivers preventive and curative service through its STI/RTI Clinics with the assistance of a counsellor.

This refresher package intends to enhance the capacities of the counsellor to deliver quality STI/RTI services to vulnerable populations. In instituting this new package the personnel in the STI division and the Counselling Unit have skillfully used the evidence available from the roll-out of the induction package in December 2009 to build and improve on their training processes. Through rigorous tracking of the training data, they have identified and addressed areas for improvement. This new package is based on a competency approach where training and measurement of training-related gains are task-oriented.

We hope through this new training programme to further strengthen our STI/RTI services and to improve the functioning of our personnel at the frontline.

**(Sayan Chatterjee)**

---

6th Floor, Chandralok Building, 36 Janpath, New Delhi-110001, Phone: 011-23325331, FAX: 011-23731746

E-mail: [nacosdg@gmail.com](mailto:nacosdg@gmail.com)

---

विद्युत, पवक वलक त कडुदुवरे लज्जिह वलरुके सेरु लुगुतु लुकि;  
**Know Your HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing**

# Acknowledgments

## ***Contributors to the training package***

Dr. Melita Vaz (Programme Officer Counselling, NACO)

Dr. Shobini Rajan (Assistant Director General, STI Division, NACO)

Dr. Aman Kumar Singh (STI Specialist, NACO)

Dr. TLN Prasad (STI Specialist, NACO)

## ***Reviewers and Field Testing***

Dr. JVDS Prasad (Andhra Pradesh State AIDS Control Society)

Dr. Rajshree Sankhe (Mumbai District AIDS Control Society)

Dr. Dipali Sankhe (Mumbai District AIDS Control Society)

Ms Maya Singh (Mumbai District AIDS Control Society)

Dr. Melita Vaz (Programme Officer Counselling, NACO)

Ms Vaibhavi Bhalekar (AVERT Society)

## ***Materials from which we have adapted material:***

National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2011). Refresher Training Programme for ICTC Counsellors (2nd Ed.). New Delhi, India: Author.

National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2009). Training manual for counsellors at STI/RTI clinics. New Delhi, India: Author.

National Rural Health Mission & National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2011). Training of medical officers to deliver STI/RTI services. New Delhi, India: Author.

# TABLE OF CONTENTS

<b>S. No.</b>	<b>Titles</b>	<b>Page No.</b>
1.	Basic Fact Sheet on Counselling	1
2.	Male & Female Anatomy	17
3.	Basic Fact Sheet on STI/RTI	28
4.	Syndromic management of STI/RTI	34
5.	Counselling at the STI/RTI Service	63
6.	Linkages at the STI/RTI Service	86
7.	Reporting at the STI/RTI Service	93
8.	Data Analysis	119



# BASIC FACT SHEET ON COUNSELLING

## At the end of this unit, participants will be able to

- Explain how counselling is different from good communication skills.
- List the four stages of the counselling process.
- Describe and demonstrate some basic counselling skills.

What is counselling? The word “counselling” is used in many places. Two simple examples

- At the beginning of every school year, there are newspaper advertisements about academic or vocational counselling. This means advice on how to get admission into a certain university or college.
- Some people speak of legal counselling. This means information on the legal options available to a person in a difficult situation.

Certainly, counselling as a profession is part of our lives today. You will notice that both examples above deal with helping people to improve their life situation. There is someone who needs some help and someone who can offer it.

What is counselling in the STI/RTI Service? The next few pages will clear up some of these issues, and, hopefully, help you, the counsellor, to understand how you can interact with patients in the STI/RTI Service in a better way.

## What is counselling?

Counselling has been defined by Burnard (1999) as “the means by which one person helps another to clarify his or her life situation and to decide further lines of actions.”

In the STI/RTI Service, the patient sitting in front of the counsellor has come there (or has been sent by the doctor) because they are suffering from some STI or RTI, because their symptoms may be really troublesome or painful. The counsellor’s role here is to make sure the patient:

- ✓ Understands the reasons for these symptoms (including past sexual behaviours),
- ✓ Understands that only a complete course of treatment will help the situation,

- ✓ Decides how to avoid future infection,
- ✓ Decides what to do to protect other people from their symptoms/ illness (e.g., referring the sexual partner for treatment).

The counsellor, therefore, assists the person/ client/ patient to improve their life in some way. This is the aim of counselling. Counselling is not “just talk” between counsellor and patient. At the end of the counselling conversation, the patient must have a better idea of what to do to improve their life or their health.

#### **Questions for the Counsellor:**

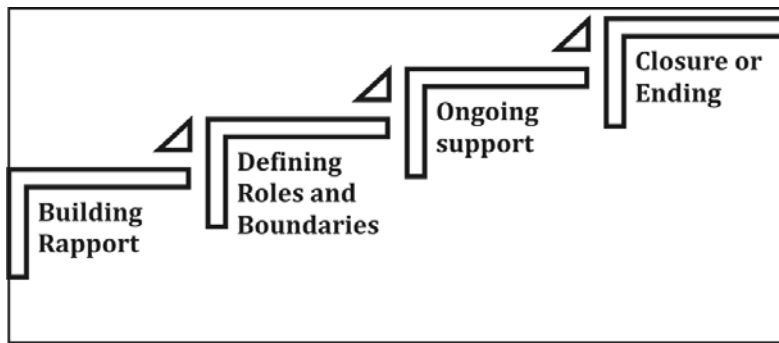
- After visiting me, can my patients say they understand the reason for their symptoms?
- Do they know the importance of completing the course of medicine?
- Do they know how to avoid future infection?
- Do they know how to protect other people from their illness (like their sexual partner or their unborn child)?

### **What happens in counselling?**

This is a very difficult question to answer because there is both a science and an art to counselling. These next few pages will describe much of the science of counselling. For example, if counselling were a bicycle or a car, we can tell you about the different parts of the car and how they operate together. But only when the person with the learner’s permit sits in the driver’s seat will they understand what driving is about. Also, it takes months of practice to become a good driver. It is the same with counselling. The more you practice the skills and concepts – the science of counselling – the sooner you will reach the stage where you are practicing counselling as an art, where counselling becomes a very graceful interaction between 2 people.

The easy way to answer the question in the title is to tell you the stages of counselling. In every counselling session there are some common stages. See the diagram below. We will also tell you some of the things a counsellor does during these stages:





Stages in Counselling

### ***Building rapport and gaining trust***



Building rapport means making sure that you and the patient are on the same wavelength, that you are talking about similar things. If the patient is worried about missing work, then building rapport

means making sure you understand the patient's current thoughts, **and** that he/ she recognizes that you are able to understand his/ her pre-occupations, other concerns, etc.

Building rapport should take place at the beginning of the relationship. It is important for the patient to trust the counsellor; otherwise they will not share their deepest fears and feelings of shame and doubt.

The counsellor can build trust and rapport by

- Asking the person's name and addressing them by name
- Using respectful language such as "Aap" in Hindi
- Looking them in the face rather than at the papers
- Explaining about confidentiality and procedures to maintain confidentiality (such as who has access to medical papers and test reports, explaining that what is said in the counselling room will remain within the treatment team)
- Setting aside other distractions such as cell phone calls, etc.
- "Mirroring" – that is subtly copying the body posture of the patient (This does work!)
- Allowing patients to tell their life events/ stories in their own words.
- Allowing people to speak rather than cutting them off

**Definition of confidentiality:** Confidentiality is the right of a person coming to counselling to share their personal and private details in the expectation that they will not be revealed to other people. The only times when confidentiality may be set aside is if there is a danger to the person's life or to someone else's life.

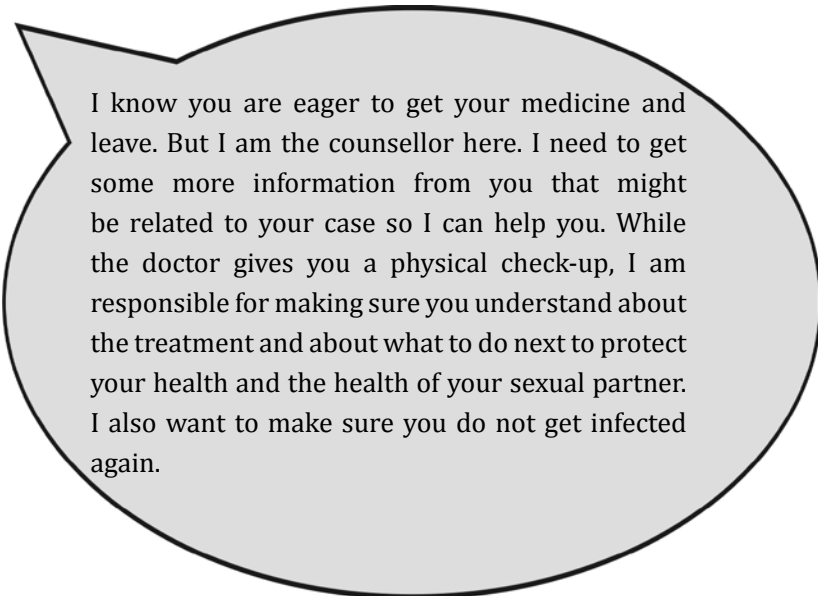
### ***Defining roles and boundaries***

Counsellors complain that some patients want to show their symptom by uncovering their body. What is happening here? Very simply, most patients are lost in more ways than one. They may be worried about whether they have reached the right room or the right person in the hospital. They are not sure what is going to happen. All they know is that the doctor sent them to you with the case paper. They may imagine that you are another doctor.

Defining roles and boundaries is the stage of counselling which helps the patient to understand why they have been sent to you. You can clarify that counselling is more than just about giving out the STI/RTI drug kits. During this stage of counselling, you can explain what will happen during the rest of the session. You can also explain how your role is different from that of the doctor.

The counsellor can say something like this:

I know that your ante-natal check-up has been long and confusing. You have met many people since you first came to the hospital. And now you have been sent to me. Let me explain why you have been sent to me.



I know you are eager to get your medicine and leave. But I am the counsellor here. I need to get some more information from you that might be related to your case so I can help you. While the doctor gives you a physical check-up, I am responsible for making sure you understand about the treatment and about what to do next to protect your health and the health of your sexual partner. I also want to make sure you do not get infected again.

Notice how the two speech bubbles are slightly different. Here you also see that the counsellor is trying to make the patient comfortable, trying to establish rapport while explaining her/ his own role. These dialogues cannot be automatic or learned by heart. They must match the needs of the patient. Remember! You have to get on the same wave length. If you say something that is straight out of a book, you will not be able to get onto the same wavelength as the person you are counselling.

During this stage you must establish the patient's needs and goals, decide which are immediate and which are long-term needs, and inform him/ her how your services may meet the immediate needs. During this stage you will also be doing a history-taking and risk assessment. We will cover these topics in later units.

Of course, you can only define the boundaries of your role to patients, if you know your role. So review your terms of reference thoroughly!

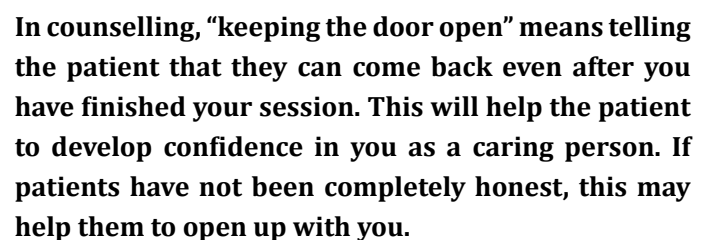
### ***Ongoing support***

You, the counsellor must help the patient to understand what is happening as well as support their healthy behaviours. For instance, you may state how difficult it must have been for the patient to come to the hospital and talk to a complete stranger about embarrassing symptoms. Another situation is supporting the patient to get their partner checked and treated if required. This is a difficult situation where the patient needs support. It is not the counsellor's job to make decisions of what the patient should do. Instead, you should present behaviour choices and explain how they will affect the person's life situation for better or worse.

A counsellor who is supportive will not show a blaming attitude towards the patient. They will be firm yet kind. They will acknowledge to the patient that some things the doctor asked/ recommended are difficult to manage – even if necessary. They will ask the patients how they will manage and then offer some strategies for achieving this. It is always helpful to have more than one strategy to offer as it gives the client the choice.

### ***Closure or ending***

Closure means ending the counselling relationship. At this time, the counsellor makes sure the person knows what they have to do to improve, knows how to do it, and has the resources/ support to carry out these actions. It is also expected that your client feels better or more hopeful than when they first came to you. Closure is not a permanent ending. While you may have helped the person to resolve their immediate situation by meeting their immediate needs, in counselling it is important to “leave the door open.” This means that you, the counsellor, must tell the patient that you are available if they still have difficulty and need your help for other needs. In the session on Linkages at the STI/RTI Service, we will discuss some common long-term needs and how to help the patient with such needs.



**In counselling, “keeping the door open” means telling the patient that they can come back even after you have finished your session. This will help the patient to develop confidence in you as a caring person. If patients have not been completely honest, this may help them to open up with you.**

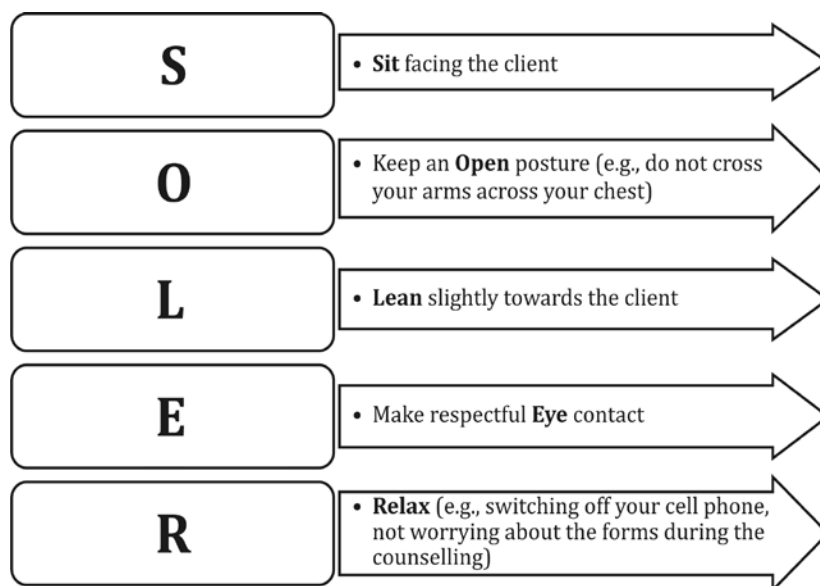
We end this section with a small reminder that the stages of counselling are not always completed in 1 single session. STI counsellors tend to see patients once only, unless you have a FSW who comes in for her regular medical check-up. Such kind of counselling is called Brief counselling where you fit everything into one or two sessions. In other types of counselling, each stage may take more than one session. But the art of counselling is such that if you practise, you become better at moving from one stage to the next. Brief counselling does not mean you can miss one step or another.

## What counsellors do?

Counselling skills are like the nuts and bolts within the car. They are what make the counselling session progress. Counselling skills are the techniques that counsellors actually practise and use to help their clients move towards the goal of improved functioning or feeling better. Like any skill or technique, the more you use them, the easier they will become for you to practise. We will first describe some counselling skills. Then we will give you a small exercise to practise

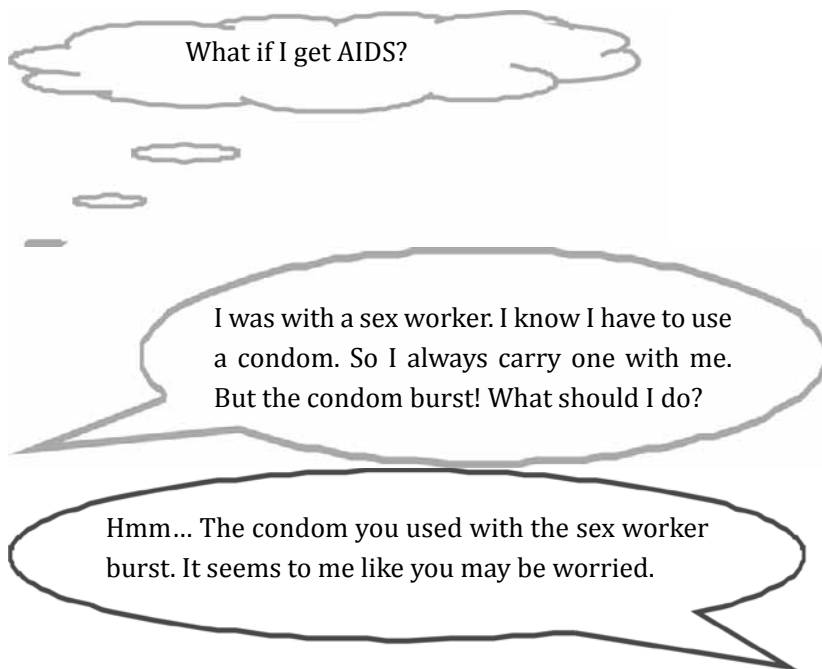
### Active Listening

It is not just enough for the counsellor to listen to the client. The counsellor must show through their words and expressions that they are giving close attention to the client. This is important for the client to build trust in the counsellor. The term SOLER is a simple way to remember the counsellor's behaviours and actions that contribute to active listening.



### Reflection of feeling

You read earlier that it is important to get onto the wavelength of the client. Reflection of feeling is a technique that tries to reach the emotions of the client. In any conversation between two people, there are both words that you hear, and feelings that are beneath the words. A good counsellor will recognise both the words and the feelings. The counselling skill here is reflection of feeling. The counsellor reflects (like a mirror) the emotions the client seems to be feeling. See the example below:



In the example here, the client did not say anything about being worried. But the counsellor has picked up the tone of worry and anxiety. Also notice that the counsellor mentions it as a tentative suggestion, not a firm conclusion: “It seems like...” The counsellor may recognize both positive feelings like pleasure and happiness as well as negative ones like anger, sadness and worry. Through reflection of feeling you can show the client that you are listening carefully and caringly. It is very important for the counsellor to go beyond the words to the feeling level. This is what makes counselling different from just good communication.



**Exercise**

Here are some trigger sentences you can use to convey reflection of feeling. Write the sentence in your local language:

It seems like... It sounds like...	
Your words (voice/ tone) show that you may be feeling...	
From what you have shared, I think you may be feeling...	



**Exercise**

Write out a response in your local language:

CLIENT STATEMENT	CLIENT EMOTION	COUNSELLOR'S STATEMENT SHOWING REFLECTION OF FEELING
My child participated in the school sports. It was a very tough competition. But guess what? He brought back the first prize!		
My father was suddenly admitted to the hospital last night because of chest pains. The whole family was there all night long. The angiography showed serious problems. We are still waiting for the doctor's decision.		

**Questioning**

Questioning is a basic counselling skill. Through sensitive questioning, you can help a client explore and understand what is happening in their lives. You will see how the basic skill of Questioning is used in the later sections on History-taking and Risk Assessment.

**There are two types of Questions:**

Questions	
Open-ended Questions	Closed Questions

## ***Types of Questions***

In counselling you use both questions but you must know when to use them.

### **Closed Questions:**

- ♦ Are you married ?
- ♦ Have you ever paid someone for sex ?
- ♦ Do you have children ?

These are all closed questions. What is common in all three? All of them have a Yes/No answer. Closed questions do not produce many details.

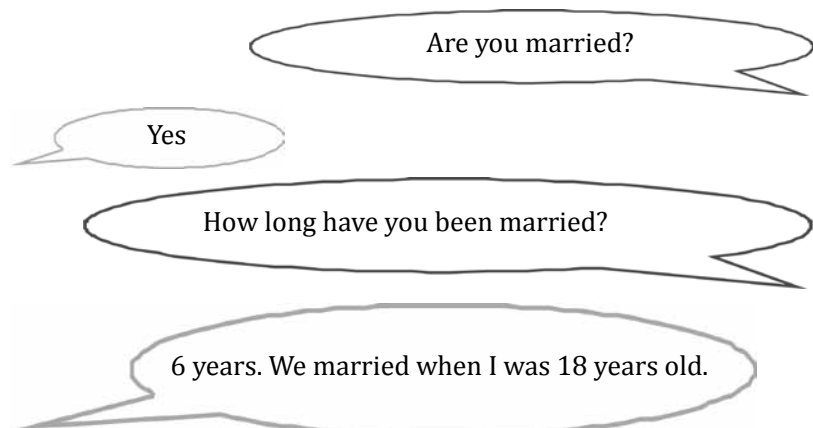
### **Open-ended Questions**

- ♦ How big is your family?
- ♦ Who are the people in your family?
- ♦ When were your children born?
- ♦ What is your job like?
- ♦ Where have you visited sex workers?
- ♦ When have you used condoms and when have you not used condoms?

These are examples of Open-ended questions. Here the client can give as much detail as she/ he feels comfortable. The counsellor can get more details of a person's life and he/ she can use these details to ask even more questions.

### **When to use these questions?**

Counsellors often want to know when they should use each type of question. The answer is you can use both. But you should use more open-ended questions. See how in the following dialogue between counsellor and client, the counsellor uses a mixture of the two types of questions.





Hmm... You married very early at the age of 18. Were you able to complete your study?

No. My mother-in-law was against.

So do you work?

No.

What about your husband?

Transport contractor.

Do you have children?

Yes.

How old are they? What do they do?

The older one is 8 years old and goes to school. The small one is 3. She stays at home with me. I take care of both of them and manage my in-laws. My father-in-law has a sickness... Lots of cough. TB. I have to keep them away from him.

So your family has 5 people including 2 children and your in-laws. You do not have a job but you have lot of home responsibilities. It sounds also like you are worried about your kids getting TB.

 **Exercise**

In the dialogue above, read the different questions asked by the counsellor and place them into the columns for Open-Ended and Closed Questions

Open-ended questions	Closed questions

### **Questions to avoid**

The leading question is one type of question which you should avoid. When the person asks a leading question, it is worded in such a way as to communicate the answer desired by the person asking the question or it reveals their own bias. Here are examples of such poor communication from different fields.

- “You’re not sexually active, are you?”
- “You’re not an MSM, are you?”
- “You’re not suffering from any ill-effects from the medicine, are you?”
- “What do you think about the terrible effect of climate change?”
- “When you faced the tsunami, were you very scared?”
- “When you found out your husband (or wife) has an STI, were you very angry?”
- “When you found out you have to take STI treatment, did you feel guilty?”
- “How fast was the bus going when it smashed into the bicycle?”
- What did your wife do when you broke up the marriage?

When you read these questions, you realize that the person who has to answer them is getting small clues about how to answer. For example, the journalist asking the question about the tsunami expects that everyone will be scared. However, some people who face such events are numb in the first few minutes. The questions on being an MSM or being sexually active reflect that the questioner is more comfortable with someone who is not sexually active or not an MSM. The question on the bus accident and on the breaking up of the marriage immediately conveys that one person is at fault. Such questions do not allow the person who has to answer to do so freely. Children, for example, are very vulnerable to such questions, and there is special training on how to question them in case of child abuse.

Definition of Being Non-judgmental: Being non-judgmental means not criticising the patient for actions that caused their problems or their ill-health even when other people may show blame and negativity. This does not mean that your own moral principles are questionable! You can have different principles in your personal life but you accept that other people make different choices.

These questions violate one of the counselling principles of being non-judgmental. The good news is that you can get the information required from each of these questions without asking a leading question. We start you off here with one example and give you space to generate the others.

 **Exercise**

Leading Question	Better way to ask the question
<ul style="list-style-type: none"> <li>• “You’re not sexually active, are you?”</li> </ul>	✓ Do you ever have sex?
<ul style="list-style-type: none"> <li>• “You’re not an MSM, are you?”</li> </ul>	
<ul style="list-style-type: none"> <li>• “You’re not suffering from any side-effects of the medicine, are you?”</li> </ul>	
<ul style="list-style-type: none"> <li>• “What do you think about the terrible policies of the new government?”</li> </ul>	
<ul style="list-style-type: none"> <li>• “When you faced the tsunami, were you very scared?”</li> </ul>	
<ul style="list-style-type: none"> <li>• “When you found out your husband (or wife) has an STI, were you very angry?”</li> </ul>	
<ul style="list-style-type: none"> <li>• “When you found out you have to take STI treatment, did you feel guilty?”</li> </ul>	
<ul style="list-style-type: none"> <li>• “How fast was the bus going when it smashed into the bicycle?”</li> </ul>	

## Repeating, Paraphrasing and Summarising

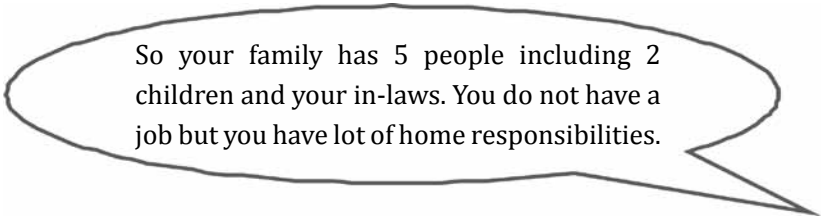
Repeating, paraphrasing and summarising are all counselling skills where the counsellor acts like a recorder playing back the words of the client. But in each case the reason is slightly different.

So look at the previous dialogue. See how the counsellor says, “You married very early at the age of 18.” This is a case of repeating. The counsellor is confirming a fact given by the client and is getting ready to ask the next question. Counsellors sometimes repeat facts because:

- ✓ They want to check they have got the right facts.
- ✓ The client may be very nervous and agitated. The counsellor repeats to calm them down (Repeat in a calm, reassuring voice)

Repeating is like reflection of feelings. But the counsellor is reflecting words/ facts in more or less the same words used by the client.

Paraphrasing is a kind of repetition. But the counsellor repeats in different words the facts of the client. See how she paraphrased the dialogue.



So your family has 5 people including 2 children and your in-laws. You do not have a job but you have lot of home responsibilities.

Paraphrasing is a way of giving back the key points so that clients can feel that they have been listened to and understood. You can use paraphrasing at regular intervals in the session.

In summarising, the counsellor is doing a big paraphrasing at the end of the interview. This is when you are ready to end the session, you repeat key points of the full session, and also repeat the key actions the person has to make. Your session would have gone through some twists and turns and now you want to make sure that key points and actions stick in the head of the client before they leave you.

### Questions for the Counsellor:

- Can you explain how each term in SOLER is important for active listening?
- Do you see how active listening can help you to do a sensitive reflection of client’s feelings?
- Is it possible to do repeating without active listening?

## How is counselling different from communication?

Some people criticize that counselling is just good communication skills. Yes! A good counsellor has to be a good communicator. But good communication alone will not help a person who needs services to get those services, or someone who must change their behaviour and actions to do so. A good counsellor is someone who uses the good communication that is possible through basic counselling skills to help people to improve their life. She/ He has a good sense of the direction the patient should take, and will carefully and sensitively guide her or him towards that path. Also we had made the point earlier that counselling reaches the emotional level of the client.

## What is beyond basic counselling skills?

In later sessions, you will continue to use the basic counselling skills. But you will see how to use them in the context of STI and HIV counselling. You will continue to use questioning in risk assessment and history-taking. You will use summarizing at the end of every session. You will use active listening skills throughout the session.

If you want to continue your development as a counsellor, there are many advance training courses which teach counselling skills related to “therapies.” You may have heard of cognitive behaviour therapy, family therapy and group therapy. We do not cover these in our three days. But you are always welcome to learn these on your own. These are advance skills. Even in these advance skills, you will continue to use the basics.

## Frequently Asked Questions



### **What is the difference between doctors and counsellors?**

Even though counsellors wear a white coat sometimes, and the patients in the hospital sometimes call them “Doctor saab,” counsellors are not the same as doctors. Here are the key differences:

Doctors have a medical degree. This allows them to physically examine a patient and prescribe medicine. Counsellors do not physically examine patients. Counsellors do not prescribe medicine. This is an important professional boundary of the counsellor.

Doctors spend just enough time examining the patient so as to determine what is wrong with them. Counsellors spend more time with patients because the assessment of the counsellor involves talking to the patient and exploring their personal behaviours.



## References

Burnard, P. (2005). *Counselling skills for health professionals* (4th ed.). UK: Nelson Thornes.

Faller, K. C. (2000). Questioning Children who May have Been Sexually Abused: A Synthesis of Research and Practice. *Journal of Aggression, Trauma, & Maltreatment*, 2 (4), 37-56.

National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2008). *Operational guidelines for Integrated Counselling and Testing Centres*. New Delhi, India: Author.

Vaz, M., Chitale, V., Nimla, B., & Dua, R. (2002). *Telephone counselling for HIV/AIDS: A trainer's guide*. Mumbai, India: Tata Institute of Social Sciences

# MALE & FEMALE ANATOMY

## At the end of this unit, participants will be able to

- Label correctly an anatomy drawing of the male and female genital organs
- Describe the structure and functioning of the male and female genital organs
- State which parts of the male or female body could be affected by STI/RTI
- Correct common misconceptions related to the male and female genital organs as well as to transmission of STI
- List common terms for male and female organs that may be used in counselling

A counsellor who counsels STI patients should have good information on genital organs to help the patients. Patients may describe their bodily symptoms in non-scientific terms and the counsellor may have to make sense of these descriptions. This unit focuses on the practical information you will require to function well as an STI counsellor. Make sure that you know the scientific terms as well as the terms used by lay people. This is important for good counselling.

## Male Genital Organs & Functions

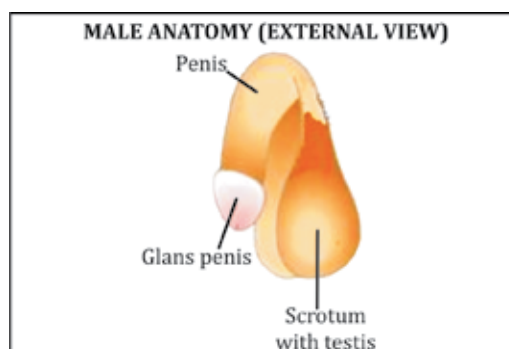
Male genital organs are situated externally as well as internally.

### The external genital organs are

- ✓ Penis
- ✓ Scrotum
- ✓ Anus

### The internal organs are

- ✓ Vas deferens
- ✓ Testes (singular testis)
- ✓ Seminal vesicles
- ✓ Prostate gland
- ✓ Urethra



### ***Penis***

Penis is the male organ. It has a shape like a cylinder. Sometimes it is hard and erect; sometimes it is flaccid. There is no bone in the penis. The penis has a lot of “spongy” vascular tissue which gets filled with blood when the man is sexually aroused. This causes the penis to become hard. When the erection subsides, the blood returns to the rest of the blood stream.

The urethra opens through the penis and this allows both urine and semen to pass – but never at the same time. The front portion of the penis is slightly expanded and is called the glans penis. It has many nerve endings and, therefore, is very sensitive. The skin over the glans is loose and thin. It is called the prepuce. It can be pushed back easily. This is the skin that is removed during circumcision.

The penis is a source of pleasure in the man. It is the organ which is placed in the vagina during vaginal sex, in the anus during anal sex and in the mouth during oral sex.

### ***Scrotum***

Scrotum is a small bag of skin which hangs behind the penis. It contains the testes. It protects the testes and maintains the temperature at which sperm are produced.

### ***Testes***

There are two testes, one testis in each scrotal bag. They are oval-shaped and small. Testes produce sperms and the male hormone testosterone. Testes are sensitive to touch and pressure. Sperms are produced in millions. Sperm production begins at approximately age 12 and continues throughout a man’s life. They are the male seed that is necessary for conceiving a baby. Testosterone is responsible for the sex drive in the male and for the development of secondary male sexual characteristics like hair on the upper lip.

### ***Vas deferens***

These are two tubes on either side of the penis (inside the body) which carry the sperms from the testes to the urethra. These are the tubes that are cut during a vasectomy. They are also called the sperm tubes.

### ***Seminal vesicles***

There are two seminal vesicles. They are bag-like structures which provide 60% of the fluid in the semen in which sperms are carried. This white fluid is called seminal fluid and it provides food for the sperms. Semen (that is seminal fluid plus sperm) is pushed out through the urethral opening. The urethral opening functions in such a way that at one time only urine or semen can flow out.



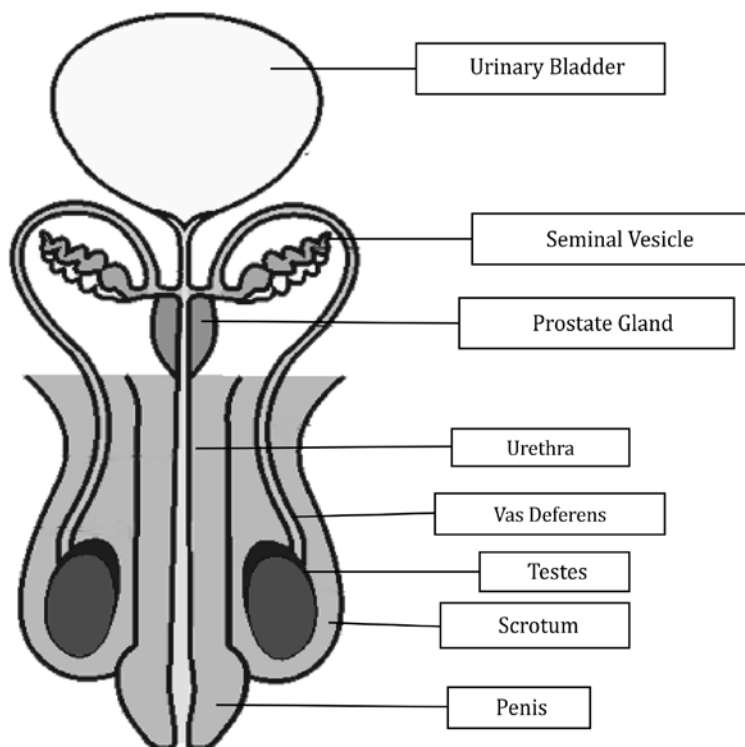


Image Courtesy of Sachin Mahadik, KEM Hospital, Mumbai

### ***Prostate Gland***

The prostate gland is the size of a walnut and it lies just beneath the urinary bladder. It secretes 30% of the fluid in the semen. The prostatic fluid is alkaline and it neutralizes the acidic environment of the male and female reproductive tracts. The prostate gland is very sensitive to stimulation (especially through anal sex) and can be a source of sexual pleasure.

### ***Urethra***

Urethra is the common outlet – through the penis - for both urine and semen. But at one time only semen or urine can flow out.

### ***Anus***

Anus is the excretory opening from the digestive tract. This opening remains tightly closed with the help of anal ring muscles, except at the time of passing stool (excreta). It is not a reproductive organ. But it is the opening that is used for anal sex.

## Frequently Asked Questions



### **Why do some boys have late appearance of beard?**

Adolescent period is from 10 to 19 years. Puberty is slightly different for every one as it depends on the level of testosterone hormone in the blood. So some boys show beard growth later than others.

### **What is masturbation? Is it bad?**

Masturbation is self-stimulation of the genitals for sexual pleasure. Both males and females masturbate. During adolescence, boys/ girls want to explore sexual pleasure. This is the period when boys have intense sexual feelings. They have erections, and they may masturbate. Masturbation is not bad, nor will it do any harm.

However, there are myths associated with masturbation such as 'Masturbation causes weakness,' or 'Masturbation diminishes the size of the penis.' Males should be told that masturbation does not affect health. But the feeling of guilt associated with masturbation can cause mental stress. Masturbation should not be a frequent, compulsive phenomenon interfering with daily chores and duties.

When advising young adult males to delay beginning their sexual life, this is one of the safer options for sexual pleasure that a counsellor may suggest if the client is willing to hear this message. Remember – counselling options are always behaviour choices.

### **Will circumcision cause the penis size to increase?**

No. Circumcision does not increase the size or length of the penis. It is merely the surgical removal of the foreskin.

## Frequently Asked Questions



### **What is Homosexuality? Why are homosexuals at greater risk?**

Homosexuality means preference for persons of the same sex. Male-male preference is also called gay behaviour while lesbianism is the term used for female-female preference. Men who have sex with men generally have oral sex, mutual masturbation or anal sex. During anal sex the erect penis of the penetrative male partner enters the anal opening of the receptive partner. Sometimes, the skin around the anal opening may tear because the anal opening is small and not elastic like the vaginal opening. The chances of HIV transmission are thus high in unprotected anal sex if one of the partners is infected. Lesbian women are at low risk of sexual transmission through female-female sexual activity as there is limited exchange of body fluids.

### **Who are eunuchs?**

A eunuch is a person in whom secondary male sexual characteristics (such as beard and moustache) do not develop either due to the absence of hormones or due to a castration operation. In a castrated male, the testes have been removed. If the castration was before puberty; then the secondary male sexual characteristics do not develop. The absence of male hormone results in certain characteristics like female voice and absence of facial hair. If the testes are removed after puberty, the 'secondary male' sexual characteristics already acquired will tend to become less prominent and may diminish. Castration may also involve removal of the penis.

A eunuch is still a sexual being and may have sex either as a penetrative partner or as a partner being penetrated. Removal of the penis does not mean an end to sexual activity.

## Frequently Asked Questions



### ***What are 'Night-Falls' or 'nocturnal emissions'?***

Night-fall means ejaculation of sperm during sleep. It involves mostly adolescents and young adults. It is also called a 'wet dream.' Once the vesicles are filled with semen, it contracts and the semen flows out through urethral opening. The stimulation for the contraction of the seminal vesicles is generally sexual thoughts in the minds of young males. Sexual thoughts are a natural part of the growing up. However, males may feel that they will become weak if they 'lose their vital fluid.' This is because in India, there is a common misconception - 'One drop of semen is equal to 40 drops of blood loss.' They may get embarrassed and scared about night-falls occurring at regular intervals. However they can't share these worries with anybody and may get easily misled.

### ***Why do some patients come with worries about 'dhat'?***

In India, there is a common cultural misbelief that losing semen causes weakness. When such a belief causes worry and anxiety, it is termed by psychiatrists as the 'dhat syndrome.' Common expressions from patients might be, "One drop of semen is equal to 40 drops of blood." These are wrong beliefs. They are a mental anxiety and not an STI. However, they should be handled sensitively as it is sometimes difficult to change the belief of a patient when his entire community shares that belief. Excessive worry may require a psychiatric referral.

### ***How is Vasectomy done? Will there be ejaculation after vasectomy?***

In vasectomy, the vas deferens tubes are cut underneath the scrotum. After vasectomy, seminal vesicles continue the production of seminal fluid. Erection and ejaculation of seminal fluid continue to occur when the man is sexually stimulated but it does not contain sperms.

## Female Genital Organs & Functions

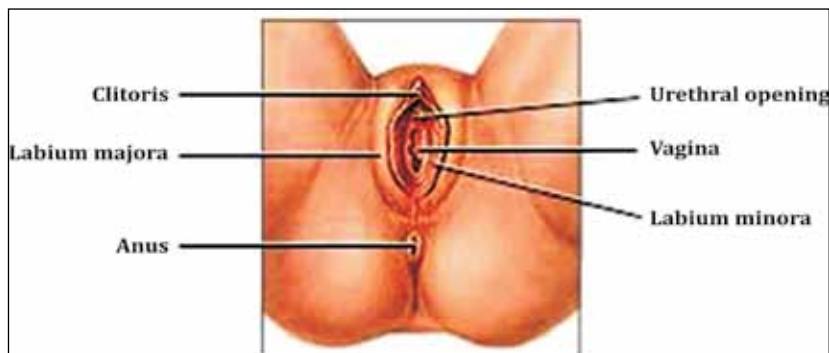
Female genital organs are situated externally as well as internally.

### The external genital organs are

- ✓ Labia Majora (singular Labium)
- ✓ Labia Minora
- ✓ Clitoris
- ✓ Vaginal opening
- ✓ Urethral opening
- ✓ Anus

### The internal genital organs are

- ✓ Vagina
- ✓ Cervix
- ✓ Uterus
- ✓ Fallopian tubes
- ✓ Ovaries



### ***Labia majora***

Labia majora are two spongy folds of skin that are covered with pubic hair. They enclose and protect the vaginal opening and the other structures.

### ***Labia minora***

Labia minora are two folds of skin lying inside the labia majora. These “lips” protect the vaginal and urethral (urinary) openings.

### ***Clitoris***

Clitoris is a pea-shaped organ. It is highly sensitive and the seat of sexual pleasure for the female. This structure corresponds to the penis in the male. The clitoris is situated where the upper part of the labia minora meet. The urethral opening and the vaginal opening are situated below the clitoris.

### ***Vagina***

Vagina is the muscular tube that can expand to accommodate the penis during sexual intercourse and the foetus during child-birth. Menstrual blood flows out from the uterus through the vagina. There are nerve endings in the vagina which make it sensitive to pressure and provide some sexual pleasure. The vagina ends at the cervix.

The vaginal opening is sometimes covered by a thin membrane which is called the hymen. There is a general misbelief that the presence of the hymen indicates virginity in the female. It is also wrongly believed that the hymen ruptures only at the time of first sexual intercourse, and bleeding occurs. Actually, the hymen can be ruptured even earlier during strenuous physical activities. Further, even if the hymen ruptures during first sexual intercourse, the bleeding may not be visible except for slight spotting.

### ***Cervix***

The cervix is the opening to the uterus. It is located at the lower end. The menstrual blood comes out from the uterus into the vagina through this opening.

### ***Uterus***

Uterus is a pear-shaped organ approximately the size of a closed fist. It is hollow and muscular, and is situated in the lower abdomen below the navel. It is sandwiched between the urinary bladder and rectum. It is capable of expanding to accommodate the foetus during pregnancy and returning to its normal size after child-birth. During periods, the menstrual blood comes from the endometrial (inner) lining of the uterus. The upper portion of the uterus contracts when the woman experiences an orgasm – the height of sexual pleasure.

### ***Fallopian Tubes***

Fallopian tubes are two in number. They stretch out like arms on either side of the uterus and extend to the ovaries but do not touch them. When the ovum (woman's egg) is released from the ovaries, the fallopian tube draws the ovum into the tube and pushes it towards the inner end of the tube and the uterus. Fertilization of the ovum takes place in the fallopian tube. The fallopian tubes contract during orgasm.

### ***Ovaries***

There are two ovaries on either side of the uterus. Their size and shape is approximately that of an almond. Each ovary lies near the opening of a fallopian tube but is not attached to it. The ovaries produce ova (female eggs) and secrete the female hormones – oestrogen and progesterone. Approximately one ovum is released every month

while the woman is in her reproductive period. In the reproductive lifespan of a woman, only about 400 mature ova are produced. After the age of 40 to 45 years, ovulation and menstruation stop.

### **Some additional information on the menstrual cycle**

Girls start menstruating between the ages of 10 to 19 years. Every month, 5 to 6 ova start maturing, but the only most mature ovum gets released. It is drawn inside the fallopian tube and starts moving towards the uterus. At the same time, oestrogen and progesterone hormones cause thickening of the endometrium (inner lining of the uterus) and make it ready to receive the ovum if it is fertilized by a male's sperm.

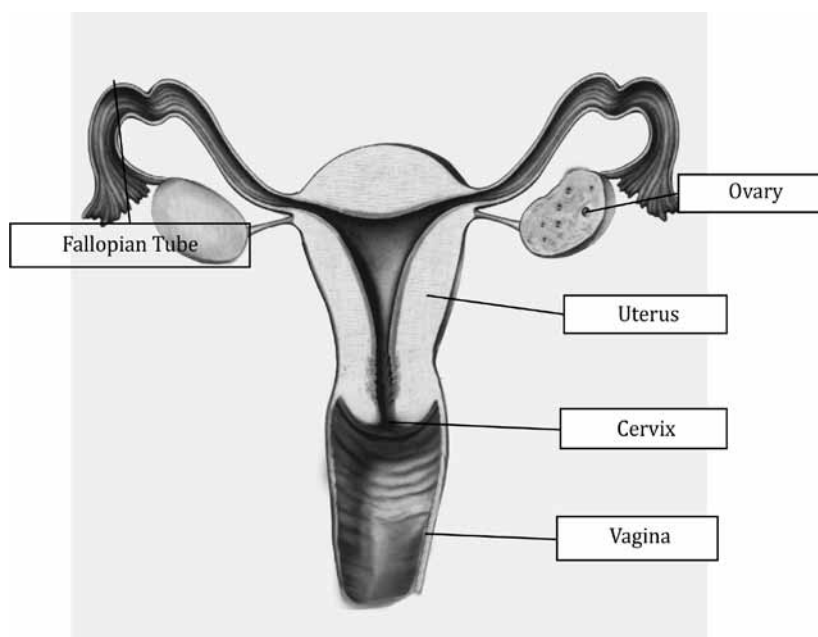


Image Courtesy of Sachin Mahadik, KEM Hospital, Mumbai

If the ovum is not fertilized, it will degenerate. As the lining of the uterus is not required to nurture the foetus, it will be shed as menstrual bleeding. This is how menstruation occurs. About 50 ml of blood is lost during each menstruation. Menstrual bleeding normally lasts for 3 to 7 days. The cycle gets repeated every 28 to 30 days.

There is a great deal of variation in the length of the cycle, amount and duration of menstrual bleeding and regularity from one woman to another. Some women bleed a lot in a given period and for a longer period of time. Others have very scanty bleeding. One big cause for such scanty bleeding is Anaemia. Another instance when women may have lighter menstrual bleeding is if they take the oral contraceptive pill (Mala-D)

The most important aspect of the menstrual cycle is the fertile period: Only three days in the entire menstrual cycle of 28-30 days constitute the fertile period. It is marked by the release of whitish

mucus discharge (like raw egg-white or the fluid present when cooking brinjal). This mucus discharge is normal. Counsellors should distinguish normal mucus discharge from abnormal presentations. The chances of conception are limited to a day before and two days after ovulation.

### ***Menstrual Hygiene***

Bathing daily during menstruation is essential. Washing the genital region daily with mild soap and lukewarm water helps prevent distinct body odour.

Pads and napkins - A soft cotton cloth or sanitary napkin should be used during menstruation. Sanitary pads should be changed 3 to 4 times a day depending on the flow. The woman should always clean the genital area each time she changes the pad. She should wash her hands with soap and water.

If cloth pads are used, then they should be washed in water with soap and completely dried – in the sunlight. Damp cloths should not be used as they increase the chances of infection. Also, she should avoid sharing the same cloth pad with other female family members – to avoid transmission of infection. Every 3 to 4 months, a new cloth should be used and the old one discarded. If sanitary napkins are used, they should be used once and then disposed. For disposal, it is important to wrap the pad in a paper and discard it in the dustbin.

In case of females who are sero-positive, the disposable pads should be soaked in water with bleaching powder before disposal. Cloth pads should be immersed in water with bleaching powder for twenty minutes before washing thoroughly with soap.

### ***Development of Breasts***

Though breasts are present in both males and females, the female breast is more pronounced. The size of the breast depends on the overall build of the woman. Whether small or big, breasts are able to fulfil their function - production of milk for breastfeeding the child after delivery from the milk glands.

## **Where do STI/RTI occur?**

### ***STI/RTI in females***

In women, RTI that involve the outer genitals, vagina and cervix, are called lower reproductive tract infections while infections in the uterus, fallopian tubes, and ovaries are called upper reproductive tract infections.



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



### ***STI/RTI in males***

RTI in men generally begin in the lower reproductive tract (the urethra). If untreated, the infection may climb through the vas deferens (sperm tube) to the upper reproductive tract (which includes the testes). RTI could also lead to prostatitis (inflammation of the prostate).

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



### **References**

National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2011). Refresher Training Programme for ICTC Counsellors (2nd Ed.). New Delhi, India: Author.

Prakash O. (2007) Lessons for postgraduate trainees about Dhat syndrome. Indian Journal of Psychiatry, 2007 (49) 208-10.

# BASIC FACT SHEET ON STI/RTI

## At the end of this unit, participants will be able to

- Define STI and RTI
- Name some basic STI and RTI
- List the modes of transmission of STI and RTI
- Describe conditions that put people at greater risk of STI and RTI
- Correct common misconceptions related to transmission of STI

Counsellors in STI/RTI services interact with people who have STI and RTI. Before learning what you should do with them, you should be able to answer these basic questions:

- What are STI and RTI?
- How do they spread?
- What puts people at risk of STI and RTI?

## What are STI & RTI?

STI is a short form for Sexually Transmitted Infection. RTI is a short form for Reproductive Tract Infection.

Sexually transmitted infections (STI) are infections that are spread primarily through person-to-person sexual contact. STI reflects modes of transmission of infection (i.e., how the infection is spread). Several, in particular HIV and syphilis, can also be transmitted from mother to child during pregnancy and childbirth, and through blood products and tissue transfer.

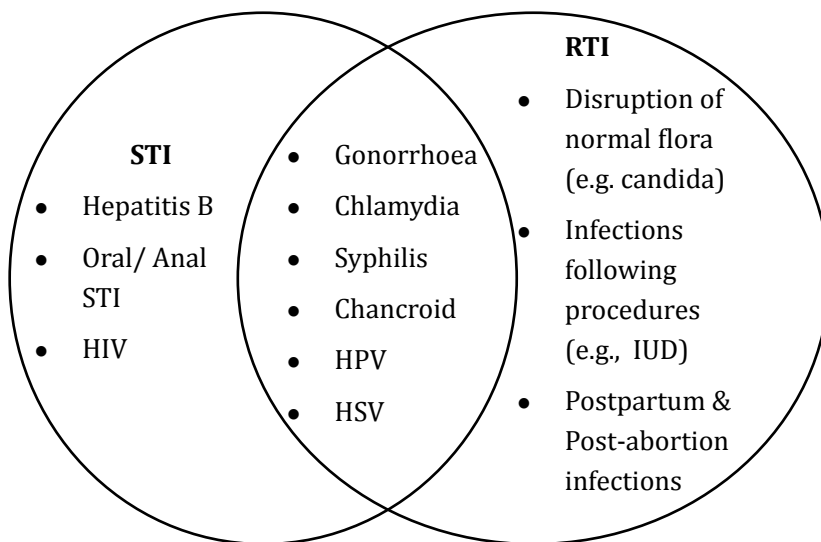
So, STI are mainly spread through sexual contact. That is why they are called sexually transmitted infections. But as we see from the definition above, the same organisms which cause STI could also be spread through other routes: from mother to child during pregnancy or during childbirth, and through blood products and tissue transfer.

Reproductive tract infections (RTI) are infections which are present in the reproductive tract of males or females. RTI represents site of infection – that is the reproductive tract.

Some RTI are caused in the same way as STI. But RTI could also be caused by overgrowth of normal organisms in the reproductive system (e.g., bacterial vaginosis) or they could be infections caused by improper medical procedures such as catheterization, termination of pregnancy or IUD insertion.



Not all reproductive tract infections are sexually transmitted and not all sexually transmitted infections are located in the reproductive tract.



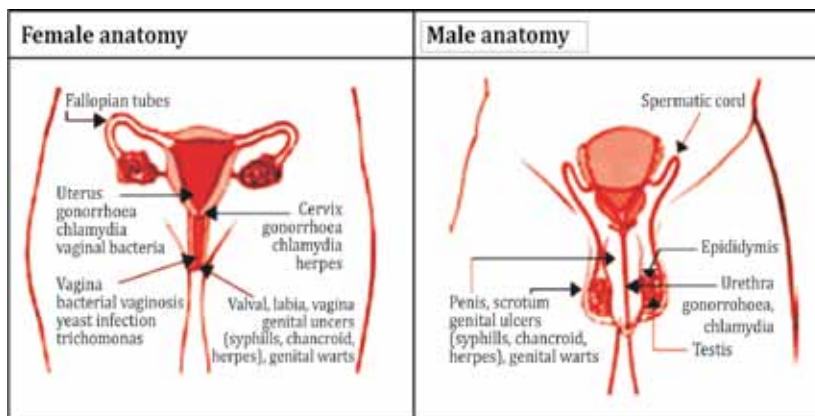
**In men, RTI affect**

- ✓ Penis
- ✓ Testes
- ✓ Scrotum
- ✓ Prostate

**In women, RTI affect**

- ✓ Vagina
- ✓ Cervix
- ✓ Uterus
- ✓ Fallopian tubes
- ✓ Ovaries

Sexually transmitted infections tend to affect the same parts of the body.



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

### Why should we worry about STI?

- STI often (but not always) cause discomfort and pain to people who have them.
- STI spread quite easily to other people.
- STI can cause serious health problems such as infertility, stillbirth, ectopic pregnancy and blindness in newborns.
- Shame and guilt over behaviours that cause STI make people delay treatment or visit quack doctors for help.

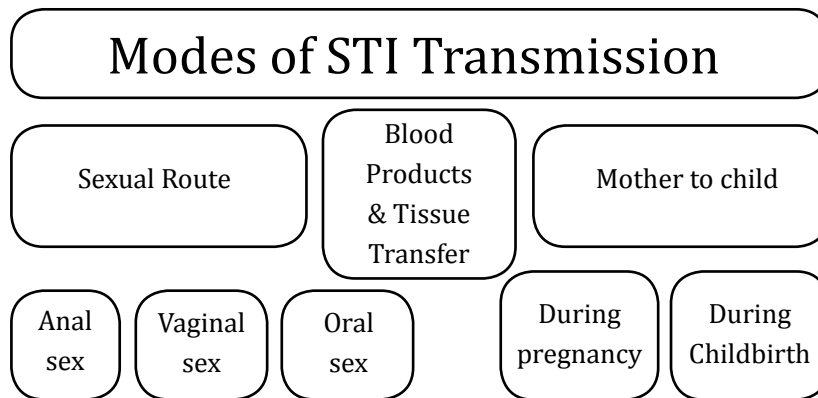
So it is important for you, the counsellor, to help every person coming to your clinic to get the treatment they require and to emphasize to them the importance of complete treatment.

### What are some common STI?

There are more than 30 different types of STI. They are caused by bacteria, viruses and parasites. Some common STI are gonorrhoea, chlamydial infection, syphilis, trichomoniasis, chancroid, genital herpes, genital warts and hepatitis B infection. Human immunodeficiency virus (HIV) infection which leads to AIDS is also an STI. It is possible to have more than one STI at the same time.

However, we will see later that we do not need to learn all these different names because the National AIDS Control Programme uses the Syndromic Management approach.

### How do STI spread?



As we saw in the definition of STI, though they mainly spread through sexual contact, there are other ways of transmission. Since a pregnant woman could spread STI to her unborn child, it becomes important to screen her and treat her. That is why counsellors in STI/RTI Services should spend some of their working time with women in ante-natal care (ANC). When you look at the diagram, you also recognize that the sexual route could be through vaginal sex, oral sex or anal sex. Before you counsel someone, you must be sure you know what each of these terms mean. Also make sure that during counselling you address any misconceptions such as, “Patients cannot have more than one STI at a time,” or “Sex with a menstruating woman causes STI.”

### Who is at risk of STI?

Anyone who has unprotected sexual contact with a person infected with an STI is at risk of STI. They may also get STI such as syphilis if they receive a blood transfusion from that person. For this reason all units of blood in the blood bank are screened for major STI such as syphilis, hepatitis and HIV.

But some people are more prone to STI such as:

- People who have many sexual partners
- People who frequently change their sexual partners
- People who have many acts of sex without protection of condoms

### ***Women are more prone to get STI.***

The reasons are:

- Biological vulnerability: During sex, their sexual organs offer a greater surface area for transfer of STI organisms

- Social vulnerability: Women are socially less able to refuse unwanted sexual contact or to insist on condom usage.

Another important difference between men and women is

- Appearance of STI in women: STI in women may not be visible because there may not be any obvious signs and symptoms. In other words, women may be asymptomatic. So they are less likely than men to receive treatment.

### ***Adolescents are more prone to get STI.***

**The reasons are:**

- Biological vulnerability: The genital organs in adolescent girls are not mature or fully developed, and this makes them more susceptible to gonorrhoea, chlamydia and HIV.
- Social vulnerability: Adolescents may have little control over choosing their partners, number of partners, and context of sexual activity. They face barriers to accessing condoms which could help to protect them from unsafe sexual activity.

Moreover, once they are infected they face:

- Systemic barriers: They may not be able to access health services and treat their STI/RTI.

### ***Type of sexual contact***

Some forms of sex like anal sex make the transfer of STI organisms easy.



But all forms of sexual contact can transmit infection



#### **Questions for the Counsellor:**

- ✓ Do you know how to ask a client about oral sex? What about vaginal sex? What about anal sex?



## References

National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2011). Training of Medical Officers to deliver STI/RTI services. New Delhi, India: Author.

Stallworth, J., Roofe, M., Clark, L. F., Ehiri, J. E., Mukherjee, S., Person, S., et al. (2004). Predictors of sexual involvement among adolescents in rural Jamaica. *International Journal of Adolescent Medicine and Health*, 16(2), 165-178.

World Health Organisation (n.d.). Sexually Transmitted Infections. <http://www.who.int/tdr/diseases-topics/sti/en> as on May 15, 2012.

In the previous unit, you learned some basic facts about STI. This

**At the end of this unit, participants will be able to**

- Differentiate between signs and symptoms.
- Explain the concept of syndromic case management
- Apply the information sheets for management of common syndromic conditions in India.
- List patient education relevant to each of the syndromic conditions.
- Explain why HIV is an STI requiring special services.

unit will build on that foundation to give you more information about specific infections that are common to India. You will also learn how they are managed using syndromic case management. More important to your role as a counsellor, you will learn what kind of patient education you should give for each of these conditions. The unit contains 12 very important information sheets. While it is difficult to learn all this by heart, we encourage you to keep reading these sheets so you become very familiar with them.

**The key idea of this unit is not that counsellors should become doctors but that they should know how to support doctors through suitable patient education and counselling.** This is a key professional boundary of counsellors.

## Sign or Symptom

At the heart of this unit is the difference between sign and symptom. They are not the same.

**Symptoms** are the complaints reported by the patient to the doctor.

**Signs** are what the doctor sees when he/she examines the patient physically.

People who show no symptoms but still have an infection are called

Doctor, what should I do? When I go to the toilet and pass a stool, **I see blood in the stool.**

Hmm... Let me take a look. Please turn around...  
**Oh! I can see you have an ulcer on your anus.**



asymptomatic. Even when asymptomatic, their health may become worse and they can transmit the infection to other people such as their sexual partner or, in case of a woman, an unborn child. They require to be diagnosed and treated.

- ✓ In its early stages, HIV infection is often asymptomatic.
- ✓ In women, many of the organs affected by an STI are inside. So infected women may be asymptomatic.

***The common signs and symptoms of STI/RTI in males are***

- ✓ Urethral discharge/ burning or pain during urination/ frequent urination
- ✓ Genital itching
- ✓ Swelling in groin/ scrotal swelling
- ✓ Blisters or ulcers on the genitals, anus, mouth, lips
- ✓ Itching or tingling in genital area
- ✓ Ano-rectal discharge
- ✓ Warts on genitals, anus or surrounding area

***The common signs and symptoms of STI/RTI in females are***

- ✓ Unusual vaginal discharge
- ✓ Genital itching
- ✓ Abnormal and /or heavy vaginal bleeding
- ✓ Pain during sexual intercourse
- ✓ Lower abdominal pain (pain below the belly button, pelvic pain)
- ✓ Blisters/ulcers on the genitals, anus or surrounding area, mouth, lips

Syndromic management of STI relies heavily on the doctor recognizing the signs and eliciting the symptoms from patients.



**Exercise: Sign/ Symptom**

**As a comprehension check, see if you can put these terms into the columns for Sign or Symptom**

1. Woman says, "I have a discharge from my vagina."
2. Discharge is seen from the anus.
3. On physical examination, sores, ulcers, blisters, small hard lumps or rashes are seen in and around the sexual organs
4. Man says, "Oh! I have a discharge from my penis."

5. Teenager says, “My mouth burns when I have to eat food.”
6. Doctor examines teenager’s mouth and finds blisters or sores inside the mouth.
7. Sore throat sensation
8. Pain in vagina while having sex
9. Burning sensation in vagina
10. Lower abdominal pain
11. Frequent urination
12. Patient complains of swelling of scrotum/ groin area

SIGN	SYMPTOM

### Syndromic case Management

Syndromic case management of STI is a public health approach to treatment that has been supported by the World Health Organisation. In this approach, the health care provider uses the symptoms reported by the patient as well as the signs he/ she observes during the physical and internal examination to identify the syndrome affecting the patient, and gives treatments for all infections (if not the most common ones) that could possibly cause that particular syndrome.

What does this mean in actual terms? The health care provider is trained so that during the first visit itself, he/ she can help the patient to access treatment. The patient does not need to wait for a laboratory test result.

**The advantages are:**

- Often the discomfort from the symptoms may be reduced more quickly
- We can reduce the time that the sexual partner is exposed to possible infection (that is we can make the patient non-infectious at the earliest)
- We can reduce the possibility that the patient may decide not to come back.

This is different from traditional treatment.

Earlier we gave the names of some STI such as Hepatitis B and syphilis. A health care provider who uses the syndromic case management approach will use terms such as vaginal discharge syndrome or lower abdominal pain syndrome. Next we examine some common syndromes. As we examine the syndromes and read about syndromic management through colour-coded kits, we should keep the following points about treatment in mind.

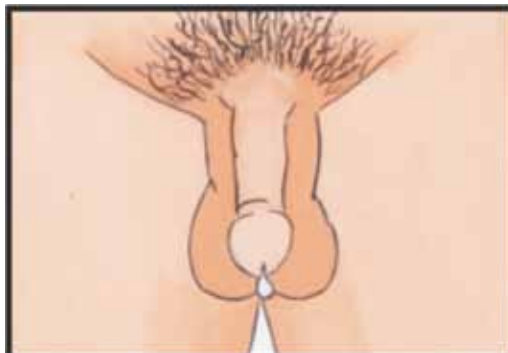
**Treatment**

- ✓ To be taken from a trained doctor
- ✓ To be taken for the duration prescribed
- ✓ To be taken in the dosage prescribed
- ✓ To be given to the sexual partner
- ✓ To use condoms during treatment

## Urethral Discharge Syndrome

### **COMMON SYMPTOMS**

- Urethral discharge syndrome is seen in males.
- Discharge is from the penis. The discharge could be pus or mucoid; the quantity may be copious or limited.
- There may be associated burning or discomfort while passing urine.
- There may be pain during erection or during sexual intercourse.



### **TRANSMISSION**

- The syndrome is caused by Gonorrhoea (Gonococcus), Chlamydia and/or Trichomonas infection.
- The client can get the infection from an infected partner by having unsafe sexual practices. It may be transmitted through unsafe vaginal, oral or anal sex with either a female or a male partner who is infected.
- The sexual partner who is infected with Gonorrhoea, Chlamydia or Trichomonas, may be symptomatic or asymptomatic.

### **PREVENTION**

- The client should avoid any sexual contact with partner/s until the treatment is completed and until the discharge is fully stopped. If abstinence is not possible the client should use a condom, consistently and correctly, during each and every sexual act.
- It is important to inform the doctor, if the partner is pregnant, as treatment will help in preventing spread of infection to the newborn child.

### **TREATMENT**

- Urethral discharge syndrome can be cured IF the client and his partner/s takes proper and full course of treatment simultaneously.
- The treatment should be taken at the clinic under the supervision of the staff. This is DOTS-STI (Directly Observed Treatment - Short Term).
- The prescribed medication should be taken along with plenty of water.

**DRUG REGIME**

- Azithromycin (1gm) - single dose
- Cefixime (400 mg) - single dose



**COMPLICATIONS**

- If not diagnosed and treated early, complications such as epididymo-orchitis and urethral narrowing may occur.
- He may also become sterile.
- This infection in women will cause infertility.
- Very rarely, the infection may spread to other parts of the body (disseminated gonococcal infection).
- If patient transmits Gonorrhoea and Chlamydia to a pregnant partner, she may transmit it to the baby during delivery. It may affect the baby's eyes and even lead to loss of eyesight.

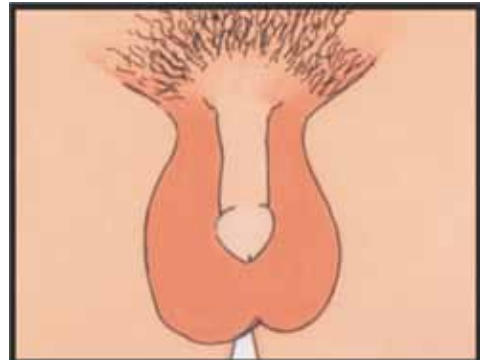
**PARTNER REFERRAL**

- It is important to inform any sexual partner/s he has had in the last one month about the infection and to encourage the partner/s to come to the clinic for treatment.

## Painful Scrotal Swelling Syndrome

### **COMMON SYMPTOMS**

- Painful scrotal swelling syndrome is seen in males.
- Patient will present with pain and swelling in the scrotum.
- There might be associated discharge from private parts of the body. The discharge is usually mucous/serous and the quantity may be scanty.
- There may be burning sensation or discomfort while passing urine.
- There may be pain during erection or during sexual intercourse.



### **TRANSMISSION**

- It is caused by Gonorrhoea and Chlamydial infections.
- This syndrome is due to complication of untreated or inadequately treated urethral discharge syndrome.

### **TREATMENT**

- Painful scrotal swelling syndrome can be cured provided the client and his partner/s take proper and full course of treatment.
- The treatment should be taken at the clinic under the supervision of the staff. This is DOTS-STI (Directly Observed Treatment - Short Term).
- The prescribed medication should be taken along with plenty of water.
- The patient should return to the clinic if he has problems with the medicine or if the symptoms do not go away.
- The patient should avoid sex until treatment is completed (for seven days after completion of therapy) and make sure he does not pass the infection to others. Also, sex should be avoided until a partner completes treatment (for seven days after completion of therapy) so that there is no re-infection. If abstinence is not possible, the client should use a condom, consistently and correctly, during vaginal, anal, and oral sex.
- After seven days, the patient should return to the clinic for follow up

**DRUG REGIME**

- Azithromycin (1gm) - single dose
- Cefixime (400 mg) - single dose

**COMPLICATIONS**

- If left untreated or inadequately treated, the painful scrotal swelling can cause urethral stricture (narrowing) and infertility.



**PARTNER REFERRAL**

- It is important to inform any sexual partner/s he has had in the last two months about the infection and to encourage the partner/s to come to the clinic for treatment.

**Be careful!**

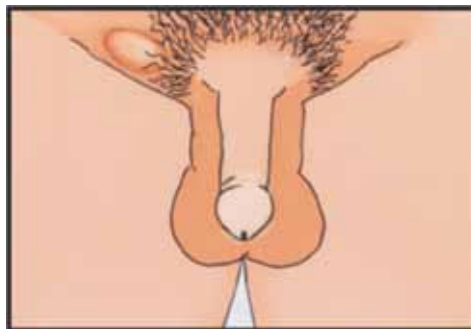
- Some medicines are not safe to take during pregnancy so the pregnancy status of the client's female partner should be confirmed.



## Inguinal Bubo Syndrome

### COMMON SYMPTOMS

- Painful swelling in one or both groins.
- Usually there are no ulcers on genitals
- Sometime the swelling may rupture causing discharge which may lead to sinus formation
- The syndrome is also known as Lympho Granuloma Venereum (LGV)



### TREATMENT

- The treatment schedule of the syndrome should be explained to the client (since it has the longest treatment out of all the syndromic management kits- 21 days). It is important to take the medicines regularly and complete the treatment even if the symptoms go away.
- The client should return to the clinic if she/he has problems with the medicine or if the symptoms do not go away.
- The client should avoid sex until treatment is completed (for 21 days) so as to make sure he does not pass the infection to others. Also she/he should avoid sex until his/her partner completes treatment (for twenty one days) so that she/he does not get re-infected. If sexual abstinence is not possible, the client should use a condom, correctly and consistently, during vaginal, anal, and oral sex.
- The client has to attend the clinic on the 7th, 14th and 21st day for follow-up.
- Sexual partners should be treated simultaneously for 21 days with the same medicines.

### DRUG REGIME

- Doxycycline (100 mg) - BID for 21 days
- Azithromycin (1gm) - single dose





**COMPLICATIONS**

- If left untreated or inadequately treated, Inguinal Bubo can cause swelling in the inguinal region, leading to multiple painful ulcers, discharging sinuses, genital swelling, rectal discharge, bleeding, and rectal strictures.
- If left untreated, it could produce swelling and distortion of external genitalia.

**Be careful!**

- Some medicines are not safe to take during pregnancy so the pregnancy status of the client (or the female partner) should be confirmed.



## Genital Ulcer Disease Syndrome (Non-herpetic)

### COMMON SYMPTOMS

- There may be sores or ulcers on genitals.
- Sores may also be seen on anus, mouth or on lips.
- The ulcers may be single or multiple. They may be painful or painless.
- There may also be swelling of lymph nodes on one or either groin.



### TRANSMISSION

- Genital ulcers are transmitted through contact with sores on the vagina, penis, anus, rectum, mouth, or lips.
- It could be caused by syphilis, chancroid, donovanosis or granuloma inguinale.
- The infections can also be passed to others even after the sores have healed or when they are not present.

### PREVENTION

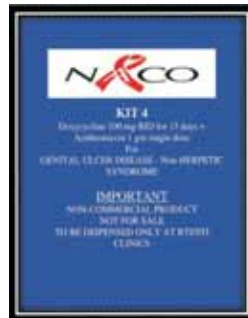
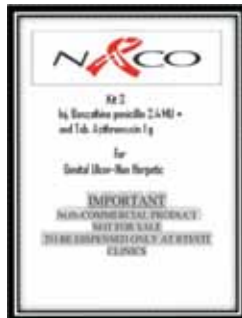
- To reduce the chances of infecting sexual partners, partners should avoid any contact with the sores until they are completely healed.
- The easiest way to avoid contact is not to have sex until the sores are fully healed or to use a condom during sex. However, transmission can still occur if the condom does not cover the sores.

### TREATMENT

- Genital ulcer disease syndrome – non herpetic can be cured with a single dose of Benzathine penicillin (injection) and a single dose of Azithromycin (tablet) under the supervision of clinic staff.
- Check for drug allergy.
- The client should return to the clinic if there are problems with the medicines.
- The client should attend the clinic for follow up after seven days of treatment.

## DRUG REGIME

- Injection Benzathine penicillin 2.4 million unit to be given in divided dose in each buttock after skin testing. Azithromycin (1gm) – single dose.
- If patient is allergic to penicillin then use Kit 4 consisting of:
  - ♦ Doxycycline (100 mg) - BID for 15 days
  - ♦ Azithromycin (1gm) - single dose



## COMPLICATIONS

- If left untreated or inadequately treated, genital ulcer disease syndrome – non herpetic may lead to complications over a period of time.
- If left untreated, syphilis could damage the cardio-vascular and central nervous system, eventually causing death.
- In pregnant women, syphilis could be transmitted to the baby, causing stillbirth, the death of the baby or anomalies. This can be avoided if the woman is treated early in pregnancy.
- If left untreated, chancroid could cause swollen lymph nodes (glands) in the groin that can rupture and drain pus.
- Most importantly, like in case of all STI/RTI, an individual with genital ulcer disease syndrome has five to ten times more risk of getting/ giving HIV infection.

## PARTNER REFERRAL

- It is important to inform any sexual partner/s he or she has had in the last three months about the infection and to encourage the partner/s to come to the clinic for treatment.

### **Be careful!**

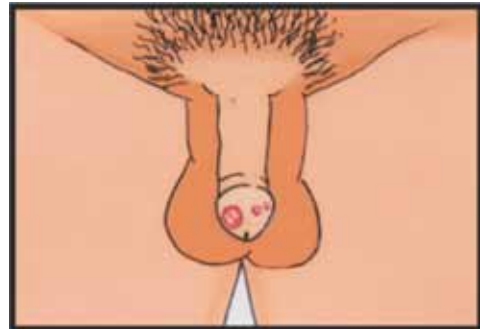
- Some medicines are not safe to take during pregnancy so the pregnancy status of the client (or the female partner) should be confirmed.
- All pregnant clients and their partner(s) should let their doctor know that they are pregnant so that the doctor can help to protect the baby from transmission during



## Genital Ulcer Disease Syndrome (Herpetic)

### **COMMON SYMPTOMS**

- There may be sores or ulcers on genitals.
- Sores may also be seen on anus, mouth or on lips.
- There may be vesicles/ erosions and they may be painful.
- There may also be swelling of lymph nodes on one or either groin.
- Sometimes, the client may experience tingling in the genital area preceding the herpetic vesicular eruption.
- Patients may complain of recurrence of symptoms.



### **TRANSMISSION**

- Genital ulcers are transmitted through contact with sores on the vulva, penis, anus, rectum, mouth, or lips.
- The cause could be herpes.
- Herpes can be transmitted from the mouth to the genitals or from the genitals to the mouth during oral sex. In such cases even oral sex poses high risk.
- Herpes can also be passed to others even after the sores have healed or when they are not present.

### **PREVENTION**

- To reduce the chances of infecting sexual partners, partners should avoid sex until the sores are fully healed or use a condom, consistently and correctly, during sex and ensure the sores are covered by the condom.
- Some people have attacks of herpes during stressful times. So the patient should look at ways to reduce stress.
- A person with herpes infection often feels a tingling or itchy feeling at the site where an attack is about to occur. The risk of transmission is high just before and during an outbreak. If possible, the client should avoid sex at these times.

### **TREATMENT**

- The genital ulcer disease syndrome (herpetic) can be treated. Herpes sores heal on their own after 7-10 days. But the virus stays

in the body after the sores are healed. Medicines can shorten the time of healing.

- The client should return to the clinic after 7 days.

**DRUG REGIME**

- Acyclovir (400 mg) - Orally TID for 7 days

**COMPLICATIONS**

- Some people experience repeated attacks of herpes sores.

**PARTNER REFERRAL**

- There is no need to routinely treat the partners unless they too have symptoms.



**Be careful!**

- All pregnant clients and their partner(s) should let their doctor know that they are pregnant so that the doctor can help to protect the baby from transmission during delivery.



## Vaginal Discharge Syndrome (Vaginitis)

### **COMMON SYMPTOMS**

- Vaginal discharge syndrome is seen in females.
- The common symptoms of vaginal discharge syndrome are unusual quantity of vaginal discharge, itching around genitalia, bad odour of the discharge and change in colour of the discharge.



### **TRANSMISSION**

- Sometime vaginal discharge is caused by change in the normal environment in the vagina.
- Sometime the causes for vaginal discharge are yeast infections, which can occur with excessive antibiotic use, diabetes or not maintaining proper hygiene of genitals, including menstrual hygiene.
- It is also likely to be transmitted through unprotected sexual intercourse.

### **PREVENTION**

- To reduce the chances of getting a vaginal infection in the future, the client should avoid douching, re-using sanitary pads, using dirty clothes and scented soaps, wearing tight pants and synthetic underwear.
- Condom use for vaginal sex might also help prevent recurrence.

### **TREATMENT**

- Vaginal discharge syndrome can be cured with single-dose treatment.
- It is important that every client, who comes in with a vaginal discharge complaint, should undergo internal examination using a speculum.
- The client should be motivated to take the medicine under supervision at the clinic itself.
- The client should avoid sex until treatment is completed (for seven days after completion of therapy). If abstinence is not possible, the client should use a male or female condom during

vaginal, anal, and oral sex.

- The partner of the client needs to be treated only when the partner has symptoms like burning sensation on the penis, mucoid discharge or cracks (fissures) on foreskin.
- After 7 days of treatment, the client should return to the clinic.

### **DRUG REGIME**

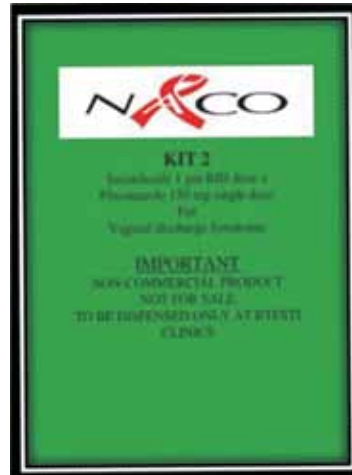
- Secnidazole (1gm) - 2 tablets stat
- Fluconazole (150 mg) - single dose

### **COMPLICATIONS**

- In pregnant women, the Vaginitis infection can cause early labour and delivery

### **PARTNER REFERRAL**

- It is important to inform any sexual partner/s who may be symptomatic and encourage them to come to the clinic for treatment.



### **Be careful!**

- In some cases, vaginal discharge may not be caused by an STI. To prevent negative or blaming responses from clients and/or their partner/s, the counsellor should consider each case on an individual basis.
- Some medicines are not safe during pregnancy so pregnancy status of the client should be confirmed
- The medicines used to treat vaginal discharge syndrome can make the client sick (nausea, vomiting, flushing, sinking feeling) if she drinks alcohol (beer, liquor, or wine) during treatment. To prevent this, the counsellor should advise the client to not drink any alcohol until 24 hours have passed since taking the last dose.



## Cervical Discharge Syndrome (Cervicitis)

### COMMON SYMPTOMS

- Cervical discharge syndrome is seen only in females.
- In case of cervicitis, the common symptom is vaginal discharge which releases foul smell and has a change in colour. The quantity of discharge is usually scanty.



### TRANSMISSION

- This syndrome could be transmitted through unprotected peno-vaginal sex with an infected partner.
- To reduce the chances of getting a cervical infection in the future, correct and consistent use of condoms for every sexual encounter is important.

### TREATMENT

- Cervical discharge can be cured with single-dose treatment.
- It is important that every client, who comes to the clinic with vaginal/cervical discharge complaint, should undergo internal examination using a speculum.
- The client should be motivated to take the medicine, under supervision, at the clinic itself.
- The client should avoid sex until treatment is completed. If abstinence is not possible, the client should use a condom, consistently and correctly, during vaginal, anal, and oral sex.
- The client should return to the clinic after seven days of treatment.
- The partner should be treated with the same medicines.

### DRUG REGIME

- Azithromycin (1gm) - single dose
- Cefixime (400 mg) - single dose

### COMPLICATIONS

- The infection can spread to the uterus (womb) and fallopian tubes, causing pelvic inflammatory disease (PID), which can make it





difficult for the client to become pregnant.

- It can increase the risk of ectopic pregnancy (pregnancy outside the uterus).
- In pregnant women, the infection can cause early labour and delivery and can be passed to the baby.

### ***PARTNER REFERRAL***

- It is important to inform any sexual partner/s she has had in the last one month about the infection and to encourage these partner/s to come to the clinic for treatment.

### ***Be careful!***

- Some medicines are not safe to take during pregnancy so the pregnancy status of the client should be confirmed.



## Lower Abdominal Pain Syndrome (LAP)

### COMMON SYMPTOMS

- Lower abdominal pain syndrome is seen only in females.
- The most common symptom is pain in lower abdomen, especially during sexual intercourse.
- There could be irregularities in the menstrual cycle.
- Sometimes there might be discharge from the vagina and complaints of backache.
- Sometimes there could be constitutional symptoms such as fever, body aches, nausea and vomiting.



### TREATMENT

- LAP syndrome could be PID (Pelvic Inflammatory Disease). It can be treated.
- It is important to take the medicine the right way and complete treatment even if the symptoms go away.
- The client should return to the clinic if she has problems with the medicine or if the symptoms do not subside within 72 hours.
- The client should avoid vaginal sex until after treatment to promote healing and to make sure she does not pass the infection to others. Also vaginal sex should be avoided until after the partner completes treatment so that the client does not get re-infected. If abstinence is not possible, the client should use a male or female condom during vaginal, anal, and oral sex.
- The client should return to the clinic for follow-up on the 3rd, 7th and 14th day from the day of treatment.

### DRUG REGIME

- Cefixime (400 mg) - single dose
- Metronidazole (400 mg) - BID for 14 days
- Doxycycline (100 mg) - BID for 14 days

### COMPLICATIONS

- PID can make it difficult for the client to become pregnant. It can make her infertile, or can increase her risk of ectopic pregnancy (pregnancy outside the uterus).

- PID can cause chronic lower abdominal pain and painful intercourse.



### **PARTNER REFERRAL**

- It is important to inform any sexual partner/s she has had in the last two months about the infection and to encourage these partner/s to come to the clinic for treatment.

### **Be careful!**

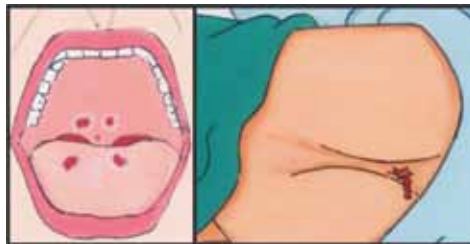
- The counsellor should explore recent incidents of intrauterine contraceptive devices (insertion,) abortions etc.
- Since the risk of ectopic pregnancy (a life-threatening condition) is increased in women who have had PID, the Counsellor should tell the Client that ...
  - ♦ If she is pregnant, she should report to a hospital at the earliest to rule out ectopic pregnancy.
  - ♦ She should go to a health care facility immediately if she experiences the following signs of ectopic pregnancy
    - ♦ Irregular bleeding or spotting with abdominal pain when her period is late or after an abnormally light period.
    - ♦ Sudden intense persistent pain or cramping pain in the lower abdomen, usually on one side or the other.
    - ♦ Faintness or dizziness that lasts for more than a few seconds (may be signs of internal bleeding).
- The medicines used to treat lower abdominal pain can make the client sick (nausea, vomiting, flushing, sinking feeling) if she drinks alcohol (beer, liquor, or wine) during treatment. To prevent this, the counsellor should advise the client to not drink any alcohol until 24 hours have passed since taking the last dose.



## Oral and/or Anal STI

### COMMON SYMPTOMS

- The individual may have symptoms of ulcers/sores /blisters/ discharge/growth at oral and/or anal regions.



### TRANSMISSION

- These may be caused due to Gonorrhoea, Chlamydia, Syphilis, and Genital herpes.

### TREATMENT

- Most oral and anal STI can be cured with single-dose treatment.
- Some oral and anal STI require different types of treatment along with medicines.
- The client should be motivated to take the medicine under supervision at the clinic itself. This is DOTS-STI.
- The partner is to be treated with the same medicines.
- The client should avoid sex until treatment is completed. Sex should also be avoided until the partner completes treatment so that the client does not get re-infected. If abstinence is not possible, the client should use a condom, consistently and correctly, during vaginal, anal, and oral sex.
- The client should return to the clinic after seven days of treatment.

### DRUG REGIME

- Azithromycin (1gm) - single dose
- Cefixime (400 mg) - single dose

### COMPLICATIONS

- In men, ano-rectal discharge can cause pain, tenesmus and rectal stricture, leading to difficulty in passing stools.
- In men and women, anal ulcers can cause swelling of the regional lymph nodes, leading to multiple painful ulcers and discharging sinuses.
- In pregnant women, infections transmitted to the baby, cause serious consequences such as abortion, still birth and conjunctivitis in newborn.



**Be careful!**

- Some medicines are not safe to take during pregnancy so the pregnancy status of the client should be confirmed

**Warts****COMMON SYMPTOMS**

- These can be, single or multiple, soft painless growths which look like a cauliflower.
- They may appear around anus, genitals and oral cavity in both men and women.

**PREVENTION**

- The client should avoid any sexual contact with partner/s until treatment is completed and all warty lesions are cleared. If abstinence is not possible, the client should use a condom, consistently and correctly, during vaginal, anal, and oral sex.
- It is important to inform the doctor if the partner is pregnant as treatment helps in preventing spread of infection to the newborn.

**TREATMENT**

- Warts can be cured IF the client and partner/s takes proper and full course of treatment.
- Local application of 20% Podophyllin should be repeated weekly till the lesions are cleared.
- Sometimes warts are treated by cautery.

**COMPLICATIONS**

- Certain varieties of warts may cause cervical cancer in women.
- Genital warts in a pregnant woman can be transmitted to a baby during delivery.

**Be careful!**

- Podophyllin is not safe to use during pregnancy so the doctor should know the pregnancy status of women patients and female partners of male patients.



## **Genital Louse Infestation**

### ***COMMON SYMPTOMS***

- Itching and scratching which may be limited to genital area.
- Nits can be seen over the shaft of pubic hair

### ***PREVENTION***

- The client should avoid any sexual contact with partner/s until the treatment is completed and until all genital lice (plural of louse) are cleared. If abstinence is not possible, the client should use a condom, consistently and correctly, during vaginal, anal, and oral sex.

### ***TREATMENT***

- Genital louse infestation can be cured IF the client and his/her partner/s take proper treatment.
- Treatment includes application of Permethrin 1% around the genital area and washed off after 10 minutes
- In few cases, re-treatment is required after 7 days.

### ***COMPLICATIONS***

- Eczematization
- Secondary infection leading to pus formation

## Molluscum Contagiosum

### **COMMON SYMPTOMS**

- These are multiple, soft, painless smooth, pearl-like swellings.
- They may appear anywhere on the body. When acquired due to unsafe sexual practices, they occur on the genital area.
- They may occur on the face and may be big in size

### **PREVENTION**

- The client should avoid any sexual contact with partner/s until the treatment is completed and until all Molluscum lesions are cleared. If abstinence is not possible, the client should use a condom, consistently and correctly, during vaginal, anal, and oral sex.

### **TREATMENT**

- There is a cure for this condition provided the client and his/her partner/s take proper treatment.
- Each molluscum is opened with a needle (extirpation) and the inner side is touched with 30% TCA (Trichloro Acetic Acid)..
- Sometimes the Molluscum are treated by cautery

### **COMPLICATIONS**

- If not diagnosed and treated early, they may spread all over the body.
- They may get infected causing pain and pus formation.

## **Genital Scabies**

### ***COMMON SYMPTOMS***

- Itching of genitals, especially at night
- Other members of the family may also have similar symptoms
- They may appear on any of the body folds. If acquired due to unsafe sexual practices, they occur on the genital area.

### ***PREVENTION***

- The client should maintain hygiene.

### ***TREATMENT***

- Scabies can be cured IF the client and his/her partner/s take proper treatment.
- Overnight application of Benzyl benzoate lotion or Permethrin cream all over the body and bathing next morning is required.
- All family members should be treated.

### ***COMPLICATIONS***

- Eczematization
- Kidney damage
- Contact dermatitis



## HIV/AIDS

We have included this section in your unit so that you recognise that HIV is first and foremost an STI.

### What is HIV/AIDS?

HIV is a virus. Its full form is Human Immunodeficiency virus. It spreads through:

- ✓ Sexual contact between a male and a female, or between two males – where one partner is infected (or between two females when they share sex toys).
- ✓ Blood transfusion of infected blood or blood products
- ✓ From an infected mother to her child during pregnancy, during child-birth, and through breast-feeding.
- ✓ Sharing/ using of infected syringes, needles and sharps



HIV causes the condition known as AIDS. AIDS is the short form of Acquired Immune Deficiency Syndrome. AIDS is a condition where the HIV that is within the infected person's system starts to break down the person's defence system against illness (namely the CD4 cells – a type of white blood cell). When the person's defence system becomes weak, they quickly develop other infections. Sometimes these other infections which are called Opportunistic Infections, make the person's health so bad that they may even die. AIDS is also a syndrome.

### Why treat AIDS differently?

You may ask why HIV/AIDS as a sexually transmitted infection is it not covered directly under the STI programme. The reason for this is that HIV was a new infection that was discovered in 1983 (AIDS was first recognised in 1981). But in those early days, HIV/AIDS was mostly observed in gay men – namely men who have sex with men. This made it difficult for doctors and other health professionals who were not used to accepting alternative sexual lifestyles to work on this illness. Also, in those days there was no treatment for HIV infection, leave alone a cure. So to respond to this new public health challenge, separate treatment centres were established with health personnel who were given specialised training to cope with the likely possibility of death.

Today, the situation is different. We do not have a cure as yet. But we have lifelong treatments available at the ART centres that keep the breakdown of the defence system in check. We know how to

prevent infection from a mother to her baby. We recognise that our health systems are still not ready to offer services to groups such as men who have sex with men or female sex workers. So we continue to have separate projects to reach out to such groups through special projects called targeted interventions. But the National AIDS Control Organisation is working to bring AIDS into the mainstream of health services. So you will hear of developments such as integration of AIDS into the National Rural Health Mission.

### ***What should a counsellor in the STI/RTI service do in relation to HIV/AIDS?***

The terms of reference of the counsellor in the STI/RTI service state that the counsellor should:

- ✓ Explain and encourage HIV testing, establish referral services to other centres and network for expanded STI and HIV Care & Support - General Laboratory, ICTC, PPTCT, ART, CCC, and TB-HIV, etc

We will explain to you how to do this in the next units



## **References**

National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2009). *Training manual for counsellors at STI/RTI clinics*. New Delhi, India: Author.

National Rural Health Mission & National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2011). *Training of medical officers to deliver STI/RTI services*. New Delhi, India: Author.

Name of Kit	Colour	Contents	Administration	Advice
Kit 1	Grey	One Tab Azithromycin 1g +One Tab Cefixime 400 mg	To be taken as directly observed treatment at DSRC (DOT)	Both drugs are to be consumed in the presence of either counselor or doctor . Please ensure that last meal was taken more than one hour ago. DSRC to have drinking water and disposable glass to drink water.
Kit 2	Green	Two Tab Secnidazole 1 g each, + one Cap Fluconazole 150 mg	To be taken at home	Both drugs to be consumed after meals. Please ensure avoidance of alcohol consumption upto 48 hours of treatment. Avoid prescribing drugs if there is history of consuming alcohol in the last two days.
Kit 3	White	One Tab Azithromycin 1 g, and one vial of Injection Penicillin 2.4 MU  One number 21 gauge disposable needle and one number 10 ml distilled water ampoule	To be administered in DSRC	Tab Azithromycin to be ad- ministered under direct supervision of DSRC staff preferably taken on empty stomach. Injection Penicil- lin to be administered by the doctor after test dose and af- ter ensuring all precautions in place for management of possible anaphylaxis. Injec- tion Benzathine Penicillin to be administered after eat- ing, not on empty stomach. Patient should be preferably hospitalized and if not, at least made to stay at DSRC for one hour.
Kit 4	Blue	One Tab Axithromycin 1 g +30 Tab Doxyycline 100 mg	To be taken at home	Tab Azithromycin to be taken on empty stomach.  Tab Doxycycline to be taken two time a day after meals

Name of Kit	Colour	Contents	Administration	Advice
Kit 5	Red	21 Tab Acyclovir 400 mg	To be taken at home	Tab Acyclovir to be taken three times a day after meals for 7 days
Kit 6	Yellow	One Tab Cefixime 400 mg, 28 Tab Metronidazole 400 mg, + 28 Tab Doxycycline 100 mg	To be taken at home	Tab Cefixime to be administered under direct supervision of DSRC staff. Both Metronidazole and Doxycycline to be taken two time a day after meals for fourteen days. Patient should be counselled on possible side effects due to alcohol ingestion and to be advised to avoid alcohol consumption during the treatment period and upto two days after the last dose.
Kit 7	Black	One Tab Azithromycin 1 G, + 42 Tab Doxycycline 100 mg	To be taken at home	Tab Azithromycin to be taken on empty stomach. Tab Doxycycline to be taken two time a day after meals

# COUNSELLING AT THE STI/RTI SERVICE

## At the end of this unit, participants will be able to

- List the terms of reference of the counsellor in the STI/RTI service.
- Apply basic counselling skills to the process of history-taking.
- Perform a risk assessment of people presenting at the STI/RTI service.
- Develop a risk-reduction plan suitable to the risk assessment of the patient
- Demonstrate how to deliver suitable patient education.
- Demonstrate how to use a condom
- Explain the importance of partner management
- Describe two approaches to partner management

In this unit we discuss how to use basic counselling skills within the STI/RTI service. In particular, you will learn about history-taking, risk assessment and risk reduction. Before you read through this unit, make sure you know the previous units well because this unit builds on them.

We begin by reviewing the Roles and Responsibilities of counsellors at the STI/RTI Service. But we will limit the discussion in this unit to activities related to counselling.

## What do counsellors do at the STI/RTI Service?

### Information -Provision

- ◆ Provide information about STI, HIV/AIDS, Opportunistic infections, healthy lifestyle and explore any myths and misconceptions and clarify the same

### Risk Assessment & Risk Reduction

- ◆ Assist clients to correctly assess the risk for STI and HIV, motivate & help them to make plans for reducing their risk, and help/enable/empower the client through the process of adaptation of health behaviours & coping with the same

<b>Treatment-Related Services</b>
<ul style="list-style-type: none"> <li>♦ Act as an interface between client &amp; provider, organize the treatment schedule, follow up, compliance to treatment, condom usage, partner management, and syphilis screening &amp; other lab for STI/RTI</li> </ul>
<b>Services to HRG members</b>
<ul style="list-style-type: none"> <li>♦ Ensure that every HRG receives the essential STI/RTI service package including early diagnosis and treatment of current STI episode, quarterly regular check-up, presumptive treatment of sex workers and biannual syphilis screening by closed working with respective TI NGO and through outreach.</li> </ul>
<b>HIV and other referrals</b>
<ul style="list-style-type: none"> <li>♦ Explain and encourage HIV testing, establish referral services to other centres and network for expanded STI and HIV Care &amp; Support - General Laboratory, ICTC, PPTCT, ART, CCC and TB-HIV, etc</li> </ul>
<b>Patient-wise Documentation</b>
<ul style="list-style-type: none"> <li>♦ Ensure documentation of history taking, counselling and risk reduction plans and filling up &amp; maintaining patient-wise cards and clinic register.</li> </ul>
<b>Monthly documentation</b>
<ul style="list-style-type: none"> <li>♦ Collect, compile reports on computer from both Gynae and STI OPDs and prepare &amp; submit timely monthly CMIS formats in consultation with Medical Officer-in-charge</li> </ul>
<b>Monitoring Supplies</b>
<ul style="list-style-type: none"> <li>♦ Closely monitor the drug kit and condom consumption, and place appropriate indent in consultation with Medical Officer-in-charge and other designated staff, if available</li> </ul>
<b>Supervisory Visits</b>
<ul style="list-style-type: none"> <li>♦ Facilitate visit of the clinic by supervisory teams</li> </ul>

Counsellors at the STI/RTI Service have many roles and responsibilities. The official Terms of Reference for counsellors state that they will perform these under the supervision of the in-charge. The counsellor will perform these responsibilities in the Out-patient

departments of Gynaecology and Sexually Transmitted Infections.

The first 5 activities are things you do every day in your STI/RTI Service and they involve patients: Information-provision, Risk assessment and reduction, Treatment-related services, Services to HRGs, and HIV and other referrals.

The next 2 activities involve documentation: daily patient-wise documentation and monthly documentation.

Finally, you have responsibilities towards maintaining and monitoring the supply of drug kits. You also have to be prepared to have your work examined by supervisory teams from SACS or NACO.

As you can see, more of your responsibilities lie in the area of working one-on-one with patients. So you should make sure that you give enough time to each and every person who walks through the door of the STI/RTI Service seeking services and treatment.

Let us examine each of the first 3 responsibilities as they relate directly to counselling activities. The other responsibilities will be discussed in subsequent units.

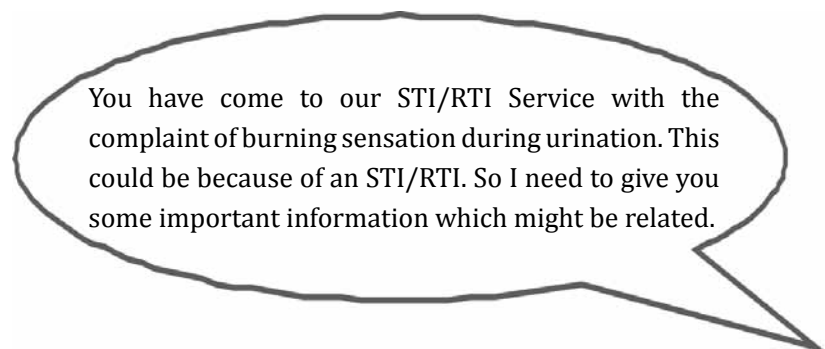
## Information provision

The first responsibility of the counsellor in the STI/RTI Service is to “Provide information about STI, HIV/ AIDS, Opportunistic infections, healthy lifestyles and explore any myths and misconception and clarify the same.” To carry out this responsibility, you must be sure that you yourself are fully aware about all these topics. For this, you may have to read your notes from this training programme more than once. Every patient has the right to clear and correct information to make good health decisions.

### *What information to provide*

#### **Facts about STI/RTI and HIV**

The counsellor’s responsibility is to cover briefly information about HIV/AIDS and about STI/RTI as they relate to the person visiting the STI/RTI Service: Help him/ her to see why he/ she needs to know about all these topics, that they are relevant. You could introduce this by saying:



### *Correcting Misinformation*

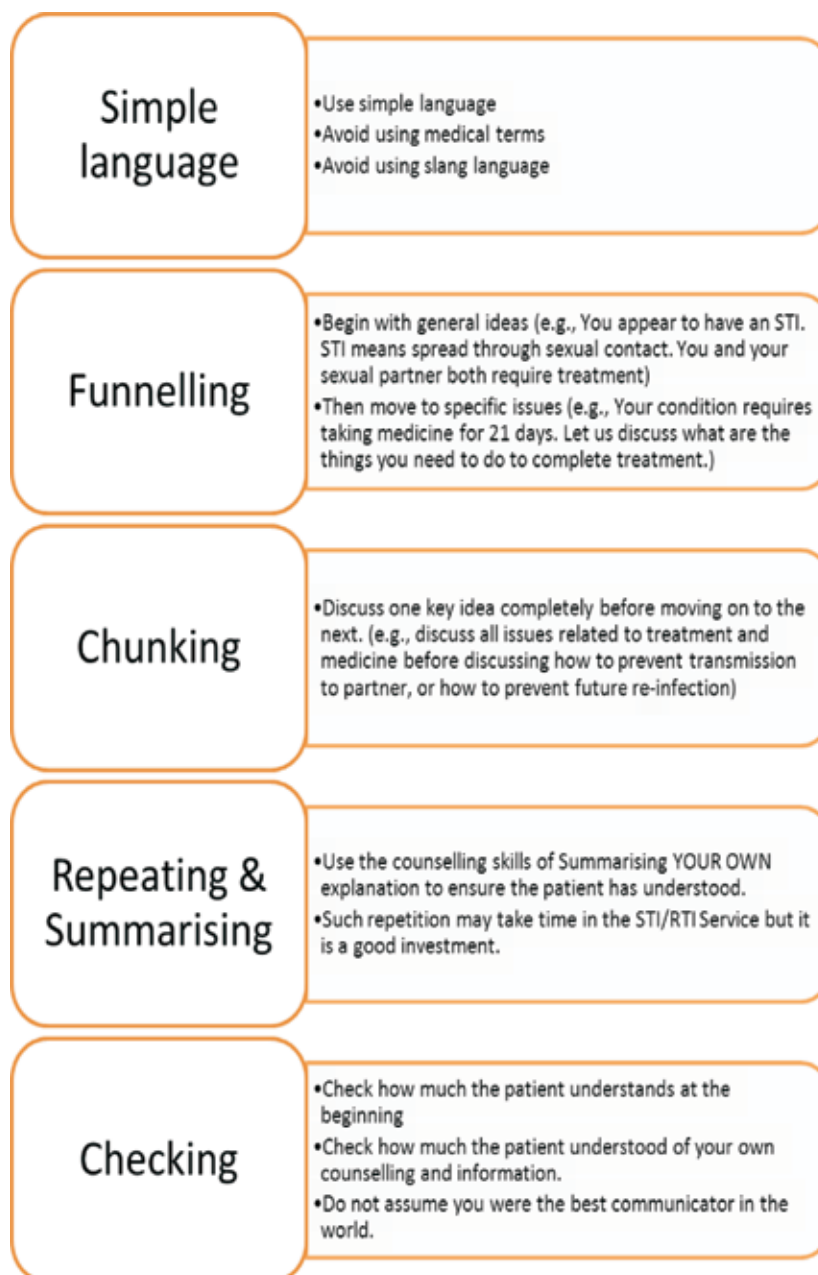
Lay people often have many wrong beliefs about the cause of their STI/RTI condition and how to treat it. One common wrong belief, for instance, is that having sex with a virgin girl will cure the STI/RTI. It is important for the counsellor to ask patients a simple question at the beginning of the counselling interaction: “What do you think has caused your condition, and what do you think you need to do to get well?” You, the counsellor, should note any misinformation and misbeliefs that are mentioned, and address them sensitively and carefully during the course of the session. Even when patients do not mention such wrong beliefs, you should make sure that this topic is addressed briefly. One way is to simply say something like, “Before you leave, I want to make sure that you understand very clearly what has caused your condition, and what will improve it.”



## How to do information-provision

The next issue is how to convey the information to the patient. There are many ways that people learn about health issues. Advertisements on the radio and television convey health information. Posters on the walls of the hospital waiting area convey information. The counsellor will also provide information. But while the other methods convey messages for the general public, the counsellor's information-giving must be very specific to each person. One patient's needs are different from the next. Their ability to understand is also very different.

Here are some guidelines on effective ways of giving information.



## Risk Assessment and Risk Reduction

Risk Assessment and Risk Reduction are two counselling skills that are specific to anyone who works with people who might be at risk of, or already suffering from an STI. They relate to finding out ALL the risky behaviours of the person and then helping the person to adopt ways to reduce the behaviours that expose them and their sexual partner(s) to harm. (For pregnant women, the objective of treatment also considers the limiting the possibility of transmission to the unborn child.)

### **History Taking**

Risk assessment is done as part of History taking. History taking is a general medical process where the doctor is trying to find out the problem that made the person come for treatment. Counsellors also perform history taking. The next step for the doctor is to do a physical examination of the patient. For the counsellor, the next step after the history taking is to link up the facts of the person's behaviour to the plan they need to follow to improve their health. This means the counselling will be tailored to suit the person. For instance, you cannot give instructions meant for a pregnant woman to a man!

In history-taking, the counsellor will probe about the symptom that is bothering the patient: specifically why the client has come to the STI/RTI service, since when they have been bothered by that sign/symptom, what measures they have taken for relief, and sexual partner's health. While a counsellor may not be able to do anything directly for the physical symptom, he/ she should recognize that the patient was driven to visit the service because of that symptom. So this is a good starting point for the counselling, it is a good point to show empathy and acceptance. As the doctor must have probed these questions well, you need not spend too much time here.

At this point, you should know the symptoms of STI/RTI well.

If you do not, please review the earlier unit



### **Risk assessment**

Risk Assessment also involves a series of questions. But the focus moves to the antecedent condition – that is to the possible cause of the health condition – the sexual behaviour of the client. Here the counsellor must try to establish a complete picture of ALL the sexual behaviours of the patient with ALL sexual partners.

Here you are going to use both open-ended and closed questions.

At this point, you should know the difference between these two types of questions. If you do not, please review the earlier unit



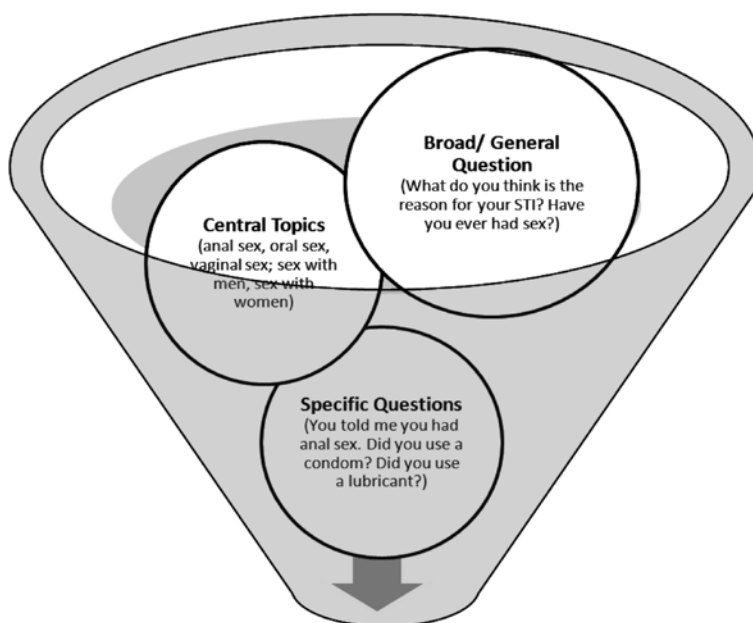
Since you are going to cover different types of behaviours, you may wonder where to begin. You can use the Funnelling Technique. Here you open the dialogue with a broad, general question. Then you move to some central topics relevant to that client. For each central topic, you may have some smaller but more specific questions.

**Broad Question: What are your symptoms?**

- ✓ Specific Question: Since how long have you had this discharge?
- ✓ Specific Question: Have you noticed any changes in the discharge across the month?

**Second Broad Question: Have you ever had sex?**

- ✓ Central Question: You said you have had sex. Have you ever had vaginal sex?
  - ◆ Specific Question: With whom did you have vaginal sex?
  - ◆ Specific Question: Did you use a condom during that incident?
- ✓ Central Question: Have you ever had anal sex
  - ◆ Specific Question: With whom did you have anal sex?
  - ◆ Specific Question: Did you use a condom during that incident?



**Funnelling Questions**

**During risk assessment make sure you cover the following:**

- ✓ How did he/ she have sex? Or What kind of sexual behaviours he/ she had? (i.e., anal sex, vaginal sex, oral sex)
- ✓ When did these behaviours occur?
- ✓ Where did these behaviours take place?
- ✓ With whom did these behaviours take place?
- ✓ How often does he/ she have sex?
- ✓ Whether he/ she uses any protective measures during ALL sexual acts?



A simple way to introduce the topic is: “The symptoms you mention are often related to sexual behaviour. So I will now ask you some questions about this. I request you to be truthful so I can help you. What you say to me is only known to me and the doctor.”

One question about history taking and risk assessment is how far back to go with the questioning. This depends. Some STI like herpes are recurrent and their antecedent cause may be a few years ago. So a nice way to probe is “Have you ever...?” Based on the answers, decide the extent to which the client’s behaviour places him/ her at risk. In case of clients who do not report their own risk, assess the behaviour of the partner also. The information from the assessment will be used later for Risk Reduction.



One common mistake counsellors make is that when they have found the patient answering Yes to one question, they note that down and stop asking about other situations. So if a male patient answers Yes to the question of having sex with a sex worker, the counsellor may fail to ask questions about sex with a regular unpaid partner like the wife. Or if a woman answers about sex with the husband, the counsellor fails to probe about vaginal, anal and oral sex. It is a general rule: Ask EVERY client about EVERY behaviour!

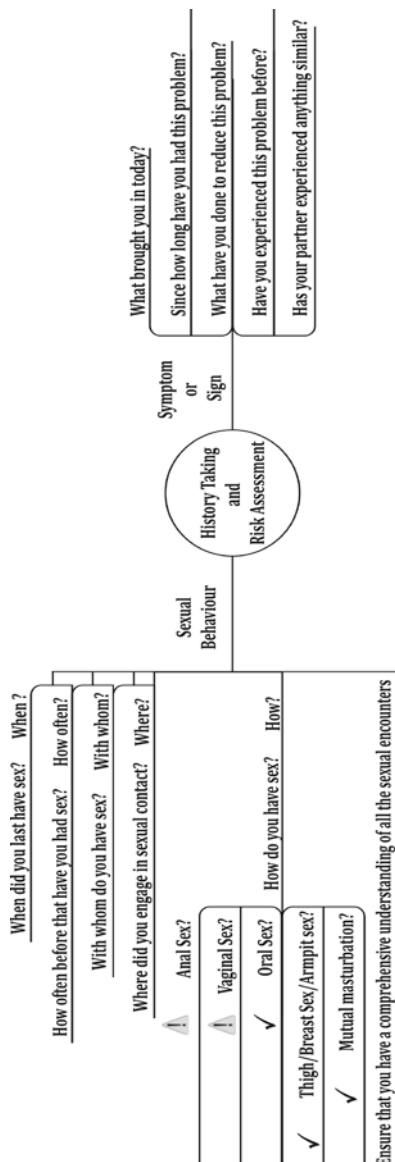
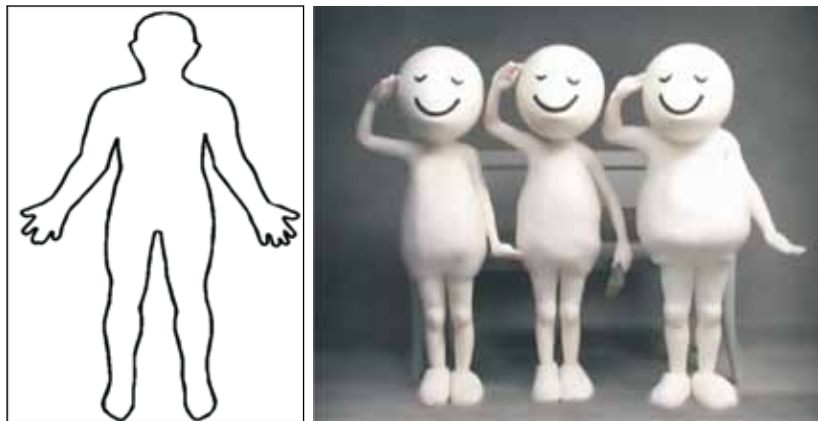
Make sure you ask about anal sex, vaginal sex and oral sex!



A good counsellor will ask the clients these difficult questions and record their answers without judging their character or morals. This is a key quality of counselling. Show by your language and your behaviour that you respect the client even if their behaviour does not match your personal standards or expectations. This is the counselling principle of being non-judgmental.

Some patients may have difficulty understanding even the most simple question. You can help them to understand what you mean by using a simple outline of the human body and pointing to it when you

ask your questions. Point to the mouth when you ask about oral sex. Point to the anal area when you ask about anal sex. When choosing an outline, make sure that it has no details that will embarrass the patient and cause him or her to avoid eye-contact during counselling. Here we show you 2 examples.



Let us recap the information we read so far on risk assessment by looking at the diagram on the next page. We see that history taking and risk assessment are processes that go together.

Even though we discussed history taking about reported symptoms first, we have shown it on the right-hand-side, and we have shown sexual behaviour assessment on the left. This is done to remind you that the behaviour is the cause of the problem/ symptom. Make sure that your patient also understands this.

Here you may also be able to see the funnelling technique, namely how you have to explore each branch in detail.

Will this risk assessment take time? Yes. It will. But it is central to STI counselling. You, the counsellor, CANNOT miss it. In the next couple of pages, we will explain how to use the information to reduce risk.

We focused mainly on sexual behaviours. We advise you not to start your risk assessment with questions about transmission through blood and blood products because some patients may be embarrassed to discuss their private behaviours. If the question about blood-related transmission is presented first, they may say Yes to avoid answering the later questions. But in such cases, your counselling will be incomplete because you may miss something very critical.

## Risk Reduction

So now you have completed your history taking and risk assessment. You will use the information you learned about the patient's life to give specific suggestions and guidance on how he/she could improve it:

- ✓ Namely how to get well,
- ✓ How to reduce getting infected again in future, and
- ✓ How to avoid infecting other people with the STI/ RTI : sexual partner(s), and, for pregnant women, unborn children.

For getting well, you, the counsellor will emphasize taking the full and complete treatment. You may request the patient to take the first dose in your presence.

But the next two items deal with the counselling technique of risk reduction.

### **Key points about Risk Reduction**

- ✓ In risk reduction, address each and every risk behaviour mentioned by the patient and give a specific suggestion for how to make it safer. So when you come to this part of the counselling session, it should be clear that you cannot make the same risk reduction suggestions to all patients. If a patient mentions 2 different types of risk behaviours, namely anal sex and vaginal sex, then make sure you cover both.



- ✓ Discuss the more risky behaviours first. One simple way to help patients reduce risk is to help them move down this upside-down triangle towards less risky behaviours.
  - ◆ For men who have anal sex with women, suggest replacing with vaginal sex where there is less friction, or with oral sex.

- ♦ For men who have anal sex with men, suggest replacing with oral sex
- ✓ For all kinds of sexual behaviours where there is penetration of one's person's sexual organs into another person (penis into anus, penis into vagina), strongly recommend the use of condoms.
  - ♦ Follow this with a condom demonstration on a penis model.
  - ♦ Recommend the use of non-penetrative sexual options: mutual masturbation, breast sex, thigh sex, armpit sex. Explain that when there is no exchange of bodily fluids infections cannot be transmitted sexually.
- ✓ Suggest that they should reduce the number of sexual partners
- ✓ Correct misinformation:
  - ♦ "I have sex with clean women (or men)."
  - ♦ "I have sex only with minor girls."
  - ♦ "I check my partner's body for infection."
  - ♦ "I do not ejaculate (discharge semen) inside my partner."
  - ♦ "I always wash myself carefully after having sex."
  - ♦ "I use two condoms during sex."
  - ♦ "I put something in my vagina to prevent infection."
- ✓ Use simple and clear language.
- ✓ Link your suggestions to what the patient told you: "You told me that you have anal sex. One way to reduce your risk here is to use a condom with a water-based lubricant." This will keep you from making generic statements like "You should have safer sex."
- ✓ Repeat and summarize so you can be sure the patient has had a chance to absorb the information.
- ✓ Ask questions to check whether they have understood.





**Questions for the Counsellor:**

- When you read the list of misinformed beliefs above, can you think of a way to correct these wrong beliefs?
- Review the sheets for the syndromic conditions in the unit on Syndromic Management of STI/RTI. Do you see risk reduction suggestions?

When you think of the stages of counselling, it will help you to remember that history taking and risk assessment are part of the first 2 stages of counselling. Risk reduction is part of the last two stages of counselling. At this point it should be clear that you will be using the skill of summarizing frequently.



**Exercise**

**The Right and Wrong Way**

Here are some risk behaviours. Explain which risk reduction dialogues are more suitable. You can choose more than one option. Explain also why you did not choose certain suggestions. Try to think of suggestions which have been missed.

Person 1 is a truck driver:  
I like to have anal sex with my truck cleaner. I sometimes have sex with prostitutes. Here too I prefer anal sex.

a) Don't drink alcohol.

b) Don't visit sex workers.

c) Stop having anal sex.

d) Reduce partners.

e) Use a condom in every sexual act.

Person 2 is a FSW:  
I always use condoms with clients when they have vaginal sex. Sometimes when the client pays extra I have anal sex.

f) Masturbate.

g) Try mutual masturbation.

h) Don't have sex.

Person 3 is a college student:  
I only have sex with my girl friend. She was my first lover. I was her first lover.

i) Try to replace anal sex with vaginal sex.

j) Have safer sex.

k) Try to replace vaginal sex with oral sex.



## Treatment-related Services

The third responsibility of the counsellor in the STI/RTI service is to act as an interface between the client and the provider, organize the treatment schedule, follow up, compliance to treatment, condom usage and partner management, syphilis screening and other lab tests for STI/RTI.

### ***Patient Education***

For this, you will have to do a lot of Patient education. Patient education involves explaining to a patient some specific things about his/ her condition:

- ✓ What caused it?
- ✓ What to do to treat it?
- ✓ What behaviours/ things to avoid?
- ✓ How to prevent it from being treated improperly or incompletely?
- ✓ What activities will interfere with proper treatment?
- ✓ How to avoid a relapse?
- ✓ What additional tests are required?

The counsellor will do a lot of information provision – but information provision specific to the patient's diagnosis.

### ***Organise the treatment schedule***

Educate the patient on the treatment prescribed – namely the dosage, number of pills per day, number of days of treatment and conditions under which to take the medicine (before/ after meals, foods to avoid, etc.)

### ***Follow up***

Ask the patient to come back after 3/7/14 days to inform about the outcome of treatment – whether the symptoms were relieved, difficulties in taking treatment, etc. During follow-up, repeat the messages about safer sex practices in all future sexual acts.

### ***Compliance to treatment***

Explain to the client very clearly that it is important to complete the treatment even if symptoms disappear. If symptoms stop, this does not mean, the STI has been cured. Some STI are treatable with just a single dose or an injection. But some require a longer patient effort.

In case of some medicines, there is a bad reaction if taken with other substances. If you are aware, prepare the patient so that they do not lose faith in the medicine. This is a counselling skill called anticipatory guidance.

Anticipatory guidance is a counselling skill where you prepare the patient for some situation that they might expect. For instance, anticipatory guidance is used to prepare young parents for the next developmental stage of their baby, students for public examinations or candidates for job applications. It is helpful whenever a person faces a new situation where they might be unprepared for what is to happen. The counsellor tells them what to anticipate or expect. Such a warning is expected to reduce the stress of the “unknown” and to be prepared to manage to stress of the “known.” Health professionals use the skill of anticipatory guidance to warn patients about how long medicine will take to act, the side-effects caused by the medicine (if taken alone or in combination) and the fact that occasionally symptoms may clear up before the disease is cured.

### ***Condom usage***

Condoms are made of latex or polyurethane. These materials are a barrier which prevents passage of sperm, STI organisms or HIV. So they protect the person wearing them from unplanned pregnancies and from infection of STI or HIV.

Every STI/RTI service must have sufficient stocks of condoms to give patients.

Every STI/RTI service counsellor must know how to explain the importance of condoms and must be able to demonstrate how the condom is to be worn. Explain to all STI patients that it is necessary to wear condoms in all sexual encounters unless one is in a relationship where both partners are completely sexually faithful to each other. This will not prevent unplanned pregnancy.

#### **General instructions for condom use:**

The condom does not include spermicide. If you want additional protection, you must add your own spermicide.

- ✓ Use a new condom EACH time you have sex.
- ✓ Use each 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 damaged.
  - ◆ The condom is dried-out.
  - ◆ The colour is uneven or has changed.
  - ◆ The condom is unusually sticky.








### ***Female Condom***

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

# CONDOM DEMONSTRATION - MALE

	<p><b>Step 1: Open package</b></p> <ul style="list-style-type: none"> <li>• Use a new condom each time you have sex</li> <li>• Check that it has not expired and that the packaging has no holes by pressing the pack between your fingers</li> <li>• Push condom to one side of package to allow room to tear open other side</li> <li>• Remove condom carefully</li> <li>• DO NOT use finger nails, teeth or sharp objects to open package or remove condom</li> </ul>
	<p><b>Step 2: Put it on</b></p> <ul style="list-style-type: none"> <li>• Squeeze closed top end of condom to make sure no air is inside (can make it break)</li> <li>• Place condom over top of erect penis</li> <li>• With other hand, unroll condom gently down the full length of your penis (one hand still squeezing top end)</li> </ul>
	<p><b>Step 3: During sex</b></p> <ul style="list-style-type: none"> <li>• Make sure condom stays in place</li> <li>• If it comes off, withdraw your penis and put on a new condom before intercourse continues</li> <li>• Once sperm has been released into condom (ejaculation), withdraw the erect penis and HOLD the condom in place on penis</li> </ul>
	<p><b>Step 4: Dispose of condom</b></p> <ul style="list-style-type: none"> <li>• Remove condom ONLY when penis is fully withdrawn</li> <li>• Keep both penis and condom clear from contact with your Partners body</li> <li>• Knot the end of the used condom</li> </ul>
	<ul style="list-style-type: none"> <li>• Place in tissue or bag before throwing it in dustbin</li> <li>• DO NOT flush condoms down the toilet. It will block the system.</li> </ul>

# CONDOM DEMONSTRATION - MALE

	<p><b>Before intercourse</b></p> <p><b>Step 1 : Open package</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul>
	<p><b>Step 2 : Put it in</b></p> <ul style="list-style-type: none"> <li>The closed end of the female condom will go inside your vagina. Squeeze the inner ring between your thumb and middle finger.</li> </ul>
	<p><b>Step 3 : Assure right position</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><i>Note: The lubrication on the female condom will make it slippery, so take your time to insert it.</i></p>
	<p><b>During sex</b></p> <p><b>Step 4 :</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>
	<p><b>After intercourse</b></p> <p><b>Step 5: Dispose of condom</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>Throw the female condom away. Do not reuse it.</li> </ul>

## **Partner management**

Partner management is an important part in control and prevention of STI/RTI. We need partner management to prevent:

- ✓ STI re-infection
- ✓ Further spread of STI
- ✓ Possible long term effects of untreated STI for the partner

Partners of infected patients may not seek STI services because

- ✓ They may not have symptoms
- ✓ They may not be aware of confidentiality assurances at the STI/RTI Service
- ✓ General embarrassment

So the counsellor must undertake this sensitive activity.

For all STI it is necessary to do partner management with sexual partners. Emphasize that all sexual partners should get checked for STI and should be treated if needed. While it may not be possible to track all partners, the primary partner or regular partner should be checked.

### **Approaches to Partner Management**

We will discuss two approaches to Partner Management:

- ✓ Referral by index client
- ✓ Referral by providers

#### **Referral by index client**

In this approach, the index client informs his/her partner(s) of possible STI/RTI infection. This approach does not involve extra personnel, is inexpensive and does not require any identification of partners. However, the index client requires much support from the staff of the STI/RTI service. A partner notification card with relevant diagnostic code should be given to each index client, where partner management is indicated. This approach may also include use of client-initiated therapy for all contacts.

The index client might approach partner treatment in the following ways:

- ✓ By directly explaining to the partner/s about STI and the need for getting treated
- ✓ By motivating and accompanying the partner/s to the treatment centre/ health care provider
- ✓ By asking the partner/s to attend the clinic without specifying the reasons
- ✓ By providing referral card to the partner/s and asking him/her to attend the clinic.

### **Referral by providers**

Here the STI service provider contacts the partner(s) of the index client through a partner notification card or through telephone calls. The information from the client is used confidentially to trace and contact partners directly. This approach needs extra staff and is expensive. Telephone calls are less expensive and do not require extra staff. Here, the person requiring psychological support and understanding is the sexual partner who is contacted.

### **Issues to be considered**

Telling a partner is often difficult as it can lead to conflicts and distrust in a relationship. Clients need to feel convinced that:

- ✓ The benefits are greater than the possible problems
- ✓ Partner notification and treatment is needed even if the partner does not show any symptoms
- ✓ The partner will be provided with confidential STI treatment services

### **How to make the client referral mechanism feasible**

To make referrals by the index client feasible the clinic must take the following steps:

- ✓ Make the patient take his/ her own STI/RTI treatment

This is important to treat the infection in the presenting patient.

- ✓ Help him/her understand how to avoid re-infection

Explain that it is possible to get infected again if STI is not treated in the sexual partner (s). Remember the patient is in a psychologically ready state to receive this message because they are keen to improve their health condition.

- ✓ Help him/her understand importance of possible transmission that might have occurred and further transmission

Explain that it is necessary to avoid re-infection during the treatment period (e.g., through temporary sexual abstinence or through using a condom) as well as to avoid re-infection in the long-term future (that is by treating sexual partners, and by using condoms in all sexual encounters). Sometimes patients say that they will simply change their sexual partner. In such a case, do not make a huge issue. Explain that they should still use condoms in all sexual encounters. But try to get details of the sexual partner so that a provider referral can be done.

- ✓ Help him/ her on how and what to communicate with partner(s)

It is difficult for any patient to tell a sexual partner that he/she has an STI. Possible reasons are stigma, embarrassment and guilt. You,



the counsellor must be encouraging and supportive. Help the patient to build courage for this task. Practise statements he/ she could use with the partner. Explain that the relationship may suffer damage but this damage need not be permanent. Explain that the act of getting the partner to treatment is an act of caring. One way to work through this difficult situation is to help them to tell their partner that both the infection and the relationship are important and should be addressed but that addressing the infection is more critical to health. Help the patient to explore ways they can repair the relationship if they are interested in such suggestions.

### ***Syphilis screening and other lab tests***

Encourage all patients coming to the STI/RTI Service to undergo syphilis and HIV testing. HIV tests may be available at the ICTC or at the general laboratory of the hospital. Most cases of syphilis and HIV infection are asymptomatic. Screening of these conditions will help to diagnose these conditions early, and the patient who is detected as having this condition can get the necessary treatment. The medical provider may recommend other laboratory tests to help with diagnosing the condition. You, the counsellor, must encourage the patient to undergo these tests and explain the reason for the same.

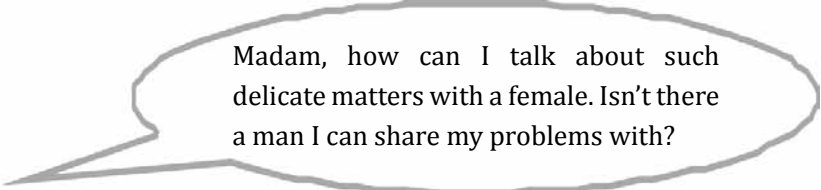
#### **Questions for the Counsellor:**

- Review the sheets for the syndromic conditions in the unit on Syndromic Management of STI/RTI. Do you see areas for patient education? Do you see areas for anticipatory guidance?

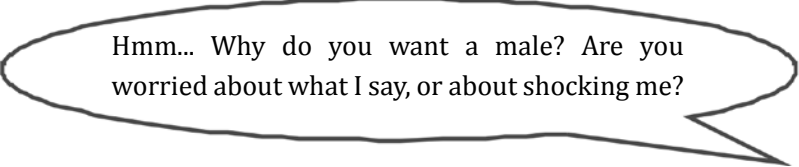


## Dealing with Shame and Guilt

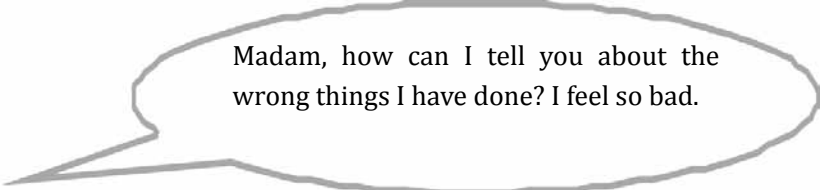
As STI are associated with sexual behaviour, one common emotional reaction in patients attending the STI/RTI service is a sense of guilt and shame. This is where the counsellor must play a supportive role. You can use the counselling skill of normalisation. In normalisation, the counsellor reassures the client that their reaction is normal and expected. Recognising that other people share an emotional state or a physical condition serves the function of helping the patient to relax. Begin first with recognising the emotional state of the client. Then, if the emotion expressed is common, explain carefully that many people in a similar situation feel the same way.



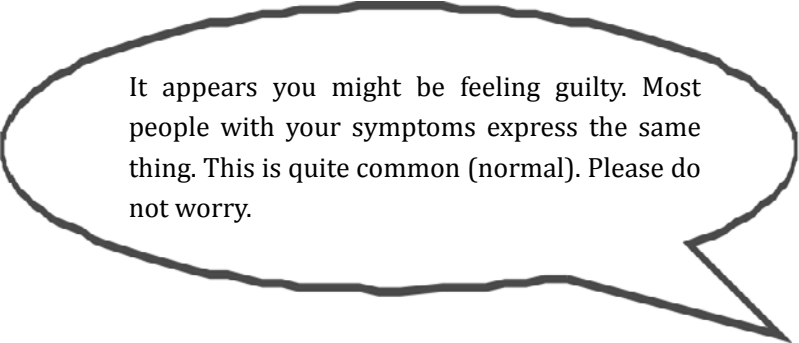
Madam, how can I talk about such delicate matters with a female. Isn't there a man I can share my problems with?



Hmm... Why do you want a male? Are you worried about what I say, or about shocking me?



Madam, how can I tell you about the wrong things I have done? I feel so bad.



It appears you might be feeling guilty. Most people with your symptoms express the same thing. This is quite common (normal). Please do not worry.

Normalisation is a counselling technique used to reassure clients that what they are experiencing by way of an emotional reaction, physical sensation or bodily function is experienced by other people in a similar situation, and is therefore normal. For instance, a young girl who is scared on the occasion of her first menstruation can be reassured that this has happened to other females also, and that she should, therefore, not worry. Another example is of a new mother who worries that she does not feel as maternal as other people expect her to be: She can be reassured that she is not alone in her emotional reaction, that sometimes child labour and the aftermath make it difficult to focus on anything other than one's own internal condition, and that her emotional reaction is likely to change after some time. A counsellor should normalize feelings and experiences. For instance, suicidal behaviour is an extreme step. Here the counsellor can reassure the person who voices feeling suicidal by saying, "It is common for a person at some time in their life to feel suicidal, like there is nothing that can be done to manage a life situation as complicated as yours. But suicide is a very extreme step. Let us see how we can do something to change your situation." Notice how the counsellor brought the conversation to action. What you should not normalize are actions that harm yourself and others. For instance, "It is common for people to feel angry to the point that they would like to injure the person causing the anger. However, we know that we cannot carry that thought into action. So let us explore an alternative action to take that expresses your anger in a safe manner."



## **References**

Morgan, D. (1998). Focus group kit: Planning focus groups. London, UK: Sage Publications.

National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2009). Training manual for counsellors at STI/RTI clinics. New Delhi, India: Author.

National Rural Health Mission & National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2011). Training of medical officers to deliver STI/RTI services. New Delhi, India: Author.

Vaz, M., Chitale, V., Nimla, D. & Dua, R. (2002). Telephone counselling for HIV/AIDS: A trainer's guide. Mumbai, India: Tata Institute of Social Sciences.

Welsby, P.D. (2002). Clinical history taking and examination. UK: Churchill Livingstone.

# LINKAGES AT THE STI/RTI SERVICE

**At the end of this unit, participants will be able to**

- List the key linkages the counsellor at the STI/RTI service should establish.
- Describe strategies for creating those linkages.

When you read the Terms of Reference of the counsellor at the STI/RTI service, you will notice some key communities and populations that are mentioned. Let us first list these and then describe them in detail:

- 1) Key populations or high-risk groups (HRG) (5th TOR)
- 2) Pregnant women (7th TOR)

These tell us the key linkages for the counsellor at STI/RTI Service:

- ✓ Targeted Intervention projects
- ✓ Integrated Counselling and Testing Centres
- ✓ Antenatal Services
- ✓ Sexual and Reproductive Health Services (SRH Services)

Let us examine each in detail.

## TI Projects

TI stands for Targeted Intervention projects. There are different types of TI projects run under the National AIDS Control Programme:

- ✓ Female Sex Workers
- ✓ Men who have Sex with Men
- ✓ Injecting Drug Users
- ✓ Truck Drivers
- ✓ Migrants

As you already saw in a previous unit, HIV/AIDS is associated with stigma and discrimination because it was seen in people whose behaviour is often condemned by general society, namely men who have sex with men, female sex workers and intravenous drug users. Members of these groups experience a lot of discrimination when they try to seek health services in a government hospital and this makes them less likely to visit services. However, their behaviours place them at risk of both HIV/AIDS and STI/RTI. TI projects are

specialized community-based organisations which try to reach out to these individuals and ensure that they receive health services.

A counsellor at the STI/RTI service needs to link up with these organisations because the communities they serve are likely to need STI/RTI services.

### **What the counsellor should do in relation to TI projects**

The counsellor's Terms of Reference state that she/he should ensure that every HRG client receives the essential STI/RTI service package including early diagnosis and treatment of current STI episode, quarterly regular check-up, presumptive treatment of sex workers and biannual syphilis screening by closely working with respective TI NGO and through outreach. Most HRG clients visit the ICTC for HIV testing. The counsellor at the STI/RTI service should use the opportunity to convert the ICTC visit to a session at the STI/RTI service as well. Provide all the essential services as mentioned below.

Here we see that people who use TI services are encouraged for:

- ✓ Regular medical check-up every 3 months
- ✓ Screening for syphilis every 6 months

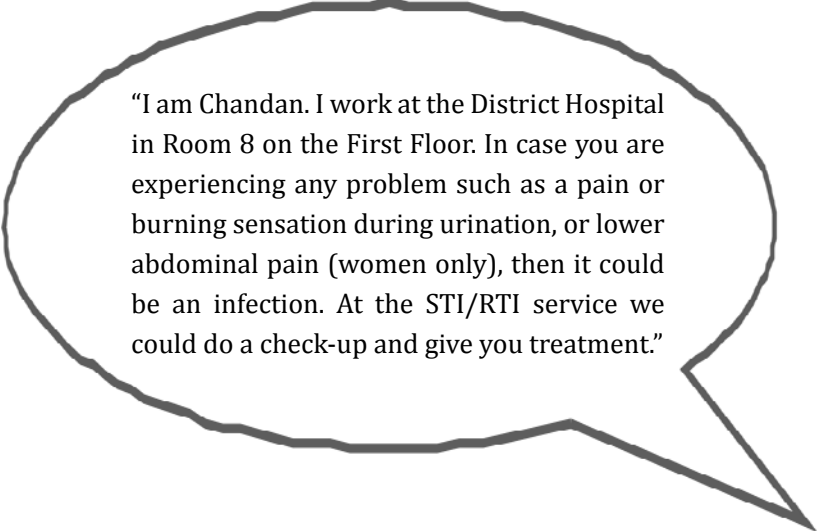
You, the counsellor at the STI/RTI service, should

- ✓ Maintain a list of all TI projects in your district with address and telephone numbers of key staff.
- ✓ Make sure that these TI projects know where the STI/RTI service is located, the timings and the services available.
- ✓ Keep in frequent contact with the TI projects.
- ✓ Do outreach to the TI projects once a week so that
  - ♦ You gain familiarity with the issues of the community members
  - ♦ They become familiar with your presence and become aware of the services of the STI/RTI service and the need to use them.
- ✓ Be present and be polite when TI project staff and/or TI members visit your centre for services.
  - ♦ While you should be accepting and respectful to ALL patients, you should recognize that members of TI communities are particularly distrustful of formal set-ups because of their past experience.
  - ♦ Be respectful.
  - ♦ Do a complete and thorough history, explaining that you are not asking them these questions out of idle curiosity but in order to help them.

- ✓ Remind them that special services are available to them, explain the need for these services.

### **What the counsellor should do during outreach to TI projects**

- ✓ Make a plan so that you visit one TI a week.
- ✓ Each week, visit a new TI till you have covered all the TI projects in your district. Then start all over with the first ones.
- ✓ Share your plan with your medical in-charge so that he/ she is aware of your work plans and movements.
- ✓ Visit the TI in the afternoon preferably:
  - ◆ It is likely that you will have out-patient duties in the morning
  - ◆ Many TI projects report that their members are asleep in the morning
- ✓ Telephone ahead to the TI project so that they are aware of your visit.
- ✓ Carry some form of identification when you visit the TI project.
- ✓ Carry some IEC materials if provided by the SACS. We recommend making a rubber stamp with the address of the hospital and the STI/RTI service and stamping these details on the IEC material.
- ✓ When you visit the TI project, make sure you understand their services completely.
- ✓ On subsequent visits, arrange to visit hot spots in the community **ALONG WITH** the TI workers.
- ✓ When interacting with community members, introduce yourself politely to HRG community members and explain your services:



“I am Chandan. I work at the District Hospital in Room 8 on the First Floor. In case you are experiencing any problem such as a pain or burning sensation during urination, or lower abdominal pain (women only), then it could be an infection. At the STI/RTI service we could do a check-up and give you treatment.”

- ✓ Remember what you learned about the stages of counselling. As this is the first contact with a potential client, it is very important to focus on rapport and building trust.
- ✓ Emphasize that you will provide confidentiality.
- ✓ Be prepared to answer questions on personal issues. You will notice in the previous dialogue, we did not ask individual questions because this is not the place to do so. However, if people in the community ask questions about their problems, then please be prepared to answer. Explain the connection between STI symptoms, STI and the possibility of treatment. Invite them to visit you in the hospital.
- ✓ Educate yourself about the issues of people using the TI projects.

## ICTC

ICTC stands for Integrated Counselling and Testing Centre. These are likely to be located at your hospital as well as at other sub-district health facilities in your district. You, the counsellor at the STI/RTI service, must explain and encourage HIV testing, establish referral services to other centres and network for expanded STI and HIV Care & Support - General Laboratory, ICTC, PPTCT, ART, CCC, and TB-HIV, etc.

Though the STI/RTI service examines and treats patients for STI and RTI conditions, it must also recognise that these individuals may also be at risk of getting HIV infection.

If your risk assessment shows sexual risk behaviours then

- ✓ respectfully explain the need for HIV testing
- ✓ explain how and where they can access an HIV test
- ✓ give them hope by explaining that there are treatment services available at the ART centre but that getting the HIV test done is the first step
- ✓ make a referral and be supportive towards the patient
- ✓ keep the door open in case the patient wants to wait a while to think this over
- ✓ check with the ICTC counsellor if the patient reached.

Remember that the ICTC based in the hospital is the most convenient according to you but patients have other options in the district. To make sure you are reaching the patients to the most convenient ICTC, carry a list of all ICTCs including Facility-based ICTCs (FICTC) in your district with their complete details. Also make sure that all the ICTCs in your district know where the STI/RTI service is located.

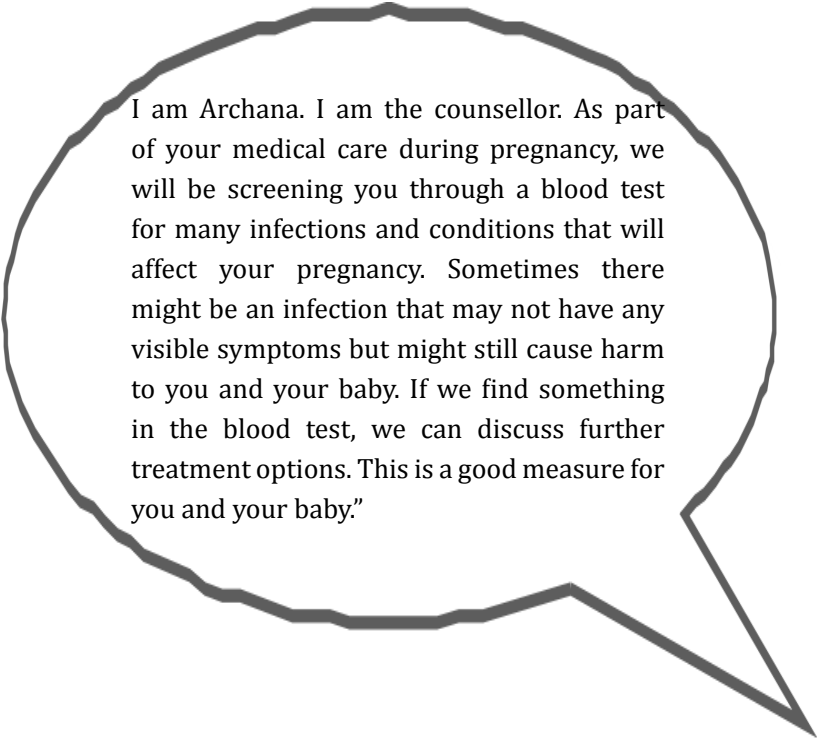


## Antenatal Services

If you recall the unit on Basic Factsheet of STI/RTI, you will remember that there is a high chance of a pregnant woman who is infected with such infection of transmitting the infection to the unborn child. So there is a need for screening and treating her to prevent transmission of infections to the new-born.

You, the counsellor at the STI/RTI Service must have a presence in the Gynaecology department as well as the Skin department. While the Skin department attends to people who seek services for STI, the Gynaecology department will have a high case load of pregnant women who are seeking antenatal care. Since many women who are infected with STI are asymptomatic, it becomes all the more important to ensure that they undergo the full package of ANC – antenatal care – which includes syphilis screening.

You may not be the only counsellor in the Gynaecology department. There might be an ICTC counsellor who is offering PPTCT services. PPTCT stands for Prevention of Parent to Child Transmission (of HIV). Just as STI/RTI might be transmitted to the unborn child, HIV might also be transmitted through the same route. Therefore, you should co-ordinate with the counsellor who provides PPTCT services in your district hospital, and offer testing for HIV as well as syphilis. Apart from treatment of the pregnant woman if she is eligible, there are drugs that can be given to the mother just before delivery and to the baby just after birth to reduce such transmission. These are life-saving measures that are available free-of-cost.



I am Archana. I am the counsellor. As part of your medical care during pregnancy, we will be screening you through a blood test for many infections and conditions that will affect your pregnancy. Sometimes there might be an infection that may not have any visible symptoms but might still cause harm to you and your baby. If we find something in the blood test, we can discuss further treatment options. This is a good measure for you and your baby."



In case the pregnant women are found to be carrying some infection during the ante-natal check-up make sure that you link them to the right service so that they can receive help. Do this linkage in a timely manner, and check later if the patient reached.

## **Sexual and Reproductive Health Services**

The patients who come to the STI/RTI Service may have other health needs. One such need is for sexual and reproductive health services. Here we describe some linkages that the counsellor should develop for some of these needs. For this, you should

- ✓ Prepare a local directory of the services available in your district/ city
- ✓ Make sure you have proper addresses and telephone numbers
- ✓ Give simple and clear instructions to the client about how to reach these services

### **Adolescent Reproductive and Sexual Health**

Earlier in this course you learned that adolescents are especially vulnerable to STI. You may meet many young people in your counselling practice. But your adolescents have many other health needs and your service may not be able to provide for all of them. So you should refer these young clients to the ARSH clinics which are specially set up by the Government to meet Adolescent Reproductive and Sexual Health needs.

### **Medical Termination of Pregnancy**

Some women who are pregnant may want to have an abortion. For this you should send them to the department in the hospital which provides abortion. It is also important to keep handy some contacts of private facilities in case the client prefers private services.

### **Post Pregnancy Needs**

A large number of your clients will be pregnant women. You may even meet some who come to you after delivery. Their needs might be related to the birth of their baby. Some may require help to prevent getting pregnant again. For this purpose, you should know where they can access such services as the contraceptive pill (Mala-D), copper-T, injectables or the condom.

### **Infertility Treatment**

When you learned about STI/RTI, you saw that one consequence of such syndromes could be infertility. This is a particularly devastating condition for many people who might like to have a child. For them, it is important to know where they can get their infertility examined and treated.

### **Erectile Dysfunction**

As you cannot discuss STI/RTI without talking about sex, it is possible that male patients may confide their sexual problems. One common problem is erectile dysfunction. Make sure you know where treatment is available for this condition and guide the person to the service properly.

### **Why should counsellors bother about these needs?**

When reading the list it may appear that some are not connected with STI/RTI. So counsellors may ask why they should bother about these needs.

- ✓ For this we remind you to review the stages of counselling. There you learned that the counsellor must identify the immediate and long-term needs of the patient. Treating the STI is the immediate need. But these other issues are long-term and must be addressed.
- ✓ It is the ethical responsibility of counsellors to give correct and timely information that can reduce the client's suffering and restore their health.
- ✓ Helping the patient with needs beyond STI/RTI will build confidence of the patient in the counsellor.
- ✓ Counsellors must learn to be non-judgmental about their clients.

#### **Questions for the Counsellor:**

- Do you know how to ask about additional health needs beyond STI/RTI?
- Do you have proper contact details for various services in your city/ district?
- Do you know how to guide clients properly to reach these services?



#### **References**

National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2009). Training manual for counsellors at STI/RTI clinics. New Delhi, India: Author.

National Rural Health Mission & National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2011). Training of medical officers to deliver STI/RTI services. New Delhi, India: Author.

# REPORTING AT THE STI/RTI SERVICE

**At the end of this unit, participants will be able to**

- List the reporting formats of the STI/RTI Service.
- Fill these reporting formats accurately.

The Terms of Reference of the counsellor at STI/RTI Service mention documentation very clearly:

- ✓ Patient-wise Documentation
  - ◆ Ensure documentation of history taking, counselling and risk reduction plans and filling up & maintaining patient-wise cards and clinic register.
- ✓ Monthly Documentation
  - ◆ Collect, compile reports on computer from both Gynae and STI OPDs and prepare & submit timely the monthly CMIS format in consultation with Medical Officer-in-charge
- ✓ Monitoring Supplies
  - ◆ Closely monitor the drug kit and condom consumption and place appropriate indent in consultation with Medical Officer-in-charge and other designated staff, if available

We have mentioned the TOR related to supply-monitoring because there is a format related to this activity.

To fulfil these reporting duties, there are 7 records that are maintained at the STI/RTI Service. These are partly filled by the medical officer and by the counsellor. But physically safeguarding them is the counsellor's responsibility. Further, they should be available for on-site data verification during any supervisory visit from officials of DAPCU, SACS or NACO.

1. Patient Wise Card
2. STI/RTI Register
3. Counsellor's Diary
4. Indent Form
5. Stock Register

## 6. Referral Form

## 7. STI/RTI Monthly Reporting Format

Let us examine each of these records in detail. But first we will see some common errors that counsellors make.

### Common Errors in Reporting

#### **Counsellors try to fill the reports at the end of the month**

Try to fill your reports regularly. The STI Master Register may also be updated once a week. Filling your records on a regular basis ensure that they do not become a burden for you, the counsellor. Well-maintained records reflect the good work of the team at STI/RTI Service.

#### **Counsellors first write in a rough register**

Sometimes we see counsellors maintaining a rough record and then writing it officially in neater writing. It is important for you to avoid such double-work. Make your work easier. We are not saying that neat writing is not important. But neatness should not come at the cost of maintaining timely reports.

#### **Counsellors use white ink in reports to correct mistakes**

Registers are an important official record. While mistakes are inevitable, use of white ink is a bad habit. It is suggested to simply strike through the wrong information neatly and write the correct facts like this:

*Wrong information*      *Right information.*

### Patient-wise Cards

#### **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 the service provider.
- 3) Write the patient ID number.
  - ♦ Write the patient ID number starting from 00001 and write consecutive numbers from April to March.
  - ♦ 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 the clinic during supervisory visits.

The STI/RTI service providers include.

- ✓ Providers at all designated STI/RTI and ObGyn clinics (health care facilities located at area/ district hospitals, teaching hospitals attached to medical colleges etc).
- ✓ Providers with targeted interventions providing STI/RTI services for high risk groups.

### Specific instructions

- 1) Write the date of visit under Date column
- 2) Check the following patient details
  - ✓ Check the appropriate box under Sex for-Male or Female or Transgender.
  - ✓ Under Age, write the completed years as reported by the patient.
  - ✓ In the New Client column, check "Yes" if the patient is a New client, i.e. attending that particular STI/RTI Service for the first time or with a fresh episode. Check "No" if the patient has visited that STI/RTI Service previously.
- 3) For Type of Visit, check the type of visit only AFTER the examination is completed
  - ✓ Check "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
    - ◆ A known herpes patients visits with recurrent infection, check New STI/RTI box
  - ✓ Check "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).

4) For Patient Flow

- ✓ Check “**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 “**Direct walk in**” if the patient attended the clinic directly.

5) Under STI/RTI risk assessment

- ✓ Check the appropriate box after taking the detailed “**Medical history**” from the patient.
- ✓ Check the appropriate box after taking the detailed “**Sexual history**”
- ✓ Check the appropriate box after conducting a detailed “**Physical examination**”
- ✓ Check the appropriate box after conducting detailed “**Internal examination**”
- ✓ Write the key points of significance from history in the box provided.

6) Under STI/RTI syndrome diagnosis

- ✓ Check the appropriate box as per the diagnosis made
- ✓ While making the syndrome diagnosis, **ONLY** the standardized definitions given will be followed
- ✓ The box should be filled in even if the diagnosis is made on clinical or etiological basis
- ✓ If the patients have more than one syndrome or condition, check all the appropriate syndromes and/or conditions diagnosed
- ✓ Given below are the detailed descriptions of the different syndromes:
  - ♦ **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).

- ♦ **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 genital 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).
- ♦ **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.
- ♦ **Lower abdominal pain (LAP):** Female with Lower Abdominal Pain or tenderness, or Cervical motion tenderness.
- ♦ **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.
- ♦ **Ano-rectal discharge (ARD):** Male, female or transgender with symptoms of tenesmus or if ano-rectal discharge seen on examination.
- ♦ **Inguinal bubo (IB):** Individuals with inguinal bubo and NO genital ulcer. (Syndromic or Clinical diagnosis of LGV should be included here).
- ♦ **Painful scrotal swelling (PSS):** Male or transgender (with intact genitalia) with painful scrotal swelling (primarily caused by infection of Gonococci and Chlamydia).
- ♦ **Genital warts:** Individuals with anal or genital warts.
- ♦ **Genital scabies:** Tick if patient is diagnosed as having genital scabies.
- ♦ **Genital Pediculosis:** Tick if patient is diagnosed as having genital pediculosis.
- ♦ **Genital molluscum:** Check the box if the patient is suffering with molluscum lesions over the genitalia.
- ♦ **Asymptomatic (Serological Syphilis):** Check the box if the patient is found serological syphilis.

- ♦ **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 asymptotically after not attending any clinical service for six consecutive months or more.
- ♦ **Other (specify):** Individuals attending with any other STI/RTI related condition.

7) Under Examination findings

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

8) Under Laboratory Tests Performed

- ✓ Summarize the findings of any of the laboratory tests performed in the appropriate boxes: RPR/VDRL Test, Gram Stain, KOH, Wet Mount and HIV.

- ✓ For RPR/VDRL test

- ♦ Check if Rapid Plasma Reagin (RPR)/VDRL test is conducted and found reactive.
- ♦ Write the highest titers reactive.

- ✓ For Gram stain

- ♦ Check the box for “ICDC” if urethral and endo cervical smears demonstrates >5 PMN/hpf and intracellular gram-negative diplococci inside polymorph nuclear cells.
- ♦ 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.
- ♦ Check the box for “None” if urethral smears demonstrates <5 PMN/hpf and no intracellular gram-negative diplococci inside polymorph nuclear cells.
- ♦ Check the box for “None” if endo cervical smears demonstrates <10 PMN/hpf and no intracellular gram-negative diplococci inside polymorph nuclear cells.
- ♦ 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).



- ✓ For KOH
    - ◆ 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.
    - ◆ Check the box for “Pseudohyphae”-If budding yeast/hyphae is seen under light microscope
    - ◆ Check the box “None”-if negative for whiff test and pseudohyphae.
  - ✓ For Wet mount
    - ◆ Check the box for “Trichomonads”-if Motile trichomonads seen under light microscope (10x).
    - ◆ Check the box for “Clue cells”-if Clue cells comprise more than 20% of all epithelial cells in any view under light microscope.
  - ✓ For HIV
    - ◆ Check the box for “Reactive”-if an HIV test is performed as per national HIV testing guidelines and declared as reactive
    - ◆ Check the box for “Non Reactive”-if an HIV test is performed as per national HIV testing guidelines and declared as non reactive
- 9) For **Details of STI/RTI Treatment Given** these are the critical points:
- ✓ This section has ‘four’ components: Kits, General Medicines, Drugs Used and Other Services Provided
  - ✓ For Kits
    - ◆ There are pre-specified colour coded kits starting from No 1 to 7.
    - ◆ Check the appropriate 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
  - ✓ For 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 under General Medicines. Treatment regimens should be in accordance to National Technical Guidelines for Managing RTI including STI ( August 2007).
- ✓ Any other drug administered or prescribed to patient which do not fall into any of the mentioned categories would also be mentioned here.

10) Under **Other Services Provided** there are 4 subsections that are basically concerned with non-medical interventions that round out the service given to patients.

- ◆ Under **Patient education**, check the relevant box if the individual patient is provided counselling on Partner(s) treatment, Condom usage and disposal, and on Other risk reduction communication.
- ◆ Under **Partner treatment**, check the relevant box for each of the following: Prescription written or Medications given.
- ◆ Under **Condoms**, check all the relevant boxes for: Condom given free, Sold (Social marketed), Prescribed and/or Demonstrated

All clinics should have a penis model for demonstration purpose.



- ✓ Under Referrals,
  - ◆ Check the relevant boxes if referrals have been made to ICTC, PPTCT, DMC, Care and support centre, ART centre, PLHA networks, etc.
  - ◆ In case of referrals to other agencies, then check this box, and specify the place of referral.
  - ◆ Always get feedback of the referral and document this 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.
- ✓ Check IEC **materials given**, if take-home IEC material is provided.
- ✓ Check **Append with results if any other tests performed** if such is the case and append the copies of these test(s) results

# 1. STI/RTI Patient Wise Record

1. STI/RTI Patient Wise Record			
NATIONAL AIDS CONTROL ORGANIZATION STI / RTI PATIENT WISE RECORD			
Provider Name Clinic Name Clinic Unique ID Number	Patient ID Number: Patient OP Number		
<b>Date</b>	<b>Patient Detail</b> Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Age New Client <input type="checkbox"/> Yes <input type="checkbox"/> No Type of visit <input type="checkbox"/> New STI/RTI <input type="checkbox"/> Repeat STI/RTI Patient flow <input type="checkbox"/> Referred <input type="checkbox"/> Direct walk in	<b>STI / RTI Risk Assessment</b> <input type="checkbox"/> Medical History taken <input type="checkbox"/> Sexual History taken <input type="checkbox"/> Physical examination conducted <input type="checkbox"/> Speculum and/or Proctoscopic exam conducted <input type="checkbox"/> Significant points in bullets <b>Examination findings:</b>	<b>STI / RTI syndrome diagnosis</b> <input type="checkbox"/> Vaginal Cervical Discharge <input type="checkbox"/> Genital pediculosis <input type="checkbox"/> Genital warts <input type="checkbox"/> Lower Abdominal Pain <input type="checkbox"/> Asymptomatic (serological syphilis) <input type="checkbox"/> Presumptive treatment <input type="checkbox"/> Others (specify)-
		<b>Lab Test Performed</b> RPR <input type="checkbox"/> Reactive <input type="checkbox"/> Titre Gram Stain <input type="checkbox"/> ICDC <input type="checkbox"/> WBC <input type="checkbox"/> None Nugent's score+Ve <input type="checkbox"/> Whiff test +ve <input type="checkbox"/> Pseudohyphae/Spores <input type="checkbox"/> None Wet Mount <input type="checkbox"/> Motile Trichomonads <input type="checkbox"/> Clue Cells <input type="checkbox"/> None HIV <input type="checkbox"/> Reactive <input type="checkbox"/> Non reactive	
	<b>Details of STI/RTI treatment given</b> Kits (If available) <input type="checkbox"/> Kit 1 (Grey) <input type="checkbox"/> Kit 2 (Green) <input type="checkbox"/> Kit 3 (White) <input type="checkbox"/> Kit 4 (Blue) <input type="checkbox"/> Kit 5 (Red) <input type="checkbox"/> Kit 6 (Yellow) <input type="checkbox"/> Kit 7 (Black) General Medicines <input type="checkbox"/> Adrenaline <input type="checkbox"/> Antihistamines <input type="checkbox"/> Hydrocortisone <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Metaclopramide <input type="checkbox"/> Ranitidine Drugs used (If KITS are not available) <input type="checkbox"/> Acyclovir 400 mg <input type="checkbox"/> Amoxicillin 500 mg <input type="checkbox"/> Azithromycin 1 gm <input type="checkbox"/> Benz Penicillin 2.4MU <input type="checkbox"/> Benzyl benzoate 25% <input type="checkbox"/> Cefixime 400 mg <input type="checkbox"/> Ceftriaxone 250 mg & 1 gm <input type="checkbox"/> Ciprofloxacin 500 mg <input type="checkbox"/> Clotrimazole 500 mg <input type="checkbox"/> Doxycycline 100mg <input type="checkbox"/> Erythromycin 500 mg <input type="checkbox"/> Fluconazole 150mg <input type="checkbox"/> Metronidazole 400 mg <input type="checkbox"/> Secnidazole 500 mg	<b>Other services provided</b> Patient education <input type="checkbox"/> Partner treatment <input type="checkbox"/> Condom Usage <input type="checkbox"/> Other risk reduction Partner treatment <input type="checkbox"/> Prescription written <input type="checkbox"/> Medication given Condoms <input type="checkbox"/> Given free <input type="checkbox"/> Sold / Social Marketed <input type="checkbox"/> Prescribed <input type="checkbox"/> Demonstrated	Referrals <input type="checkbox"/> ICTC <input type="checkbox"/> PPTCT <input type="checkbox"/> Designated <input type="checkbox"/> Microscopy centre <input type="checkbox"/> Care and Support <input type="checkbox"/> ART centre <input type="checkbox"/> PLHA network <input type="checkbox"/> Others (specify) <input type="checkbox"/> IEC material given <input type="checkbox"/> Append results if any other tests performed

## 2. STI/RTI Register

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-Herpetic 3=GUD-Non Herpetic 4=Vaginal-cervical discharge 5=Inguinal Bubo 6=Gential Scabies 7=Ano-rectal Discharge 8=Gential 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 (P/walk in (W) or Referred then specify	STI/RTI Syndrome diagnosis	Treatment Provide		Condoms	Partner Management		Referred to	Lab investigations			
									Kit (if available) Specify kit number	Drugs Prescribed		Counselling Done: Yes /No.	Number of pieces provided		Partner Notification 1-Yes, 2 No	Partner managed 1-Yes, 2 No	Outcome of referral	RPR test
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
11																		
12																		
13																		
14																		
15																		
16																		
17																		
18																		
19																		
20																		
21																		
22																		
23																		

### 3. Counsellor's Diary

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

4. Indent Form							
Name of the Hospital :							
Clinic Unique ID number:							
SI 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





## STI/RTI Referral Form

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 counsellor/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/Counsellor/Lab In-charge



## STI/RTI Monthly Report

### 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

### Who should fill this?

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

- ✓ Providers at all designated STI/RTI clinics: They will fill Sections 1, 2, 3, 5, 7 and 8. STI/RTI Services that also have a Laboratory service should fill Section 6.
- ✓ Targeted Interventions providing STI/RTI services for High Risk Behaviour Groups: They will fill Sections 1, 2, 3, 4 and 7.

### Specific instructions

#### 1) Under the General Information column

- ✓ Fill the **Unique ID** as provided by your SACS
- ✓ Fill the name of your hospital or institution in the column Name of the STI/RTI Clinic/Gynae OPD/TI NGO
- ✓ Fill the data required in the column Address of STI/Gynae Address including state, city, district, Block/Mandal and pin code.
- ✓ For Reporting period, write the Reporting month and year in the form of MM and YYYY. For example: the data for the month January, 2011 would be reported in February 2011. So the reporting month is 01 and year is 2011.
- ✓ In the sections Name and phone number of the Officer in-charge, fill the details of the medical officer who is in charge of the STI/RTI Service

## 2) For Section 1: No. of Patients availed STI/RTI services in this month

- ✓ General Instructions
  - ◆ This section 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 the appropriate age and sex category
  - ◆ Fill in the total number of STI/RTI visits under the specific category as per the descriptions below.
- ✓ Under Clinic visit with STI/RTI complaints and were diagnosed with STI/RTI, fill the number of individuals who visited with any STI/RTI complaints as per the STI/RTI patient-wise card and who were treated. This indicates fresh STI/RTI episodes.
- ✓ Under Clinic visit with STI/RTI complaint but were NOT diagnosed with an STI/RTI, fill the number of individuals who visited with any STI/RTI complaints as per the STI/RTI patient-wise card but were not diagnosed with STI/RTI.
- ✓ Under Clinic visit for syphilis screening (Exclude ANC), mention the total number of patients who came for syphilis screening to STI/RTI Services WITHOUT including ANC attendees.
- ✓ For TI-NGOs-RMC, PT, Syphilis Screening (whichever applicable) is a section that will be filled only by TI-NGOs.
  - ◆ Fill here all those HRG (without diagnosed STI/RTI) who attend the STI clinic for Regular Medical Check-up (RMC), Presumptive Treatment (PT) and Syphilis screening\*
  - ◆ \*If any HRG attending for RMC or syphilis screening or PT is found to have an STI/RTI, they should be entered in row 1 only.
  - ◆ If any HRG availing more than 1 service (eg RMC + Syphilis screening, PT + syphilis screening, Symptomatic STI + Syphilis screening) they should be entered only once in one row based on his/her having an STI/RTI or not.
- ✓ In the section **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)

- ✓ For **Age group and Sex**: Fill the number of individual availed STI/RTI services under appropriate categories
- ✓ **Total no. of visits** is auto-calculated in the software. The total gives total attendance of individuals at STI/RTI clinic.

### 3) For Section 2: STI/RTI Syndromic Diagnosis

- ✓ General instructions
  - Should be reported by all STI/RTI service providers
  - Should be filled for persons with STI/RTI complaints who made a clinic visit and who were diagnosed with STI/RTI only (Section 1 Row 1)
  - Should be filled when Diagnosis could be reached on syndromic/clinical/etiological basis
  - Consolidated number of STI/RTI patients diagnosed with the following syndromes should be filled up: Vaginal/Cervical Discharge, Genital Ulcer Disease (GUD) Non Herpetic, Genital Ulcer Disease (GUD)-Herpetic, Lower Abdominal Pain (LAP), Urethral Discharge (UD), Ano-rectal Discharge (ARD), Inguinal Bubo (IB), Painful Scrotal Swelling (SS), Genital warts, Other STIs, Serologically +ve for syphilis.
  - Vaginal/Cervical Discharge (VCD) is applied for the following cases: 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)
  - Genital Ulcer Disease (GUD)-Non Herpetic is applied for the following cases: Female or male or transgender with genital or anorectal ulceration and with NO blisters (vesicles). (All STI syndromic, clinical or etiological diagnosis relating to genital 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)

- ♦ Genital Ulcer Disease (GUD)-Herpetic is applied for the following cases: Female or male or transgender with genital or anorectal blisters (vesicles) with ulcers or recurrence primarily caused by herpes simplex virus type 2.
- ♦ Lower Abdominal Pain (LAP) is applied for the following cases: Female with Lower Abdominal Pain or tenderness, or Cervical motion tenderness
- ♦ Urethral Discharge (UD) is applied for the following cases: Male or transgender with intact genitalia with Urethral Discharge with or without dysuria or other symptoms
- ♦ Ano-rectal Discharge (ARD) is applied for the following cases: Male, female or transgender with symptoms of tenesmus or if ano-rectal discharge seen on exam
- ♦ Inguinal Bubo (IB) is applied for the following cases: Individuals with inguinal bubo and NO genital ulcer. (Syndromic or Clinical diagnosis of LGV should be included here)
- ♦ Painful Scrotal Swelling (SS) is applied for the following cases: Male or transgender (with intact genitalia) with painful scrotal swelling (primarily caused by infection of Gonococci and Chlamydia)
- ♦ Genital warts is applied for the following cases: Individuals with anal or genital warts.

#### **4) For Section 3: Details of Other Services provided to patients attending STI/RTI clinics in this month**

- ✓ General instructions:
  - ♦ 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.
- ✓ For Number of patients counselled, fill the total number of persons attending at the STI/RTI clinic who were provided STI/RTI counselling.
- ✓ For Number of condoms provided, fill the total number of condoms provided to the persons attending at the STI/RTI clinic.
- ✓ For Number of RPR/VDRL tests conducted, fill the total number of RPR/VDRL tests conducted for persons attending at the STI/RTI clinic.

- ✓ For Number of patients found reactive, fill the number detected reactive on the RPR/VDRL test of the above.
- ✓ For Number of partner notification undertaken, fill the total number of partner notifications undertaken of index STI/RTI patients treated.
- ✓ For Number of partners managed, fill the total number of partners of index STI/RTI patients who also attended the clinic and received services appropriate to their situation.
- ✓ For Number of patients referred to the ICTC, fill the number of persons attending at the STI/RTI clinic who were referred to the ICTC.
- ✓ For Number of patients found HIV infected (of above), fill the number detected as HIV-reactive from the Number of patients referred to the ICTC.
- ✓ For Number of patients referred to other services, fill in the number of persons attending at the STI/RTI clinic who were referred for any other services like care and support, tuberculosis screening etc.

#### 5) Section 4: STI/RTI Service for HRGs

- ✓ Should be filled by the TI-NGO providing services to high risk behavior group (HRG).
- ✓ For Number of new individuals visited the clinic,
  - ◆ Fill in the total number of new HRG 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.
- ✓ For **Number of presumptive treatment (PT) provided for Gonococcus and Chlamydia**, fill in the total number of HRG individuals 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 (2007).
- ✓ For Number of regular STI check-ups (RMC) conducted,
  - ◆ Fill in the number of HRG individuals who attended the clinic for STI/RTI services without being symptomatic and who 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.

#### **6) Section 5: ANC Syphilis Screening in this Month**

- ✓ Should be filled by all NACO-designated STI/RTI clinics.
- ✓ The data should be drawn from the records of the ANC clinic in the hospital.
- ✓ Should ONLY include Information for women making the first visit for ANC.
- ✓ For Number of ANC first visits in the month (Registration), write the number of pregnant women registered for the first time with the ANC clinic during the month.
- ✓ For Number of RPR/VDRL tests Performed, write the number of registered pregnant women undergone RPR/VDRL test during the month\*
- ✓ For Number of RPR/VDRL tests reactive (qualitative), write the number of pregnant women found reactive for RPR/VDRL test\*, of the Number of RPR/VDRL tests Performed
- ✓ For Number of RPR/VDRL tests reactive  $\geq 1:8$  (quantitative), write the number of pregnant women whose RPR/VDRL test\* titre is  $\geq 1:8$ , of the above.
- ✓ For Number of pregnant women treated for syphilis, write the number of pregnant women diagnosed with syphilis who have undergone treatment

#### **7) Section 6: Laboratory Diagnosis of STI/RTI**

- ✓ Should be filled by all NACO-designated STI/RTI clinics.
- ✓ The data in this section should not include ANC syphilis screening.
- ✓ 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).
- ✓ For 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)
  - ♦ For RPR test reactive  $\geq 1:8$ , fill in the number of

RPR/VDRL tests reactive at or above 1:8 titres among men, women and others\*, of the Total RPR/VDRL test performed.

- ✓ For Total Gram stain performed, fill in the total number of gram stain performed among men (urethral smear) and women (endocervical smear and vaginal discharge smear)\*
  - ♦ For Gonococcus +ve, fill in the 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

Indicator Definition/Explanation

- ♦ For Non Gonococcal Urethritis/cervicitis-Pus cells +, fill in the 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

- ♦ For Nugent's +ve, fill in the number of smears positive for Nugent's score. Nugent's score is positive when the score is between 7 to 10
- ✓ For Wet mount tests performed, fill in the total number of wet mounts performed among women
  - ♦ For Motile trichomonads +ve, fill in the number of wet mounts that demonstrated Motile trichomonads seen under light microscope (10x)
  - ♦ For 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
  - ♦ For 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
  - ♦ Fill None, when none of the above-mentioned tests are positive

- ✓ For KOH test performed, fill in total number of KOH tests performed among women
  - ◆ Under Candidiasis+, fill in the number of KOH slides that demonstrated budding yeast/hyphae under light microscope
  - ◆ For None, fill in the number of KOH slides that have not demonstrated budding yeast/hype under light microscope
- ✓ Under 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).

## 8) 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
- ✓ Opening Stock is auto calculated in the software. This gives number of STI/RTI drug kits/reagent/RPR, TPHA test kits available on the first day of the month.
- ✓ Under Number received in this month, write the number of STI/RTI drug kits/reagent/RPR, TPHA test kits received during the month.
- ✓ Under Number consumed, write the number of STI/RTI drug kits/reagent/RPR, TPHA test kits utilised or distributed during the month.
- ✓ Under Damage/Wastage, write the number of STI/RTI drug kits/reagent/RPR, TPHA test kits wasted or damaged during the month.
- ✓ Closing stock 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.
- ✓ Stock sufficient for approximate month 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.



- ✓ Under 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
- ✓ Under Quantity, write the quantity of the drug kit, condom and reagent kit having earliest expiry date

### 9) 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
- ✓ Under **Medical Officer/s**, fill the following details: 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
- ✓ Under **Staff Nurse**, fill the following details: 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
- ✓ Under **Lab Technician**, fill the following details: 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
- ✓ Under **Counsellor**, fill the following details: 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

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																
<b>Total No of visits</b>																

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			Total
	Male	Female	TS/TG	
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				
Nugent's 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					



## References

National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2009). Training manual for counsellors at STI/RTI clinics. New Delhi, India: Author.

National Rural Health Mission & National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India (2011). Training of medical officers to deliver STI/RTI services. New Delhi, India: Author.

# DATA ANALYSIS

## Facility level dashboard indicators

Name of DSRC				
Quarter: April to June				
		April	May	June
Average footfall per each working day		0		
% of male symptomatic attending DSRC		0%		
VCD:LAP		0/0		
GUD:UD (Males)		0/0		
% of STI attendees screened for Syphilis		0%		
% of STI attendees missing Syphilis screening		0%		
% of Sero-reactivity of Syphilis among STI attendees		0%		
% of attendees ANC undergoing Syphilis screening (ANC)		0%		
% of attendees ANC Missing Syphilis screening (ANC)		0%		
% Seroreactivity of Syphilis among ANC attendees		0%		
% of ANC syphilis seroreactive individuals treated		0%		
% of STI attendees referred for HIV testing		0%		
% Seroreactivity of HIV among referred STI attendees		0%		
% of STI attendees undergoing Presumptive Treatment (PT)		0%		
% of STI attendees undergoing regular medical checkup (RMC)		0%		
Stock sufficient for how many months and earliest expiry date of drug kits and test kits	RPR tests			
	Pre-packed STI Kit 1			
	Pre-packed STI Kit 2			
	Pre-packed STI Kit 3			
	Pre-packed STI Kit 4			

Name of DSRC				
Quarter: April to June				
		April	May	June
Stock sufficient for how many months and earliest expiry date of drug kits and test kits	Pre-packed STI Kit 5			
	Pre-packed STI Kit 6			
	Pre-packed STI Kit 7			
	Condom Pieces			

Key DSRC monthly statistics as per NACO CMIS					
S. No	Indicator	April	May	June	July
1	Total no of STI/RTI episodes managed				
2	Total no of first clinic visits for STI/RTI				
3	Total no of syndromes diagnosed				
4	Number counselled				
5	Percentage counselled				
6	No of partners notified				
7	No tested for syphilis				
8	No found positive of above				
9	No treated of above				
10	No of ICTC referral				
11	No found positive				
12	No pre-ART registered				
13	Total number of ANC visits				
14	Total no of ANC syphilis screening				
15	No found positive of above				
16	No treated of above				

