Clinical Guidelines

Targeted STI Services
Modhumita: The New "Gold Standard" In Clinical Services

Modhumita is a name associated with Drop In Centers that offer high quality STI care targeted to high risk populations. It is a concept that represents the "Gold Standard" in quality clinical services. The logo and slogan "বদ্ধু কাছে মনের কথা!" captures the essence of excellence in STI care, treatment, and services. This requires a quality client centered approach that will include: teaching people about STI, HIV and AIDS risk assessment; promoting monthly STI checkups irrespective of symptoms and signs; ensuring clients are offered safe clinical assessment with appropriate diagnosis and treatment; ensuring that all clients are offered STI and HIV counselling, advise on compliance with medication, condoms and help with partner notification and treatment; provision of effective prevention strategies such as behavior change; and effective program and clinic management responsive to the needs of the target population.

All of the services that Modhumita Drop in Centers will offer will reflect the essence of a true friend; a friend with whom the clients can share every intimacy in confidence and feel welcomed and cared for. It is that vital blend of excellent medical services and sincere, heartfelt empathy for targeted high risk clients that will be the gold standard in quality STI care. Realization of this standard is simply not possible without you.
Targeted STI Services

Clinical Guidelines
Special thanks to the managers and staff of BWHC HBSW project in Dhaka who helped develop and field test many of the tools and standards presented in this guide.

Additional thanks to the representatives of the UNICEF, HAPP programme and all the NGOs operating under this programme for their inputs into the clinical and record keeping elements of this guide.

The clinical guidelines are based on the National Recommendations for STI Case Management: High Risk Groups, approved in 2004 by the National AIDS/STD Programme (NASP), Directorate General of Health Services, Ministry of Health & Family Welfare, Bangladesh.
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral Drugs</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communications</td>
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<td>DIC</td>
<td>Drop In Centre</td>
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<tr>
<td>DOT</td>
<td>Directly Observed Therapy</td>
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<tr>
<td>ESM</td>
<td>Enhanced Syndromic Management</td>
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<td>FA</td>
<td>Facility Assessment</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FO</td>
<td>Finance Officer (FHI)</td>
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<td>FSW</td>
<td>Female Sex Worker</td>
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<td>GH</td>
<td>General Health</td>
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<td>GO</td>
<td>Governmental Organisation</td>
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<td>HBSW</td>
<td>Hotel based Sex Worker</td>
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<td>HCW</td>
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<td>HIV</td>
<td>Human Immuno Deficiency Virus</td>
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<td>IA</td>
<td>Implementing Agency</td>
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<td>IDU</td>
<td>Injecting Drug User</td>
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<td>Monitoring and Evaluation</td>
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<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MSCS</td>
<td>Marie Stopes Clinic Society</td>
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<td>MSM</td>
<td>Men who have Sex with Men</td>
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<td>Male Sex Worker</td>
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<td>NASP</td>
<td>National Aids and STI Programme</td>
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<td>NGO</td>
<td>Non Governmental Organisation</td>
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<td>OW</td>
<td>Outreach Worker</td>
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<td>PE</td>
<td>Peer Educator</td>
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<td>PHA</td>
<td>Person or People Having HIV/AIDS</td>
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<td>PM</td>
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<td>PO</td>
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<td>PPT</td>
<td>Periodic Presumptive Treatment</td>
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<td>QAT</td>
<td>Quality Assurance Team</td>
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<td>RPR</td>
<td>Reactive Plasma Reagin</td>
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<td>Street Based Sex Worker</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>SWOT</td>
<td>Strengths Weaknesses Opportunities Threats</td>
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<td>TO</td>
<td>Technical Officer (FHI)</td>
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<td>UP</td>
<td>Universal Precautions</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<td>WR</td>
<td>Waiting Room</td>
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These clinical guidelines are for doctors and nurse-counsellors providing STI services in all FHI-assisted DICs. The diagnostic flow charts and treatment regimes are based on the NASP recommendations for targeted STI interventions. This manual complements the Minimum Standards: Targeted STI Services and Toolkit: Targeted STI Services.
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1

GENERAL APPROACH TO STI CASE MANAGEMENT

THE NEW APPROACH TO STI CASE MANAGEMENT

All male and female sex workers and other high risk persons:
• Attend the STI clinic on a monthly basis for a full sexual health check up.
• Receive a full sexual history and safe sexual health examination when they attend the STI clinic. This includes a speculum examination for women and, when indicated proctoscope examination for men and women.
• Receive presumptive treatment for Gonococcal and Chlamydial infection at their first visit.
• Receive, after seeing the doctor, STI and HIV counselling; condoms and condom demonstration; advice on compliance with treatment; and advice on contact tracing.
• Are treated with single dose highly effective antibiotics (where possible and appropriate).
• Are treated according to the new STI flowcharts.
• Are treated in a friendly, respectful, tolerant and non-judgmental manner at all times.
• Can be assured of complete confidentiality of medical information at all times.

REFERRAL

• Refer clients to a specialist whenever there is an STI case with complications and whenever the doctor is unsure about the diagnosis.
• Make sure that clients referred for VCT receive pre-test and post-test counselling from a counsellor who has been trained in HIV counselling and VCT.
• Keep information about clients referred for VCT, and test results, confidential. See STI Case Management Tool 2: Referral services for information and contacts.
• Refer clients at high risk of Hepatitis B (sex workers, MSM and IDU) who have not had a Hepatitis B vaccination, for serology and vaccination where possible.
FOLLOW UP

- Ask clients with uncomplicated cases of vaginal discharge, cervicitis/vaginitis and UDS to return if symptoms do not go away or recur.
- Follow up clients with genital ulcer, PID, scrotal swelling and inguinal bubo until the ulcer heals or symptoms resolve. If possible, GUD should be followed up with 3 monthly RPR.
- Follow up complicated cases of any STI until the client is well or referred to a specialist.
WELCOME YOUR CLIENT

Greet clients, offer a seat, sit near enough to talk comfortably and privately. It is better to sit at right angles to a client rather than on the other side of a desk or table. Use a welcoming tone of voice and avoid intimidation with authority.

ENCOURAGE YOUR CLIENT TO TALK

Look at the client when you talk, ask questions, nod as they speak, say 'mmm hmmm' or 'tell me more about that'. These 'encouragers' show you are listening and are interested.

LOOK AT YOUR CLIENT

Looking at clients helps them to talk more comfortably. Have a warm and friendly expression on your face.

LISTEN TO YOUR CLIENT

Listen carefully to what your client has to say. Use encouragers to show you are interested in their story.
SEXUAL HISTORY FOR MALES AND FEMALES

GENERAL POINTS

• Take a sexual history from every client attending the clinic. Taking a good sexual history is essential, as it ensures that you are not making assumptions about the client.

  Example 1: When taking a history from a man who has sex with men, it is not helpful to simply label him 'KOTI' as this assumes that the client only has receptive anal intercourse with other men. He may, for example, also have insertive anal intercourse with men and women.

  Example 2: When taking a history from a female sex worker, remember that she may have different sexual practices with her regular partner than with her clients, and may also have sexual contact with other women.

• Collect detailed data on sexual practices once the doctor has established rapport with the client.

• Ensure client privacy throughout the consultation.

• Use vernacular words rather than technical terms.

• Ask open-ended questions but do not be afraid to be direct in order to obtain clear answers.

SYMPTOMS

Explore symptoms described by the client that may indicate the presence of an STI. These may be volunteered by the client or discovered by direct questioning. They include:

• Genital ulceration
• Vaginal discharge
• Skin rash

• Urethral discharge
• Sore throat or mouth
• Lymphadenopathy
Symptoms that are of particular importance in MSM include:

- Symptoms of viral hepatitis
- Diarrhoea
- Peri-anal pain
- Constipation
- Anal discharge
- Psychosexual issues

**STI HISTORY**

Explore past history of STI, including:

- Previous sexual health issues or diagnoses
- Knowledge of STI and HIV risk factors
- Whether the client has received vaccination for Hepatitis B
- Symptoms and diagnoses in recent sexual partners

**SEXUAL BEHAVIOUR**

Explore sexual behaviour to find out about factors that may affect the client's sexual health. Ask about:

- Last sex contact with other partner(s)
- The number of sexual partners in the last week/month/3 months as appropriate
- The gender of sexual partner(s)
- The type of sexual behaviour practiced (see examples in Figure 3.1, Box 3.1 & 3.2)
- Whether condoms were used the last time and in general
- Sex work
- Sex with men and women
- Erectile dysfunction

**RELATIONSHIP HISTORY**

Explore relationship history. Ask the client if they have a regular partner (male or female), other partners, and about their partner's sexual activity.

**MEDICATION AND ALLERGIES**

Explore medication and allergies. Ask about current or recent medication and any allergies to medication.

*Adapted from: Venereology Society of Victoria. National Management Guidelines for Sexually Transmissible Infections. Melbourne: Venereology Society of Victoria (Australia), 2002; Clinical Guidelines for Sexual Health Care of transgender people and Men who Have Sex with Men in Asia; Clinical Practice in Sexually Transmissible Infections, McMillan, Young, Ogilvie, Scott; HIV/AIDS Prevention and Care in Resource Constrained Settings, FHI.*
Figure-3.1: Sexual positions male and female

Box-3.1: Example of sexual behaviour

<table>
<thead>
<tr>
<th>Insertive penis-anal sex</th>
<th>Oral-anal sex</th>
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<tr>
<td>Receptive penis-anal sex</td>
<td>Oral-vaginal sex</td>
</tr>
<tr>
<td>Penis-vaginal sex</td>
<td>Oral-penis sex</td>
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</tbody>
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Box-3.2: Example questions to find out help about sexual behaviour.

- In order to take the best possible care of you I need to ask a few questions about your sexual behaviours. ‘Anything we discuss stays in this room.’
- Do you have sex with men, women or both?
- What types of sex do you have (e.g. anal, oral, vaginal)?
- When you say oral sex does that mean that you lick or suck the man's genitals and/or the man licks and sucks your genitals?
ANOGENITAL EXAMINATION FOR MALES

GENERAL POINTS

- Ensure privacy.
- Ask the client to undress to expose their body from navel to knees. Do not observe clients while they undress.
- Wash your hands with soap and water.
- Set up any examination instruments such as proctoscope while the client undresses.
- Ask the client if he is ready to be examined. If so, ask him to lie on the examination bed and draw the examination curtain around the couch.
- Examine the mouth with a torch and tongue depressor for signs of pharyngeal infection.
- Switch on the examination light to illuminate the anogenital area.
EXAMINATION OF THE FRONT

- Put on disposable gloves.
- Inspect the skin from navel to knees for altered pigmentation, rashes, scars or lumps.
- Inspect any hair for signs of ecto-parasite infestations.
- Palpate for inguinal lymph node enlargement and tenderness.
- Inspect the inguinal folds for rashes or lumps.
- Palpate the contents of the scrotum for lumps and tenderness. Do this by gently cradling each testicle in one hand while feeling for the epididymis with the fingers of the same hand. With the other hand, gently roll the vas deferens to detect any lumps.
- Inspect the skin along the length of the penis from base to the tip. Note any lumps, rashes or ulcers.
- Retract the foreskin (if present) to inspect for lumps, rashes, ulcers and discharge.
- Inspect the urethral meatus by parting the tip bilaterally. Note any discharge, ulcers or lumps.
- Milk the urethra from the base of the penis to the tip to check for the presence of discharge.

EXAMINATION OF THE BACK

- Ask the client to turn onto the left side (left lateral position) to bend both knees and flex the hips to 45°.
- Ask the client to place their right hand on their right buttock and to draw it upwards. This gives full exposure of the peri-anal area and allows you to have both hands free for inspection and examination. (You may wish to kneel down or sit on a chair to save you from bending your back.)
- Inspect the buttocks, perineum and peri-anal area. Note any lumps, ulcers, rashes, scars or discharge.
- Perform proctoscopy where appropriate (see following page).
- Wash hands with soap and water.
- Ask the client to get dressed.
PROCTOSCOPE EXAMINATION

- Conduct proctoscopy (male or female) if a client has any anorectal signs or symptoms or has had recent unprotected receptive anal intercourse.
- Ask the client to lie in the left lateral position.
- Smear lubricating jelly onto the anal verge and the length of the proctoscope.
- Rest the proctoscope at the anal verge until the sphincter relaxes, then insert slowly while applying gentle constant pressure. Allow the proctoscope to follow line of least resistance rather than pushing. Generally aim towards the navel. Elevation and relaxation of the buttocks aids insertion, as does asking the client to "bear down" as if opening the bowels.
- Remove the introducer once the proctoscope has reached its limit.
- Observe, using the examination light: colour and texture of rectal mucosa; presence of discharge; presence of ulceration; bleeding; lesions.
- Slowly remove the proctoscope, checking for haemorrhoids and/or other lesions on withdrawal.
- Perform, if indicated, with gloved right index finger, examination of prostate and lower rectum.
- Remove and dispose of gloves, then wash hands with soap and water.

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SEXUAL EXAMINATION FOR WOMEN

GENERAL POINTS

- Ensure privacy.
- Ensure a female attendant if the examiner is a male.
- Ask the client to remove clothing to expose the skin from navel to knees. Set up any examination instruments such as speculum while the client undresses. Do not observe clients while they undress.
- Ask the client if she is ready to be examined. If so, ask her to lie on the examination bed and draw the curtain around the bed.
- Examine the mouth with a torch and tongue depressor for signs of pharyngeal infection.
- Switch on the examination light to illuminate the anogenital area.
EXTERNAL EXAMINATION

- Abdomen: inspect and palpate the abdomen for tenderness, guarding, masses and inguinal lymphadenopathy.
- Pubic area: inspect for pubic lice, warts, molluscum contagiosum and ulcers.
- Perineum, peri-anal region and anus: inspect for lesions such as warts, anal fissures.
- Labia and introitus: separate and inspect the labia majora, the inner labia and introitus for warts, herpes lesions, discharge, inflammation of Bartholin's Glands.
- Urethra and paraurethral glands: insert a finger into the vaginal orifice and milk for discharge.

SPECULUM EXAMINATION

- Carefully pass a bivalve speculum. The speculum should be lubricated with clean water (if vaginal or cervical swabs are to be taken for lab tests) or a small amount of water based lubricant (if no swabs are to be taken). It should be passed vertically.
- Once the speculum is 2/3 passed, carefully rotate and open it.
- Locate the cervix. Note the character of any vaginal fluid, the appearance of the vaginal walls, the appearance of the ecto-cervix and the character of any cervical discharge.

Figure-5.2: Steps in speculum examination

BIMANUAL EXAMINATION

- Use the lubricated index and second finger of the right hand to gently separate the labia and then pass the two fingers into the vagina.
- Palpate the anteverted uterus by passing the fingers of the right hand to the anterior fornix while the fingers of the left hand are placed well above the symphysis pubis.
- Palpate the retroverted uterus from the posterior fornix.
- Examine the uterine appendages from the lateral fornices where any swelling may be palpated between the fingers of the two hands.
- Feel for swellings in the rectovaginal pouch (pouch of Douglas). Note any
tenderness, swelling, cervical motion tenderness.

**Figure-5.3: Bimanual exam**

The left hand is placed flat on the lower abdomen so that the uterus, Fallopian tube & the ovaries can be palpated between the left hand and the right hand.

Adapted from: Venereology Society of Victoria. National Management Guidelines for Sexually Transmissible Infections. Melbourne: Venereology Society of Victoria (Australia), 2002; Clinical Guidelines for Sexual Health Care of transgender people and Men who Have Sex with Men in Asia; Clinical Practice in Sexually Transmissible Infections, McMillan, Young, Ogilvie, Scott; HIV/AIDS Prevention and Care in Resource Constrained Settings, FHI.
• **Figure 6.1**: FEMALE SEX WORKER - Enhanced syndromic management flow chart for diagnosis of cervicitis and vaginitis (speculum & lab)

• **Figure 6.2**: FEMALE SEX WORKER - Enhanced syndromic management flow chart for diagnosis of cervicitis and vaginitis (speculum)

• **Figure 6.3**: FEMALE GENERAL POPULATION - Vaginal Discharge Syndrome flow chart (speculum)

• **Figure 6.4**: ALL FEMALES - Lower abdominal pain in women

• **Figure 6.5**: MALE - Urethral discharge syndrome

• **Figure 6.6**: MALE - Scrotal swelling syndrome

• **Figure 6.7**: MALE & FEMALE - Management of GUD without RPR test

• **Figure 6.8a**: MALE & FEMALE - Management of GUD with RPR testing

• **Figure 6.8b**: MALE & FEMALE - Management of RPR test results in clients with GUD

• **Figure 6.9**: MALE & FEMALE - Inguinal bubo syndrome

• **Figure 6.10**: NEONATAL CONJUNCTIVITIS
**Figure-6.1: FEMALE SEX WORKER - Enhanced syndromic management flow chart for diagnosis of cervicitis and vaginitis (speculum & lab)**

- **Monthly clinic visit for sex worker**
  - Take history and examine client (including speculum)

  **Positive for one of the following?**
  - Not seen in clinic in last 3 months
  - Not 100% condom use in last work day or no condom use during last sex
  - Any vaginal discharge from history and/or examination
  - Cervical motion tenderness on bimanual examination
  - Visible mucopus from cervix
  - Cervix friable (contact bleeding)

- **Laboratory Tests**
  - Whiff test and pH
  - Wet mount clue cell, trichomonas, spores, mycelium
  - Blood for RPR first visit and 3 monthly

- **Laboratory Tests**
  - Whiff test and pH
  - Wet mount clue cell, trichomonas, spores, mycelium
  - Gram stain cervical exudate
  - Blood for RPR first visit and 3 monthly

- **STI treatment table**

  1. Azithromycin 1g stat + Cefixime 400mg stat
  2. Metronidazole 2g stat
  3. Fluconazole 150mg stat

- **STI treatment 1 - All patients**
  - Presumptive NG or >25 pus cell PMI/HFP on Gram stain

- **STI treatment 2 - All patients with RTI/STI**
  - Wet mount positive for spores/mycelia

- **STI treatment 3 - All patients with no infection risk counselling**
  - Wet mount positive for trichomonas
  - 4 Cs & HIV
  - 3Cs & HIV
Figure 6.2: FEMALE SEX WORKER - Enhanced syndromic management flow chart for diagnosis of cervicitis and vaginitis (speculum).

Monthly clinic visit for sex worker

Take history and examine client (including speculum)

Positive for one of the following?
- Not seen in clinic in last 3 months
- Not 100% condom use in last work day or no condom use with last sex
- Any vaginal discharge from history and/or examination
- Cervical motion tenderness on bimanual examination
- Visible mucopus from cervix
- Cervix friable (contact bleeding)

YES
- STI treatment 1
- STI treatment 2
- 4Cs & HIV risk counselling

NO
3Cs & HIV counselling

Curd like discharge

YES
STI treatment 3

(after 7 days)
If symptoms/signs persist, does history confirm re-infection or poor compliance?

YES
Re-treat

NO
Refer

STI treatment table
1. Azithromycin 1g stat
   + Cefixime 400mg stat
2. Metronidazole 2g stat
3. Fluconazole 150mg stat

Note: For any pelvic or lower abdominal pain, GUD or any other genital disease, continue to follow the ESM flowchart, but also use the LAP or GUD flow charts as appropriate.
Figure 6.3: FEMALE GENERAL POPULATION - Vaginal Discharge Syndrome flow chart (speculum)

Client complains of vaginal discharge

Take history and examine client (including speculum)

Risk assessment positive?
- Cervical motion tenderness on bimanual examination
- Cervical mucopus
- Friable cervix
- Partner with STI in last 4 weeks

YES

- STI treatment 1
- STI treatment 2
- 4Cs & HIV risk counselling

YES

Curd like discharge

Discharge:
- profuse
- watery
- greyish white
- foul smelling
- frothy

YES

STI treatment 3

STI Treatment 2 (BV/TV)

YES

(after 7-10 days)
If symptoms/signs persist, does history confirm re-infection or poor compliance?

YES

Re-treat

NO

Refer

NO

STI treatment table
1. Azithromycin 1g stat + Cefixime 400mg stat
2. Metronidazole 2g stat
3. Fluconazole 150mg stat

(after 7-10 days)
If symptoms/signs persist does history confirm re-infection or poor compliance?

YES

Re-treat

NO

STI treatment 1
- STI treatment 2
- 4Cs & HIV counselling

Note: For any pelvic or lower abdominal pain, GUD or any other genital disease, continue to follow the VDS flowchart, but also use the LAP or GUD flow charts as appropriate.
Figure-6.4: ALL FEMALES - Lower abdominal pain in women

Client complains of lower abdominal pain

Take history and examine

Missed or overdue period? or
Recent delivery/abortion/miscarriage? or
Abdominal guarding? or
Rebound tenderness? or
Abnormal vaginal bleeding?

YES

Refer urgently for surgical or gynaecology assessment

NO

Cervical motion tenderness? or
Lower abdominal tenderness with Vaginal discharge or pus from cervical os?

YES

Treat for PID
4Cs & HIV counselling
Follow up in 3 days or sooner

NO

Any other illness found?

YES

Manage appropriately

FSW - Treat client as indicated by the Enhanced Syndromic Management flowcharts

GENERAL POPULATION - Treat client as required by VDS flowchart, STI & HIV counselling, condom promotion

Immediate hospitalisation of clients is required when:
- The diagnosis is uncertain
- Surgical emergencies such as appendicitis, ectopic pregnancy cannot be excluded
- A pelvic abscess is suspected
- Severe illness precludes out-patient management
- The client is pregnant
- The client is unable to follow an out-patient regime
- The client has failed to improve with out-patient treatment

(after 3 days) Improved

YES

Continue treatment
Follow up after 14 days
4Cs & HIV counselling

NO

Refer for gynaecology opinion
Figure 6.5: MALE - Urethral discharge syndrome

Client complains of urethral discharge or Dysuria (confirm that dysuria is not caused by dehydration)

Take history and examine. Milk urethra and use proctoscope if necessary

Positive for one of the following?
- Unprotected receptive or insertive anal intercourse in last 4 weeks
- Unprotected vaginal intercourse with female sex worker in last 4 weeks
- Client has done sex work in last 4 weeks
- Inconsistent condom use in last week or no condom use with last sex
- Urethral discharge confirmed

YES

STI Treatment 1
- 4Cs & HIV counselling

(after 7-10 days)
If symptoms/signs persist, does history confirm re-infection

YES
Re-treat with STI treatment 1

NO

STI treatment 2 (TV)

(after 7-10 days) Improved

YES
2 Cs & HIV counselling

NO
Refer

NO

STI treatment 2
1. Azithromycin 1g stat + Cefixime 400mg stat
2. Metronidazole 2g stat
3. Fluconazole 150mg stat

2Cs & HIV counselling
Figure-6.6: MALE - Scrotal swelling syndrome

Client complains of scrotal swelling/pain

Take history and examine

Swelling/pain confirmed?

Testis rotated or elevated, or history of trauma?

Refer for surgical opinion

- Reassure
- Analgesia
- Scrotal elevation & support
- 2Cs & HIV counselling

STI Treatment 1 (CT/NG)
- 4Cs & HIV counselling
- Review in 7 days or earlier if necessary; if worse, refer

STI treatment 1
- Azithromycin 1g stat
- Cefixime 400 mg stat
**Figure-6.7: MALE & FEMALE - Management of GUD without RPR test**

1. **Client presents with genital ulceration**
2. **Take history and examine**
   - **Genital ulceration present?**
     - **NO**
       - Reassure
       - 2 Cs & HIV counselling
     - **YES**
       - **Blisters/vesicles present?** or Past history of painful blisters? or Recurrent multiple ulcers?
         - **NO**
           - Treat Syphilis 1 & Chancroid
           - 4Cs & HIV counselling
           - Review in 7-10 days
         - **YES**
           - **Ulcer healing?**
             - **YES**
               - Continue follow up till ulcer healed and then at 6 months
             - **NO**
               - Refer

**Note:** If possible all syphilis patients should be followed up with RPR testing. All patients should be treated as syphilis of unknown duration (benzathine Penicillin 2.4 IU IM weekly for 3 weeks). Exceptions to this are (1) first even sex less that 2 years ago (2) previous negative RPR or TPHA test (3) syphilitic ulcer positively identified within 2 years.
**Figure-6.8a: MALE & FEMALE - Management of GUD with RPR**

- **Client presents with genital ulceration**

- **Take history and examine?**

  - **Genital ulceration present?**

    - **NO**
      - Reassure
      - 3 monthly RPR
      - 2 Cs & HIV counselling

    - **YES**

  - **Blisters/vesicles present?** OR **Past history of painful blisters?** OR **Recurrent multiple ulcers?**

    - **NO**
      - Do RPR

    - **YES**
      - Manage RPR result as per RPR flowchart (below)

- **Do RPR**

- **Manage as presumptive herpes**

- **If RPR (+ve) treat for syphilis 1 as in Box A in flowchart 8b**
Figure-6.8b: MALE & FEMALE - Management of RPR test results in clients with GUD

**Box A**
- Treat for *syphilis* 1
- Do 4Cs & HIV counselling
- Review in 7-10 days
- Follow RPR titration 3 monthly

**Ulcner healing 7-10 days?**
- **NO**
  - Treat for chancroid and/or refer

- **YES**
  - **Falling titre or low titre maintained over 6 months?**
    - **NO**
      - Retreat as new *syphilis* 1 infection starting Box A
    - **YES**
      - **NO**
        - Retreat as new *syphilis* 1 infection starting Box A
      - **YES**
        - **NO**
          - No further treatment
          - Continue 3 monthly RPR
        - **YES**
          - No further treatment
          - Continue 3 monthly RPR

**NOTE:**
- Do RPR on first visit and 3 monthly
- Treat all RPR (+ve)
- Whenever possible confirm (+ve) RPR by TPHA; but initial treatment should be based on positive RPR alone
- Repeat RPR/TPHA for (-ve) RPR in GUD
- Confirmed negative TPHA indicates false RPR
- Refer client if treatment fails/re-infection twice
Figure 6.9: MALE & FEMALE - Inguinal bubo

1. Client complains of inguinal swelling

2. Take history and examine

3. Inguinal/femoral Bubo(s) present?
   - NO: Any other genital disease?
     - NO: 2Cs & HIV counseling
     - YES: Use appropriate flow chart
   - YES: Ulcer(s) present?

4. Ulcer(s) present?
   - NO: Use genital ulcer flow chart
   - YES: Treatment for chancroid and LGV
     - If fluctuant, aspirate through healthy skin
     - 4Cs & HIV counselling
     - Ask client to return for review in 7 days, and continue treatment if improving or refer if worse

LGV treatment
- Azithromycin 1g stat
- Doxycycline 100 mg bd x 14 days
Figure-6.10: *Neonatal conjunctivitis*

- Neonate with eye discharge
  - Take history and examine
  - Bilateral or unilateral swollen eyelids with purulent discharge
    - Yes: Reassure mother
      - Advise to return if necessary
    - No: Improved
      - Yes: Refer
        - STI treatment 1
          - Azithromycin 1g stat
          - Cefixime 400 mg stat
      - No: Continue treatment until completed
        - Reassure mother

Note: All neonates with bilateral or unilateral swollen eyelids with purulent discharge should receive treatment for both gonococcal and chlamydial conjunctivitis.
## Partner Treatment

<table>
<thead>
<tr>
<th>Primary Infection in Client</th>
<th>Recommended Partner Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervicitis/vaginitis</td>
<td>Treat partner for chlamydia and gonorrhoea with STI treatment 1</td>
</tr>
</tbody>
</table>
| Vaginitis (Trichomonas and/or Bacterial Vaginosis) | - Doctor makes clinical decision on aetiology  
  - If TV more likely, partner should be treated with Metronidazole 2g stat or 400mg bd 7 days  
  - If BV more likely, partner treatment not required |
| PID                        | Treat partner for chlamydia and gonorrhoea with STI treatment 1 |
| Candidiasis                | Treat partner for candidiasis with STI treatment 3 |
| Scrotal Swelling Syndrome  | Treat partner for chlamydia and gonorrhoea with STI treatment 1 |
| Inguinal bubo syndrome     | Azithromycin 1g DOT for chancroid and Doxycycline 100mg twice daily for 14 days or Erythromycin 500mg 4 times a day for 14 days for LGV |
| GUD                        | Treat partner for syphilis and chancroid |
| Herpes                     | Partner requires full sexual health history and examination  
  - If herpes lesions are present then treatment for herpes may be given |
| Genital warts              | Partner requires full sexual health history and examination  
  - If genital warts are present then treatment for genital warts should be given |
| Neonatal conjunctivitis    | Both parents should be treated for chlamydia and gonorrhoea with STI treatment 1 |
| Scabies                    | Treat partner for scabies |
| Pubic lice                 | Treat partner for pubic lice |
ESSENTIAL STI DRUG LIST AND STI TREATMENT REGIMES

• **Table 8.1**: List of essential drugs for STI services
• **Table 8.2**: List of essential drugs for abscess management
• **Table 8.3**: STI drug treatment regimes
<table>
<thead>
<tr>
<th>Name of the drug</th>
<th>Indication</th>
<th>Contraindication</th>
<th>Cautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azithromycin 500mg</td>
<td>Chlamydia</td>
<td>Hepatic impairment</td>
<td>Pregnancy, breast feeding, renal impairment</td>
</tr>
<tr>
<td>Cefixime 200mg</td>
<td>Gonococcus</td>
<td>Cephalosporin hypersensitivity</td>
<td>Penicillin hypersensitivity</td>
</tr>
<tr>
<td>Metronidazole 400mg or Secnidazole/Ornizole (500mg)</td>
<td>Bacterial vaginosis</td>
<td>Concurrent alcohol consumption</td>
<td>Hepatic impairment, pregnancy, breastfeeding, renal impairment</td>
</tr>
<tr>
<td>Fluconazole 150mg</td>
<td>Candida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clotrimazole cream</td>
<td>Candida</td>
<td></td>
<td>Avoid contact with eyes</td>
</tr>
<tr>
<td>Benzathine penicillin 2.4 IU IM</td>
<td>Syphilis</td>
<td>Penicillin hypersensitivity</td>
<td>Cephalosporin hypersensitivity, renal impairment</td>
</tr>
<tr>
<td>Ceftriaxone 250mg IM</td>
<td>PID</td>
<td>Cephalosporin hypersensitivity</td>
<td>Hepatic and renal impairment, penicillin hypersensitivity</td>
</tr>
<tr>
<td>Doxycycline 100mg</td>
<td>Chlamydia</td>
<td>Ages under 12 years, pregnancy, breastfeeding</td>
<td>Hepatic impairment or receiving hepatotoxic drugs</td>
</tr>
<tr>
<td>Acyclovir 200mg</td>
<td>HSV-2</td>
<td></td>
<td>Renal impairment, pregnancy, breastfeeding</td>
</tr>
<tr>
<td>Erythromycin 500mg</td>
<td>Syphilis</td>
<td></td>
<td>Hepatic and renal impairment, pregnancy, breastfeeding</td>
</tr>
<tr>
<td>Erythromycin syrup</td>
<td>Ophthalmia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permethrin 5% cream</td>
<td>Pubic lice</td>
<td></td>
<td>Avoid contact with eyes and broken or infected skin</td>
</tr>
<tr>
<td>Podophyllin 15-25%</td>
<td>Genital warts</td>
<td>Pregnancy, breast feeding, children</td>
<td>Avoid normal skin, open wounds, face, eyes</td>
</tr>
<tr>
<td>Benzyl Benzoate 25%</td>
<td>Scabies</td>
<td></td>
<td>Children (not recommended), avoid eyes plus broken and infected skin, breastfeeding</td>
</tr>
<tr>
<td>Adrenaline 1:1000 injection</td>
<td>drug allergy</td>
<td>Hypertension, pregnancy</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>Hydrocortisone 100mg injection</td>
<td>drug allergy</td>
<td>Systemic infection without specific antimicrobials</td>
<td>Adolescents, pregnancy, breast feeding, plus many more</td>
</tr>
<tr>
<td>Chlorpheniramine 10 mg injection</td>
<td>drug allergy</td>
<td></td>
<td>Pregnancy, breastfeeding, hepatic and renal impairment</td>
</tr>
</tbody>
</table>
Table 8.2: List of essential drugs for abscess management

<table>
<thead>
<tr>
<th>Name of the drug</th>
<th>Indication</th>
<th>Contraindication</th>
<th>Cautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penicillin V</td>
<td>Streptococcus</td>
<td>Penicillin hypersensitivity</td>
<td></td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>Streptococcus</td>
<td>Penicillin hypersensitivity</td>
<td></td>
</tr>
<tr>
<td>Flucloxacillin</td>
<td>Staphlococcus</td>
<td>Penicillin hypersensitivity</td>
<td></td>
</tr>
<tr>
<td>Co-amoxiclav</td>
<td>Streptococcus</td>
<td>Penicillin hypersensitivity, Hepatic impairment, pregnancy, renal impairment</td>
<td></td>
</tr>
<tr>
<td>Erythromycin (in penicillin allergic patients)</td>
<td>Streptococcus</td>
<td>Penicillin hypersensitivity, Hepatic and renal impairment</td>
<td></td>
</tr>
<tr>
<td>Metronidazole</td>
<td>Anaerobes</td>
<td>See Table 8.1.</td>
<td></td>
</tr>
<tr>
<td>Iodine</td>
<td>Cleaning wound</td>
<td>Iodine hypersensitivity</td>
<td>Avoid contact with eyes and mucus membranes</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>Analgesia</td>
<td></td>
<td>Maximum dose 4g per day, hepatic and renal impairment</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>Analgesia Anti-inflammatory</td>
<td>Peptic ulcer disease</td>
<td>Pregnancy, breastfeeding, coagulation defects, hepatic or renal impairment, cardiovascular disorders</td>
</tr>
<tr>
<td>Co-trimoxazole</td>
<td>Not indicated for abscess management as ineffective against streptococcus and staphlococcus</td>
<td></td>
<td>Hepatic and renal impairment, pregnancy, breast feeding</td>
</tr>
</tbody>
</table>

Note:
1. Recommended antibiotic regime for abscess management: Penicillin V 250mg qds or amoxicillin 250 - 500 mg tds, PLUS flucloxacillin 250-500mg qds or co-amoxiclav 375mg tds PLUS metronidazole 400mg tds. All antibiotics given for 7 days and then review the patient. In the case of penicillin allergic patients, use erythromycin 500mg qds PLUS metronidazole 400mg tds.
2. The information given above is a guide and does not contains only the main side effects and contraindications for each drug, in addition to this guide, the prescribing physician should consider all other possible side effects and drug interactions when prescribing. This is of particular importance with women who may have an undiagnosed pregnancy; drug users who may have concomitant Hepatitis C infection; any patient who may be taking anti tuberculosis medicine or drugs against hepatitis or HIV.
<table>
<thead>
<tr>
<th></th>
<th>Drugs</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STI treatment 1</strong></td>
<td>Azithromycin 1g DOT + Cefixime 400mg DOT</td>
<td>Cervicitis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urethral Discharge Syndrome</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scrotal Swelling Syndrome (NB: Scrotal Swelling Syndrome requires treatment for chlamydia and gonococcus, alternative treatment for chlamydia is given below)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STI treatment 2</strong></td>
<td>Metronidazole 2g DOT +</td>
<td>Bacterial Vaginosis</td>
</tr>
<tr>
<td></td>
<td>Metronidazole 400mg tds 7 days or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Secnidazole 2g DOT*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trichomonas Vaginalis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Use of Metronidazole in first trimester of pregnancy is not recommended unless the benefits outweigh the potential hazards</td>
</tr>
<tr>
<td><strong>STI treatment 3</strong></td>
<td>Fluconazole 150mg*</td>
<td>Candida albicans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Should not be prescribed during pregnancy or lactation. Clotrimazole or Miconazole 150 mg tab or cream intravaginally for 3 days can be used</td>
</tr>
<tr>
<td><strong>PID treatment</strong></td>
<td>Ceftriaxone 250mg IM stat + Doxycycline 100mg bd 14 days* + Metronidazole 400mg bd, 14 days*</td>
<td>Pelvic inflammatory disease (PID)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Should not be prescribed during pregnancy or lactation</td>
</tr>
<tr>
<td><strong>Genital herpes treatment 1</strong></td>
<td>Acyclovir 200 mg five times daily for 7 days</td>
<td>First clinical attack of genital herpes and recurrences if severe or complicated</td>
</tr>
<tr>
<td><strong>Genital herpes treatment 2</strong></td>
<td>Acyclovir 400 mg twice daily continuously</td>
<td>Frequent recurrences (&gt;6/year)</td>
</tr>
<tr>
<td><strong>Chancroid treatment</strong></td>
<td>Azithromycin 1g DOT or Erythromycin 500mg 4 times a day for 7 days</td>
<td>Non-herpetic genital ulcer unresponsive to syphilis treatment. See flowchart</td>
</tr>
<tr>
<td><strong>Alternative chlamydia treatment</strong></td>
<td>Doxycycline 100mg twice daily for 7 days or Erythromycin 500mg 4 times a day for 7 days</td>
<td>For treatment of Chlamydia infection as alternative to single dose Azithromycin 1g. Compliance with 7-day regime is essential to confirm at follow up</td>
</tr>
<tr>
<td><strong>Drugs</strong></td>
<td><strong>Indication</strong></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td><strong>LGV treatment</strong></td>
<td>Doxycycline 100mg twice daily for 14 days or Erythromycin 500mg 4 times a day for 14 days</td>
<td>Diagnosis of LGV should be made by an STI specialist</td>
</tr>
<tr>
<td><strong>Syphilis treatment 1</strong></td>
<td>Benzathine penicillin 2.4 IU IM Single dose (1.2 IU each buttock)</td>
<td>&lt; 2 years duration</td>
</tr>
<tr>
<td>Non penicillin allergic including pregnancy</td>
<td>Benzathine penicillin 2.4 IU IM weekly for 3 weeks</td>
<td>&gt; 2 years duration or <strong>unknown duration</strong></td>
</tr>
<tr>
<td><strong>Syphilis treatment 2</strong></td>
<td>Doxycycline 100mg twice daily for 15 days</td>
<td>&lt; 2 years duration</td>
</tr>
<tr>
<td>Penicillin allergic NON pregnant</td>
<td>Doxycycline 100mg twice daily for 28 days</td>
<td>&gt; 2 years duration or <strong>unknown duration</strong></td>
</tr>
<tr>
<td><strong>Syphilis treatment 3</strong></td>
<td>Erythromycin 500mg four times daily for 15 days</td>
<td>&lt; 2 years duration</td>
</tr>
<tr>
<td>Penicillin allergic and pregnant</td>
<td>Erythromycin 500mg four times daily for 20 days</td>
<td>&gt; 2 years duration, <strong>unknown duration</strong> and any late syphilis</td>
</tr>
<tr>
<td>Note: There are recorded incidences of treatment failure with erythromycin which may lead to congenital syphilis. In this case penicillin sensitivity testing in a hospital with full resuscitation facilities may be indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Genital warts</strong></td>
<td>Podophyllin 10 - 25% in tincture of benzoin compound repeated at weekly intervals or Referral for cryotherapy/surgical removal</td>
<td>Warts detected on clinical examination (Podophyllin contraindicated in pregnancy)</td>
</tr>
<tr>
<td><strong>Pediculosis pubis</strong></td>
<td>Permethrin 5% cream</td>
<td>Eggs or adult lice seen on examination</td>
</tr>
<tr>
<td><strong>Scabies</strong></td>
<td>Permethrin 5% cream or Benzyl benzoate lotion 25%</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>Indication</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Neonatal conjunctivitis (treatment)</strong></td>
<td>All neonates with bilateral or unilateral swollen eyelids with purulent discharge should receive treatment for both gonococcal and chlamydial conjunctivitis</td>
<td></td>
</tr>
<tr>
<td>Syrup Erythromycin 50 mg/kg/day, orally 6 hourly for 14 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable Ceftriaxone 50 mg/kg (maximum 125mg), intramuscular as a single dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Neo-natal conjunctivitis (prevention)</strong></td>
<td>Apply to the eyes of all infants at the time of delivery</td>
<td></td>
</tr>
<tr>
<td>Apply 1% silver nitrate solution or 1% tetracycline ointment to the eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anaphylaxis treatment</strong></td>
<td>Confirmed allergic reaction</td>
<td></td>
</tr>
<tr>
<td>Adrenaline 0.5 ml 1:1000 IM Stat. Repeat at 5 min intervals if required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlorpheniramine 10-20mg slow IV injection</td>
<td>+ See Box 8.1 for further information</td>
<td></td>
</tr>
<tr>
<td>Hydrocortisone 100-300mg IV injection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DOT = directly observed therapy; bd = twice daily

**Note: Metronidazole in pregnancy:** Although not recommended for treatment of BV or TV in the first trimester of pregnancy, treatment may be given where early treatment has the best chance of preventing adverse pregnancy outcomes. In this instance a lower dose should be given: 2g single oral dose rather than a long course for 7 days
Management of anaphylaxis

- ALL clinics administering antibiotic medications, particularly by intramuscular (IM) injection, should be adequately equipped and prepared to manage an allergic or anaphylactic reaction. Essential drugs and equipment for the management of anaphylaxis include:
  - Adrenaline (epinephrine) 1:1,000 for injection
  - Antihistamines for injection and oral administration (e.g. promethazine, chlorpheniramine)
  - Hydrocortisone for injection
  - Ambu bag for ventilation

- It is not expected that clinics should be able to manage more than immediate, emergency life-saving aspects of dealing with a client with an anaphylactic reaction. Clients should be transferred to the nearest hospital or other appropriate facility as soon as it is safe to do so.

Skin testing and penicillin

- This is not recommended as routine practice by CDC (2002) or WHO (2004).

- Clients known to be allergic or at high risk of being penicillin allergic should receive alternative treatment such as tetracyclines for syphilis

- If it is decided that a client requires penicillin (e.g. a pregnant woman with high RPR and allergy to penicillin) then desensitisation can be carried out. However, this also carries the risk of a life-threatening anaphylactic reaction and should only be performed in situations where adequate facilities are present (e.g. ITU, anaesthetist, endo-tracheal tubes etc).
COUNSELLING GUIDE: THE 4CS AND HIV COUNSELLING

GENERAL POINTS

• The 4Cs are: counselling, compliance, condoms, and contacts.
• The doctor should give a brief 4Cs intervention to all clients as appropriate.
• The counsellor is able to spend more time with clients and should provide the 4Cs and comprehensive HIV counselling.
• Every client with an STI must receive and understand the following messages:
  - Sexual contact is the usual cause of the disease.
  - There are other modes of HIV STI transmission such as intravenous drug use and mother to child
  - Without treatment STI may cause severe complications.
  - STI increases the risk of HIV transmission.
  - STI and HIV can cause illness in an unborn child while the child is being born. e.g. neonatal conjunctivitis, congenital syphilis, HIV infection
• Clients should receive the 4Cs after seeing the doctor because:
  - A client who has just had an STI diagnosed is generally at their most receptive to education. They now have proof that it can happen to them, not just to others. Without education, there is a risk that clients will transmit the infection to their sexual partners.
  - A client can only receive appropriate advice on compliance once the doctor has prescribed medication and contact tracing can only be effectively pursued if the client has had an STI diagnosed by the doctor.
  - The counsellor may need to clarify some issues the client discussed with the doctor. Discussing the client’s infection will enhance their trust and adherence to health care workers’ advice.
• There is no set order for delivering the 4Cs. However, clients tend to be more responsive to messages about their own cure, followed by the treatment of those close to them, such as a spouse. They often have less interest in discussing the long-term consequences of STI, especially the risk of HIV and the behavioral changes required to prevent its spread.
COUNSELLING

- Identify and deal with issues that may cause the client anxiety or distress (e.g. informing the partner/spouse about the infection; learning about and coming to terms with complications such as infertility; coping with chronic/incurable infections such as herpes, HIV or genital warts; feelings of guilt).
- Assess actual and self-perceived HIV and STI risk.
- Help the client to recognise barriers to risk reduction.
- Negotiate an acceptable and achievable risk reduction plan.
- Support client-initiated behaviour change.

EDUCATION

- Discuss the nature and possible consequences of any infection(s) identified.
- Describe how to avoid re-infection.
- Explain how to recognise symptoms and the importance of early treatment seeking for STI.
- Give advice on seeking VCT for high-risk clients.

COMPLIANCE

- Emphasise the importance of completing all the treatment.
- Ensure the client knows when to return for follow up or check-ups.
- Ensure the client understands the reason for referral to a specialist and how to get to the referral centre.
- Advise the client on the importance of taking the drugs prescribed by the doctor and that medicines prescribed by a traditional healer or pharmacist may not be effective in treating STI.
- Ask the client if they foresee any obstacles to taking the full course of medication/following through with the referral, and work out a solution.

CONDOMS

- Emphasise and explain the importance of condom use for dual protection (prevention of STI/HIV and unintended pregnancy).
- Explain and demonstrate how to use condoms (male & female), and ask the client to demonstrate (see Figure-9.1: Steps for use of the Male Condom & Figure-9.2: Steps for use of the female Condom).
- Provide some condoms (male & female).
- Discuss how to negotiate condom use with a partner. Acknowledge that it is not always easy to do this, and help the client find solutions. While there may not be time for a lengthy discussion, at a minimum get the client to think of the approaches he or she might use.
Figure-9.1: Steps for Use of the Male Condom

1. Carefully open the package so the condom does not tear. Do not unroll the condom before putting it on.

2. If not circumcised, pull foreskin back, squeeze tip of condom and put it on end of hard penis.

3. Continue squeezing tip while unrolling condom until it covers whole of penis.

4. Always put on a condom before entering partner.

5. After ejaculation (coming), hold rim of condom and pull penis out before penis gets soft.

6. Slide condom off without spilling (semen) inside.

7. Tie and wrap the condom in paper, (If available) then throw in dustbin, wash hands.

8. Burn or bury with other trash, wash hands.
সঠিক নিয়মে মহিলা কনডম ব্যবহারের পদ্ধতি

ধাপ নং-১
কনডমের পাকেটটি হাতে নিয়ে মেয়াদিকাল পর হয়ে গেছে কিনা দেখে নিন।

ধাপ নং-২
দুই হাত দিয়ে পাকেটের ভান দিকের উপরের অংশে থাক বরাবর ছিটন।

ধাপ নং-৩
কনডমটি প্যাকেটের ভেতর হতে সরে করে আনুন এবং নিষ্ঠুরত্ব হওয়া কনডমে পর্যাপ্ত লুটিরিয়েট লাগানো আছে কিনা।

ধাপ নং-৪
এক হাত দিয়ে কনডমটি এমনভাবে লম্বা করে ধরন যাতে বাইরের রিংটি উপরের দিকে এবং ভেতরের রিংটি নীচের দিকে বৃদ্ধি থাকে।

ধাপ নং-৫
বাইরের দিক হতে কনডমের ভেতরের রিংটি দুই
-তৃতীয়াংশ সামনের দিকে রেখে দুই আইল দিয়ে
চেপে ধরুন। কনডমটি সাজের বেদনা হওয়া প্রবেশ
করার জন্য হতে বৃড়ত্ব ও মাখের আইল
দিয়ে ভেতরের রিংটি সর করে চেপে ধরুন।
মুখ আইলের মধ্যে স্থানে তর্কিনি রাখুন।

ধাপ নং-৬
কনডমটি এরকম ধর্ষ অবস্থায় বসে, খুবে বা
দেখানো কোনও ভেতরে প্রবেশ করার জন্য
প্রস্তুত হওয়া।

Figure-9.2: Steps for Use of the female Condom
CONTACTS

- You will need to develop a partner referral system specific to your locality. This involves: (1) setting up linkages with local STI service providers (e.g. local GPs or MSCS clinics); (2) training the service providers in the recommended partner treatment for specific syndromes; (3) development of partner referral cards; (4) setting up a monitoring and supervision system; (5) making adjustments to the system as required. Your local QAT and FHI TO-STI will help you with setting up your partner notification system.

- Once a system is in place the counselor should follow the simple steps below:
  
  ➢ Explain why contact tracing and partner treatment is an important part of STI case management.
  
  ➢ Ask the client if he or she has a partner who might need treatment. For clients with many partners, such as sex workers, it is unrealistic to try to trace all partners and may, in fact, place the client at risk. However, most clients will have regular, non-commercial partners who could be targeted for partner treatment.
  
  ➢ Discuss how the client can discuss the issue with their partner. Even in the best relationships STI can be a difficult topic to bring up. The client will be more likely to approach their partner if the counsellor helps him or her think about how to do this. Rehearsing the conversation with the counsellor can be helpful, and does not take much time.
  
  ➢ Provide partner notification referral cards according to the protocol in your DIC. An example of a partner notification letter is provided below (see Figure-9.3)
Figure-9.3: Example of partner notification letter.

This letter is given to a patient diagnosed with an STI to give to his/her partner. The letter requests that the partner come to a clinic for treatment. The clinic address is written at the bottom of the letter and the STI syndrome code of the index patient is also written on the letter. When the partner arrives at a designated clinic and shows this letter, he/she will receive a consultation free of cost and medicine at a 50% discount.
CONTRACEPTION AND PREGNANCY

All DICs should provide the following contraceptive service as appropriate for the target population:

- Male Condom
- Female Condom
- Oral Contraceptive pill (Combined pill and Mini pill)
- Injectable Contraceptive (Depo Provera).

Referral for other contraceptive methods and pregnancy should be offered as required.

Figure-9.4: Person being referred to contraceptive centre e.g. MSCS
# OUT-PATIENT REFERRAL FORM

## OUT-PATIENT REFERRAL

**NEW DHAKA STI CLINIC**

AIDS Prevention and Control Project

<table>
<thead>
<tr>
<th>PROJECT OFFICE DIC</th>
<th>DIC SOUTH</th>
<th>DIC NORTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Manager</td>
<td>DIC Manager</td>
<td>DIC Manager</td>
</tr>
<tr>
<td>28 Toyenbee Circular Rd.</td>
<td>43 Johnson Rd.</td>
<td>H# 64/2 New Airport Rd.</td>
</tr>
<tr>
<td>4th Floor</td>
<td>3rd Floor</td>
<td>2nd Floor</td>
</tr>
<tr>
<td>Motijheel</td>
<td>Dhaka</td>
<td>Mohakali</td>
</tr>
<tr>
<td>Dhaka</td>
<td>Tel: 0173 011 613</td>
<td>Dhaka</td>
</tr>
<tr>
<td>Tel: 7162511</td>
<td>Email: <a href="mailto:bwhchbsw@dhaka.net">bwhchbsw@dhaka.net</a></td>
<td></td>
</tr>
</tbody>
</table>

**Referred to:**

**Patient details:**

Patient name: ________________  Registration number: ________________  Age: ______

**Clinical information:**

**History:**

**Examination findings:**

**Laboratory results:**

**Diagnosis:**

**Reason for referral:**

Referred by: ________________  Signature: ________________  Date: __/__/__
11

CLINICAL COUNSELLING DATA RECORDS (STI HEALTH CARDS)

1. STI HEALTH CARD : High Risk Women
2. STI HEALTH CARD : High Risk Men
3. STI HEALTH CARD : High Risk Women with Lab
STI HEALTH CARD - HIGH RISK WOMEN

1. **PATIENT DETAILS** - filled out by receptionist
   
   Name: ________________ Age: ___ Date: __/__/___ ID Number: __________ Last visit: ____ Weeks

2. **HISTORY** - filled out by doctor
   
   **Present Complaint** - receptionist transfers data from this section to CLINIC REGISTER:
   
   1. ____________________
   
   2. ____________________
   
   3. ____________________

   **History of Present Complaint:**

   **Sexual History:**

<table>
<thead>
<tr>
<th>Last sex</th>
<th>When?</th>
<th>With whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   Types of sex?  anal □   vaginal □   oral □   group□   other:___________

   Was a condom used? yes□   no □

<table>
<thead>
<tr>
<th>Last working day</th>
<th>How many partners?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   Types of sex?  anal □   vaginal □   oral □   group□   other:___________

   Was there 100% condom use in your last work day? yes □   no □

   | Regular partner | Do you have a regular lover? yes□   no □   male □   female□   other:___________
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   Types of sex?  anal □   vaginal □   oral □   group□   other:___________

   How often do you use a condom? always □   sometimes □   never □

3. **Past Medical History:**

   Previous STI: __________

   Other: __________

4. **Drug History:**

   Hormonal contraception: __________

   Other medication: __________

   Allergies (general & penicillin): __________

   Intravenous drug use: Yes □   No □   Specify: __________

5. **Obstetric & Gynaecology History:**

   No. previous pregnancies: ________

   No. children: ________

   No. previous MR: ________

   No. previous miscarriages: ________

   LMP: ________

   Age first menstruation: ________

   Current pregnancy: Yes □   No □   Don’t know □
3. **EXAMINATION**

<table>
<thead>
<tr>
<th>General:</th>
<th>Anaemia □ Jaundice □ Cyanosis □ Temp. ______ Weight: ________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mouth: ________ Pulse: ________ BP: ________</td>
</tr>
<tr>
<td>Abdomen:</td>
<td>normal □ tenderness □ guarding □ masses □ nodes □</td>
</tr>
<tr>
<td></td>
<td>other: ____________________________________________</td>
</tr>
<tr>
<td>Pubic area:</td>
<td>normal □ lice □ warts □ molluscum □ ulcers □</td>
</tr>
<tr>
<td></td>
<td>other: ____________________________________________</td>
</tr>
<tr>
<td>External genitalia:</td>
<td>normal □ rash □ ulcer □ excoriation □ wart □ scabies □ nodes □</td>
</tr>
<tr>
<td></td>
<td>other: ____________________________________________</td>
</tr>
<tr>
<td>Perineum/perianal:</td>
<td>normal □ rash □ ulcer □ excoriation □ wart □ discharge □</td>
</tr>
<tr>
<td></td>
<td>other: ____________________________________________</td>
</tr>
<tr>
<td>Vagina vault/walls:</td>
<td>normal □ rash □ ulcer □ excoriation □ polyp □</td>
</tr>
<tr>
<td></td>
<td>other: ____________________________________________</td>
</tr>
<tr>
<td>Vaginal discharge:</td>
<td>absent □ present □ colour: ________ odour: ________ quantity: ________</td>
</tr>
<tr>
<td></td>
<td>other: ____________________________________________</td>
</tr>
<tr>
<td>Cervix:</td>
<td>normal □ contact bleeding □ ulcer □ inflammation □ ectopy □</td>
</tr>
<tr>
<td></td>
<td>other: ____________________________________________</td>
</tr>
<tr>
<td>Cervical discharge:</td>
<td>absent □ present □ clear □ purulent □ mucopurulent □</td>
</tr>
<tr>
<td></td>
<td>other: ____________________________________________</td>
</tr>
<tr>
<td>Bimanual examination:</td>
<td>normal □ cervical motion tenderness □ tender adnexae □</td>
</tr>
<tr>
<td></td>
<td>unilateral mass □ bilateral mass □</td>
</tr>
<tr>
<td></td>
<td>other: ____________________________________________</td>
</tr>
</tbody>
</table>

Additional findings:
4. RISK ASSESSMENT Any 'yes' = risk assessment positive. Needs treatment for cervicitis/vaginitis. All 'no' = risk assessment negative.
   First visit or not seen in clinic in last three months: Yes □ No □
   Not 100% condom use in last work day or no condom use last client: Yes □ No □
   Vaginal discharge on history and/or examination: Yes □ No □
   Cervical motion tenderness: Yes □ No □
   Cervical mucopus: Yes □ No □
   Cervical friability (contact bleeding): Yes □ No □
   Risk assessment positive: Yes □ No □

5. PATIENT CATEGORY & DIAGNOSIS - Receptionist transfer data from this section to CLINIC REGISTER
   Monthly checkup: Yes □ Specify: ____________
   Follow up (same STI problem in last 2 weeks): Yes □ Specify: ____________
   Partner referral: Yes □ Specify: ____________
   Symptoms: Yes □ Specify: ____________
   New STI diagnosis: Yes □ Comment: ____________
   General health only: Yes □ Specify: ____________
   Cervicitis/vaginitis from risk assessment positive: Yes □ Comment: ____________
   GUD: Yes □ Comment: ____________
   PID: Yes □ Comment: ____________
   Genital warts: Yes □ Comment: ____________
   Other STI: Yes □ Specify: ____________

6. TREATMENT - Receptionist transfer data from this section to CLINIC REGISTER

<table>
<thead>
<tr>
<th>STI</th>
<th>General Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>STI treatment 1 – DOT: Yes □</td>
<td>Ranitidine 150mg b.d. (20 tab): Yes □</td>
</tr>
<tr>
<td>STI treatment 2 – DOT/long course (circle): Yes □</td>
<td>Antacid 1 tab tds (30 tab): Yes □</td>
</tr>
<tr>
<td>STI treatment 3 – DOT: Yes □</td>
<td>Multivitamin 1 tab o.d. (30 tab): Yes □</td>
</tr>
<tr>
<td>PID treatment: Yes □</td>
<td>Folate 1 tab o.d. (30 tab): Yes □</td>
</tr>
<tr>
<td>Genital herpes treatment 1: Yes □</td>
<td>Paracetamol 1-2 tab 4hrly prn (15 tab): Yes □</td>
</tr>
<tr>
<td>Syphilis treatment 1 (non penicillin allergic): Yes □</td>
<td>Chlorpheniramine 5mg tab tds (15 tab): Yes □</td>
</tr>
<tr>
<td>Syphilis treatment 2 (penicillin allergic non preg.): Yes □</td>
<td>Albendazole 400mg 1 tab stat (1 tab): Yes □</td>
</tr>
<tr>
<td>Chancroid treatment: Yes □</td>
<td>Amoxicillin 250mg tds (21 tab): Yes □</td>
</tr>
<tr>
<td>Other STI treatment (specify below): Yes □</td>
<td>Erythromycin 250mg tab (40 tab): Yes □</td>
</tr>
</tbody>
</table>
Other drugs required prescribed as private prescription (write private prescription with carbon paper in space below):

7. FOLLOW-UP AND REFERRAL - Receptionist transfer data from this section to CLINIC REGISTER

Out-patient referral  Yes ☐
Follow up date       Yes ☐

Doctor name: ___________________________ Doctor’s signature: ___________________________

COUNSELLOR - 4Cs - Receptionist transfer data from this section to CLINIC REGISTER

STI & HIV information: ☐
Compliance: ☐
Condoms: ☐
Contact tracing: ☐
Counselling: ☐

Counselor name: ___________________________ Counselor’s signature: ___________________________
STI HEALTH CARD - HIGH RISK MEN

1. PATIENT DETAILS - filled out by receptionist
   Name: ____________________ Age: ______ Date: __/__/____ ID Number: ______ Last visit: ______ Weeks

2. HISTORY - filled out by doctor
   Present Complaint - Receptionist transfer data from this section to CLINIC REGISTER:
   1. ______________________
   2. ______________________
   3. ______________________
   History of Present Complaint:

   Sexual History:

<table>
<thead>
<tr>
<th>Last sex:</th>
<th>When?</th>
<th>With whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of sex?</td>
<td>anal □</td>
<td>vaginal □</td>
</tr>
<tr>
<td>Was a condom used?</td>
<td>yes □</td>
<td>no □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If does sex work:</th>
<th>How many partners in last work day?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of sex?</td>
<td>anal □</td>
</tr>
<tr>
<td>Was there 100% condom use in your last work day?</td>
<td>yes □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regular partner:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a regular lover?</td>
</tr>
<tr>
<td>Types of sex?</td>
</tr>
<tr>
<td>How often do you use a condom?</td>
</tr>
</tbody>
</table>

   Past Medical History:
   Previous STI: ____________________ Other: ____________________

   Drug History:
   Current medication: ____________________ Allergies (general & penicillin): ____________________ Intravenous drug use: yes □ no □

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Quantity</th>
<th>Time taking drug</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 3. EXAMINATION

<table>
<thead>
<tr>
<th>General:</th>
<th>Anaemia □</th>
<th>Jaundice □</th>
<th>Cyanosis □</th>
<th>Temp. _____</th>
<th>Weight: ______</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pulse: ____</td>
<td>BP: _____</td>
<td>Mouth: ____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pubic area:</td>
<td>normal □</td>
<td>lice □</td>
<td>warts □</td>
<td>molluscum □</td>
<td>ulcers □</td>
</tr>
<tr>
<td></td>
<td>other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External genitalia:</td>
<td>Skin: normal □</td>
<td>rash □</td>
<td>ulcer □</td>
<td>wart □</td>
<td>scabies □</td>
</tr>
<tr>
<td></td>
<td>Scrotum: normal □</td>
<td>swelling □</td>
<td>Epididymis: normal □</td>
<td>swelling □</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spermatic cords: normal □</td>
<td>swelling □</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urethral discharge:</td>
<td>absent □</td>
<td>present □</td>
<td>clear □</td>
<td>purulent □</td>
<td>muco-purulent □</td>
</tr>
<tr>
<td></td>
<td>other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perineum/perianal:</td>
<td>normal □</td>
<td>rash □</td>
<td>ulcer □</td>
<td>excoriation □</td>
<td>wart □</td>
</tr>
<tr>
<td></td>
<td>other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proctoscopy:</td>
<td>normal □</td>
<td>inflammation □</td>
<td>ulcer □</td>
<td>contact bleeding □</td>
<td>polyp □</td>
</tr>
<tr>
<td>(case of receptive anal sex without condom)</td>
<td>other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectal discharge:</td>
<td>absent □</td>
<td>present □</td>
<td>clear □</td>
<td>purulent □</td>
<td>muco-purulent □</td>
</tr>
</tbody>
</table>

Additional findings:

---

### 4. SPECIMEN COLLECTION & RESULTS – Receptionist transfer data from this section to CLINIC REGISTER

Blood taken: Done □ Not done □ Comment: ________________

RPR: Positive □ Negative □ Inconclusive □ Comment: ________________

TPHA: Positive □ Negative □ Inconclusive □ Comment: ________________
5. **PATIENT CATEGORY & DIAGNOSIS** - Receptionist transfer data from this section to CLINIC REGISTER

| Monthly check up: | Yes ☐ | No ☐ | Specify: ____________ |
| Follow up (same STI problem in last 2 weeks): | Yes ☐ | No ☐ | Specify: ____________ |
| Partner referral: | Yes ☐ | No ☐ | Specify: ____________ |
| Symptoms: | Yes ☐ | No ☐ | Specify: ____________ |
| New STI diagnosis: | Yes ☐ | No ☐ | Comment: ____________ |
| General health only: | Yes ☐ | No ☐ | Specify: ____________ |
| UDS: | Yes ☐ | No ☐ | Comment: ____________ |
| Scrotal swelling: | Yes ☐ | No ☐ | Comment: ____________ |
| GUD: | Yes ☐ | No ☐ | Comment: ____________ |
| Anal STI: | Yes ☐ | No ☐ | Comment: ____________ |
| Other anal problem: | Yes ☐ | No ☐ | Specify: ____________ |
| Genital warts: | Yes ☐ | No ☐ | Comment: ____________ |
| Other STI: | Yes ☐ | No ☐ | Specify: ____________ |

6. **TREATMENT** - Receptionist transfer data from this section to the CLINIC REGISTER

<table>
<thead>
<tr>
<th>STI</th>
<th>General Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>STI treatment 1 – DOT:</td>
<td>Ranitidine 150mg b.d. (20 tab): Yes ☐</td>
</tr>
<tr>
<td>STI treatment 2 – DOT/long course (circle):</td>
<td>Antacid 1 tab tds (30 tab): Yes ☐</td>
</tr>
<tr>
<td>STI treatment 3 – DOT:</td>
<td>Multivitamin 1 tab o.d (30 tab): Yes ☐</td>
</tr>
<tr>
<td>PID treatment:</td>
<td>Folic acid 1 tab o.d. (30 tab): Yes ☐</td>
</tr>
<tr>
<td>Genital herpes treatment 1:</td>
<td>Paracetamol 1-2 tab 4hrly prn (15 tab): Yes ☐</td>
</tr>
<tr>
<td>Syphilis treatment 1 (non penicillin allergic):</td>
<td>Chlorpheniramine 5mg tab tds (15 tab): Yes ☐</td>
</tr>
<tr>
<td>Syphilis treatment 2 (penicillin allergic):</td>
<td>Albendazole 400mg 1 stat (1 tab): Yes ☐</td>
</tr>
<tr>
<td>Chancroid treatment:</td>
<td>Amoxicillin 250mg tds (21 tab): Yes ☐</td>
</tr>
<tr>
<td>Other STI treatment (specify below):</td>
<td>Cefradine 500mg qds (28 tab): Yes ☐</td>
</tr>
<tr>
<td></td>
<td>Flucloxacillin 250mg qds (40 caps): Yes ☐</td>
</tr>
<tr>
<td></td>
<td>Erythromycin 250mg tab (40 tab): Yes ☐</td>
</tr>
</tbody>
</table>
Other drugs required prescribed as private prescription (write private prescription with carbon paper in space below)

7. FOLLOW-UP AND REFERRAL - Receptionist transfer data from this section to CLINIC REGISTER

Out-patient referral: Yes ☐

Follow-up date: __________________________

Doctor name: ____________________________ Doctor's signature: __________________________

8. COUNSELLOR - 4Cs - Receptionist transfer data from this section to CLINIC REGISTER

STI, HIV & injection information: ☐

Compliance: ☐

Condoms: ☐

Contact tracing: ☐

Counseling: ____________________________

Counselor name: __________________________ Counselor's signature: __________________________
STI HEALTH CARD – HIGH RISK WOMEN WITH LAB

1. PATIENT DETAILS - filled out by receptionist
   Name: ___________________________   Age: _______   Date: __/__/___   ID No.: _______   Lab No.: _______   Last visit: _____ Wks

2. HISTORY – filled out by doctor

Present Complaint - Receptionist transfer data from this section to CLINIC REGISTER:
1. ___________________________________________________________
2. ___________________________________________________________
3. ___________________________________________________________

History of Present Complaint:

Sexual History:

<table>
<thead>
<tr>
<th>Last sex:</th>
<th>When? ___________________________</th>
<th>With whom? ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Types of sex? anal □ vaginal □ oral □ Group □ Other: _______</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Was a condom used? yes □ no □</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last working day:</th>
<th>How many partners? ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Types of sex? anal □ vaginal □ oral □ Group □ Other: _______</td>
</tr>
<tr>
<td></td>
<td>Was there 100% condom use in your last work day? yes □ no □</td>
</tr>
</tbody>
</table>

| Regular partner:  | Do you have a regular lover? yes □ no □ male □ female □ Other: _______ |
|-------------------| Types of sex? anal □ vaginal □ oral □ Group □ Other: _______ |
|                   | How often do you use a condom? always □ sometimes □ never □ |

Past Medical History:

Previous STI: ___________________________   Other: ___________________________

Drug History:

Hormonal contraception: ___________________________   Other medication: ___________________________

Allergies (general & penicillin): ___________________________   Intravenous drug use: Yes □ No □ Specify: _________

Obstetric & Gynaecology History:

No. previous pregnancies: _______   No. children: _______   No. previous MR: _______

No. previous miscarriages: _______   LMP: _______   Age first menstruation: _______

Current pregnancy: Yes □ No □ Don’t know □
3. EXAMINATION

| General: | Anaemia □ Jaundice □ Cyanosis □ Temp: _____ Weight: _____ |
| Mouth: | Pulse: | BP: |
| Abdomen: | normal □ tenderness □ guarding □ masses □ nodes □ |
| Other: | |
| Pubic area | normal □ lice □ warts □ molluscum □ ulcers □ |
| Other: | |
| External genitalia: | normal □ rash □ ulcer □ excoriation □ wart □ scabies □ nodes □ |
| Other: | |
| Perineum/perianal: | normal □ rash □ ulcer □ excoriation □ wart □ discharge □ |
| Other: | |
| Vagina vault/walls: | normal □ rash □ ulcer □ excoriation □ polyp □ |
| Other: | |
| Vaginal discharge: | absent □ present □ Colour: _____ Odour: _____ Quantity: _____ |
| Other: | |
| Cervix: | normal □ contact bleeding □ ulcer □ inflammation □ ectopy □ |
| Other: | |
| Cervical discharge: | absent □ present □ clear □ purulent □ mucopurulent □ |
| Other: | |
| Bimanual examination: | normal □ cervical motion tenderness □ tender adenexae □ |
| Unilateral mass □ Bilateral mass □ |
| Other: | |

Additional findings:

   First visit or not seen in clinic in last three months:  Yes ☐ No ☐

   Not 100% condom use in last work day or no condom use with last client: Yes ☐ No ☐

   Vaginal discharge on history and/or examination: Yes ☐ No ☐

   Cervical motion tenderness: Yes ☐ No ☐

   Cervical mucopus: Yes ☐ No ☐

   Cervical friability (contact bleeding): Yes ☐ No ☐

   **Risk assessment positive:** Yes ☐ No ☐

5. **SPECIMEN COLLECTION**

   Patients risk assessment positive require vaginal swab 1 & 2, vaginal secretion pH & 'whiff' test

   Patients risk assessment negative require all the above plus cervical swab.

   All patients require blood for RPR 3 monthly

   Cervical swab – Gram’s stain for PML/ICD: Done ☐ Not done ☐ Comment: __________

   Vaginal swab – Gram’s stain for Nugent’s: Done ☐ Not done ☐ Comment: __________

   Vaginal swab – wet mount: Done ☐ Not done ☐ Comment: __________

   Vaginal secretion - 'Whiff' test: Done ☐ Not done ☐ Comment: __________

   Vaginal secretion – pH: Done ☐ Not done ☐ Comment: __________

   Blood: Done ☐ Not done ☐ Comment: __________

6. **RESULTS** – Receptionist transfer data from this section to CLINIC REGISTER

   KOH: Positive ☐ Negative ☐ Inconclusive ☐ Comment: __________

   Vaginal pH: Positive ☐ Negative ☐ Inconclusive ☐ Comment: __________

   Wet mount BV: Positive ☐ Negative ☐ Inconclusive ☐ Comment: __________

   Wet mount TV: Positive ☐ Negative ☐ Inconclusive ☐ Comment: __________

   Nugents Score (BV): __________

   Wet mount CA: Positive ☐ Negative ☐ Inconclusive ☐ Comment: __________

   Cervicitis: PML/ICD: Positive ☐ Negative ☐ Inconclusive ☐ Comment: __________

   RPR: Positive ☐ Negative ☐ Inconclusive ☐ Comment: __________

   TPPA: Positive ☐ Negative ☐ Inconclusive ☐ Comment: __________
7. **PATIENT CATEGORY & DIAGNOSIS** - Receptionist transfer data from this section to CLINIC REGISTER

   Monthly checkup: Yes □  Comment: ____________

   Follow up (pt seen with same problem in last 2 weeks): Yes □  Comment: ____________

   Partner referral: Yes □  Comment: ____________

   Symptoms: Yes □  Comment: ____________

   New STI Diagnosis: Yes □  Comment: ____________

   General health only: Yes □  Specify: ____________

   Cervicitis/vaginitis from risk assessment positive: Yes □  Comment: ____________

   GUD: Yes □  Specify: ____________

   PID: Yes □  Comment: ____________

   Genital warts: Yes □  Comment: ____________

   Other STI: Yes □  Specify: ____________

8. **TREATMENT** – Filled out by doctor.

<table>
<thead>
<tr>
<th>STI</th>
<th>General Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>STI treatment 1. – DOT:</td>
<td>Ranitidine 150mg b.d. (20 tab):</td>
</tr>
<tr>
<td></td>
<td>Antacid 1 tab tds (30 tab):</td>
</tr>
<tr>
<td>STI treatment 2. – DOT/long course (circle):</td>
<td>Multivitamin 1 tab o.d (30 tab):</td>
</tr>
<tr>
<td>STI treatment 3. – DOT:</td>
<td>Folse tab 1 tab o.d. (30 tab):</td>
</tr>
<tr>
<td>PID treatment:</td>
<td>Paracetamol 1-2 tab 4hrly pm (15 tab):</td>
</tr>
<tr>
<td>Genital herpes treatment 1:</td>
<td>Chlorpheniramine 5mg tab tds (15 tab):</td>
</tr>
<tr>
<td>Syphilis treatment 1. (non penicillin allergic):</td>
<td>Albenazole 400mg 1 tab stat (1 tab):</td>
</tr>
<tr>
<td>Syphilis treatment 2. (penicillin allergic non preg.):</td>
<td>Amoxicillin 250mg tds (21 tab):</td>
</tr>
<tr>
<td>Other STI treatment (specify below):</td>
<td>Cefradine 500mg qds (28 tab):</td>
</tr>
<tr>
<td></td>
<td>Erythromycin 250mg tab (40 tab):</td>
</tr>
</tbody>
</table>

Other drugs required prescribed as private prescription (write private prescription with carbon paper in space below):
9. FOLLOW-UP AND REFERRAL - Receptionist transfer data from this section to CLINIC REGISTER

Out-patient referral  Yes ☐
Follow up date  Yes ☐

Doctor name:  Doctor’s signature:

10. COUNSELOR - 4Cs - Receptionist transfer data from this section to CLIIC REGISTER

STI & HIV information:  □
Compliance:  □
Condoms:  □
Contract tracing:  □
Counselling:  □

Counsellor name:  Counsellor’s signature:
12

REFERRAL SERVICES

- **Table 12.1**: Service delivery points for people with HIV and AIDS
- **Table 12.2**: Clinical Management of HIV/AIDS - List of Service Providers in Dhaka, Chittagong and Sylhet
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Services</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashar Alo Society</td>
<td>Counselling</td>
<td>Dhaka Office:&lt;br&gt;House # 3/3 (GF), Road # 3&lt;br&gt;Block-A, Lalmatia, Dhaka-1207</td>
</tr>
<tr>
<td></td>
<td>Health services and treatment support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home-based care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Antiretroviral support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Small grants for income generation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counselling</td>
<td>Chittagong Office:&lt;br&gt;753, Mehedibag, Chittagong&lt;br&gt;Phone # 0172-271900</td>
</tr>
<tr>
<td></td>
<td>Health services and treatment support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home-based care</td>
<td></td>
</tr>
<tr>
<td>Jagori/ICDDR,B</td>
<td>VCT</td>
<td>Dhaka Office:&lt;br&gt;First floor of Agrani, ICDDR B, Mohakhali, Dhaka-1212</td>
</tr>
<tr>
<td></td>
<td>Ongoing counselling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-patient health services</td>
<td>Phone # 017-3008839 (Ms. Arunthia Zaidi, VCT Central Coordinator)</td>
</tr>
<tr>
<td>Samajik Shayastha Kendra (SSK)</td>
<td>Out-patient health services</td>
<td>Plot-8, Main Road-3, Section-7, Mirpur, Dhaka-1216&lt;br&gt;9015183 (chamber), 9013530 (res)&lt;br&gt;Cont. per: Dr. Mostafa Abdur Rahim</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mukto Akash</td>
<td>Counselling</td>
<td>Dhaka Office:&lt;br&gt;House # 49/1, Babor Road, Block-B, Mohammadpur, Dhaka-1207&lt;br&gt;Phone # 9136570</td>
</tr>
<tr>
<td></td>
<td>Health and nutrition support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vocational training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult literacy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counselling</td>
<td>Chittagong Office:&lt;br&gt;Jaman Villa, 494 Paltan Road, Dampara, Chittagong&lt;br&gt;Phone # 031- 653653, ext-106</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counselling</td>
<td>Khulna Office:&lt;br&gt;68/1 Khan-A-Sabur Road, near Hadis Park, Khulna</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counselling</td>
<td>Sylhet Office:&lt;br&gt;House # 6 (1st floor), Road # 31, Block-D, Shahjalal Upashar&lt;br&gt;0171-315138 (Mr. shamsul Alam)</td>
</tr>
<tr>
<td>Organisation</td>
<td>Services</td>
<td>Address</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Confidential Approach for AIDS prevention (CAAP) | ▪ On-site counselling  
▪ Online counselling  
▪ HIV testing  
▪ Health services and treatment support | House-63/D, Road-15  
Dhaka-1213  
9881119, 9884266 |
| Paricharjaya                                     | ▪ Treatment support for skin diseases and STI | 12/C Asad Avenue, Mohammadpur, Dhaka-1207  
Phone # 9134892, 8122194 |
| ICDDR,B                                          | ▪ CD4 count                                   | Virology, Laboratory Sciences Division  
Mohakhali, Dhaka-1212 |
| Armed Forces Institute of Pathology              | ▪ HIV testing (ELISA & WB)  
▪ CD4 count  
▪ Viral load | Dhaka Cantonment  
Phone # 8825211  
(office of Major General Motiur Rahman) |
| AITAM Welfare Organization                       | ▪ In-patient health care                      | House # 45, Road # 2, Janata Housing Society, Mohammadpur, Dhaka-1207  
Phone # 9121828 |
| Bangabandhu Sheik Mujib Medical University (BSMMU) | ▪ HIV testing (ELISA & WB)  
▪ Limited counselling | Shahbag, Dhaka  
Phone # 8617099 |
| Bangladesh National Women Lawyer’s Association (BNWLA) | ▪ Legal support                         | House 60/A, Road # 27, Dhanmondi  
Phone # 8123060, 8125866 (Ms. Rebaka Sultana, Advocate Salma Ali)  
Hotline: 0171-800400-01 |
Table 12.2: Clinical Management of HIV/AIDS - List of Service Providers in Dhaka, Chittagong and Sylhet

<table>
<thead>
<tr>
<th>Name of Provider</th>
<th>Present Designation</th>
<th>Educational qualification and training</th>
<th>Contact address</th>
<th>Work Station</th>
<th>e-mail address</th>
<th>Contact Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Mohammed Moshtaq Pervez</td>
<td>Medical Officer</td>
<td>MBBS, MPH</td>
<td>Jagori, VCT Center, ICDDR, Mohakhali, Dhaka-1212</td>
<td>Dhaka</td>
<td><a href="mailto:Eparvez@bdonline.com">Eparvez@bdonline.com</a> <a href="mailto:Drmp6817@yahoo.com">Drmp6817@yahoo.com</a></td>
<td>019-327979</td>
</tr>
<tr>
<td>Dr. Abu Sayed Zakaria</td>
<td>Assistant Professor</td>
<td>MBBS, MPH, MD in Dermatology &amp; Venereology</td>
<td>Department of Skin &amp; V.D. Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka</td>
<td>Dhaka</td>
<td>NA</td>
<td>018-238575</td>
</tr>
<tr>
<td>Dr. Md. Ferdous Ahsan</td>
<td>Medical Officer</td>
<td>MBBS, Diploma in Dermatology and Venereology (DDV)</td>
<td>Central Skin &amp; Social Hygiene Center Agrabad, Chittagong</td>
<td>Chittagong</td>
<td>NA</td>
<td>0172-063778 8954291 (res)</td>
</tr>
<tr>
<td>Dr. Safir Uddin Ahmed</td>
<td>Lecturer</td>
<td>MBBS, MPH (PH), DDV</td>
<td>Community Medicine Department, Sylhet MAG Osmani Medical College, Sylhet.</td>
<td>Sylhet</td>
<td>NA</td>
<td>0171-967255 0821-725604 (res)</td>
</tr>
<tr>
<td>Dr. A.Q. M. Serajul Islam</td>
<td>Professor and Ex- head</td>
<td>MBBS, DDV, Post doctoral fellow in STDs &amp; AIDS</td>
<td>Dept. fo Dermatology &amp; Venereology, Chittagong Medical College &amp; Hospital</td>
<td>Chittagong</td>
<td><a href="mailto:Aqmseraj@gononet.com">Aqmseraj@gononet.com</a> <a href="mailto:Bsfax@abnetbd.com">Bsfax@abnetbd.com</a></td>
<td>880-31-657620 (res), 0171-749449</td>
</tr>
<tr>
<td>Dr. A.K. M. Mosharraf Hossain</td>
<td>Assistant Prof. Of Respiratory Medicine</td>
<td>MBBS, FCPS</td>
<td>Dept. of Medicine, BSMMU, Dhaka</td>
<td>Dhaka</td>
<td>NA</td>
<td>8610652, 8628687 (chamber), 9662584 (res) 0171- 521898</td>
</tr>
<tr>
<td>Name of Provider</td>
<td>Present Designation</td>
<td>Educational qualification and training</td>
<td>Contact address</td>
<td>Work Station</td>
<td>e-mail address</td>
<td>Contact Phone number</td>
</tr>
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<td>----------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
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<td>-------------------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>Dr. Shibbir Ahmed</td>
<td>Assistant Professor</td>
<td>MBBS, DPH</td>
<td>Community Medicine Department, Sylhet MAG Osmani Medical College, Sylhet.</td>
<td>Sylhet</td>
<td>NA</td>
<td>0821-760655 (res) 0171-385500</td>
</tr>
<tr>
<td>Dr. Mustafa Abdur Rahim</td>
<td>Executive Director</td>
<td>MBBS</td>
<td>Samajik Shasthya Kendra, Plot-8, Main Road, -3, Section-7, Mirpur, Dhaka-1216</td>
<td>Dhaka</td>
<td><a href="mailto:Iqbwahm@bangla.net">Iqbwahm@bangla.net</a></td>
<td>9015183 (chamber) 9013530 (res)</td>
</tr>
<tr>
<td>Dr. Mohammad Hossain</td>
<td>Medical Counselor</td>
<td>MBBS</td>
<td>Confidential Approach for AIDS prevention (CAAP), House-63/D, Road-15, Dhaka-1213</td>
<td>Dhaka</td>
<td><a href="mailto:Caap@citechco.net">Caap@citechco.net</a></td>
<td>9881119, 9884266</td>
</tr>
<tr>
<td>Dr. Md. Sirajuddin</td>
<td>Associate Prof. &amp; Head of the Department</td>
<td>MBBS, DDV, DD, Higher training in dermatosurgery</td>
<td>Department of Skin &amp; V.D. Sylhet MAG Osmani Medical College, Sylhet.</td>
<td>Sylhet</td>
<td>NA</td>
<td>011-316147 0821-719930 (res)</td>
</tr>
<tr>
<td>Dr. Taimur Newaz</td>
<td>Prof. &amp; Head of the Dept. of Medicine, Vice Principal</td>
<td>FRCP, FRCPE, SACP, MBBS, MRCP</td>
<td>Bangladesh Medical College, Dhanmondi, Dhaka</td>
<td>Dhaka</td>
<td><a href="mailto:Bmch@bangla.net">Bmch@bangla.net</a></td>
<td>8811960 (chamber), 018-240828</td>
</tr>
<tr>
<td>Dr. Fatema ZAnnat</td>
<td>PDO-HIV-positive support group</td>
<td>MBBS</td>
<td>Dhaka Field Office, CARE Bangladesh, House # 49/1, Block-B, Babar Road, Mohammadpur Housing Estate, Dhaka-1207</td>
<td>Dhaka</td>
<td><a href="mailto:Fatema@caredfo.dhaka.net">Fatema@caredfo.dhaka.net</a></td>
<td>9136924, 8123364 ext-110</td>
</tr>
</tbody>
</table>
GLOSSARY
&
BIBLIOGRAPHY
<p>| <strong>Acquired Immuno Deficiency Syndrome (AIDS)</strong> | A disease caused by infection with the human immunodeficiency virus (HIV-1, HIV-2) and is often accompanied by opportunistic infections such as Pneumocystis carinii pneumonia, toxoplasmosis, tuberculosis. |
| <strong>Algorithm</strong> | A flowchart used to diagnose STI syndromes |
| <strong>Autoclave</strong> | A pressurized, steam-heated vessel used for sterilization. |
| <strong>Blood borne pathogen</strong> | A germ or microbe which is found in the blood and can be transmitted through contact with blood e.g. HIV, Hepatitis B and C virus. |
| <strong>4Cs</strong> | Counselling for HIV and STI risk reduction; Compliance with prescribed medication; Contact tracing of the patient’s sexual partners; Condom promotion |
| <strong>Confidentiality</strong> | The ethical principle or legal right that a physician or other health professional will hold secret all information relating to a patient, unless the patient gives consent permitting disclosure. |
| <strong>Consultation</strong> | A meeting with a health professional to discuss medical issues. A medical consultation for sexual health means that the patient will be asked some sensitive questions about their sexual practices (sexual health history) and receives a full examination of the genitals and abdomen (sexual health examination). |
| <strong>Consumable</strong> | Materials used in a clinic that need to be replaced as they are used. e.g. needles and syringes are used only once and as they are consumed in this way they need to be replaced by ordering and buying more |
| <strong>Decontamination</strong> | This is the first step in instrument processing. It kills viruses (like HIV, hepatitis B and C) and many other microorganisms. It makes items safer to handle by staff that perform cleaning and the following steps of processing. Usually decontamination is achieved by submerging items in 0.5% chlorine solution. |
| <strong>Diagnosis</strong> | The act or process of identifying or determining the nature and cause of a disease or injury through evaluation of patient history, examination, and review of laboratory data. |
| <strong>Drop-in centre</strong> | A community based centre where members of the target population can drop in during opening times, to access services such as: clinical care for STI, general health problems, abscess management; recreation; counseling; to meet friends; literacy classes; bathroom and sleeping facilities etc. |</p>
<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Done intermittently and at the end of a project. It is usually done through surveys and requires extra staff, time and funds. It feeds back into the planning/re-planning process at longer intervals than monitoring.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flow chart</td>
<td>A tool which aids in logical decision making by indicating a course of action based on simple yes and no questions.</td>
</tr>
<tr>
<td>High-level disinfection</td>
<td>A process that eliminates many or all pathogenic microorganisms on inanimate objects like instruments with the exception of a high number of bacterial spores. It eliminates bacteria, viruses, fungi, and parasites but does not kill all bacterial endospores. It is used as the third step in instrument processing when sterilization is not available or feasible.</td>
</tr>
<tr>
<td>High risk behaviours</td>
<td>Behaviours which increase the chance of contracting and spreading infectious diseases. These activities include sex work, unprotected sex with multiple partners, and injection drug use.</td>
</tr>
<tr>
<td>Human Immuno Deficiency Virus</td>
<td>A retrovirus that causes immune system failure and debilitation resulting in AIDS.</td>
</tr>
<tr>
<td>Incinerator</td>
<td>A furnace for burning medical waste completely.</td>
</tr>
<tr>
<td>Indicator</td>
<td>A device for showing the operating condition of a system. An indicator should be: valid - measure what it was intended to measure; reproducible - give the same result independent of the observer; simple - easy to measure; acceptable - should be ethically and culturally appropriate. Indicators require a commitment with regard to amount and timing.</td>
</tr>
<tr>
<td>Inventory</td>
<td>A checklist by which the manager can keep account of what equipment or consumables are present in the clinic and which need to be ordered and bought.</td>
</tr>
<tr>
<td>Monitoring</td>
<td>An ongoing process, done routinely. It does not require extra resources. Observations are fed directly into the implementation process</td>
</tr>
<tr>
<td>Needlestick injury</td>
<td>Wounds caused by needles that accidentally puncture the skin. Needlestick injuries transmit infectious diseases, especially blood-borne viruses. These injuries can occur at any time when people use, disassemble, or dispose of needles.</td>
</tr>
<tr>
<td>Organogram</td>
<td>A chart that clearly displays who is responsible for what in an organization and can also show how each person relates to another in management terms</td>
</tr>
<tr>
<td>Outreach</td>
<td>A systematic process where outreach workers go out into a community to directly contact the target population in their own environment and provide services to them.</td>
</tr>
<tr>
<td>Partner notification/ contact tracing</td>
<td>The process of identifying relevant contacts of a person with an STI so that they can be made aware of their exposure. Relevant contacts include those with whom the infected person has had sex during the infectious period of the particular infection.</td>
</tr>
<tr>
<td><strong>Peer educator</strong></td>
<td>Representative from a high risk group who is trained to educate and heighten the awareness of other members from the same high risk community on HIV/AIDS/STI prevention.</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Proctoscope</strong></td>
<td>A proctoscope is a rigid, hollow, tubular instrument about 10 cm long and 2 to 3 cm wide, with a central removable introducer. Short, plastic, disposable proctoscopes are recommended, to prevent cross-contamination. Metal proctoscopes that can be sterilised or disinfected between patients can also be used but must be warmed with water before insertion. Show the patient the proctoscope before you insert it.</td>
</tr>
<tr>
<td><strong>Purchase order</strong></td>
<td>The contract between an IA and a clinical service provider, where the IA buys clinical services from the provider. The contract includes aspects such as the provision of a doctor, nurse, counsellor and equipment necessary to provide STI care for patients.</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>In a health care setting, quality consists of the proper performance of interventions that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on the mortality, morbidity, disability and malnutrition of the target population (WHO).</td>
</tr>
<tr>
<td><strong>Quality Assurance</strong></td>
<td>A process through which an organization is accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating and environment in which excellence in clinical care will flourish.</td>
</tr>
<tr>
<td><strong>Safe sex</strong></td>
<td>Any form of sex where infected blood, semen or vaginal fluids does not pass directly from the body of one person into the body of another. This may include avoiding anal or vaginal intercourse, or the correct use of condoms.</td>
</tr>
<tr>
<td><strong>Sexual health examination</strong></td>
<td>A sexual health examination means that the doctor will do a thorough examination of the patients genitals. It means the patient will have to undress and expose the genitals, the doctor will inspect and palpate the external organs. He/She will also look at the cervix or rectum and do an internal examination with the hands if necessary. All of these things are done very gently and are not painful.</td>
</tr>
<tr>
<td><strong>Sexual health history</strong></td>
<td>A sexual health history means that the doctor will ask personal questions about who the patient has sex with, what kind of sex do they have, how often do they have sex, how best to enjoy sex etc. These questions are essential to assess the patient’s risk and make important decisions about treatment and prevention.</td>
</tr>
<tr>
<td><strong>Sexually transmitted infection</strong></td>
<td>Infections transmitted through unprotected sexual activity that generally infect the sexual and reproductive organs. These infections may have no signs or symptoms, but can still be contagious.</td>
</tr>
<tr>
<td><strong>Sharps</strong></td>
<td>Devices and equipment with sharp points or edges such as hypodermic and suture needles, intravenous blood collection devices, phlebotomy devices, scalpels, etc.</td>
</tr>
<tr>
<td>Sign</td>
<td>Definition</td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
</tr>
<tr>
<td>Signs</td>
<td>A visible body manifestation that serves to indicate the presence of malfunction or disease.</td>
</tr>
<tr>
<td>Speculum</td>
<td>A metal instrument that is inserted into the vagina and then opened so that the cervix and interior of the vagina can be examined</td>
</tr>
<tr>
<td>Sterilization</td>
<td>It is the third step in instrument processing and it ensures that instruments and other inanimate objects are free of all microorganisms including bacteria, viruses, fungi, parasites and also bacterial endospores. Because sterilization is the only procedure that kills all microorganisms it is preferred over High Level Disinfection when cleaning items that will come in contact with the bloodstream or tissues under the skin. It can be performed using steam (autoclaving), dry heat, or chemicals.</td>
</tr>
</tbody>
</table>
| Supportive supervision | Addresses staff’s needs for  
- Mentoring and coaching  
- Information, training and development  
- Supplies, equipment and infrastructure  
Considers staff as team members  
Promotes joint problem-solving  
Engages in two-way communication  
Provides technical update  
Delegates problem solving related to day-to-day problems  
Enables staff to continuously improve quality and meet clients’ needs  
Serves as liaison between site staff and institution. |
| Symptoms | Any sensations or changes in bodily function that is experienced by a patient and is associated with a particular disease. |
| Treatment | Administration or application of remedies to a patient for a disease or injury; medicinal or surgical management; therapy. |
| Universal precautions | “Universal Blood and Body Fluid Precautions” were a set of infection precaution recommendations introduced in 1985 by the Centers for Diseases Control of America due to threat posed by the HIV epidemic. They were developed mainly to protect hospital personnel from being infected with bloodborne pathogens such as HIV and Hepatitis B and C. Initially, Universal Precautions applied mainly to blood and other fluids containing visible blood and also to semen and vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid. Few years later these recommendations were updated to include not only blood and other fluids containing visible blood but also blood; all body fluids, secretions, and excretions except sweat, regardless of whether they contain visible blood; non-intact skin and mucous membranes. The new recommendations were called Standard Precautions but still now some people will refer to them as Universal Precautions. |
| Unsafe sex | Any form of sexual activity in which infected blood, semen or vaginal fluids could pass directly in to the body of another. There are a variety of sexual practices that can make this transfer happen, and this needs to be discovered through the sexual history. |
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