MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS USING SYNDROMIC MANAGEMENT APPROACH

A Service Provider's Handbook

Third Edition

May 2008

Ministry of Health - Malawi

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Section 1

About the Handbook

"What have you heard about sexually transmitted diseases?"

From: Uganda School Health Kit
MOH/UNICEF

PREFACE

By way of reducing the incidence of HIV and other STIs, the Fourth National Health Plan (1999 – 2004) identifies "adopting syndromic management of STIs in all health centres, with appropriate training" and "integrating STI syndromic management in training curricula of medical doctors, nurses, medical assistants and clinical officers" as two of the main activities towards this aim. The National Reproductive Health Strategy 1999 – 2004 and the Malawi National HIV/AIDS Strategic framework 2000 – 2004 further endorse the importance of improving the management of STIs both in their own right, and in the prevention of transmission of HIV.

The Malawi Government adopted the Syndromic Management Approach in STIs in 1992, a policy decision endorsed by the results of a STI care management survey by Chilongozi *et al* (1996). The Ministry of Health was assisted by JSI-STAFH project in the implementation in 5 pilot sites. Based on the results of the JSI-STAFH project evaluation in 1997, service providers and trainers handbooks were revised and the duration of the training was extended to two weeks.

This edition of the service providers handbook updates the earlier versions based on the review and revision of the SMA Flowcharts by the STI taskforce in 2002. The taskforce aimed to make the flowcharts more user friendly, which has resulted in merging the 4 separate flowcharts for Genitourinary symptoms in women into one flowchart named Abnormal Vaginal Discharge. Two new flowcharts have been introduced, one for recurrent urethral discharge and one for neonatal conjunctivitis. All antibiotic regimens recommended in the flowcharts are based on previous guidelines, WHO recommendations and clinical efficacy studies carried out in Lilongwe by the University of North Carolina Project in 2001 and 2007.

A new focus on the human aspects

This handbook maintains the core work on the syndromic management of STIs found in the previous manuals, with a focus on the **human** context in which the treatment and prevention occur. The assumption made is that the health care worker is as human as the client, and therefore faces the same types of difficulty in human and sexual relationships as the client. Many alternative approaches to communication in relation to safer sex and partner notification have almost entirely ignored the human difficulties people face in achieving either one, and many have been content with the delivery of simplistic messages concerning individual behaviour. This understanding has led to the initial focus in the Handbook on preparing the health worker in a number of ways both for the technical aspects of the work as well as for human skills in self-awareness and communication that will improve interactions with other staff and clients. Such skills will increase the likelihood that the work in the unit will be conducted in a better way, that the quality of care for the client is improved and that clients feel more capable of introducing change into their interactions with sexual partners.

The involvement of sexual partners

As was noted above, a particular deficiency of many previous approaches has been the focus on individual behaviour in the absence of the context of a client's life and the variety of factors that determine their real power to do things. A particular innovation in this Handbook is the move towards reviewing with the client the possibilities for dialogue

with their sexual partners so that they can increase the likelihood of treatment of the partner, and establish the most relevant methods of safer sex together.

Community aspects

The final chapter focuses on the role of the health care worker in the communities of which they are a part. A variety of roles are explored—from helping the health worker look at the difficulties posed for them in sexual and human interaction by social and other pressure, to seeing the opportunities for review of societal attitudes with various other members of their communities.

ACKNOWLEDGEMENTS

The Ministry of Health and Population wish to sincerely acknowledge all contributions that individuals and partner organisations have made towards the development of these guidelines. Specifically, the ministry wishes to acknowledge the financial contribution from WHO under the Sexual and Reproductive Health Programme, the technical contribution from the National AIDS Commission especially through the participation of Dr. Andrina Mwansambo in the STI Task Force and the STIs prevalence data and other technical inputs from the University of North Carolina funded project. Technical and financial support from WHO Malawi country office.

The ministry further wishes to acknowledge the valuable contribution of the Reproductive Health Unit, the College of Medicine, Banja La Mtsogolo, Malawi College of Health Sciences and others who are too numerous to name. All this would have not been possible without the dedication of the STI advisory group to see the guidelines through.

Thank you to all members of the STI task force for valuable contribution, including:

Mr. Mr. D. Chilongozi; UNC Project
Mrs H Milonde; KCH STI Dept.
Mr Gift Kamanga ; UNC Project
Dr Andrina Mwansambo-NAC
Mr. Ken Chirwa; MCHS
Mr H. Katengeza; MOH-RHU
Mr. A. Nkhata; MOH-HIV Dept
Dr..J.Kumwenda; COM
Dr. C. Mwansambo; KCH
Mr T Bonyonga BLM
Dr Sam Phiri; Lighthouse KCH

Furthermore, the ministry would like to thank the contributors of the 1993 STI treatment guidelines for laying out the fundaments on which the revised guidelines have been built:

Dr. G. Liomba; NACP
Mr. C. Forshaw; MEDP
Dr. R. Mataya; Blantyre Adventist Hospital
Dr. P. Kazembe; Kamuzu Central Hospital
Mr. S. Makombe; NACP
Dr. C. Costello Daly– STAFH project
Mr. R. Verhage; CMS
Dr. G. Lule: College of Medicine
Dr. E. Raatsma;Kasungu D. Hospital

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LIST OF ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
AVD	Abnormal Vaginal Discharge
BA	Balanitis
BU	Bubo (Enlarged inguinal lymph nodes syndrome)
CHAM	Christian Hospital Association of Malawi
GUD	Genital Ulcer Disease
AVD	Abnormal Vaginal Discharge in women
HIV	Human Immuno-deficiency Virus
IPCC	Interpersonal Communication and Counselling
LAP	Lower Abdominal Pain in women
KCH	Kamuzu Central Hospital, Lilongwe
MOH	Ministry of Health
MPC	Malawi Prescriber's Companion
MSTG	Malawi Standard Treatment Guidelines
NAC	National AIDS Commission
OPD	Outpatient Department
PID	Pelvic Inflammatory Disease
QECH	Queen Elizabeth Central Hospital, Blantyre
SS	Scrotal Swelling
STAFH	Support to AIDS and Family Health Project (funded by USAID, Malawi)
STI	Sexually Transmitted Infection
UD	Urethral Discharge
USAID	United States Agency for International Development
VDRL	Venereal Disease Research Laboratory slide test antigen
WHO	World Health Organisation

INTRODUCTION

Purpose of the Handbook

This Handbook was designed as a training tool and reference book for health care workers undergoing training on the syndromic management of STIs, conducted by the Malawi Ministry of Health (MOH) and the National AIDS Commission (NAC).

This Service Providers Handbook is expected to be used at every health facility, both public and private, throughout Malawi.

The Significance of STIs

Many developing countries, including Malawi, have high rates of sexually transmitted infections (STIs). Gonorrhoea, syphilis and HIV are among the most widely known, although there are more than 20 other STIs. Malawi's national HIV prevalence rate in 2008 was estimated to be 12% (the rate in women of reproductive age was estimated at 19.5%). There is also concern about the prevalence of syphilis—in 2007 the overall rate was estimated to be 1.1% (NAC 2007, HIV & Syphilis sero-survey). World-wide, an estimated 300 million people are infected with curable STIs every year (UNAIDS 2002), making STIs nearly as prevalent as malaria.

In Malawi, the prevalence of STIs other than HIV is high and the resultant drain on limited health care resources is substantial. Data from the MoH indicate that STIs are the fourth most common reason for outpatient visits to medical facilities. In addition to the large numbers who have symptoms, a great many more people are not even aware that they have an STI since they have no symptoms or are not aware of the symptoms. For example, a study of antenatal women at an urban clinic in Blantyre found that while only 11 percent reported having had an STI in the last 3 years, 42 percent actually had an STI at the time of the study (Dallabetta, 1993).

Failure to diagnose and treat STI at an early stage may result in serious complications and sequelae, including infertility, foetal wastage, ectopic pregnancy, anogenital cancer and premature death, as well as neonatal and infant infections.

Consequences of STIs

The consequences of untreated STIs can be devastating and include the following:

- blinding eye infections or pneumonia in new-borns (gonorrhoea);
- chronic abdominal pain or infertility in women (gonorrhoea and chlamydia);
- spontaneous abortion (syphilis);
- ectopic pregnancy (gonorrhoea and chlamydia);
- cervical cancer (human papilloma virus);
- infertility in men (gonorrhoea and chlamydia);
- death (AIDS and untreated syphilis);
- increased risk of HIV infection (most classical STIs);
- irreversible damage to brain and heart (late in the course of acquired syphilis);
- extensive organ and tissue destruction in new-borns (congenital syphilis);
- social disruption (e.g., divorce of infertile wives; spouse abuse related to learning partner is infected).

How are STIs transmitted?

There are three modes of transmission:

- sexual intercourse—the main mode;
- mother to child transmission - infection in neonates and infants may occur through in-utero or during birth;
- HIV can be transmitted through breast-feeding. It occurs in a small, though significant, number of infants whose mothers are HIV-infected.

The Link Between STIs and AIDS

The appearance of the human immunodeficiency virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS) have focused greater attention on the control of STI. The need for the control of STI has become more urgent since STIs are now recognised as independent risk factors for HIV transmission.

A person with STI has a much higher risk of *acquiring* HIV from an infected partner and a person infected with both HIV and another STI has much greater risk of *transmitting* HIV to an uninfected partner.

The risk of sexually transmitting HIV may be increased 5 to 10 times in the presence of a STI. While increased risk is highest for ulcerative diseases, the non-ulcerative diseases such as Chlamydia and Gonorrhoea are also known to increase the risk of acquiring and transmitting HIV during sexual contact due to an increase in the number of white blood cells (which have receptor sites for HIV) in the genital tract, and because genital inflammation may result in damage of genital epithelial tissues that can allow HIV to enter the body more easily.

HIV infection may complicate diagnosis and treatment of other STIs because HIV may change the patterns of disease or clinical manifestation of certain infections and may affect laboratory results. In people with HIV infection, STI symptoms may be more severe, the period of infectivity may be increased and standard treatments may fail. Independent of their role in HIV transmission, STIs and their complications result in substantial morbidity and mortality.

A study in Tanzania using community based Syndromic Management Approach of STIs, showed that the number of new HIV infections in the population was cut by 42%.

THE INTERRELATIONSHIPS BETWEEN HIV AND STI
• **The main mode of transmission of HIV and other STI is sexual intercourse**
• **The measures for preventing both are the same**
• **There is increased transmission of HIV in the presence of other STI**
• **HIV affects the natural history and possibly the response to therapy of a number of STI including, Chancroid, syphilis, genital herpes and genital warts**
• **There is possibly an acceleration in the progression of HIV disease in the presence of other STI**
• **Treating STI effectively reduces the transmission of HIV significantly**

Effective management of STI is an important cornerstone of STI control, as it prevents the development of complications, decreases the spread of these diseases in the community and offers a unique opportunity for targeted education about HIV prevention.

TRAINING OBJECTIVES

The training is organised with the following objectives:

GENERAL OBJECTIVE

To assist healthcare workers acquire knowledge, skills and right attitude in handling STI clients in the health facilities.

SPECIFIC OBJECTIVES

- To explain the importance of STI control in Malawi
- To identify and explain the common STI in Malawi
- To discuss the concept of STI comprehensive case management using syndromic management approach.
- To identify the STI syndromes and their management
- To explain the aspect of education and counselling for STI clients.
- To discuss case finding through partner notification and management of partners
- To demonstrate comprehensive STI case management using SMA flowcharts

EXERCISE 1

These questions will be asked during training

1. Describe current methods of safer sex.
2. State in broad terms the significance of STIs in Malawi.
3. Describe 6 consequences of infection with STIs.
4. Describe the three modes of transmission of STIs.
5. Describe the links between HIV and other STIs.

Section 2

Initial steps

Introduction

The story below illustrates some of the problems faced by a person with an STI. As you read this story, think about the person described and how the disease has affected her physically, psychologically and socially.

Chikondi is a 24 year old woman, married with 3 children. Her husband works and stays in town. He comes home every fortnight.

Seven days

A week after the last visit of her husband Madaliso, she started having excessive offensive vaginal discharge and some pains in her abdomen. She didn't know what it was and talked about it with her friend Nambewe. Nambewe told her that it might be a Sexually Transmitted Disease and advised her to see a traditional healer. Chikondi got embarrassed and angry since she has never slept with any other man than her husband, and did not do anything.

Eleven days

Four days later, Chikondi consulted a traditional healer without the knowledge of the relatives of her husband because she thought the relatives may think she has been going about with other men. The traditional healer gave her a concoction to drink twice daily for a week.

Eighteen days

However, after completing this treatment the symptoms got worse and the relatives of her husband (who was still in the town) decided to take her to the hospital, where she was not examined physically and was given white tablets to be taken while at home without any explanation.

Twenty days

Two days later she developed severe lower abdominal pains and was taken back to the hospital where she was examined thoroughly, and admitted with a diagnosis of severe Pelvic Inflammatory Disease for which she was treated. She was asked to inform her husband to come and be treated as well.

Twenty one days

When Madaliso came home, Chikondi shouted at him and blamed him for infecting her. First Madaliso refused to admit that he could have done such a thing but after a long argument he admitted that he had had symptoms when he last came home but had been afraid of informing her. Finally, Madaliso agreed to go for treatment.

The above story illustrates many of the challenges a person with an STI faces. Chikondi doesn't just have a medical problem. Instead, she has a medical problem which is complicated by a wide range of social and psychological issues, including problems with her husband and with her relatives. Because of these concerns, she delays in seeking treatment until she is quite ill. It is important in the above story to notice the long time intervals at each stage—in which time she remains ill and her husband remains infectious with whomever he has sex. And when she does seek help, she is not just seeking help for the illness but for the related problems. If these problems are not

addressed, she may not talk with her husband, running the risk of being re-infected. Even in deciding to talk to her husband, she may need advice on how to handle his anger and denial.

When a service provider sees a client with an STI it is not only the symptoms of illness that are the focus of attention. It is the whole client. Unless the service provider relates to the concerns of the whole client, the other concerns of education, partner notification, prevention of re-infection and counselling are unlikely to be effective.

When a person contracts an STI, the physical, psychological and social impacts of the disease affects not only the person alone, but also his/her sexual partner(s), members of his/her immediate and extended family, as well as friends and other members of the community.

It is for these reasons that the prevention and treatment of STIs requires a careful and holistic approach to the person who finally comes to a clinic for treatment (most often after considerable delay). It is not an STI that is to be treated—it is a person with a set of complex problems, being assessed by a person with the same cultural background and sensitivities.

As a service provider also has a life of their own, they will also face the same range of difficulties as their clients when it comes to being interested in or being able to practice safer sex, having concerns about being infected with HIV or STIs, or even about the ways in which they can interact with their colleagues or other people.

This manual therefore takes the service provider through a series of stages in which the various aspects that are important to the holistic management of people with STIs can be addressed—both from the point of view of the concerns of the service provider as well as from those of the client.

CASE STUDY 1

1. Identify two social or psychological issues that might delay a person from seeking STI treatment or from having safer sex.
2. Discuss the importance of addressing an STI as a psycho-social problem, as well as a medical problem.
3. Discuss the difficulties a service provider might face in relating to a client with STIs.

Introduction

Health care workers should be careful about their own attitudes, feelings, fears and prejudices before they can provide sensitive care to clients and interact with their colleagues in a productive way. The following story illustrates some of the ways that health care workers' attitudes, beliefs and personal circumstances can affect the way they work with colleagues or clients.

> *Chifundo is a nurse midwife who works in the STI clinic. She reports late for duty this morning because she has been up all night with her son who had a high fever and had to take him to a relative for care in the morning. When she arrives at the clinic at 9:00 am, she finds a long queue of clients in the waiting area. She immediately begins attending to the first client. She obtains the history of the illness and begins to examine the client. In the middle of examining the client, she realises that she had not restocked the drug supply the previous afternoon. With little explanation to the client, she rushes to discuss this matter with the pharmacist on duty. She doesn't close the door well and the embarrassed client has to pull on his pants to go to close the door.*
>
> *Chifundo returns to find the client complaining to the other clients. Chifundo continues the examination and finds the client has a urethral discharge. She then shouts "Why were you grumbling about me with those people outside? If you were more careful, you wouldn't have to come with this terrible disease to waste my time." The client leaves feeling embarrassed and angry, and vows to his friend in line that next time he will get medicine from the traditional healer who at least treats him politely. The others waiting in the queue express their agreement with this idea.*

This story illustrates how a health care worker's personal life, and his or her attitudes toward people can interfere with effective care. In the story above, Chifundo clearly had her own set of problems. It is hard not to sympathise with Chifundo. She is harassed, she has an ill son, and on top of that she hears people complaining about her. Is there any way she could react differently?

How Attitudes and Beliefs affect interactions

Health care workers are affected by their beliefs, attitudes and environment, just like everyone else. However, because they are professionals, they should look out for internal and external factors (such as attitudes, beliefs, cultural values and social norms) that might negatively affect their interactions with their colleagues and clients, and think how to minimise their impact.

Some common examples of attitudes and beliefs that might negatively affect client care are listed below:

- Being judgmental
- Being angry
- Blaming others
- Being embarrassed by sexual matters
- Rejecting the client
- Discriminating against the client because of his or her disease
- Disrespecting the client
- Feeling isolated professionally
- Feeling guilty or ashamed of one's work
- Feeling resentment toward clients
- Feeling inadequate or under-trained
- Feeling incompetent
- Feeling helpless
- Feeling fatalistic

These feelings are not unique to the workplace. They are not only in relation to STIs, although STIs are unique in many ways because of personal attitudes relating to sex and behaviour. You may have these feelings in many other situations. In normal life there are many ways of dealing with such feelings and reducing their impact on ourselves and others.

Managing feelings

Different people react differently to different situations and problems. In normal life, how do you learn to modify or control these reactions?

- Sometimes you can recognise your own reactions yourself and control them. Sometimes, just recognising the attitude or feeling helps decrease its intensity.
- Sometimes you hide your own knowledge of the reasons for your reactions and it takes others to tell you that you are not being fair, that you are taking out your own feelings on others.
- Sometimes elders will advise you that if a friend comes to you in an angry way, you should not confront them; or you may be told how to react in a different way to the person's reactions: to behave positively when the other person is negative. In many communities, when people quarrel or misunderstand, another person is brought in to mediate.
- At other times, additional information on a subject may diminish biases (e.g., when one learns that one cannot contract AIDS from touching a person with HIV infection, one is more likely to be friendly to the person).

In many cases, however, it is necessary to spend additional time looking at the situation to determine exactly why one is responding so strongly. In many cases, individuals can see where their own biases lie. This process may take place internally or it may involve interacting with supervisors, colleagues, family members or friends.

When trying to address attitudes and feelings that affect clients, interactions and performance, the following steps can be useful:

1. Acknowledge the feeling and recognise that it may be influencing your work performance or interactions with others.
2. Take some time to reflect on the feelings and attitudes. Consider how these attitudes may have influenced your behaviour.
3. Decide whether you think you can overcome these feelings by yourself.
4. If you don't feel you can overcome these feelings by yourself, decide who you could ask for assistance. Possible sources of advice might include colleagues, supervisors, friends or family.
5. If you have a supportive work team (discussed in the chapter on *Team Work* on Page 24), consider bringing your problem before the group. You might find that others have similar attitudes and feelings. You can then work together to develop strategies for addressing these problems.

Values Clarification

Values are ways of thinking that develop through individual experience, parental example, education and the internalisation of social, cultural and religious expectations. In many cases, people are not aware of their values or how those values affect their work and relationships. It is important for persons working with STI clients to examine their own values relating to sexual behaviour because these values may be reflected in negative attitudes toward persons with STIs. For example, a health care provider may feel that widows and teenagers who are not married should not have sex. If the provider lectures the client about not having sex, rather than discussing the different alternatives (e.g., abstinence, condoms) for avoiding the negative consequences of sexuality, the client may feel ashamed of discussing his or her situation with the provider. The provider would have then missed an opportunity for helping the client make an informed decision about his or her sexual behaviour.

Such beliefs and attitudes, and their effects on clinical practice, can be reviewed as part of a group using Values Clarification Exercises. These exercises provide a structured format for identifying attitudes, beliefs and values. Once each member has identified his or her basic values on a subject, the group discusses the issue and how the different attitudes reflected in the group might affect client care. In general, a wide variety of opinions are shared and group members begin to see that there are valid points in each person's way of looking at things. This can help individuals become more clear about their own values as well as encourage them to consider other perspectives.

CASE STUDY 2

1. Identify the external factors and personal attitudes that might have contributed to Chifundo's poor performance.
2. Discuss how Chifundo could have reacted more positively and professionally.

Introduction

Once you have looked at your own attitudes, what is the best way of approaching someone? Good communication and interaction is the backbone of effective health work. A health care worker who interacts with empathy, interest and respect with his or her colleagues, clients and community members is much more likely to achieve:

- better support at work,
- a productive session with the client,
- Effectiveness in raising issues in the community of which you are a part.

In the case of STIs, good communication and interaction is also extremely important in obtaining the interest of the client and relevance to their own situation so that they treat themselves properly and communicate with their partners.

The following stories show some of the ways that communication and interaction are important. **Remember that these stories also show the ways in which communication affects your interactions with anyone—including your colleagues.**

Nachisale's Story—Part 1

Nachisale is 18 years old. A few days after her boyfriend came to visit from town, she discovered sores on her genitals. When they didn't go away, she went to the village STI clinic. She was wearing her only dress which was ragged and stained. It had last been washed three weeks previously.

When she entered the consultation room, the service provider barely glanced up from his paperwork. He thought to himself, *"She smells terribly."*

"What can I do for you?" asked the service provider.

"I've sores underneath," said Nachisale. The service provider hardly looked at her, got his pen and scribbled on a paper. He told her to take it to the pharmacy to get medicines.

Nachisale went to the pharmacy and handed over the prescription to a man in a white dust coat at the window who avoided her eyes. He just collected the drugs (red and black capsules) and told her *"Take two tablets, four times a day for six days."*

Nachisale wondered what was wrong with her but was afraid of asking the clinician any questions so she accepted the treatment quietly.

Nachisale's Story—Part 2

Nachisale took the medicines for the next six days but there was no improvement in her symptoms. When she finally got up enough courage to tell her uncle about her problem, he decided to take her to another hospital which was 10 kilometres from her village.

Nachisale put on the same dress.

As soon as Nachisale entered the room, the service provider introduced herself as Anaphiri and offered Nachisale a seat. She had to help Nachisale take her seat because the sores made it difficult to sit properly.

Anaphiri looked at Nachisale and asked *"You look like you are in great pain, what is wrong with you?"* Nachisale explained that her boyfriend had recently visited her from town and two weeks later she had noticed sores on her genitals.

Anaphiri listened to Nachisale attentively while nodding her head. Then she asked Nachisale *"What did you do about this problem?"* Nachisale explained that she had gone to her village clinic where she was given some red and white capsules. She could not remember the names of the drugs but she produced a wrinkled paper and handed it to Anaphiri.

Anaphiri asked, *"Were you examined at the village clinic?"*

Nachisale said, "No".

Anaphiri asked *"What happened then?*

Nachisale said, *"I was given that ticket to collect drugs."*

"Then what happened?" Anaphiri asked.

"I didn't get better," said Nachisale, *"so I decided to come here."*

Anaphiri then examined Nachisale, explaining what she was doing. She explained the diagnosis and prescribed the correct drugs for treating the conditions she discovered during the examination. She advised Nachisale on how to take the drugs in the correct doses. She asked Nachisale whether she would be able to talk with her boyfriend to persuade him to come for treatment and to use condoms. When Nachisale said it would be difficult, Anaphiri helped Nachisale to think of ways in which she might do this.

When her boyfriend came to the village the following weekend, Nachisale had the confidence to discuss the issue with her boyfriend, and help him overcome his own anger. He then also went for treatment.

The Importance of Empathy

These two stories illustrate the difference between (1) disrespectful treatment of a person, combined with ineffective communication and (2) empathetic and respectful treatment of a person, using good communication techniques. In this situation, ask yourself:

"*If I were Nachisale, how would I like to be treated?*"

Review the two scenarios and imagine how Nachisale probably felt after each encounter. Consider also how the different types of interaction between the client and the provider affected the outcomes of the consultation. How are the two situations different?

Some possible answers include:

If I were Nachisale, after the first clinic visit I would have felt:

- Very embarrassed because I knew that I hadn't bathed properly and I looked poor.
- Very worried and scared as well since I didn't know what was wrong with me.
- Afraid of the examination.
- Afraid they would use unsterile instruments and I would get infected with HIV.

If I were Nachisale, after the second clinic visit I would have felt:

- Reassured by the second provider because she welcomed me and listened to my problem and explained what was wrong with me.
- Comfortable during the examination because the provider explained the procedure to me.
- Better when I left because she talked to me kindly.

Your own experience

The last time you were ill, what happened?

- How did you feel?
- What did you do?
- What do you think helped you?
- Would you have preferred anything to have been different in the ways in which people interacted with you?

If you answer these questions truthfully, you may find that you did not get out what you wanted to say, or that you would have preferred it if others had been more welcoming of questions, or that you would have preferred to have been able to consider options on your own.

A man named Limbani was asked the above questions, and these were the answers he gave:

> " I had a problem—a rash—and I was afraid it was HIV-related. I waited for quite a while and it didn't go away. Since I had become worried I told my wife, who is a nurse. She was very receptive, sat down and listened to my problem. She didn't take it emotionally but was serious about it. She said "lets hope it's not HIV-related". After looking at it she decided it was only a fungal infection. I went to the doctor to see if he could solve the problem. I went into his office, he told the two students to leave and then he shut the door. He examined me and explained what the problem was. Then he gave me medication. After a week I was disappointed because I didn't see any changes, but then I remembered the doctor had told me to continue the medication for a month when at that time, it would heal. He told me to come back then, if it hadn't."

Limbani described what happened to him when he had a symptom and was afraid it was HIV related. This was really the main problem—not the rash. However, he only asked his wife about the rash, as she was a nurse and because he knew she would be helpful—but he did not tell her about his worry about HIV. She listened without passing no any judgement or blame and because she was perceptive she reassured him that it may not be HIV related and advised him to see a doctor. The doctor was supportive, ensured

privacy and confidentiality by asking the students to leave the room and by closing the door. He listened carefully, examined Limbani and explained the problem. He gave medication to take for a month explaining that it would take that long for the rash to disappear. He also told Limbani to return if the rash didn't disappear after that time.

Limbani had a problem and indirectly asked for help by talking about the symptom. The entire process involved several aspects of communication including, no doubt, much body language that would have allowed his wife to see his hidden anxiety.

What do the stories tell us?

They clearly show us that people like to:

- Be talked to openly.
- Be listened to and to provide their own view of events.
- Be taken seriously.
- Be reassured.
- Know what is wrong with them.
- Like to have explanations given to them in clear and simple language.

The responses also show that having an illness is not just having symptoms—it raises other problems, often with worrying social implications to the sick person.

In Part 1 of Nachisale's story, the service provider did nothing to make Nachisale feel comfortable. In addition, he did not even conduct an examination before deciding on the diagnosis and treatment. He seemed more concerned about the offensive odour resulting from her discharge than about the fact that she was obviously embarrassed. Nachisale obviously felt that she could not ask any questions because the provider was either busy or uninterested. She left the clinic not knowing what was wrong with her or how to prevent it from happening again. In fact, because the provider did not emphasise the importance of treating her partner, she would probably have been re-infected quickly, even if she had received the proper treatment on this occasion.

Nachisale's experience in Part 2 was markedly different.

- The provider was **warm** and **helpful** and seemed **interested** in the problem presented.
- The interest was shown by asking **open questions** that tested the provider's ideas (or pre-conceptions), and helped the client respond.
- This provider conducted a thorough history and examination, and **explained** what she was doing during the examination. This helped her come to an accurate diagnosis and helped Nachisale learn more about her body and reasons for her current complaint.
- This provider also used the opportunity to **discuss** the possibilities of preventing STIs in future and of communicating with her partner.
- She was quite open without being **condemning** or **judgmental**. This probably contributed to Nachisale's confidence in approaching her partner about the matter of the present infection, as well as the need to take steps to avoid future infections.

How counselling differs

Limbani's story shows that it is helpful to separate this overall process of communication (or ways of interaction with another) from the process of counselling. Counselling is face to face communication in which one person helps another to review a range of options for further action, to make their decisions about these and to act on them.

Wider implications

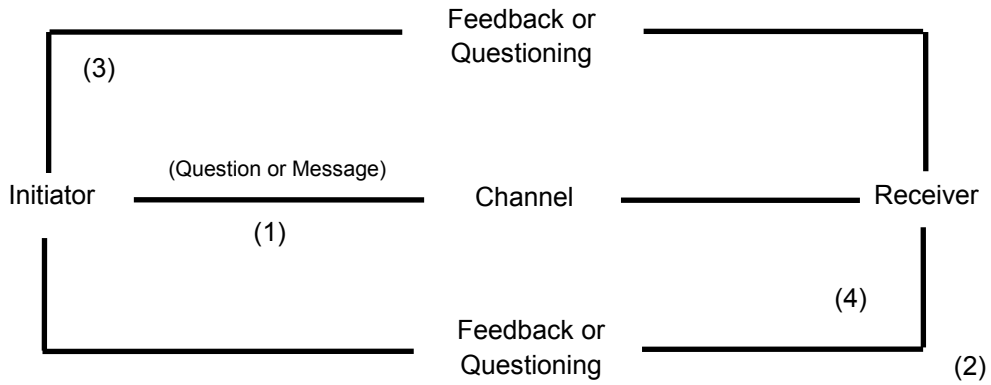
The overall processes of communication are applicable to all aspects of interaction with the client or with other people. Thus the same principles apply to counselling, which is a more specialised type of communication. Perhaps you can see how the same principles apply to your interactions with other members of the team in your unit—they will help form and maintain a good team.

The Communication Cycle

The stories above illustrate many of the basic principles of communication. Communication involves transmitting information, thoughts and feelings between persons through words, actions and symbols—as a result of asking questions or raising concerns or making statements. Communication has many purposes, including the following:

- Answering concerns or problems
- Establishing rapport
- Providing information
- Motivating
- Persuading
- Encouraging

The following diagram shows the dynamic and interactive nature of communication.



As this diagram shows, communication involves at least 2 parties: an initiator and a receiver. The *initiator* sends a *question or a message* through a *channel* to the *receiver*. The receiver then sends *feedback* to the initiator and the *communication cycle* is set off. Once the cycle is in motion, it is clear that the process is interactive and can have a variety of outcomes on both the initiator and the receiver. The initiator is generally the client who comes with a problem.

The effectiveness of communication depends on a number of factors. Some of these factors are

1. the clarity of the question or original statement,

2. the receptivity of the listener,
3. the agreement between the verbal and non-verbal channels of communication (i.e., what is said as well as how it is said)
4. The appropriateness of the medium for the type of message—e.g., individual counselling, group education, small media (such as leaflets and posters), mass media (such as newspapers).

Nachisale's story provides a useful context for examining how these factors can affect the outcome of a medical visit. In Part 1, it appears that very little communication actually took place. Nachisale's initial communication regarding her illness was clear but the provider was not very receptive, possibly because of his own biases. Although he did respond verbally, his non-verbal behaviour (not looking up, not doing an examination) suggested a lack of interest, which effectively shut off the communication process. Nachisale did not feel comfortable asking questions and was left feeling confused and uncertain. Thus, the provider lost an opportunity to gain additional information from Nachisale which might have proved useful, both in making the correct diagnosis and in encouraging treatment compliance and prevention.

In Part 2, the communication process was much more interactive. The second provider was warm and attempted to put Nachisale at ease—through her questions, the way she said things and through her actions. This set the stage for Nachisale to tell her problem in a more complete way. Because the provider did a thorough history and examination, she was able to make an accurate diagnosis. As important, however, she was able to influence the client to comply with the treatment and initiate changes in her sexual relationships.

To summarise, a good communicator has the following characteristics:

- Honesty
- Empathy
- Ability to pose open questions that explore the situation
- Flexibility
- Sensitivity
- Genuineness
- Good listening ability

While even the best communication, education and counselling skills do not always result in behaviour change, they can significantly increase the probability of change by allowing the client a chance to discuss the factors that make behaviour change more or less difficult. The acronym **CLEARR** is useful in remembering the key points necessary for good **VERBAL** communication skills:

Clarify **L**isten actively **E**ncourage **A**cknowledge **R**eflect and **R**epeat	**VERBAL SKILLS**

The acronym **ROLES** is useful in remembering good **NON-VERBAL** communication skills:

Relax Be **O**pen **L**ean towards the client appropriately **E**ye contact, as appropriate **S**it comfortably	**NON-VERBAL SKILLS**

As this chapter makes clear, empathy, respect and good communication skills are essential to improving work by improving interactions with colleagues and clients alike. These skills can improve diagnostic accuracy and treatment compliance, and play an important role in ensuring partner notification and prevention of future illness.

In all instances try to ensure that people do not feel rushed when trying to communicate. Give adequate **time** to any interaction, or at least make sure that what time there is, is used well—by concentrating attention on the people who are interacting with you and by using all the above skills

The physical environment

In addition to the social and psychological aspects of interaction, it is important to remember that you can ensure the physical environment is conducive to good interaction.

Make sure there is

* adequate space
* adequate ventilation
* cleanliness
* privacy
* lack of noise

Privacy is defined as space out of anyone else's sight and hearing where the client can raise his or her concerns and the service provider can examine the client without any interruptions.

PRIVACY AND CONFIDENTIALITY ARE ESSENTIAL!!!!

Interactions with colleagues

In the above cartoon, two members of staff are already quarrelling. Yet it is possible that with a bit more forethought, they could have avoided the situation by putting into practice the principles of communication mentioned above. Perhaps you will now be able to see how the use of **CLEARR** and **GATHER** can apply to almost any type of interaction.

CASE STUDY 3

1. Explain why communication is important in work related to STIs.
2. Give examples of effective and ineffective communication
3. Describe how the principles of communication relate to your interactions with your colleagues.

TEAM WORK

Introduction

A team is a "high-performing task group whose members are interdependent and share a common performance objective".

Both clients and staff benefit when there is good teamwork.

"*Mutu umodzi suzenza denga.*"
(*"A person alone can't lift a roof by himself.")*

Different aspects of teamwork are particularly important in the health care setting:

- The need for persons with different roles and skills to work together to achieve a common objective;
- The need for these persons to support each other in facing the many challenges of working together.

In a family, just as each member develops a role and is given a role by the others, so each one is dependent on the others for support and assistance. Similarly, friendship is never a one-sided thing—something that is given to you alone—it is something shared between people.

We often think that a good team is one that is able to provide us with the support and understanding that we need. When this does not happen, we often complain—forgetting that as part of a team we ourselves have a responsibility for the support and understanding of others. The actions of all the people in the unit, whether they are working directly together or not, have an impact on the lives and feelings of all the others in the unit.

As in any grouping of people, it takes a lot of effort to be a useful member of a team. You have to be able to:

- Develop a sense of responsibility for your role and for others;
- Accept accountability for your actions;
- Be trusted by the others.

These can only be achieved through your actions.

Demonstrating your qualities

The actions which demonstrate these qualities are that you are:

- Trustworthy;
- Open;
- Flexible in problem-solving;
- Accepting of others;
- Dependable in your role and your attendance;
- Willing to listen to the perspectives of others;
- Respectful of differences of opinion;
- Considerate and kind;
- Have a sense of humour.

If you do make such efforts, and those around you do the same, a feeling of being a member of a team nearly always comes about naturally. The sense of belonging is valuable for everyone.

Qualities you don't like

You can put some of these qualities in perspective by thinking for a moment about the qualities you do not like in other members of a team

- Selfishness
- Backbiting
- Being self-centred
- Dogmatic
- Rude
- Arrogant
- Domineering
- Dishonest
- Irresponsible
- Favouritism
- Unreliable
- Jealous
- Autocratic
- Remote
- No sense of humour
- Undermining of others

Now stop for a moment and think. Do you think any of these qualities might ever have been applied to yourself? It is very difficult to accept that this might be the case—and often we dismiss such accusations if we ever hear them by saying *"That's not true"* or *"They don't understand me"*. However, the important thing is that someone else may believe them, and we have to work hard to try to correct the impressions through our actions.

Some people think that being part of a team will keep them from expressing disagreement or maintaining their individuality. In fact, however, good teams encourage the expression of disagreement because understanding different perspectives on an issue often leads to a more balanced decision.

Starting and maintaining a team

Once people feel they are ready to work together as a team, they are ready to coordinate their activities and plan together. The decision to develop a team approach does not always have to come about as a result of a decision from a manager. It is in the interests of every member of a unit to try to get the team working together. If this is not currently being done, it may be useful to suggest it to others.

The next step is for each individual in the group to commit to working together as a group. The important issues here are ***reciprocity*** and ***accountability***. Reciprocity means that the group members offer support and assistance to each other. It is important to remember that the actions of each person in the unit have a direct impact on the others in the unit, as well as on the clients.

Teamwork builds as individuals take responsibility for working toward the common goal, and feel that they are accountable for their efforts to the others in the team. When each individual consistently does his or her best, both technically and inter-personally, team members begin to trust each other.

Who to Involve

Often you may feel that a team should only be composed of people that are doing the same job. In fact it should be composed of all those who have a common objective but who have different functions in meeting this objective. In a health unit (as will be discussed later in this section) a large number of people including the ground staff are involved in meeting the objective of care of the client and preparation of the unit. They are also involved in meeting the objectives of the special programmes or areas of special focus that the unit has as part of national planning. The unit team should have representatives of all these different aspects of the unit's work.

Different teams may be necessary for working toward different levels of an objective goal. For example, one objective of a health facility may be to provide effective and efficient client care. However, the director of a health facility may require different team members than a ward supervisor may require, because the level of the problems each person must consider is different. In many cases, individuals may be members of more than one team, such as when ward supervisors serve on the director's team while also contributing the teams on their own wards.

Common objectives

In starting as a team, it is important to try to come to agreement on the common objectives of the team as a whole. There are two types of objective for the team to consider:

- Task-oriented objectives;
- Problem-oriented objectives.

Task-oriented team objectives

The task-oriented objectives include tasks in which several or all members of a team are involved, such as client management. A good team would look at the range of activities for a unit and decide how best to monitor and evaluate these activities so as to improve the overall unit performance. Thus, in the example of client management, the team

would look at all the steps taken by a client from the time of entry to the unit to the time of departure and subsequent follow-up. These might include:

- Ensuring the correct reception of the client at the unit
- Ensuring the resources of the unit are sufficient for the correct management of the client.
- Accurate assessment of the client with accurate diagnosis and treatment of the condition
- Provision of education that is relevant to the client's situation and understanding.
- Provision of appropriate support and follow up to the client and his or her partners.

Problem-oriented objectives

Problem-oriented objectives often derive from analysis of task-oriented objectives. It might be, for example, that the team notices that few people are returning for follow-up of STI management. It would be up to the team to work out the principal reasons for this, and then to see what steps they should take to relate to the problem. In this particular example, the service providers will want to look at the issues with other members of the communities and groups of people they serve, and then explore possible solutions with the community groups [see the chapter on ways service providers can interact with their communities on page 127].

Another example might be that staff are noticing that most people with symptoms of STIs in their community prefer to go to a herbalist or to a local shop for drugs, rather than attend the clinic. This could be for a variety of reasons (people may dislike staff attitudes, they may be concerned over lack of confidentiality, they may believe the treatments are not effective, they may be too ashamed) but again it is up to the staff of a unit to explore these issues amongst themselves and in their own community.

In other words, the work of the staff and the team is now considered to extend beyond the clinic walls in order to address issues of interactions between the community and the clinic.

Rules

Once the team has established its goals and the steps necessary to achieve them, it should decide on regular meeting dates to monitor progress toward meeting these goals. Problems and obstacles will be an important focus of each meeting. Such meetings work best when certain rules of order are followed during each meeting. In particular, teams should strive to encourage participation and freedom of expression so that all members' views are heard. This can be done by having a chairperson who maintains order while helping to summarise and clarify issues brought to the floor. Supervisors, in particular, should be encouraged to listen carefully to the concerns raised by junior staff because this increases their sense of participation in and commitment to the teams' goals.

Rules for conduct might relate to:

- How to raise and handle disputes and concerns;
- When to meet and how frequently;
- Respecting each others' views;
- Encouraging active thinking and contributions;
- Freedom of expression;

- Setting boundaries (such as avoidance of intrusion into personal life);
- Meeting targets, deadlines, dates;
- Establishing times for joint exercises such as values clarification, or updating of knowledge;
- Involvement of all in planning and decision-making.

In-service Education

When a client comes to a health unit with an STI, the first person they meet is the receptionist or client attendant. They will often ask questions and advice of these staff, and even drugs or condoms. They then meet an STI service provider, and they may go on to see a pharmacist. In all this, the client is making an assessment of the human and physical environments of the unit, and of the service delivery and the ways in which they are treated.

Often clinical workers tend to think they are the only people who deal with clients and are the sole providers of a service. But the real fact is that even ward attendants and other non-clinical personnel are involved in providing services to a smaller or larger extent. They may also be fulfilling roles in their families and communities.

In this regard the STI service providers, like any other health personnel, should try to take time to educate non-clinical staff on the services being provided and the areas in which they are asked for information or advice.

Investment in these team members is likely to pay off in terms of client satisfaction because in many cases, clients seem to find it easier to ask questions and raise complaints to the non-clinical staff members. Thus, those staff members should have a general idea about the services provided in the clinic, and the process involved in obtaining treatment. In addition, when support staff understand how their work fits into the big picture, e.g., why it is so important to sterilise equipment properly, they are more likely to take pride in their work. This can be achieved by involving them in meetings, checking what clients or communities ask them, and finding out what they would like to learn more about. The in-service education can then be geared to their identified needs.

It is also important to remember that **everybody** learns in such interactions: thus it is possible for clinical staff to learn from the non-clinical staff things about client or community attitudes and beliefs of which they had had no idea.

Supportive Supervision

Supervision is an integral part of the effective treatment and prevention of STIs, yet it is often overlooked. When used properly, it provides team members with positive reinforcement for what they are doing well and concrete suggestions for improvement in areas where they have deficiencies. Many people have been exposed to harsh and critical supervisory styles and are therefore fearful that supervision will only involve 'checking on' or 'disciplining' them. Facilitative supervision is uses an approach that emphasizes mentoring, joint problem solving and two-way communication between the supervisor and those being supervised. It reminds us that traditional "inspection" alone is not conducive to helping facilities achieve continuous quality improvements. Team members can contribute their own ideas on how to improve individual and team performance.

The purpose of a supervisory system is to ensure the quality of program and clinic operations and to enable staff to perform to their maximum potential. Traditional approaches to supervision emphasise 'inspecting' facilities and 'controlling' individual performance. However, improving program performance and maintaining program standards works best when individuals begin to develop a sense of responsibility for their own actions, supported by a commitment to the objectives of the team. The supervisor merely facilitates this by clearly establishing the expectations and helping individuals determine what they need to do to improve their performance. Supervision then becomes less punitive and more supportive, and both clients and staff benefit.

Introduction

Chifundo's story in the chapter on '*Preparing Yourself*' (see Page 13) showed some of the difficulties that arise if the clinic is not properly prepared. Unfortunately, in some clinics professional staff may feel that it is not their responsibility to maintain equipment, handle the disinfection procedures or ensure the availability of supplies. They are all too ready to blame others if everything is not quite right.

The following statement from a Malawian Clinical Officer shows what happens when individuals do not take responsibility for cleaning up after themselves:

> " The reason I was not washing my hands in the hospital setting was that the clinical offices are shared. As a result, when you come you find that the tap and the sink are soiled with vomitus and faces, and you don't have the desire to wash because you feel like you will get more infections than what you already have. As a result, we examine several patients without washing hands. After seeing patients, I can wash hands either at home, or in the operating theatre dressing room where the sink and the taps are clean. The other problem is that the towels used for wiping hands remain unwashed for some time and are very dirty—so much so that clinicians don't use them."

When people become dispirited or frustrated they may not see alternatives. However, even with more conducive conditions, bad habits may develop and interfere with infection control procedures. For example, some clinicians interviewed during the evaluation of the STI program commented that most Malawians would not consider eating without washing their hands, and everywhere people ensure they find water to do so. Yet, because of habit or hopelessness, these same people may not make the extra effort to maintain hygienic standards in the clinic.

What maybe more surprising, however, is that some individuals do manage to maintain their standards, often displaying great ingenuity in the process. These are the words of a Malawian matron:

> " In one visit I went to a clinic in the north, I was surprised to find a medical assistant who had devised his own way of ensuring he could wash his hands between seeing each client. He had got an old intravenous saline drip bag and made an opening in the top into which to place water. He modified the delivery set and hung the whole thing over a basin so that he could open the flow of the water on to his hands."

To ensure that your own clinic provides clients and staff with the best possible work conditions, review the current situation with the team (see the chapter on *'Team Building'* on Page 24). Are there problems in getting equipment sterilised, in maintaining clean water and soap for hand-washing, or in keeping equipment in order? Ask yourselves "What can be done to overcome these difficulties?" Perhaps even more importantly, ask yourselves, "Who will take responsibility for doing these things and making sure that things get done properly?"

This chapter will help you address the most common concerns in clinic management. These include the following:

- management of materials, equipment & drugs
- preparation of the physical environment
- time management
- infection prevention
- record keeping and reporting

All team members must agree to work together to complete the tasks they agreed upon. Regular review of each of these areas will pinpoint problems and allow team members to develop ways to overcome them.

Management of Materials and Equipment

Ideally, a clinic which provides STI services should have the following:

1. Equipment

Trolley
Examination light
Bivalve vaginal specula
- Small
- Medium
- Large

Trays with covers
Gallipots
Receivers
Cheatle forceps container
Cheatle forceps
Sponge holding forceps
Basins (Plastic)
Autoclave or water-boiling steriliser
Torch/Angle-poise lamp
Pedal bin
Pails with lid (plastic)
- mop
- Glove
- Instruments

Sharps disposal container
Soap dish (prime store)
Cups
Fan
Water jug (plastic)

2. Supplies

Gloves
Soap/Vim
Cotton wool
Sanitary pads
Disinfectants
Mops
Brooms
Brushes
Stationery items

3. Furnishings

Mackintosh
Sheets
Draw sheets
Hand towels
Hanging rail and curtains
Hand towels
Pillows
Pillow cases

4. Furniture

Examination Couch
Table with drawers
Chairs
Small bench
Large bench
Stepping Stool

5. Client educational materials

Flipcharts for men/women
STI leaflets

Partner notification slips or rubber stamp
Posters

Demonstration penis

Management of Drugs

Stocks should be assessed at the beginning of each day. At least five complete courses of drugs for each syndrome should always be kept in stock. The following chart can be used for tracking drug stores:

DRUGS	AMOUNT IN STOCK	
	Clinic	Pharmacy
Gentamicin (80mg/2cc) vials		
Benzathine penicillin 2.4 MU vials		
Sterile water (10cc) vials		
Doxycycline 100mg tablets		
Erythromycin 250mg tablets		
Metronidazole 200mg (or 250mg) tablets		
Clotrimazole 500mg pessaries		
Clotrimazole cream		
Podophyllin paint 20% strength		
Syringes 10cc disposable		
Needles 21G disposable		
Azithromycin 500mg tablets		
Male Condoms		
Female condoms		
Cefotaxime injectables		

Logistics Management Information System

The LMIS is the MoH medical supply system of inventory management, recording and reporting for drugs, contraceptives and other medical supplies. The system ensures that all Malawians are able to receive the drugs they need and receive quality treatment when they visit a Reproductive Health Service Facility. The LMIS 01-A form (see next page) must be person in charge of drug stores to order contraceptives, STI drugs and other supplies from Central Medical Stores. The total quantity required will be calculated by the DHO pharmacist. Please note that the CMS will not provide any drugs without a complete LMIS 01A form from your facility. NO FORM = NO DRUGS!!!!

For further information about the LMIS and their forms, please see the “Malawi Health Logistics Management Systems Manual 2003”.

Time Management

The purpose of time management is to organise and arrange the use of time so that clients are seen efficiently and effectively. Time management is a skill that must be developed through practice. While it often seems more difficult at first than just reacting to what comes, disciplined practice of time management can ultimately result in much greater effectiveness and much less frustration. Some suggestions for improving your use of time are listed below.

- set objectives in order of importance
- list activities to be done to achieve the objectives
- provide some unscheduled time each day in order to flexibly attend to emergencies
- prioritise the activities

- develop a work plan
- delegate when possible or ask for extra help from supervisors

Avoid time wasters such as:

- ***long telephone conversations***
- ***Chatting with colleagues or drop in visitors.***
- ***delays in obtaining drugs and supplies from the pharmacy***
- ***interruptions caused by improperly arranged furniture***

Physical Environment

The physical environment of the health facility is important to both the health care worker and the client. A well-arranged workspace allows the provider to get his or her tasks done efficiently and with good humour. The basic requirements for creating a healthy physical environment are listed below:

- Good ventilation and adequate lighting
- A waiting area with adequate benches and IEC materials
- Consultation and treatment rooms with the necessary materials, equipment, furniture and drugs stocked, organised and labelled
- An established system for client flow and control
- Adequate audio or visual teaching aids
- Provisions for maintaining privacy

Record Keeping and Reporting

Records are important for documenting, controlling and assessing the services provided by the STI clinic. There are a variety of different types of records, which correspond with the different levels of management in the health care system. For example, there are individual client records, which document the diagnosis and treatment given at a particular contact, and there are monthly clinic records which indicate how many cases of a particular STI syndrome were seen in any given month. These records help both clinical and management staff assures quality client care and assess progress toward achieving the objectives of the STI clinic.

Some of the most common forms and records used in the STI clinic are described below:

- **Health Passport—**Every STI clients should have a health passport where information about the type of service given is recorded. The passport also contains personal information about a client. However, treatment should not be denied if the client does not have a health passport.
- **Partner Notification Card**—This card is used for notifying sexual contacts of clients of their possible exposure to an STI. One half of the card is given to the client to give to the partner, the other half is kept in the clinic.
- **STI Register**—This register is used to record the number of STI clients presenting each day with each diagnosis or syndrome plus amount of drugs dispensed.
- **HMIS OPD Register** - This register is used to record all clients who come to the OPD; both STI and non-STI. The HMIS code for STI clients is 31.

- **LMIS 01A Form**—this form is used to record the total number of drugs in stock, quantities used and quantity required from CMS.

All of these forms are relatively simple to use but provide important information on the client, the provider and the clinic. This type of information is extremely important in monitoring disease trends and the effectiveness of public health interventions. Therefore, these forms should be completed carefully and completely to ensure that the information is reliable and valid.

REPUBLIC OF MALAWI

MINISTRY OF HEALTH

Health Centre Monthly LMIS Report LMIS -01A

Facility		**District**			**Month** **Year**		
Item No	**Item**	**Strength**	**Unit of Issue**	**Balance (Stock on Hand)**	**Losses / Expired**	**Quantity Used**	**Quantity Required**
Family Planning Items, Safe Motherhood and Sexually Transmitted Infections' Items							
CS0002	Lofemenol	Tablet	cycle				
CS0006	Ovrette	Tablet	cycle				
CS0008	0.03mg ethinylestradiol + 0.15mg levonorgestrel	Tablet	cycle				
CS0012	Medroxyprogesterone acetate injection 150mg/mL vial (Depo Provera)	Vial	each				
CS0020	Conceptrol	Tablet	piece				
CS0024	Copper T		each				
CS0040	Norplant		set				
CS0036	Condoms		piece				
ST0414	Doxycycline	Tablet	100mg				
ST0173	Erythromycin	Tablet	250mg				
ST0261	Metronidazole	Tablet	200mg				
ST0262	Metronidazole	Tablet	250mg				
B0097	Gentamycin	Ampoule	10mg/ml, 2ml				
ST0590	Nystatin Pessaries		100,000IU				
ST0224	Benzathine Penicillin		1.44g				
ST0072	Syringe hypoluer disposable		21G				
ST0404	Gentian violet paint, aqueous						
ST0624	Podophyllum paint 15% in compound bezoic tincture						
ST0088	Determine HIV	100	tests				
ST0325	Hepatitis B	100	tests				
ST0090	Unigold	20	tests				
ST0092	Veronostika	92	tests				
SM0012	Black disinfectant (SM)	5L	5L				
SM0064	Diazepam 5mg/ml, 2ml	2ml	each				
SM0081	Syntometrine (Ergometrine 0.5mg+Oxytocin 10IU/ml)	1ml	each				
SM0170	Gauze swabs 8ply	10cm x10	100				
SM0214	Catgut chromic 0 on needle rb 1/2c	40mm	12				
SM0238	Maternity pads	20	20				
SM0242	Cotton wool	500g	500g				
SM0450	Sodium chloride	0.90%	each				

Submitted by [Name]:…… ……			**Signature:…… ……**			**Date:……**	
Processed by[Name]:……..			**Signature:…… ……**			**Date:…… …….**	

Introduction

Infection prevention in STI service delivery involves taking measures to protect clinical service providers and their clients from accidental infection during clinic procedures. While infection prevention has always been an important element of clinical practice, the advent of HIV and hepatitis B viral infections has served as a potent reminder of the importance of good infection prevention procedures.

Developing effective infection prevention procedures requires understanding the disease transmission cycle (see Figure 1 below). Disease transmission occurs when the infectious *agent* is able to travel from the *reservoir (*e.g., an infected person) into a *susceptible host*. For example, a person with hepatitis B (the person is the reservoir of the infectious agent) may have blood taken with a needle (*place of exit*). If the needle is then used to take blood *(place of entry*) from another person (susceptible host) without being sterilised (method of transmission), the organism may be transmitted from the first person to the second.

In the STI Clinic, either the client or the provider may be the reservoir, i.e., either may be the source of the infection. Thus, good infection control practices protect both. There are a variety of ways to prevent the spread of infection. The easiest way to prevent the spread of infection is to kill the agent and eliminate it from the reservoir (e.g., antibiotic treatment of a bacterial infection). However, because many infections are spread without the person who is the reservoir even knowing that he or she is infected, many infection control practices focus on decreasing the opportunities for the agent to leave the reservoir or to enter the host (e.g., wearing gloves during surgery).

Universal Precautions

The concept of universal precautions requires that all appropriate precautions be taken in handling blood or body fluids for all clients, rather than just those with diagnosed infection. It is based on the fact that many infections, such as HIV and hepatitis B, can be spread through blood and body fluids even when the client does not appear ill. **Body fluids which should be considered potentially infectious include any visibly bloody body secretion, semen, vaginal secretions, tissues, cerebrospinal fluid, and synovial, pleural, peritoneal, pericardial and amniotic fluids.**

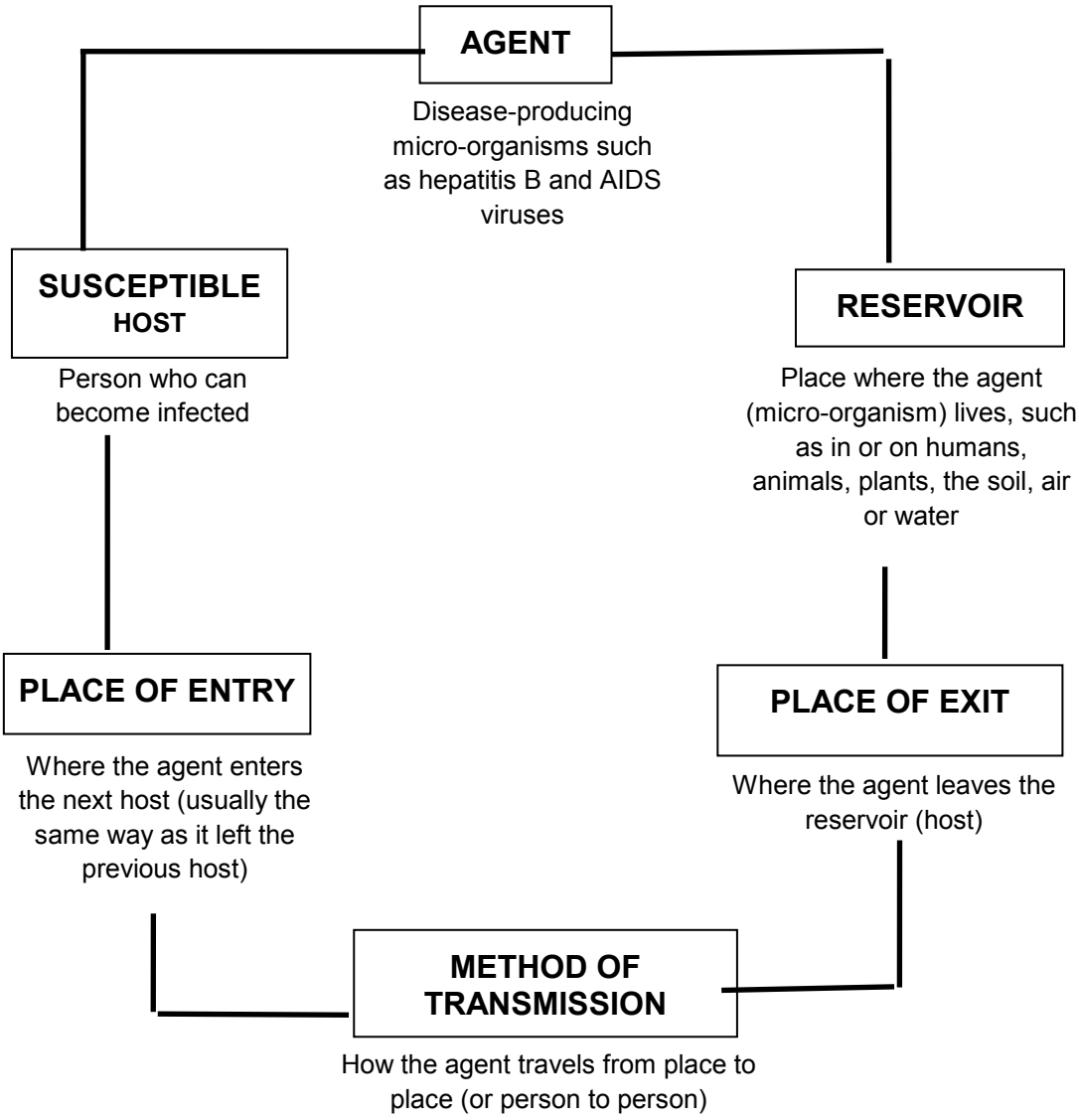
The basic principles of universal precautions are described below:

- Hands must be washed after contact with the client or potentially contaminated articles and before taking care of another client
- Articles contaminated with infectious material should be appropriately discarded or bagged and labelled before being sent for decontamination and reprocessing.
- Gloves are indicated when the possibility exists of coming in contact with blood or body fluids
- Gowns should be worn when soiling of the clothes is likely
- Gowns, masks and protective eye wear should be worn during procedures where splattering of blood or body fluids might occur.
- Hands should be washed after removing gloves and clean gloves should be used with each client

Note: There is no need to wear gloves or protective clothing when contact with the client is unlikely to result in exposure to blood or potentially infectious body fluids, e.g., shaking hands, delivering supplies and medications, removing trays, holding infants, bathing clients (without open sores).

Figure 1

The Disease Transmission Cycle



Basic Infection Prevention Methods

The basic principles of infection prevention are fairly straightforward if the following rules are remembered:

Take care of the	**skin**
Take care of the	**equipment**
Take care of the	**surfaces**
Take care of the	**linens and wastes**

Skin

Hand Washing

Hand washing with soap is one of the easiest, cheapest and most important infection prevention methods available. Clean, warm water should be used. Soap should be kept in a soap rack because micro-organisms can multiply while the soap is standing in water.

Hand washing is indicated in the following situations:

- before and after examination (direct contact with a client)
- after handling objects, such as used instruments, which might be contaminated with micro-organisms
- after touching mucous membranes, blood and body fluids (secretions or excretions)
- after removing gloves used during an examination (because gloves may have invisible holes or tears)

Wash thoroughly and promptly after accidental exposure to blood or body fluids. Even with puncture wounds, immediate washing decreases the amount of virus or bacteria in the wound, thereby decreasing the chances of infection.

Gloves

Gloves provide an important barrier to the spread of infection. Thick gloves can also protect against puncture by sharp objects that contain infectious material A separate pair of gloves should be used for each client to avoid cross-infection. New, single-use (disposable) gloves are preferable. However, gloves can be washed and sterilised, autoclaved or boiled between uses. Gloves should be used any time contact with blood or body fluids is expected.

Gloves which are cracked, or which have detectable holes or tears, should not be used. Remember to change gloves if they become torn or soiled during procedures. If gloves are not available, disinfected plastic bags are a good alternative.

In addition to using gloves, clean and cover any sores on the hands with a waterproof plaster. Infected blood, semen, vaginal secretions and body fluids containing blood can enter the body through tiny breaks in the skin. Providers can also transmit their own infections to clients if the provider has a cut or sore on his or her hands.

Gloves are indicated while performing the following tasks:

- Vaginal examinations
- Deliveries

- Instrument and linen disposal
- Instrument cleaning, disinfection and sterilisation

Antisepsis

Antiseptic solutions can kill many micro-organisms on the skin and other tissues, including most bacteria and many viruses. Use these solutions to clean the client's skin before and after any procedure, such as draining a bubo.

Equipment

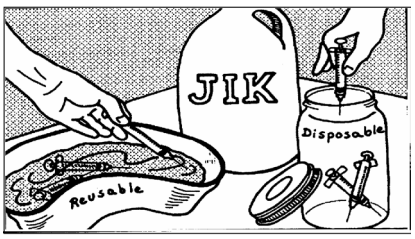
Needles and Other Sharp Equipment

Be particularly careful when handling needles, blades and other sharp instruments. Needles are in contact with blood, tissue and body fluids and, because they are so sharp, they can easily puncture the skin of those handling them. A puncture wound from a used needle allows a concentrated amount of infectious agent into the body.

Use the following precautions when working with needles, blades or sharp instruments:

- Immediately put all disposable needles and syringes into a puncture-proof container
- Immediately put all reusable sharps into containers containing 0.5% bleach solution. Leave to soak for at least 10 minutes before cleaning.
- Do not detach needles from disposable syringes
- Never recap needles

Note: If needles have to be recapped, never hold the cap while doing so. Rest the cap on the edge of a table and slide the needle in.



Decontamination

Decontamination is the first step in handling soiled equipment instruments, reusable gloves and other items. Used equipment and supplies are immersed in a bleach solution immediately after use to destroy micro-organisms. This step serves to protect staff who will handle and dispose of items which have been in contact with blood and body fluids.

Immediately after use, all equipment which has been used for examination or treatment should be placed in a 0.5% chlorine solution for 10 minutes.

The following chart should be used to prepare a 0.5% chlorine solution from pre-made solutions:

Brand of Bleach, % chlorine	**To obtain a 0.5% chlorine solution**
JIK 3.5% chlorine	1 part JIK bleach to 6 parts water
Household Bleach 5% chlorine	1 part household bleach to 9 parts

	water

To Prepare 0.5% Chlorine Solution from Liquid Bleach follow these instructions:

Read the bleach bottle label and find the (%) percentage available chlorine (or active chlorine/chlorum). If your bleach comes in unlabelled bottles in is important to find out the percentage of available chlorine from the supplier.

Use this formula to determine how many parts of water to mix with one part of bleach:

$$\left(\frac{\%\_available\_chlorine}{0.5}\right)-1$$

$$\left(\frac{5}{0.5}\right)-1=9$$

For example; if the bottle contains 5% chlorine, you now mix 9 parts of water with 1 part of bleach.

If the bottle says 48° chlorum (0.3%) = 14.4% active chlorine
(**round to 28**): You now mix 28 parts of water with 1 part of bleach.

$$\left(\frac{14.4}{0.5}\right)-1=[28.8]-1=27.8$$

Cleaning

Cleaning is an important step in providing safe, infection-free equipment, instruments and clinic facilities. A thorough cleaning of equipment or instruments with detergents and water physically removes organic material such as dust or oil. Prior decontamination in bleach solution makes cleaning easier because chlorine breaks down protein. Instruments should be cleaned with a brush in soapy water. Particular attention should be paid to toothed instruments, and instruments with screws or other areas where organic material can collect. After cleaning, instruments should be thoroughly rinsed with water to remove any detergent residue which might interfere with disinfection.

High Level Disinfection

Sterilisation is the safest and most effective method for processing instruments which come in contact with blood, tissues or body fluids. **When sterilisation equipment is not available or not suitable, high level disinfection (HLD) is the only acceptable alternative.** HLD destroys all micro-organisms, including viruses causing Hepatitis B and AIDS.

HLD is achieved by either boiling in water or soaking instruments in chemical disinfectants such as glutaraldehyde (e.g. cidex, sporicidin or Chlorhexidine) or 8% formaldehyde. Because boiling requires inexpensive equipment, which usually is readily available, it is the preferred method for small clinics or those located in remote areas. Regardless of the method selected, HLD is only effective when soiled instruments and

gloves are decontaminated and thoroughly cleaned and rinsed prior to disinfection. This process must monitored regularly by senior staff because of its importance to the health of both clients and staff.

To achieve high level disinfection through boiling, instruments must be boiled for at least 20 minutes. **Timing** should begin when the water reaches a rolling boil. All instruments should be totally submerged and nothing should be added to the container after boiling begins.

Boiling Tips

- Start timing when the water begins to boil
- Boil for 20 minutes in a container with a lid
- Completely cover all items with water during boiling
- Never add anything to the pot after boiling begins
- Air dry before use or storage

Chemical Disinfection

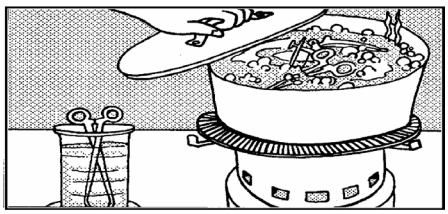
A variety of chemical disinfectants suitable for chemical disinfection are available world-wide. These include the following:

- Chlorine
- Formaldehyde (Formalin)
- Glutaraldehyde (cidex, Chlorhexidine)
- Hydrogen peroxide

For HLD, all instruments must be completely immersed in disinfectant for 20 minutes and then rinsed well in boiled water.

Sterilisation

Instruments and other items that come in direct contact with the blood stream or tissues under the skin, such as reusable needles, syringes and scalpels, should be sterilised*.* Sterilisation completely destroys **ALL** micro-organisms, including bacteria, viruses, fungi, parasites and endospores. Bacterial endospores are particularly difficult to kill because of their tough coating. Bacteria that form endospores include *Clostridia* species, which cause tetanus and gas gangrene. Sterilisation is done after instruments, gloves and equipment have been decontaminated, cleaned, rinsed and dried.



Surfaces

Surfaces in work areas should be cleaned as specified below with disinfectant solutions. The following solutions may be used for decontaminating surface areas:

- 0.5% chlorine bleach solution
- 5.0% solution of Lysol or other phenols
- Carbolic acid
- Zephiran
- Phisohex and other antiseptics

Routine cleaning of work surfaces is imperative for infection control. Gloves should be worn when cleaning. Different surfaces should be cleaned at different intervals, depending on their function, as specified below:

- Examination tables should be wiped after every client and thoroughly cleaned once a day
- Examination trolleys should be cleaned once a day or when spils more often
- Floors, walls and counters should be cleaned with a bleach solution as needed
- Spills of body fluids or blood should be cleaned **immediately**. First cover the spill with a 0.5% chlorine bleach solution and mop up after 10 minutes.

Linens and Wastes

Linens

Linens can become contaminated with blood and body fluids which can spread infection to those who handle them. Therefore, dirty linen should be handled as little as possible. The following procedures should be followed to launder dirty linen:

- Linen with large amounts of blood should be soaked in a 0.5% chlorine bleach solution for 10 minutes prior to washing
- All linen should be washed with soap and hot water
- Linen should be hung in the sun to dry, when possible

Disposal of Contaminated Wastes

Contaminated waste includes sharps, papers, dressings, swabs and other disposables which are soiled by blood and body fluids, such as vaginal discharge, urethral discharge and pus. Such materials should be put into a labelled, covered container and burned or buried. Careful disposal of contaminated wastes protects those who collect the rubbish. Burning or burying provides safety from contaminated objects than can remain infectious for several days. Contaminated rubbish should be collected at the end of every clinic day and burned at least 10 metros away from the clinic or houses.

Traffic Flow and Housekeeping Considerations

Heavy traffic increases the number of people who may be exposed to infectious agents. Therefore, client areas should be arranged so that there is minimal traffic where examinations and procedures are carried out. Soiled objects should not be allowed to cross paths with cleaned, disinfected or sterilised items.

Housekeeping staff should always use gloves to avoid contracting infection. Separate equipment (brushes, clothes) should be used for cleaning heavily contaminated areas (e.g., toilets).

Section 3:

Diagnosis & Treatment

CLIENT MANAGEMENT

Definition

Client management refers to the idea that successful treatment of a person with an illness may involve attention to the social situation and emotions of the client, in addition to the physical aspects. Management of clients with STIs, then, implies that the client is seen as more than just an illness, and that the many different factors that affect the successful treatment of the client are considered (such as helping the client discuss treatment of their partners with their partners). In fact, this comprehensive approach is really the only effective approach to management of clients with STIs because these illnesses do not occur or spread in isolation of social and inter-personal factors.

Components of Client Management

Because client management involves attention to both the medical and psycho-social aspects of the illness, it may seem needlessly time-consuming. In the short-term it may, in fact, slightly increase the time necessary for each client. Ultimately, however, this time is well-spent because it increases the likelihood that the client will comply with the treatment, discuss the issue with his or her partner and take steps to prevent future infection. The key components of client management are discussed below. Suggestions for implementing these components into the clinical contact will be discussed in more detail later using the GATHER acronym to make the steps easier to remember.

The primary components of successful client management are listed below:

Privacy. The consultation room should provide both auditory and visual privacy, so that the client feels comfortable during history taking, examination, treatment and counselling.

Confidentiality. The client should be assured that all conversations between client and healthcare worker will remain between the two of them and kept from other health care workers and patients.

Professionalism. Some of the key elements of professionalism are courtesy, respect, and maintenance of confidentiality.

Accurate syndromic diagnosis. This can be achieved by taking a thorough history and conducting a good examination.

Effective treatment. Effective treatment depends on accurate diagnosis, availability of appropriate drugs and client compliance**.**

Client education. [See page 103] Client education is necessary to ensure treatment compliance and prevent future infections. Among the items to be discussed are the following:

* The nature of the infection, its mode of transmission and complications associated with the infection.
* How to avoid infecting others and how to prevent future infection of oneself.
* Helping the client to discuss with his or her partner(s) how to achieve safer sex, and how to ensure treatment of the partner(s).
* Follow-up care.

Using the "GATHER" Acronym to Improve Client Management

The **GATHER** acronym was developed to make it easier to remember the steps in the client management process. Client management using the **GATHER** process begins as the health worker meets and interacts with a client and ends when the client is successfully treated or returns for referral or follow-up.

Greet
Ask clients about themselves
Tell basic facts about STIs
Help
Explain
Return

Each step in the **GATHER** process can be further broken down. Detailed instructions for each stage of the process are discussed below.

"GREET"

- As soon as you meet a client, give him or her your full attention
- Be polite, greet him or her, introduce yourself and offer a seat
- Ask how you can help
- Reassure the client that you will not tell others what he or she says
- Conduct counselling where no one else can see or hear

"ASK"

- Ask how you can help
- Assess client's knowledge and needs in relation to the presenting STI syndrome
- Ask about symptoms (more detailed information is available in the chapter "*History taking and Physical Examination*").
- Conduct a physical examination

"TELL"

- Tell the client about the presenting syndrome and how it is spread
- Tell the client about ways to avoid spreading the STI or being re-infected

"HELP"

- Help client make an informed decision about prevention (e.g., abstinence vs. condom use)
- Help the client think of ways to change risky behaviour

"EXPLAIN"

- Explain the findings of the examination
- Explain how to take drugs and what side effects might occur
- Explain about the importance of finishing the whole course of drugs
- Explain and demonstrate condom use
- Advise on not taking alcohol while on treatment, especially Metronidazole
- Explain contact tracing and partner notification
- Explain about follow-up

"RETURN VISIT"

- Make an appointments for a return visit
- Refer when necessary
- Repeat the GATHER process at the return visit

Using the GATHER acronym ensures that the client management process is done consistently and completely with each client.

YOUTH FRIENDLY SERVICES

Youth friendly services are defined as "*high quality health services that are relevant, accessible, attractive, affordable, appropriate and acceptable to the youth*".

Youth are just beginning to learn about sexuality and may be embarrassed or hesitant to talk about it. They may be dealing with a wide range of issues related to their sexuality, some of which can be very sensitive, such as peer pressure, sexual identity, sexual capability or sexual coercion. By using good communication skills, providers can offer youth the opportunity to express and understand their feelings about this complex subject. This in turn can result in healthy sexuality and more responsible sexual behaviour, which can prevent STIs.

Good communication skills include "reflective listening," where the provider paraphrases a statement or question and repeats it back to the youth. This can show understanding of the words, as well as concerns and feelings. Also, open-ended questions, which allow youth to talk freely, should be used. Positive body language, such as nodding to indicate that the provider is paying attention, is also important.

Providers can better communicate with youth by being sincere, honest, open-minded, non-judgmental, maintaining privacy and confidentiality. It is helpful to show respect, using a sense of humour, and show that they really care about the young person's situation.

Confidentiality is very important in serving youth. Where possible, a young person needs to be assured that information discussed will not be revealed to others.

Equipping the youth with life skills is vital and this includes decision making, assertiveness, negotiating skills just to mention a few.

Research has shown the value of sex education for the youth. The World Health Organization reviewed 1,050 scientific articles on sex education programs and found that such programs do not lead to earlier sexual activity and, in some cases even delay first intercourse. Also, beginning sex education before youth initiate sexual activity can help them develop healthy approaches to sexual behaviour before they establish unhealthy practices.

Services for youth need to be where youth are and be well-designed.

Long waiting times, impersonal staff, or judgmental providers may easily discourage youth.

Introduction

Traditional diagnosis of STIs has relied on identifying the organism causing the symptoms through sophisticated laboratory diagnosis. This is expensive and impractical in most developing countries. Even when laboratory facilities are available, it may take several days to conduct the laboratory tests and to get the results back. If the client does not receive treatment until the test results are back, he or she may have continued to spread the disease during this period.

The *syndromic approach* to STI management is based on the fact that the most common causes of STI infection generally present with certain groups of signs and symptoms. A consistent and commonly occurring group of signs and symptoms is known as a ***syndrome****.* For example, urethral discharge might be caused by *Chlamydia trachomatis or Neisseria gonorrhoea*. Thus, the symptom of urethral discharge would be the basis for identifying the syndrome. The client would then be treated for the most common infections that might have caused that particular set of symptoms and signs. In the case of urethral discharge, for example, the treatment would target both *C. trachomatis* and *N. gonorrhoea*.

What are the benefits of syndromic management?

Effectiveness

- The degree of over-treatment required is acceptable when measured against the efficiency of syndromic management and the costs of failing to treat patients for their infections, which can happen with other approaches.
- It is very difficult to make lab-based diagnosis effective or efficient, since it often misses organisms that may be present, and takes time.

Efficiency

Syndromic management is an efficient way of delivering health care to STI patients.

- The approach does not require highly-trained STI specialists, nor does it require laboratory analysis. This means that patients can be treated on their first visit to a health centre.
- There are none of the delays inherent in an aetiological approach.
- Treatment can be available wherever health services are available, so reaching far more of the population.

Outcomes

- Rapid and effective treatment, rendering clients symptom-free and non-infectious.
- Less suffering and less infectivity on the part of clients because they begin treatment immediately.
- Quick and effective therapy can promote appropriate health-care seeking behaviour for future illnesses. It can also provide clients with an incentive to notify their partners to seek treatment.

Difficulties in using the syndromic approach

In general, the advantages above outweigh the difficulties. However, it is important to be aware of these difficulties, since an evaluation of the syndromic approach in Malawi revealed that when the difficulties are not attended to, the approach does not work well.

- It requires extensive in-service training of service providers. To ensure the quality of syndromic management of people with STIs, clinicians must be trained to recognise the STI-associated syndromes and use the management flow-charts.
- It requires regular monitoring of the performance of staff since one-off training is not sufficient to help staff in an entirely new approach.
- It requires extensive orientation of managers and supervisors in health facilities, as well as of other staff, since there are many changes required in the management of drugs and of interactions with other staff.
- The long-term continued availability of the recommended drugs is essential in the achievement of quality care. The lack of specificity in the diagnosis requires that several drugs to be used when in fact only one pathogen may be present. This is a cause for concern in countries where drugs are in short supply. However, the magnitude of the STI epidemic, and its significance in the spread of HIV infection, supports the use of the syndromic approach in countries with high rates of HIV and STI infection and limited laboratory facilities.
- There must be continued epidemiological surveillance of the organisms that cause the syndromes and their resistance to drugs.

Dangers of not doing it correctly

If the syndromic approach is not carried out with an emphasis on the highest possible quality of care and accuracy of following the flowcharts

- The rate of resistance of the causative organisms to drugs increases rapidly, making the treatments ineffective.
- The increase in resistance means the need to find new and more expensive drugs, which will make it difficult to sustain as an approach.
- Clients see that they are not being treated effectively, and find alternative modes of treatment.

Common STI Syndromes

The most common STI syndromes, along with possible causes of each syndrome, are listed in the chart overleaf:

STI Syndromes

	STI SYNDROMES	CAUSES OF SYNDROMES	SYMPTOMS	SIGNS
Flowchart	Genital Ulcer Disease	• Genital Herpes • Syphilis • Chancroid • Granuloma inguinale • Lymphogranuloma venereum • *Differential Diagnosis: Trauma*	• Sores on the genitals • Pain • Swollen inguinal glands • Discharge	• Ulcers or sores on the genitals • Discharge • Phimosis • Bubo • Swelling of the genitals • Bleeding (typically associated with trauma)
Flowchart	Urethral Discharge	• Gonococcal infection • Chlamydial infection • Trichomonas vaginalis	• Urethral discharge • Burning sensation when passing urine	• Urethral discharge
Flowchart	Lower Abdominal Pain in Women	• Pelvic Inflammatory Disease caused by gonococcal, chlamydial and anaerobic bacterial infection *Differential Diagnosis* • Ectopic pregnancy • Incomplete abortion • Appendicitis	• Lower abdominal pain • Increased vaginal discharge • Vaginal bleeding • Side pain	• Fever • Lower abdominal tenderness on palpation • Vaginal discharge • Cervical excitation tenderness • Vaginal bleeding • Pelvic mass • Tenderness on the affected side • Rebound tenderness • Guarding

	STI SYNDROMES	CAUSES OF SYNDROMES	SYMPTOMS	SIGNS
Flowchart	Abnormal vaginal Discharge	• Candida • Trichomonas Vaginalis • Gonorrhoea • Chlamydia • Bacterial Vaginosis	• Abnormal vaginal discharge • Vaginal or vulvar itching • Bad odour • Vulvar swelling or soreness • Dysuria	• Abnormal vaginal discharge • Vaginal or vulvar inflammation • Inflammation of the cervix • Pain on cervical excitation
Flowchart	Scrotal Swelling	• Gonococcal infection • Chlamydial infection *Differential Diagnosis* • Trauma • Torsion of the testes • Mumps • Other bacterial infection	• Scrotal swelling • Scrotal pain on one or both testes • Urethral discharge	• Swollen scrotum • Tender scrotum • Redness of the scrotum • Urethral discharge • Fever
Flowchart	Inguinal Bubo	• Chancroid • Lymphogranuloma venereum *Differential Diagnosis* • Infected wound	• Swelling and pain in the inguinal region	• Hot, tender and painful swollen inguinal lymph • nodes • Abscess formation in the inguinal lymph nodes • Fever
Flowchart	Balanitis	• Trichomoniasis • Candidiasis • Bacterial infection • Poor personal hygiene	• Itching and pain of the glans penis • Phimosis • Discharge on the glans penis	• Follicular-like rash on the glans penis • Redness on the glans penis • Discharge on the glans penis • Phimosis
Flowchart	Neonatal conjunctivitis	• Gonococcal infection • Chlamydial infection • Bacterial / viral infection • Allergy	• Profuse purulent bilateral discharge	• Swollen red eye lids • Red conjunctiva • Profuse purulent bilateral discharge

EXERCISE 2

1. Complete the following table. Fill in what you think should appear in blocks marked with an "X":

Patient will complain of (i.e., symptoms)	Abnormalities that you may find (i.e., signs)	STI Syndrome (i.e., diagnosis)	Causes of Syndrome
X	Discharge coming out of the urethra	Syndrome of urethral discharge	Gonorrhoea Chlamydia
Sores on genitals Pain in genitals	X	Syndrome of genital ulcer disease	Genital herpes Syphilis Trauma Chancroid Granuloma inguinale Lymphogranuloma venereum (LGV)
X	X	Syndrome of abnormal vaginal discharge in women	Candida Trichomonas Bacterial Vaginosis Gonorrhoea Chlamydia
Lower abdominal pain in women	X	Syndrome of lower abdominal pain in women	Pelvic inflammatory disease (which is caused by gonococcal, chlamydial and anaerobic bacterial infection) Ectopic pregnancy, incomplete abortion, appendicitis
X	Swollen scrotum Swollen and tender testis	Syndrome of scrotal swelling	Gonococcal, chlamydial or bacterial infection Trauma Torsion of the testis Mumps orchitis
Swelling and pain in the inguinal region	X	Syndrome of inguinal bubo	Lymphogranuloma venereum (LGV), Chancroid (if ulcer is present)
Male patient complains of itchiness of the penis	X	Syndrome of balanitis	Trichomoniasis, candidiasis, and bacterial infection

Introduction

The STI Flow Charts are decision trees, which help a nurse/clinician to arrive at a syndromic diagnosis and determine the correct treatment or management plan for the client. Each flow- chart is made up of a series of steps which are shown inside boxes. Flowchart have 4 - 6 major components:

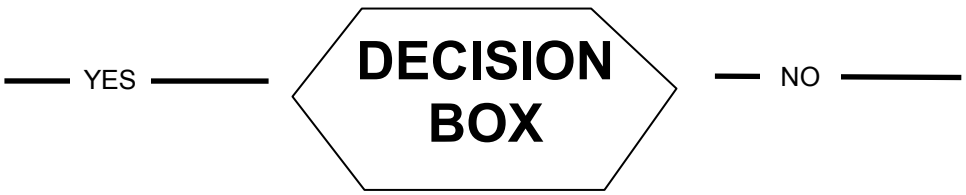
- A description of the presenting problem **(HISTORY BOX)**.
- A question regarding distinguishing features of related syndromes that are used to rule in **(QUESTION BOX)**
- Or out various diagnostic alternatives **(DECISION BOX).**
- A description of the actions that need to be carried out, based on the syndrome identified **(ACTION BOX)**
- Treatment that is supposed to be given to the client basing on the accurate syndromic diagnosis (**FIRST LINE TREATMENT BOX).**
- Additional information that clarifies a question, diagnosis or treatment **(INFORMATION BOX).**
- Information which helps to assess the risk of the client **(RISK ASSESSMENT BOX)**

The flowcharts are designed to be read following the direction of the arrows.

To use a flow chart, start with the presenting problem and proceed step-by-step from the History Box, through the various Decision Boxes, until you arrive at the Action/First Line Treatment Box. The flowcharts are designed to be read from top to bottom, following the arrows. The notes which go with the flow chart for the management of each syndrome should be read in conjunction with the appropriate flow chart. There are four types of boxes:

History Box: This always appears at the beginning of the flowchart.

Decision Box: This type of box contains a question. There are two possible paths out of the box. One is marked “yes”; follow this path if the answer to the question inside the box is “yes.” The other path is marked “no”; follow this path if the answer to the question inside the box is “no.”



Action Box: This type of box contains instructions for the clinician, such as treatment.

First-line treatment box: This rectangular box with a double border indicates the first-line treatment for the flowchart syndrome.

Information box: This rectangular box with small dotted borders gives additional information that clarifies a question, diagnosis or treatment

Risk assessment box: This rectangular box with large dotted borders helps to assess the risk of the client

Advantages and Disadvantages of Flowcharts

The advantages and disadvantages of using the STI Clinical Flowcharts are listed below.

Advantages

- Are problem-oriented
- Increase diagnostic reliability
- Can be used as training tools for primary care providers
- Allow for standardisation of treatment
- Allow for easy surveillance
- Can be used to evaluate training
- Allow treatment to be initiated at the first visit

Disadvantages

- Low sensitivity—may not catch asymptomatic disease
- Low specificity—drugs may be wasted
- Require staff training and acceptance
- Require referral centres for cases that do not respond to treatment
- Require regular review of drug effectiveness

Introduction

The history and physical examination are the foundation of accurate treatment in the syndromic management of STIs. The history also provides valuable information for prevention counselling and partner notification and treatment. The history-taking must be within the context of overall management of the client as described on page 46.

From: Uganda School Health Kit, UNICEF/MOH

To obtain a thorough history, the provider must gain the client's trust. This may be particularly challenging with STI clients because of the nature of the disease. Some clients may be uncomfortable talking about sex and others may withhold information to protect the identity of sexual partners. Some clients may be intimidated by a service provider who is of a different social status or speaks a different language, and many clients fear that the service provider will judge or criticise them. These problems may be further heightened when the service provider is a different sex than the client. To overcome these problems, the STI provider will have to work hard at establishing rapport with the client.

Establishing Rapport with the Client

In **ANY** interactions with clients, always refer to the **GATHER** process described on page 47, and use the verbal and non-verbal communication skills defined by **CLEARR** and **ROLES** defined on page 22 (all of these are also summarised on the back cover).

Privacy is essential. A private room out of anyone else's hearing is the first step in establishing an environment where the client feel safe in discussing his or her concerns. A variety of other ways the client can be made more comfortable are listed below:

- Greet the client in a friendly manner;
- Look the person in the eyes to show you are interested in them;
- Make sure that your body gives the same friendly, relaxed message as your words;
- Use the language in which the client feels most comfortable talking about sexual issues. Use words the client can understand;
- Ask the client's permission to bring up personal questions;
- Avoid dwelling on a sensitive subject if the client is reluctant to answer;
- Phrase your questions politely, however busy or rushed you may be;
- Use terms that non-medical people can understand;
- Make your questions specific and clear, so that the client knows exactly what information you need;
- Ask one question at a time. Double questions are confusing;
- Keep your questions free of moral judgement;
- Avoid 'leading' questions that ask the client to agree with you; let the client answer in his or her own words;

Obtaining the History

After establishing rapport, the provider can proceed with gathering the information necessary to make the diagnosis. Information-gathering should proceed from the general to the specific, both to allow for the systematic collection of data and to ease the client into talking about more sensitive issues.

HISTORY TAKING

The first three steps of 'GATHER' process will be utilized:

Greet
Ask
Tell

General Details

- What is your name?
- What is your age?
- How many children do you have?
- Where do you live?
- How long have you been there?
- Are you always there or you come from elsewhere?
- What is your occupation?

Symptoms of Present Illness

- What is your chief complaint?
- What other symptoms do you have?
- When did this start?

Female Clients:

- Is there pain in the lower abdominal area, especially with sexual intercourse?
- Is there any vaginal discharge other than white or clear?
- When was your last monthly period?
- Was the menstrual flow unusual in anyway? Missed or late?
- Are you using any method of family planning? What method(s)?
- How many pregnancies have you had and what were their outcomes?

STI History

- Have you ever had an STI before?
- What did you have?
- When was it?
- Were you treated? What with? Did it help?

Treatment History

- Are you taking any medications now?
- What kind of medicines?
- Are they helping you?
- Are you allergic to any kind of medicines?

Sexual History

- When did you last have sexual intercourse?
- Was this with a spouse, regular partner or casual sexual contact?
- Do any of your sexual partners have any symptoms of STIs?
- Are you married or do you have a regular partner?
- In the last 3 months have you been with a new partner?
- When did you last have sex with him/her?
- Have you or any of your sexual partners ever used a condom?
- Did you or any of your sexual partners use a condom last time you had sexual intercourse?

Risk assessment

STI risk assessment involves using clients' responses to questions about symptoms of STI, demographic characteristics and behaviour to gauge their risk of exposure to infection, and to help them perceive their own risk. Risk assessment can be used as a part of prevention counselling, or as a way to determine who should be tested or treated for STIs, or as an adjunct to the SMA flowcharts.

Service providers should keep in mind the many factors that may influence a women's perception of her own risk, including the fact that she may see herself as safe if she is monogamous, without recognising the risks posed by her partner's behaviour. Likewise, young people often do not perceive their risk of infection due to feelings of invulnerability and lack of future focus.

Examining the Client with an STI

The physical examination gives the provider a chance to confirm or rule out various syndromes. The elements of the routine physical examination of an STI client are listed below. Before beginning the examination, explain to the client what is going to be done and ask for his or her consent. Be sure that privacy is assured. Wear gloves when examining the genital area only. If gloves are not available, ask the client to expose the area him/herself. The inguinal region should be examined for lymph nodes as these can be indicative of other disease.

PHYSICAL EXAMINATION

The fourth step of 'GATHER' process will be utilised:

Help. Also note that you should provide HIV Testing and Counselling as part of Examination at the first Visit.

Examining Male Clients

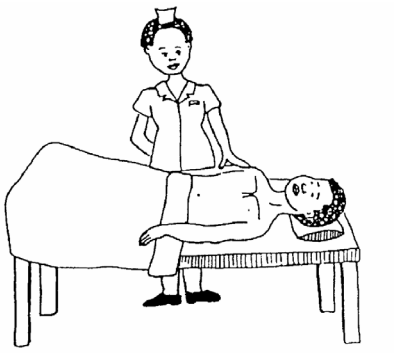
a. Ask the client to loosen his shirt or remove it.

b. Ask him to sit on a chair, then palpate the:

- anterior and posterior triangles of the neck
- submental and suboccipital areas
- axillae and epitrochlear regions

If enlarged lymph nodes are present, record their size, consistency, number and whether they are painful.

c. Ask the client to stand up and lower his trousers so that he is stripped from the chest down to the knees. It may be possible to examine him while he is standing up, though you will sometimes find it easier if the client lies down.



From: Health Worker Training in STD
Strengthening STD/AIDS Control in Kenya Project

d. Inspect the skin of chest, back, abdomen, inguinal region and thighs for rashes, swelling or ulcers.

e. Palpate the inguinal region to detect the presence of enlarged inguinal lymph nodes and buboes.

f. Examine the pubic hair for nits and lice.

g. Ask the client to bend forward or lie down and separate his buttocks with his hands so that you can inspect the anus and perineum.

h. Examine the penis, noting any rashes or sores. If foreskin is present, asks the client to retract and look at the:

- glans penis
- coronal sulcus
- frenulum
- urethral meatus

If you cannot see any urethral discharge, the urethra should be gently milked in order to express discharge.

i. Palpate the scrotum and feel for testes, epididymis and vas deferens for tenderness.

Examining Female Clients

a. While the client is seated on a chair, examine her for enlarged lymph nodes in the:

- anterior and posterior triangles of the neck
- submental and suboccipital areas
- axillae and epitrochlear regions

If these are present, record their size, consistency, number and whether they are painful.

b. Ask the client to remove her clothing from the chest down and then lie on the couch. Use a sheet to cover the parts of the body that you are not examining.

c. Inspect skin of chest, back, abdomen, inguinal region and thigh for rashes, swellings or ulcers.

d. Examine the breasts for lumps, swellings or sores.

e. Palpate the abdomen for pelvic masses and tenderness.

f. Palpate the inguinal region for presence of enlarged lymph nodes and buboes.

g. Ask the client to bend her knees and abduct the thighs, then inspect the pubic hair for nits, lice, vulva and perineum for rashes, sores and swellings.

Speculum Examination

Pass a bivalve speculum half way into the vagina at an oblique angle avoiding injury to the clitoris.

a. Turn and push further into the vagina with the blades lying horizontal.

b. Open the speculum to see the cervix using a good source of light.

c. Inspect for any cervical inflammation, discharge, ulcers and polyps (growths). Slowly withdraw the speculum while you examine the vaginal epithelium for sores, warts, inflammation and discharge. Note the colour, smell and consistency of vaginal discharge, if present.

Bimanual Examination

a. After speculum examination, insert the index and middle fingers of your gloved right hand into the vagina.

b. Place your left hand on the client's lower abdomen and palpate the structures between your two hands.

c. Palpate the uterus for size, shape and consistency and then palpate adnexes to exclude masses and tenderness.

d. Gently move the cervix bilaterally and ask if the client feels a lot of pain. If pain is present, this is known as cervical excitation tenderness.

e. If you were unable to conduct a speculum examination, use this opportunity to assess the colour, consistency and smell of the vaginal discharge.

REMEMBER

The whole 'GATHER' process is utilised when starting the process for each syndrome.

EXERCISE 3

How would you ask the patient the following in the most culturally acceptable way?

- the number of sexual partners in the past 3 months?
- any new sexual partners in the last 3 months?
- if they have traded sex for money or other gifts?

EXERCISE 4

1. What problems might you face in the examination of patients with STI?
2. Does your clinic have the necessary facilities for history and examination? (What facilities and supplies are available? What is not available? Why are the listed facilities and supplies important?)

Genital Warts

There are several methods of treating genital warts as outlined below. (see also Malawi standard treatment Guidelines.)

a) Chemical treatment
   i. **Compound podophyllin paint weekly**. Apply carefully and sparingly to lesions, avoiding normal tissue. Wash off after 1 – 4 hours. If applied to vaginal, vulvar surfaces, they should be allowed to dry before coming into contact with normal epithelium. If there is no improvement after 4-6 weeks, consider alternative treatments.

Podophyllin paint is toxic and should not be used in large amounts.
Large areas should be treated sequentially.
Podophyllin paint is contra-indicated during pregnancy and lactation.

   ii. **Silver nitrate stick applied daily**. This can be used during pregnancy and lactation as an alternative to Podophyllin paint.

b) Physical removal
   i. Liquid nitrogen
   ii. Electro-cautery
   iii. Surgical removal

Cutting away the warts (with scissors or razors) in the out-patient setting is contra-indicated since it results in excessive bleeding.

Secondary syphilis

The treatment of secondary syphilis is **Benzathine penicillin 2.4 MU IM** once a week for 3 weeks.

If the client is allergic to penicillin: **Doxycycline 100 mg** every 12 hours for 15 days or if the client is also pregnant or lactating, **Erythromycin 500mg** orally every 6 hours for 15 days.

Latent Syphilis

The latent phase of syphilis is defined by a positive syphilis serology with no clinical manifestations. It is divided into two stages and the treatment depends on the stage of infection:

Early latent syphilis: total duration of infection of not more than two years.
Treatment: Same as for secondary syphilis

Late latent syphilis: Latent syphilis of more than two years duration or of indeterminate duration.
Treatment: **Benzathine penicillin 2.4 MU IM**, once weekly for 3consecutive weeks. If the client is allergic to penicillin **Doxycycline 100mg** every 12 hours for 30 days or if the client is also pregnant or lactating, **erythromycin 500 mg** orally every 6 hours for 30 days.

As Latent Syphilis may not be detected easily in our Malawi context, and therefore the duration of disease is difficult to determine, it is advisable to treat all latent syphilis as Late latent syphilis with Benzathine Penicillin 2.4 MU IM weekly for 3 consecutive weeks.

Tertiary Syphilis including Neuro-syphilis

A) **Tertiary syphilis** which does not involve the nervous system (includes late benign syphilis and cardiovascular syphilis), the treatment is the same as in late latent syphilis.

B) **Neuro-syphilis** is treated as follows:
Aqueous Benzyl Penicillin 3MU IV every 4 hours for 14 days followed by **Benzathine penicillin 2.4 MU IM** once weekly for 3 weeks. In case the client is allergic for penicillin: **Doxycycline 100 mg orally** every 12 hours for 30 days or if the client is also pregnant or lactating, **erythromycin 500mg orally** every 6 hours for 30 days.

Congenital Syphilis

Children under the age of 2 years usually respond well to adequate doses of penicillin, but recovery may be slow in seriously ill patients.

Benzathine penicillin 50,000 units/kg IM stat – repeat after one week

Alternative treatments are described in the Malawi Standard Treatment Guidelines.

Infertility

Infertility is defined as failure to achieve pregnancy despite regular unprotected intercourse for at least 12 months. The causes of infertility affect both men and women equally.

Infertility is classified in two types:

Primary infertility: A couple has never conceived despite having regular unprotected intercourse for at least 12 months

Secondary infertility: A couple has previously conceived, but is subsequently unable to conceive within 12 months despite having regular unprotected intercourse.

The main causes of infertility are STIs, most commonly those caused by N. Gonorrhoeae and C. Trachomatis resulting in Pelvic Inflammatory Disease in women and epididymo-orchitis in men. Sometimes advanced syphilis or HIV infection may be implicated

Infertility can often be prevented by adequate and prompt treatment of all STIs

Other causes of infertility are:

1. Ovulatory factors in women – e.g. Central defects such as ovarian failure or tumors
2. Abnormal sperm motility – eg. Antibody formation
2. Abnormal spermatogenesis – eg. Chromosomal abnormalities, radiation or chemical exposure, varicocele
4. Sexual dysfunction – eg. Retrograde ejaculation, impotence
5. Anatomic disorders – eg. Undescended testis
6. Metabolic diseases in women – eg. Obesity
7. Mumps orchitis in men
8. Schistosomiasis
9. Tubo –ovarian TB and TB endometritis in women and TB orchitis in men
10. Endocrine disorders – eg. Thyroid disorders

Infertility Management

The following investigations should be conducted:

1. Stool & Urine microscopy and treat accordingly
2. Syphilis screening and treatment
3. Pelvic / abdominal ultrasound
4. Seminal analysis
5. Treat women and their partner(s) for PID

After these preliminary investigations the client should be referred for further gynaecological investigations.

All individuals or couples should undergo counselling for HIV testing

Cancer of the Cervix

Human Papillomavirus (HPV) is sexually transmitted and is the cause of genital warts. However, sometimes it causes few or no symptoms and therefore people will not know they are infected with the virus. It is estimated that 10% of women infected with HPV will develop precancerous changes in the cervical tissue (dysplasia); of which some will be limited to the outer layers of the cervical cells (carcinoma in situ CIS) and a smaller group will develop invasive cancer of the cervix, unless CIS is detected early and treated.

Currently there is no treatment for HPV infection, therefore, once infected, a person is infected for life. However, usually the active infection is controlled by the immune system and with time becomes dormant.

Risk factors for cervical cancer include sexual activity initiated before age of 18; multiple sexual partners; exposure to other STIs, a mother or sister with cervical cancer and immunosuppression due to HIV/AIDS. HIV infection is an important risk factor because it makes the cells lining the lower genital tract (vulva, vagina and cervix) more easily infected by the cancer-inducing HPV.

Prevention:

Primary infection includes risk reduction counselling to minimise risk to STI exposure.
Secondary prevention targets those women who (unknown to themselves) are already infected with HPV.

- Identify those with early, easily treatable precancerous lesions
- Treat with cost-effective treatment before lesions progress to cancer

Diagnosis can be done by a Pap-smear (which needs to be sent to Central Hospitals to be read by a histopathologist) or by Visual Inspection using a dilute solution of Acetic Acid (VIA).

VIA is recommended in resource-low settings, such as Malawi for the following reasons:

- It is non-invasive, easy to perform and inexpensive
- It can be preformed by all level of health care workers, in almost any setting
- Results are immediately available – potential for immediate link to treatment
- All supplies are locally available (light source, speculum, examining table, acetic acid (vinegar), vaginal swabs, gloves)

The following are VIA classifications of the cervix:

VIA classification	**Clinical Criteria**
Test-negative	Smooth, pink, uniform, featureless, Ectropion, polyp, cervicitis, Nabothian cysts
Test – positive	White plaques (Qcetowhite epithelium is distinctly visible)
Suspected Cancer	Cauliflower like growth or ulcer, Fungating Mass

VIA is currently being piloted in Malawi and if successful, should be rolled out throughout the country in the coming few years.
Early treatment consists of cryotherapy. This is the use of liquid nitrogen to freeze the lesions or dysplasia. In advanced stages of cervical cancer, radical surgery (removing parts of the cervix, or the entire uterus) is the only therapy.

TREATMENT OF MULTIPLE STI SYNDROMES

When clients present with more than one STI Syndrome at the same visit, they should always be treated for both syndromes.

In some cases, the treatment is the same for both conditions. For example in urethral discharge and scrotal swelling require exactly the same treatment:

UD treatment	**SS treatment**
▪ Gentamicin 240 mg IM stat ▪ Doxycycline 100 mg every 12 hours for 7 days ▪ Metronidazole 2g PO single dose. ▪ Pregnant women replace Doxycycline with Erythromycin 500 mg every 6 hours for 7 days	▪ Gentamicin 240 mg IM stat ▪ Doxycycline 100 mg every 12 hours for 7 days. ▪ Pregnant women replace Doxycycline with Erythromycin 500 mg every 6 hours for 7 days.

In this case, only one course of antibiotics is sufficient.

When two syndromes require the same antibiotic for different lengths of time, the antibiotic should be given for the longer duration. For example in enlarged inguinal lymph nodes (without ulcers) combined with urethral discharge, scrotal swelling, or abnormal vaginal discharge with positive risk assessment in women. In this case, the appropriate treatment is Gentamicin 240mg IM stat and Doxycycline 100mg orally every 12 hours for 14 days plus Metronidazole 2g stat.

When a client presents as an asymptomatic partner for one syndrome and is found to be symptomatic with another syndrome, the client should be treated for both. For example a man who presents to the clinic because his partner has genital ulcers. On examination, he is found to have urethral discharge but no ulcers. In this case, he should be treated for both genital ulcers and urethral discharge with Gentamicin 240mg IM stat. Benzathine Penicillin 2.4MU IM stat and Erythromycin 500 mg orally every 6 hours for 7 days. The man's sexual partners now need to be treated for urethral discharge as well.

Below are some examples of multiple STI syndromes and how they should be treated:

1

GUD together with UD

- Benzathine Penicillin 2.4 MU IM STAT
- Gentamicin 240 mg IM stat
- Erythromycin 500 mg every 6 hours for 7 days

2

GUD together with LAP

- Benzathine Penicillin 2.4 MU IM STAT
- Gentamicin 240 mg IM stat
- Erythromycin 500 mg every 6 hours for 10 days
- Metronidazole 400 mg every 8 hours for 10 days
- Acyclovir 800mg 12 hourly for 7 days

3

GUD together with AVD (Box 11)

with positive risk assessment

- Benzathine Penicillin 2.4 MU IM STAT
- Erythromycin 500 mg every 6 hours for 7 days
- Metronidazole 2 grams PO STAT
- Gentamicin 240mg Im stat
- Acyclovir 800mg 12 hourly for 7 days

4

GUD together with AVD (trchomoniasis)

With negative risk assessment

- Benzathine Penicillin 2.4 MU IM STAT
- Metronidazole 2 grams STAT
- Ciprofloxacin 500mg single dose
- Acyclovir 500mg 12 hourly for 7days

GUD together with AVD (Candida) with positive risk assessment

- Benzathine Penicillin 2.4 MU IM STAT
- Ciprofloxacin 500mg PO single dose
- Erythromycyin 500mg hourly for 7 days
- Clotrimazole 500m pessary STAT
- Acyclovir 800mg 12 hourly for 7 days.

5

GUD together with AVD (Box 10) with negative risk assessment

- Benzathine Penicillin 2.4 MU IM STAT
- Ciprofloxacin 500mg PO STAT
- Clotrimazole 500mg Pessary STAT
- Acyclovir 800mg 12 hourly for 7 days

6

Only if compliance with a multiple drug regimen is in doubt, treat the most severe or painful syndrome first and instruct the client to return for treatment of the second syndrome after the first course of antibiotics is completed.

Other Sources of Information on STI control

- "Sexually Transmitted Diseases" Chapter 9 in the Malawi Prescriber's Companion. Pages 87-98. Malawi Essential Drugs Programme, Ministry of Health, 1993
- "Sexually Transmitted Diseases" Chapter 19 in Malawi Standard Treatment Guidelines, 2nd Edition, 1993, Pages 138-145. Malawi Essential Drugs Programme, Ministry of Health.

GENITAL ULCER DISEASE - GUD

Introduction

A number of sexually transmitted pathogens may cause genital ulceration. In Malawi studies have shown that the commonest causes of genital ulcers are Herpes simplex virus type 2, Chancroid and Syphilis. Herpes simplex virus has been shown to be the cause of genital ulcer disease in over 60% of cases. In addition, there is evidence that *Lymphogranuloma venereum* also occurs but studies are rather limited. In Syndromic management, treatment of a client with genital ulcers should therefore adequately cover the three common causal organisms. Mixed infections also occur in about 20% of cases.

If phimosis is present (the underlying cause is usually genital ulcer disease) penile discharge can originate from under the foreskin and can mimic urethral discharge. However, if urethral discharge is present treat for both genital ulcer disease and urethral discharge.

Traditional healers sometimes treat women for STIs and other conditions by incising the vulvar mucosa. Such lesions must be differentiated from genital ulcer disease by a history and physical examination.

Genital herpes has become the commonest cause of genital ulcer disease. Classical herpes lesions appear as painful clusters of vesicles. The client often gives a history of past episodes of similar lesions.

Locally no medications need to be applied and clients with genital ulcers should be advised to wash affected areas frequently and keep lesions clean and dry. HIV positive clients should be educated on the potential recurrence of herpes ulcers; and should be educated on early symptom recognition and early clinic attendance when symptoms appear.

Management of Genital Ulcer Disease Using the Flowcharts

The causes of genital ulcers are the same in both men and women, and, therefore, the flowchart may be used for both sexes.

This flowchart is fairly straightforward. The first box asks whether an ulcer is present. If so, the clinician must determine whether or not the sores are vesicles (raised fluid-filled lesions). If they are vesicles, a presumptive diagnosis of genital herpes may be made and the client treated for genital herpes. If ulcers (open lesions) are found, the client should be treated for syphilis and Chancroid. The client should be asked to return to the clinic in 7 to 10 days to determine whether the treatment has been effective.

Box 1 The entry point to the flowchart is the complaint of genital sores or ulcers. Ulcers and sores are the same thing and mean a break in the continuity of an epithelial surface, be it skin or mucous membrane. This flowchart may be used if a client complains of genital ulcers.

Box 2/3 After obtaining the history and examining the client, proceed with HIV testing and counselling, decide whether or not the client has genital ulcers. If ulcers are found, go to **Box 7**. If not, go to **Box 4**.

Box 4 Look specifically for signs of other STIs. If the client has signs of an STI other than genital ulcers or genital vesicles, go to **Box 6**. If the client has no genital ulcers, genital vesicles nor any signs of other STI, go to **Box 5**.

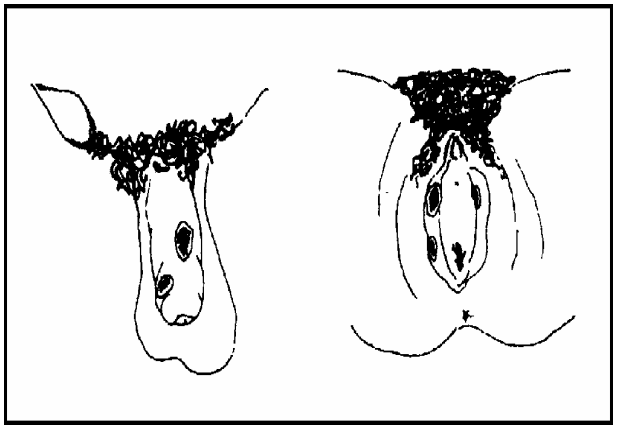
Box 5 If the client has no signs of STI, reassure him/her but take the opportunity to offer health education, counsel, promote and provide condoms.

Box 6 If the client has evidence of an STI other than genital ulcer disease, treat him/her according to the appropriate flowchart.

Box 7 The client with genital ulcers should be treated for both syphilis, Chancroid, HSV 2 and LGV

Box 8, 9 If the client hasn't improved treat with Azithromycin 2g stat where there is evidence of treatment failure.

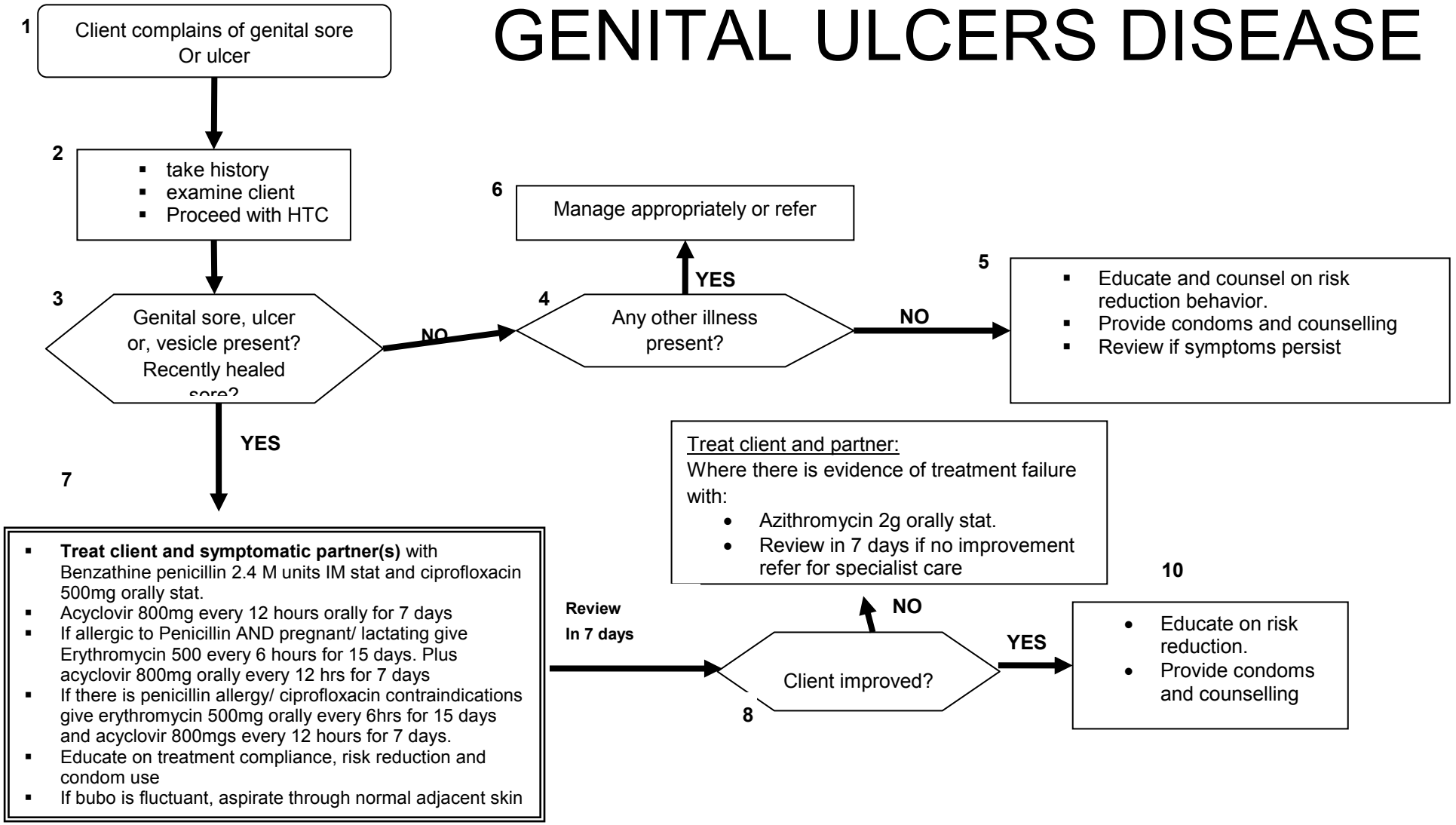
Box 10: Ulcers have healed completely – educate on risk reduction, provide condoms



CASE STUDY 4

1. A female patient presents with sores on the right labium major. Describe the specific history and physical examination findings you would expect if the ulcers were due to herpes simplex.
2. A female patient was treated by you for a genital ulcer. A week later she returns saying she is no better. You examine her and find that the ulcer that was present at the first visit is still there. Outline your management now.
3. A male patient comes to you complaining that he has a sore on the penis for 3 days. Describe in detail your management of this patient.

GENITAL ULCERS DISEASE



URETHRAL DISCHARGE - UD

Introduction

Urethral discharge, also known as urethritis, is a common presenting symptom of STIs in males. In over 98% of cases, it is caused by either *Neisseria gonorrhoea, Chlamydia trachomatis or trichomonas vaginalis* and treatment should therefore adequately cover these three organisms. Other causes of urethritis include *Candida albicans and Ureaplasma urealyticum*. The syndrome of urethral discharge occurs as a result of infection of the male urethra with any of these organisms. Clients with urethral discharge may also complain of a burning sensation while passing urine and frequent urination.

Examination will reveal a discharge coming from the urethral meatus. The discharge may be copious or it may only be slight. At times, it may be necessary to squeeze the urethra (milking) and massage it forward before the discharge becomes apparent. If there is an obvious discharge, the urethra should not be squeezed or milked. Uncircumcised clients should be examined with the foreskin retracted so that it is clear that the discharge is coming from the urethra and not from the sub-preputial space. The discharge may be frank pus, or it may be muco-purulent. Occasionally, the discharge will be fluid and white in colour.

During history taking, ask the client about recent self -treatment and how long it has been since his last urination.

If no discharge is found on examination, but the client complains of recent symptoms of discharge, urinary burning or urinary frequency, and has had sex in the last 2 weeks, treat him for urethral discharge.

Persistent or recurrent symptoms of urethritis may be due to drug resistance, poor compliance or re-infection.

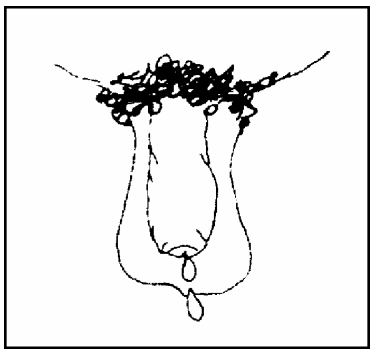
In Malawi there is evidence of a high prevalence of TV in men with urethral discharge. Therefore treatment of urethral Discharge should cover TV in the first line treatment package.

Watch out!

Be aware, however, that some men may complain of pus or dripping from the penis as a general way of saying they have some kind of STI, even in the absence of a clinically verifiable discharge. Therefore, all male clients complaining of urethral discharge should have a history taken and should be examined in order to confirm or exclude the presence of the urethral discharge.

Taking the client's word for the diagnosis, without doing a thorough history and exam, may lead to treatment of the wrong syndrome!

Where laboratory diagnosis is available, urine microscopy/ urethral smear can be performed and a result of more than 5 polymorphononuclear leukocytes (WBC) per power field (x1000) is indicitative of urethritis.



Using the Urethral Discharge flowchart

This flowchart is for use in the management of a client with urethral discharge. This symptom presents only in men.

The risk assessments in this flowchart are very straight forward, and ask if the client has had sex without a condom in the two weeks preceding this visit. This is both having unprotected sex with his regular partner, spouse or wife, and during casual or commercial sex.

Box 1 Urethral discharge or dysuria in males are the entry points to this flowchart. If a client complains that he has noticed a urethral discharge this flowchart may be used.

Box 2 After obtaining the history, performing the risk assessment and examining the client, proceed with HIV Testing and counselling.

Box 3 Decide whether or not the client has urethral discharge. If no urethral discharge is apparent, go to **Box 4**. If urethral discharge is confirmed, go to **Box 8**.

Box 4 If no urethral discharge is apparent, confirm whether or not the client has symptoms of other STIs. If no signs of other STIs go to **box 5**; if other STI symptoms present, go **to box 8**

Box 5 If the client has any signs of other illnesses go to **box 7**, if not go to **box 6**.

Box 6 Educate on risk reduction and offer and provide condoms review if symptoms persist.

Box 7 Manage and treat client according to symptoms of other illness

Box 8 If the client has urethral discharge, or if he admits has a positive risk assessment, treat him and his partner for gonococcal, chlamydial and Trichomonas infection as follows:

Gentamicin 240mg IM s tat and
Doxycycline 100mg orally ever 12 hours for 7 days*

Metronidazole 2g orally single dose

*__NOTE__: **Doxycycline** is **contraindicated in pregnant and lactating women**. During pregnancy, give the following:

Gentamicin 240mg IM stat and
Erythromycin 500 mg orally every 6 hours for 7 days.

Metronidazole 2g stat

***NOTE:** Doxycycline should be taken with food. Metronidazole is contraindicated in the first trimester of pregnancy

Box 9/10: Review after 7 days and rule out evidence of re-infection or non-compliance and if evidence of re-infection/non-compliance go to **Box 12** if not improved after compliance go to **Box 11**

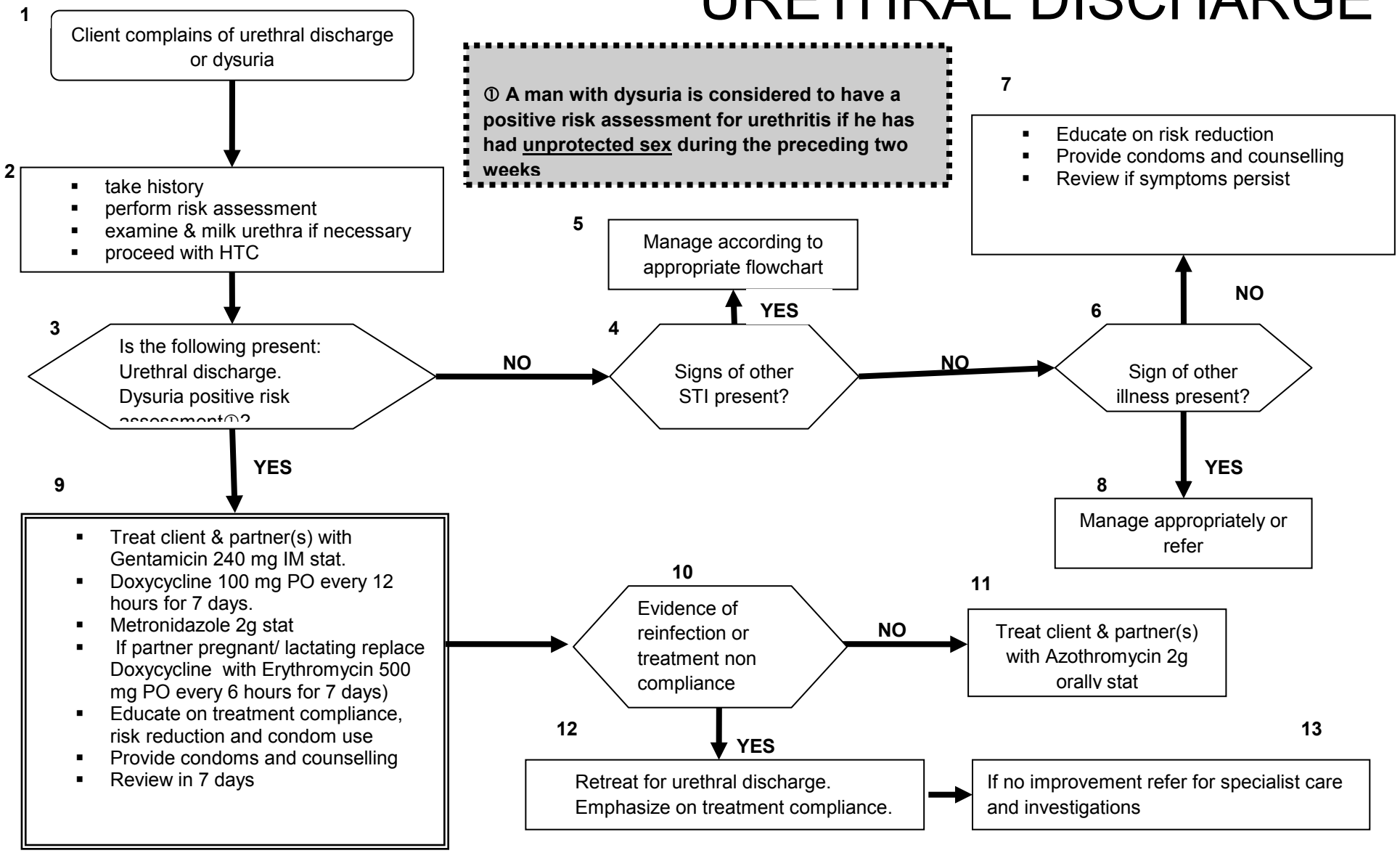
Box 11: Treat client & partners with Azithromycin 2g STAT where there is evidence of treatment failure

Box 13: If no improvement refers for specialist management

CASE STUDY 5

1. A patient comes to you complaining that he has urethral discharge. When you examine him you are unable to find any discharge. Give some reasons why you were unable to find a urethral discharge in this patient.
2. A patient was treated according to the urethral discharge flowchart for a visible urethral discharge a week ago. He has now come back to you for follow-up and you find that he still has urethral discharge. What are the possible reasons for this? How would you manage him now?
3. A patient was treated according to the flowchart for urethral discharge. At the follow up visit he no longer has a urethral discharge but he has shallow ulcers on the foreskin. What is the diagnosis? How would you manage him now?

URETHRAL DISCHARGE



Introduction

Abnormal vaginal discharge in women is extremely common and may include abnormal odour, itching, dysuria, soreness and/or swelling of the genitalia. Women develop vaginal discharge if they have vaginitis and/or cervical infections. They may also complain of vaginal discharge if they have endometrial infection or pelvic inflammatory disease (PID). But, remember also that vaginal discharge is considered normal during and after sexual activity; at various points throughout the menstrual period; and during pregnancy and lactation. Usually women who present to a health care facility complaining of a vaginal discharge do so when they perceive it as being unusual for them (e.g., the quantity, thickness or smell is abnormal for them).

A complaint of abnormal vaginal discharge, in terms of quantity, colour and odour, is most commonly due to a vaginal infection and rarely due to a cervical infection. The causes of vaginal infections are *Trichomonas vaginalis* (Trichomoniasis), *Candida albicans* (Candidiasis) and *Gardnerella vaginalis* (bacterial vaginosis). The causes of cervical infections include *Neisseria gonorrhoea* (gonorrhoea) and *Chlamydia trachomatis*. Cervical infections frequently lead to complications.

There are no rapid tests to differentiate between vaginal and cervical infection and the symptoms of vaginal discharge and other genitourinary symptoms are not specific to any single disease. One way to differentiate between the two in the absence of advanced laboratory support is to assess the client's risk status by using the risk assessment box in the flowchart.

1) If the client's husband has urethral discharge or genital ulcers, she has a positive risk assessment, regardless of the next question.

2) If the client answers yes to **two or more** of the following

- She's younger than 25 years of age
- She has a single marital status
- She's had a new sexual partner in the 3 months preceding this visit
- She's had more than 1 sexual partners in the 3 months preceding this visit

N.B.: Asking about a new partner in the past 3 months is different than asking about the total number of partners in the past 3 months. For instance, a woman who did not have more than one sexual partner in the past 3 months may still have had a single new partner in that time period. Alternatively, a woman with two steady partners for the past 3 months may not have had a new partner during that time.

Some causes of vaginal discharge, such as bacterial vaginosis and Candida Albicans, are not considered to be sexually transmitted. Positive responses to the risk assessment increase the likelihood that the client does, indeed, have an STI. Therefore, encourage partner treatment with the same regimen as the index client even if it is not certain that the client has an STI.

Management of AVD using the flowcharts

All women presenting with AVD should have a thorough history taken and should be examined, preferably with a speculum. However, there are times when supplies such as gloves and speculums are unavailable. Even then, the client can assist in the exposure of the external genitalia so that the examiner can inspect for the presence of ulcers, warts or visible discharge. When physical examination is impossible because the client refuses or because there is insufficient privacy, the health care worker will have to rely solely on the history.

Remember, however, that even an external examination of the genitalia is better than no examination at all.

The physical examination should never be omitted

Only for the convenience of the health care worker.

In the past, we used 4 different flowcharts to examine Genital-Urinary symptoms in women. Since the revision of the flowcharts, we now have one comprehensive flowchart. Don't be discouraged by the amount of information on the flowchart; you will find it is actually very simple to use and comprehensive.

Management of AVD using the flowchart

Box 1 The entry point to the flowchart is complaints of abnormal vaginal discharge in a female client. If a client presents with a vaginal discharge, abnormal odour, itching, dysuria, soreness and/or swelling, take a detailed history.

Box 2 Take history, perform risk assessment and thoroughly examine the client. Provide HIV testing and counselling

Box 3 Determine whether the client has lower abdominal pain or genital ulcers. If she gives a history of lower abdominal pain or GUD, go to **Box 4**. If not, go to **Box 5**.

Box 4 If the client gives a history of lower abdominal pain, follow the flowchart for Lower Abdominal Pain in Women. If client gives history of genital ulcers follow the flowchart for GUD.

Box 5 Determine whether vaginal discharge is present. If yes, go to **Box 9**, otherwise continue to **Box 6.**

Box 6 Perform a risk assessment of the client. If positive go to **box 7**, otherwise continue to **box 8**

Box 7 If the client has positive risk assessment, treat her and her partner for cervical infection as follows:

Gentamicin 240 mg in a single IM injection
Doxycycline 100 mg orally every 12 hours for 7 days*

**NOTE: Doxycycline is <u>contraindicated in pregnant and lactating women</u>.*
Instead of doxycycline, give the following:
***Erythromycin 500 mg** orally every 6 hours for 7 days*.

*NOTE: Doxycycline should be taken with food.

.

Educate and counsel, promote and provide condoms. Arrange to see the client again in 7 days

Box 8 If risk assessment is negative and no vaginal discharge is present, reassure client and offer follow up visit if symptoms persist.

Box 9 Assess the colour of the discharge and the look for oedema and vulvar excoriations. If discharge is white or curd-like or when there is oedema or vulvar excoriations, go to box 10. If not, then follow the arrow to box 11.

Box 10 If **risk assessment is positive**: Treat the client for Chlamydia, Gonorrhoea, and Candida Albicans as follows:
Gentamicin 240 mg IM stat and **Doxycycline 100 mg** every 12 hours for 7 days Metronidazole 2g stat and **Clotrimazole 500mg pessary Stat** ntravaginally.
All partners should be treated according to the Urethral Discharge Flowchart

Arrange to see the client again in 7 days, and go to **Box 12**.

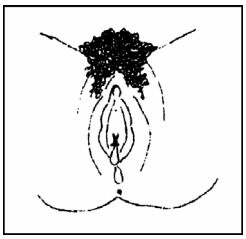
Box 11:If the **risk assessment is positive**, treat client for Chlamydia, Gonorrhoea, Bacterial Vaginosis and Trichomoniasis as follows:

Gentamicin 240 mg IM stat and **Doxycycline 100 mg** every 12 hours for 7 days and **Metronidazole 2 gram PO** stat.

If **the risk assessment is negative**, treat client only for Trichomoniasis and Bacterial Vaginosis with:

Metronidazole 2 gram PO stat

Arrange to see the client again in 7 days, and go to **Box 12**



Case Study 6

A 20 year old woman comes to you complaining that she has copious, itchy vaginal discharge for the past week. She has no sexual partners other that her husband, who is asymptomatic. She denies lower abdominal pain.

1: Describe in detail how you would go about examining the client in the following situations:

1. A speculum, light source, gloves and examination table are available in a setting with privacy
2. As in 1, but no speculum available
3. As is 1, but no gloves available

2: You examine the above mentioned woman and find a green frothy vaginal discharge but no cervical endomucopus, what is the correct treatment?

3: The same woman returns after 7 days and although she is somewhat improved, she still has discharge. Now her partner is complaining of urethral discharge, but she still has no cervical excitation tenderness or endocervical mucopus on examination.

1. What could be the reason for her symptoms
2. Give an outline of how you would manage her

ABNORMAL VAGINAL DISCHARGE

Women with vaginal discharge may be managed adequately even if a speculum examination is not possible

① A woman with vaginal discharge is considered to have a positive risk assessment for cervicitis if:
1. Her partner has urethral discharge or genital ulcers 2. If she falls into at least TWO of the following categories:
a) age less than 25 yrs **b) single marital status**
c) new partner in last 3 months **d) more than 1 partner in the last 3 months**.

1 Client complains of abnormal vaginal discharge, vulval itching or burning

2
- Take history
- Perform risk assessment
- Examine client
- Provide HTC

3 Is there any lower abdominal pain or genital ulcers?

YES

4 Manage according to appropriate flowcharts

NO

5 Is vaginal discharge present?

NO

6 Is risk assessment positive? ①

YES

7
- Treat client and partner(s) with Gentamicin 240 mg IM stat and Doxycycline 100 mg PO every 12 hours for 7 days (For pregnant/lactating women replace Doxycycline with Erythromycin 500 mg every 6 hrs for 7 days)
- If partner has genital ulcer refer to appropriate flowchart
- Educate on treatment compliance, risk reduction and condom use; provide condoms and counselling
- Offer / refer for HIV counselling and testing
- Review in 7 days

Review in 7 days

NO

8
- Reassure Client
- Educate on risk reduction and condom use
- Provide condoms and Offer / refer for HIV counselling and testing
- Review if symptoms persist

YES

9 Discharge is white and or curd-like, OR there are vulval excoriations and/or oedema

NO

10
- **If risk assessment is positive**, treat with Gentamicin 240 mg IM stat, Doxycycline 100 mg PO every 12 hours for 7 days and clotrimazole 500mg intravaginally pessary single dose.
- For pregnant/lactating women replace Doxycycline with Erythromycin 500 mg every 6 hrs for 7 days)
- Treat partner as in UD flowchart except for metronidazole, unless symptomatic
- **If risk assessment is negative**, treat only with clotrimazole 500mg Pessary intravaginally single dose.
- If partner has genital ulcers refer to appropriate flowchart
- Educate on treatment compliance, risk reduction and condom use, provide condoms and counselling
- Offer / refer for HIV counselling and testing
- Review in 7 days

11
- **If risk assessment is positive** Treat with Gentamicin 240 mg IM stat, Doxycycline 100 mg PO every 12 hours for 7 days and Metronidazole 2 g PO stat (For pregnant/lactating women replace Doxycycline with Erythromycin 500 mg every 6 hrs for 7 days)
- Treat partner as in Urethral Discharge flowchart
- **If risk assessment is negative**: treat client only with Metronidazole 2 grams PO stat.
- Educate on treatment compliance, risk reduction and condom use; provide condoms and counselling and
- Offer / refer for HIV counselling and testing
- Review in 7 days

Review in 7 days

13 **REFER**

12 Client improved?

NO

YES

14 Educate on treatment compliance, risk reduction, condom use. Provide condoms & counselling

Review in 7 days

INTRODUCTION

All sexually active women presenting with lower abdominal pain should be carefully evaluated for the presence of Pelvic inflammatory disease (PID). PID is defined as infection of the female genital tract above the internal os of the cervix. It includes all of the following conditions: endometritis, salpingitis, tubo-ovarian abscess and pelvic peritonitis. PID occurs as a result of infection ascending from the cervix and can be caused by *Neisseria gonorrhoea, Chlamydial trachomatis* and anaerobic bacteria, usually of the *Bacterioides* species. Occasionally, PID may be caused by *Mycoplasma homines*. The seriousness of PID lies in the fact that the condition can lead to pelvic peritonitis, tubo-ovarian abscess and generalised peritonitis, which can be fatal.

Another potentially life-threatening complication of PID is salpingitis. Salpingitis may lead to the fallopian tube becoming blocked, resulting in infertility. It may also lead to partial tubal obstruction. When this occurs, the very small spermatozoa may travel across the partial obstruction to fertilise the ovum, but the fertilised ovum is too large to travel down the fallopian tubes to attach to the womb, resulting in an ectopic pregnancy. The ectopic pregnancy will eventually rupture and cause massive intra-abdominal haemorrhage and death.

Symptoms suggestive of PID include abdominal pain, dyspareunia (pain on sexual intercourse), vaginal discharge, menometrorrhagia, dysuria, pain associated with menses, fever, and sometimes nausea and vomiting. PID is difficult to diagnose because clinical manifestations vary. It becomes highly probable when one or more of the above symptoms are seen in a woman with adnexal tenderness. Enlargement or induration of one or both fallopian tubes, tender pelvic mass, and direct or rebound tenderness may also be present. The client's temperature may be elevated but in many cases it is normal.

Women with PID usually present with lower abdominal pain and hence this symptom should be taken seriously. However, lower abdominal pain is a common symptom in women and **not every woman with lower abdominal pain has PID**. There are several other serious conditions which may present with the symptom of lower abdominal pain, including ectopic pregnancy, appendicitis, pelvic abscess, or a complication of pregnancy such as incomplete abortion, septic incomplete abortion and puerperal sepsis.

SYMPTOMS AND SIGNS THAT REQUIRE IMMEDIATE SURGICAL OR GYNAECOLOGICAL ATTENTION
Symptoms: Missed, overdue or delayed period Recent abortion, delivery or miscarriage Metrorrhagia **Signs:** Abdominal guarding Abdominal rebound tenderness Abdominal mass Active vaginal bleeding

Using the Flowchart for Lower abdominal pain in women

This flowchart is for clients complaining of lower abdominal pain. If the client has another complaint, such as vaginal discharge and does not complain of lower abdominal pain, use the flowcharts relating to the other symptoms as a guide to treating those conditions.

Box 1 The starting point of this flowchart is the complaint of lower abdominal pain in women

Box 2 Take a history and perform examinations on client. Provide HIV Testing and counselling. A thorough examination of the client with lower abdominal pain should include the following:

- Temperature
- Abdominal palpation to assess tenderness, rebound tenderness and guarding. Exclude masses. Abdominal palpation should be superficial at first to determine whether the area is tender. Continue with deeper palpation, making sure to press slowly and gently, and release quickly, in any area that was found to be tender on light palpation.

Severe pain on releasing pressure is known as rebound tenderness. When there is inflammation of the peritoneum, the abdominal muscles become rigid and do not allow deep palpation. This is known as guarding. Guarding and rebound tenderness are features of peritonitis or an intra-abdominal abscess.

Light abdominal palpation will allow detection of any swelling or lump in the client's abdomen. A tubo-ovarian abscess will present as a tender mass deep in the pelvic cavity.

- Perform an abdominal examination: place two fingers inside the vagina with the other hand on the lower abdomen. Examine the pelvis for masses (lumps) and tenderness. Move the cervix gently to one side and see whether this causes a lot of pain. The moving of the cervix causes a stretching of the broad ligament and if there is an acute inflammation of the fallopian tube, or if there is a tubo-ovarian abscess, the movement causes severe pain. This is known as cervical excitation tenderness.
- See whether the client has vaginal bleeding.

- See whether the client has vaginal discharge.

Box 3 Ask the following questions

- Have you missed a period?
- Is your period late this time?
- Are you having vaginal bleeding at this time?
- Have you had an abortion/miscarriage in the last 6 weeks?
- Have you had a delivery in the last 6 weeks?

If the any of the questions are answered with YES, take urgent action to refer client for surgical opinion (**Box 4**). If the questions are answered with NO, go to **Box 5**.

Box 5 Conduct Bi-manual exam and check for cervical excitation tenderness or lower abdominal tenderness with or without vaginal discharge. If non is present, continue to **Box 6**, if present go to **Box 9**..

Box 6 Check for any signs of other illnesses which may explain the complaints. If you find none, go to **Box 7**, or else to **Box 8**

Box 7 Reassure client and educate on risk reduction.

Box 8 Manage other illnesses or refer for further investigations.

Box 9 Treat client and her partner(s) for Chlamydia and Gonorrhoea, with **Gentamicin 240 mg IM** stat and **Doxycycline* 100 mg** every 12 hours for 10 days. Treat client (not the partners) for Bacterial Vaginosis **with Metronidazole 400 mg** every 8 hours for 10 days

**NOTE: Doxycycline is contraindicated in pregnant and lactating women.*
Instead of doxycycline, give the following:
***Erythromycin 500 mg** orally every 6 hours for 10 days*.

**NOTE: Doxycycline should be taken with food.*
** NOTE: Metronidazole is contra-indicated in the first trimester of pregnancy*

Box 10 After 72 hours review client and assess improvement; if she has not improved in 72 hours, **Box 12** tells you to refer the client as soon as possible, as there is likelihood of surgical emergency. If client has improved go to **box 11**

Box 11 Make sure that the client completes the full 10 day course of treatment.

Important points to remember about PID

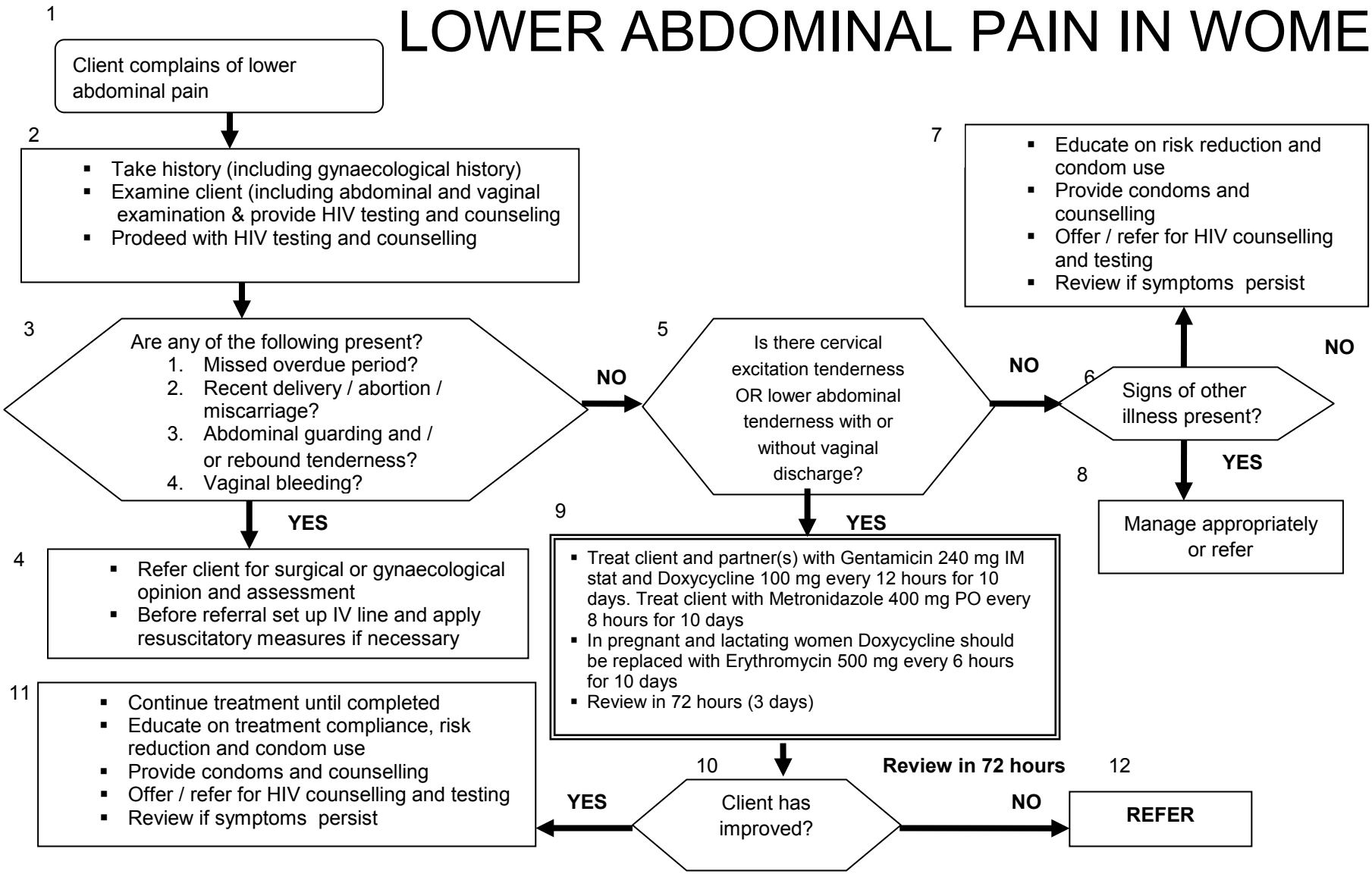
- PID is a serious condition and should be considered in every woman with lower abdominal pain. Remember, however, that not every woman with lower abdominal pain has PID.
- When examining a woman with lower abdominal pain, be sure to exclude those conditions which require immediate surgical or gynaecological treatment. The warning signs of acute illness are listed in the box below.
- When treating a client with PID, be sure to treat for gonococcal, chlamydial and anaerobic bacterial infection.

- Treat the client's partner for gonorrhoea and chlamydial infection.

CASE STUDY 7

1. A 25 year old married woman presents with a history of lower abdominal pain and vaginal bleeding after two months amenorrhoea. What important points would you like to obtain from the history? What is the most likely diagnosis? How would you manage her?
2. A single 17 year old female attends with a sudden onset of lower abdominal pain. On history, she states her last menstrual period was 2 months ago. When you examine her she is pale, has generalised abdominal pain and a blood pressure of 70/50 mm Hg. Outline your management. What is the most likely diagnosis?
3. A 35 year old married woman presents with a history of lower abdominal pain of unknown duration. You examine her and can find nothing wrong with her and so you reassure her and ask her to return if her symptoms are still present in 7 days time. As8 she is walking out of the door she says to you very shyly and looking most embarrassed, "You know, my husband has a thick discharge coming from the penis." What do you do now?

LOWER ABDOMINAL PAIN IN WOMEN



Introduction

Scrotal swelling is a serious complication of gonococcal urethritis or chlamydial urethritis which has infected the testis. When infected, the testis becomes swollen, hot and excruciatingly painful. If early effective therapy is not given, the inflammatory process will resolve and healing occurs with fibrous scarring and destruction of testicular tissue. This will render the client sub-fertile. Other causes of acute epididymo-orchitis include the mumps virus and infection with the bacterium E. Coli.

Scrotal swelling is commonly encountered in clinical practice. The symptom may be due to a long-standing problem such as a scrotal hydrocoele, varicocoele, or an inguinal hernia. It may also be due to a recent or acute illness, torsion or trauma to the testis, or an inguinal hernia which has become irreducible or strangulated. Hydrocoeles, varicocoeles, lymphatocoeles (caused by filariasis), inguinal hernia, testicular trauma and torsion of the testis are not caused by STIs. However, these conditions must be distinguished from acute epididymo-orchitis which occurs as a result of gonococcal, chlamydial or viral infection.

Urgent surgical intervention is needed for testicular torsion, testicular trauma and strangulated inguinal hernia. Persons suspected of having any of these conditions should be referred immediately to a health facility where these conditions can be treated. When a client complains of scrotal pain and/or swelling, all these possibilities must be kept in mind. A thorough history and physical examination are necessary to exclude life-threatening conditions.

Torsion of the testis

Torsion of the testis is the name given to the condition in which the testis twists around itself causing a twist in the spermatic cord, thereby blocking the blood supply to the testis. There may be total obstruction of the blood supply to the testis which causes the testis to become gangrenous and die. This condition is serious one as the gangrene can spread and lead to death. In addition, the testis becomes totally atrophic and the client becomes sub-fertile. The condition may occur bilaterally. The cause of the condition is unknown.

Clients with torsion of the testis complain of sudden onset of pain and swelling in one or both scrotal sacs. The pain is very severe and often clients also have other symptoms such as abdo8minal pain and vomiting. Examination will reveal a hot, swollen and tender scrotum. Within the scrotal sac, the testis may be elevated or rotated, and may lie in a horizontal position. Urgent surgery is required to correct the torsion and to correct the other (unaffected) testis as well.

Testicular Trauma

The acute onset of scrotal swelling may be due to trauma to the scrotal sac. This may be a result of a sporting injury or violence. The client will admit to having been injured. Examination will reveal a swollen scrotum which may be tense as a result of the accumulation of blood (the condition is known as hematocoele). If it is injured, the testis itself will also be swollen. The client should be examined for bruising of the skin of the scrotum, penis, pubis and upper thighs. The client should be referred for surgical consultation to assess the extent of the injury.

Irreducible or strangulated inguinal hernia

This is a serious condition which may lead to death if gangrene of the obstructed bowel develops. Clients should be asked about any previous history of hernia. This condition typically results in swelling which extends under the inguinal ligament; it is difficult to palpate above the ligament because of the swelling. Clients with irreducible inguinal herniae are at risk for developing strangulation and, hence, gangrene of the bowel. Urgent surgical treatment is necessary.

Using Flowchart on scrotal swelling

Box 1 This flowchart is for men who complain of having pain and or swelling of the scrotum. A thorough history and examination are essential in determining whether immediate surgical attention is necessary.

Box 2 The physical examination should include palpation of the scrotal sac, comparing the two sides. The following issues should be addressed:

- Is there swelling or pain in one or both testes?
- What is the position of the testis in the scrotal sac? Is it elevated, rotated or bruised?
- Is there an obvious urethral discharge? If there is no obvious urethral discharge, squeeze the penis and milk the urethra to express any discharge.

Box 3 If the client has pain and/or swelling in the scrotum, go to **Box 7**. If not, go to **Box 4**.

Box 4 If there is no evidence of painful and/or swollen scrotum, look for other signs of STI. **All clients should be examined for signs of other STI.** If no symptoms of another STI are found, go to **Box 5**. If another STI is found, go to **Box 6**.

Box 5 If the client has no signs of STI, reassure him but take the opportunity to educate and counsel him, and to promote and provide condoms.

Box 6 If the client has other signs and symptoms of another STI, treat him according to the appropriate flowchart.

Box 7 Determine whether there is a history of trauma, decide whether the client could have testicular torsion or a strangulated inguinal hernia. With testicular torsion, the testis is elevated or rotated. With a strangulated inguinal hernia, the scrotum is usually swollen and the testis may not be palpable. The scrotum is filled with an elongated lump which is painful and on palpation it will be difficult to define the upper limit of the mass as it extends into the abdomen under the inguinal ligament.. If there is, go to **Box 9**. If not, go to **Box 8**.

Box 8 Treat the client and his partner for gonococcal and chlamydia infection as follows:

Gentamicin 240 mg in a single IM injection, and
Doxycycline 100 mg orally twice daily for 7 days*

** Note: Doxycycline is contraindicated during pregnancy and lactation.*
Use the following regimen instead:

Gentamicin 240 mg IM stat and
Erythromycin 500mg orally every 6 hours for 7 days.

Encourage bed rest, with the scrotum elevated. Cold compresses may also be useful in decreasing swelling. Provide education and counselling and promote and provide condoms.

Box 9 Refer the client immediately for surgical opinion if the diagnosis is in doubt, if the client is severely ill or if the swelling is severe or increasing in size.

CASE STUDY 8

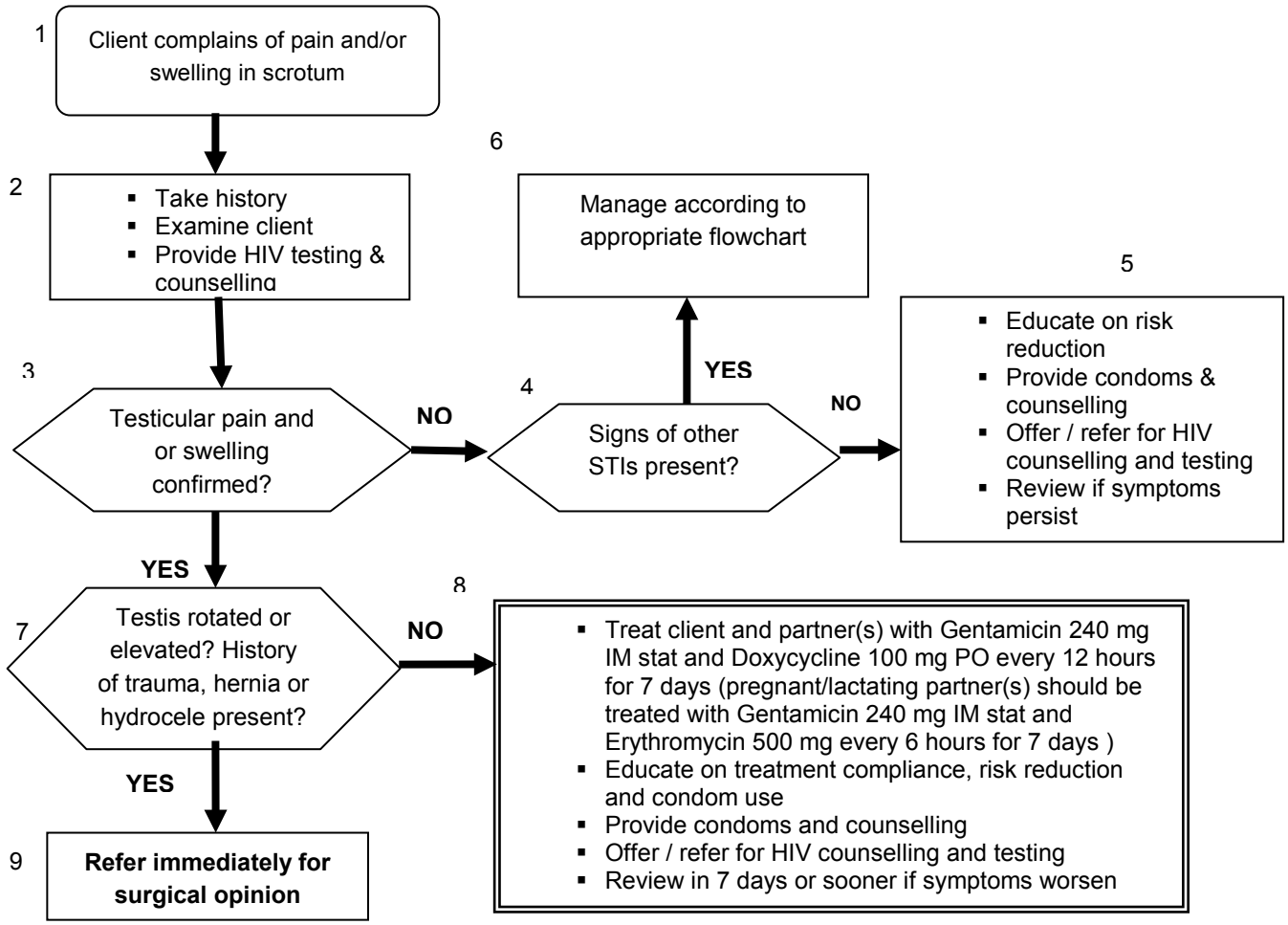
1. A 20 year old man presents with a 2 day history of pain and swelling in the right side of the scrotum following an episode of urethral discharge which was treated with some tablets obtained from a friend. On examination you find that the right testis is swollen, hot and extremely tender. You are unable to find any urethral discharge. Outline your management of this patient.

2. A patient complains of pain and swelling in the scrotum. He admits to having been kicked in the groin during a fight the night before. When you examine him you are unable to find any swelling of either testis, there is no urethral discharge and when you palpate the scrotum there is not much tenderness. You follow the flowchart and reassure the patient. He returns 2 days later and now states that he is much worse and indeed when you examine him you find a hot and swollen right scrotum.

   a) What do you think is the diagnosis?

   b) Outline your management.

ACUTE SCROTAL SWELLING



INGUINAL BUBO - BU

Introduction

Enlarged inguinal lymph nodes are painful swellings in the inguinal region which are caused by acutely inflamed and possibly suppurating inguinal lymph nodes. A bubo is a collection of inflamed inguinal lymph nodes. Enlarged lymph nodes which are not acutely inflamed are not considered to be buboes. With a bubo, the lymph nodes are acutely inflamed and so they cause pain. Because of the inflammatory process, pus may form within the nodes and a deep abscess may develop. Chancroid and *Lymphogranuloma venereum (LGV)* cause buboes. When a bubo is caused by Chancroid, a genital ulcer could also be present, but occasionally may not be. If the bubo is due to *Lymphogranuloma venereum*, a genital ulcer may not be present. Buboes may be unilateral or bilateral, thus the groin must be examined on both sides.

Lymph nodes in the inguinal region enlarge for a variety of reasons. Some of the causes are listed below:

- Septic skin lesions on thigh, leg, foot, toes, buttock, anus, perineum, scrotum, penis, labia, vulva and vagina
- Systemic infection such as hepatitis B, HIV infection, infectious mononucleosis, syphilis, tuberculosis
- Other infections such as bubonic plague, cat scratch fever, trypanosomiasis
- Lymphoma, leukaemia, Kaposi's sarcoma.

When a client presents the complaint of a swelling in the groin (inguinal area) each of these conditions must be ruled out. In addition, several other conditions which are not related to enlarged lymph nodes can cause swelling in the groin area. These include inguinal hernia, lipoma or a boil in the skin overlying the area.

Using the Flowchart on Inguinal Bubo

The flowchart for the management of buboes is a simple one. Confirm the presence of a bubo by examination. At the same time, determine whether the client also has a genital ulcer. If the client has a genital ulcer, treat him/her as described in the genital ulcer flowchart and as described in the present flowchart. This flowchart is to be used for both men and women with buboes.

Box 1 For a client to be entered into this flowchart, they must complain of inguinal swelling (bubo).

Box 2 Take a history and conduct an examination. Determine whether the client has a bubo. Also examine for the presence of generalised lymphadenopathy (indicated by the presence of enlarged lymph nodes in at least two sites other than the groin). Palpate the neck and arm pits for cervical and axillary lymph nodes. Proceed with HIV testing and counselling as part of examination.

Box 3 Decide whether the client has a bubo. If a bubo is found, then go to **Box 9**, If not go to **Box 4**.

Box 4 If a bubo is not found, look for other signs of STI. **All clients should be examined for signs of other STIs.** If no other STIs are found, go to **Box 6**. If another STI is found, go to **Box 5** .

Box 5 Manage other STIs according to their appropriate flowchart

Box 6 Determine if there are signs of other illnesses present, if so, go to **Box 8**, if not to **Box 7**

Box 7 Educate and counsel appropriately and inform client to return if his symptoms persist.

Box 8 Manage other illnesses appropriately or refer for further investigations

Box 9 Determine whether a genital ulcer is present. If the client has a genital ulcer, go to **Box 10**. If not, go to **Box 11**

Box 10 Manage for genital ulcer disease (move to GUD flowchart)..

Box 11 The client and the partner should be treated for both *Lymphogranuloma venereum* and Chancroid with:

Doxycycline 100 mg orally every 12 hours for 14 days and Ciprofloxacin 500g Orally single dose.

***NOTE: Doxycycline and Ciprofloxacin are contraindicated during pregnancy and lactation**. Instead, use:*

Erythromycin 500 mg orally every 6 hours for 14 days.

If the bubo is fluctuant, aspirate it with a wide bore needle. Always enter the bubo through adjacent normal, healthy skin, not through inflamed skin. Incision and drainage of nodes will delay healing process and are contraindicated.

Educate and counsel the client and promote and provide condoms.

Box 12 Review patient after 14 days and observe improvement. If client has improved go to **Box 13**, if no improvement go to **box 14**.

Box 13 Counsel and educate the client on risk reduction

Box 14 Refer to specialist for culture and sensitivity

CASE STUDY 9

1. A 38 year old vendor presents to your clinic with a week's history of swelling in both groins. He states that the swelling started spontaneously and there is some pain in both groins. On examination he has lymph nodes in both inguinal regions. Some lymph nodes measure up to 3 cm in diameter. There is no tenderness on palpating the groins. You also notice that he has palpably enlarged lymph nodes in both axillae. Give an outline on how you would manage this patient.
2. An unmarried 30 year old woman was treated by you a week ago for a right sided inguinal bubo and a sore on the right labium major. As you had suggested she now returns complaining that though the sore has healed the swelling has increased but is no longer painful. When you examine her you find that she has a softening bubo in the right groin. How would you manage her now?
3. Give an outline of the management of a pregnant woman who has a left sided inguinal bubo but no genital sores and no septic skin lesions on her lower limbs.

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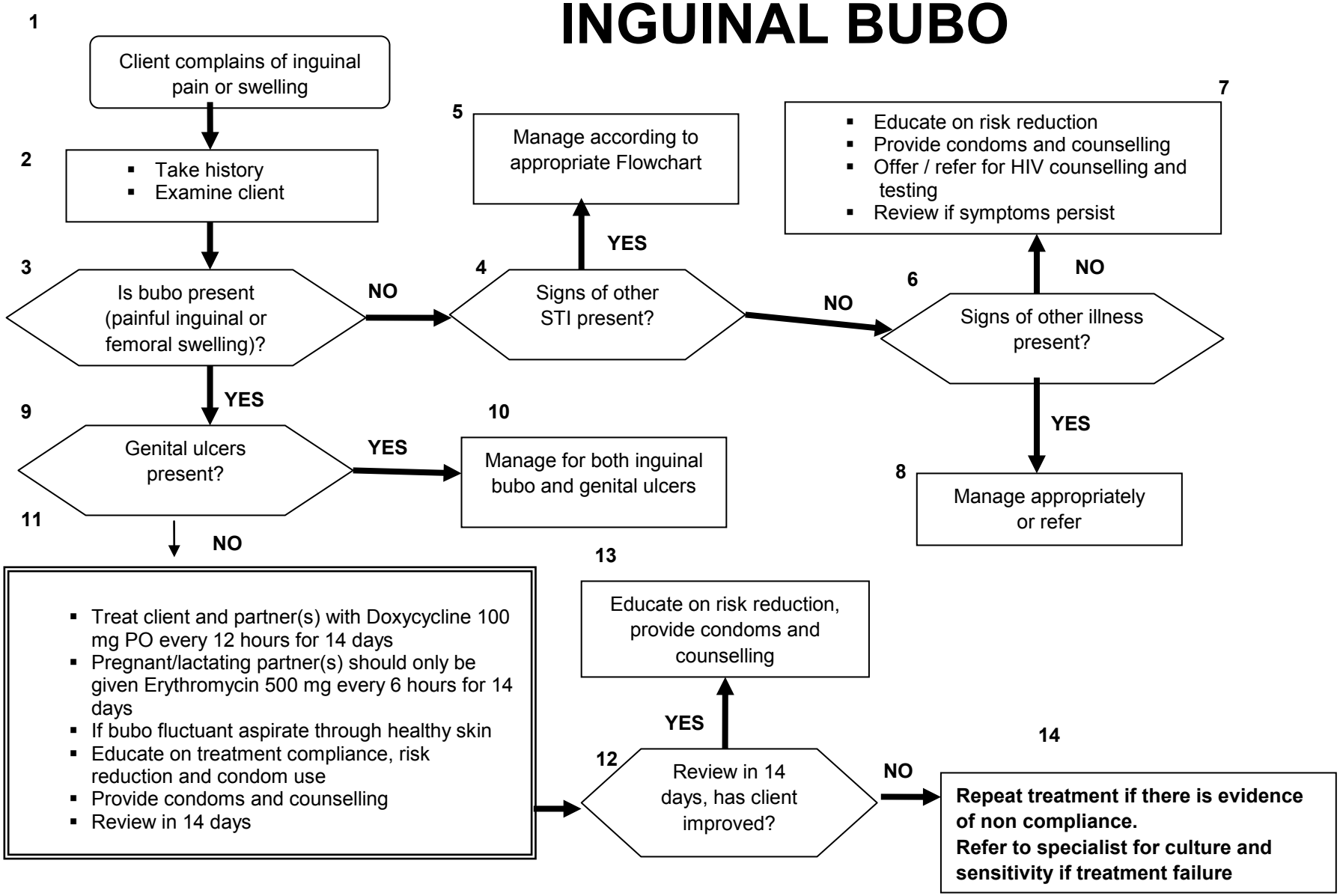
INGUINAL BUBO



BALANITIS /BALANOPOSTHITIS- BA

Introduction

Balanitis is an inflammation of the glans penis in a circumcised male. In uncircumcised males, both the glans penis and foreskin are affected, and the condition is known as balanoposthitis.

Inflammation of the glans penis does not commonly occur in circumcised males. When it does occur, it is usually the result of fungal infection. Fungal balanitis caused by Candida and the dermatophytes causes itchiness of the glans penis. The itch may be quite severe. Examination will reveal a follicular rash with some redness of the affected area. Candida balanitis occurs more commonly in persons with diabetes and in those with immuno-suppression caused by HIV infection. Another common cause of itching is *Trichomonas vaginalis*. At times, clients will state that they have a urethral discharge not realising that the discharge is coming from the space between the foreskin (prepuce) and the glans penis. Examination will reveal redness of the glans penis and sometimes sub-preputial discharge. There may be excoriation of the foreskin because of the scratching caused by the intense itching.

Balanitis can also be due to drug reactions. The glans penis and the shaft of the penis are common sites for a fixed drug eruption, the lesions of which are small (1-2 cm diameter), oval or circular areas of hyper-pigmentation or redness. The lesions of erythema multiform are concentric circles with a central vesicle.

The most common cause of balanitis appears to be poor personal hygiene. Clients who do not regularly wash under the foreskin develop an accumulation of smegma. The smegma is a good medium for many different types of bacteria, including fusospirochates and anaerobes. Examination will reveal an accumulation of offensive smegma and moistness of the glans penis. There may or may not be superficial erosions or ulcers.

The most important thing to look for during the examination is whether the client has genital ulcers. If the client's foreskin is so tight that it cannot be retracted (phimosis), assume that a genital ulcer is present and treat for genital ulcer disease.

Using the Flowchart for Balanitis/ balanoposthitis

Box 1 For clients to be entered into the flowchart they should complain of itchiness of the glans penis or say that they have noticed a discharge on the glans penis.

The following issues should be addressed during the examination:

- Specifically look for ulcers under the foreskin in uncircumcised clients. If the foreskin is not retractable (**Box 2**), palpate for ulcer (**Box 4**).
- Look for obvious urethral discharge (**Box 5**). Is there a sub-preputial discharge? If there is no obvious urethral discharge, squeeze the penis and milk the urethra in order to express any discharge.
- Look for Erythema or erosion on the glans penis.
- Proceed with HIV Testing and counselling

Box 2 Determine whether the foreskin is retractable. If the foreskin is not retractable, go to **Box 3**. If it is retractable, go to **Box 4**.

Box 3 If the foreskin is not retractable, assume that the client has a genital ulcer and manage him according to the flowchart for the management of genital ulcers.

Box 4 Examine the client carefully for genital ulcers. If genital ulcers are not present, go to Box 5. If genital ulcers are present, go to **Box 3**.

Box 5 If genital ulcers are not present, determine whether the client has a urethral discharge. If he does, go to **Box 6** If he does not, go to **Box 7**

Box 6 . Manage the client according to the flowchart for urethral discharge.

Box 6 Determine whether the client has any redness (erythema) or superficial erosions. If erythema or erosions are found, go to **Box 8**. If no erythema or erosions are found and there is no evidence of any other STI, go to **Box 7**.

Box 7 Determine if client has Erythema or erosion on the glans penis. If yes go to **box 9**, otherwise go to **box 8**.

Box 8 If the client has no signs of STI, reassure him. Take the opportunity to educate and counsel him and to promote and provide condoms.

Box 9 Treat the client for fungal infection as follows:

Gentian Violet 1% aqueous solution applied to the glans penis daily for 7 days. **Or clotrimaxzole cream topical application single dose**.

Advise the client on local hygiene, including the need to wash himself frequently with soap and water.

Treat the partner with the following:

Clotrimazole 500mg pessary single dose intra-vaginally

Educate, counsel, promote and provide condoms.

Arrange to review the client in 7-10 days time.

Box 10 When the client returns in 7 days determine whether the client still has symptoms. If the client has no symptoms, go to **Box 11**. If the client still has symptoms, go to **Box 12**.

Box 11 If the client has improved and has no signs of STI, reassure him. Take the opportunity to educate and counsel him and to promote and provide condoms.

Box 12 **If the client has still has symptoms when he returns** after 7 days, treat him and his partner for *Trichomoniasis* as follows:

Metronidazole 2 grams in a single oral dose.

Note: Advise client and partner to avoid alcohol use for

48 hours after taking Metronidazole.

Provide education and counselling and promote and provide condoms.

Important points to remember on Balanitis

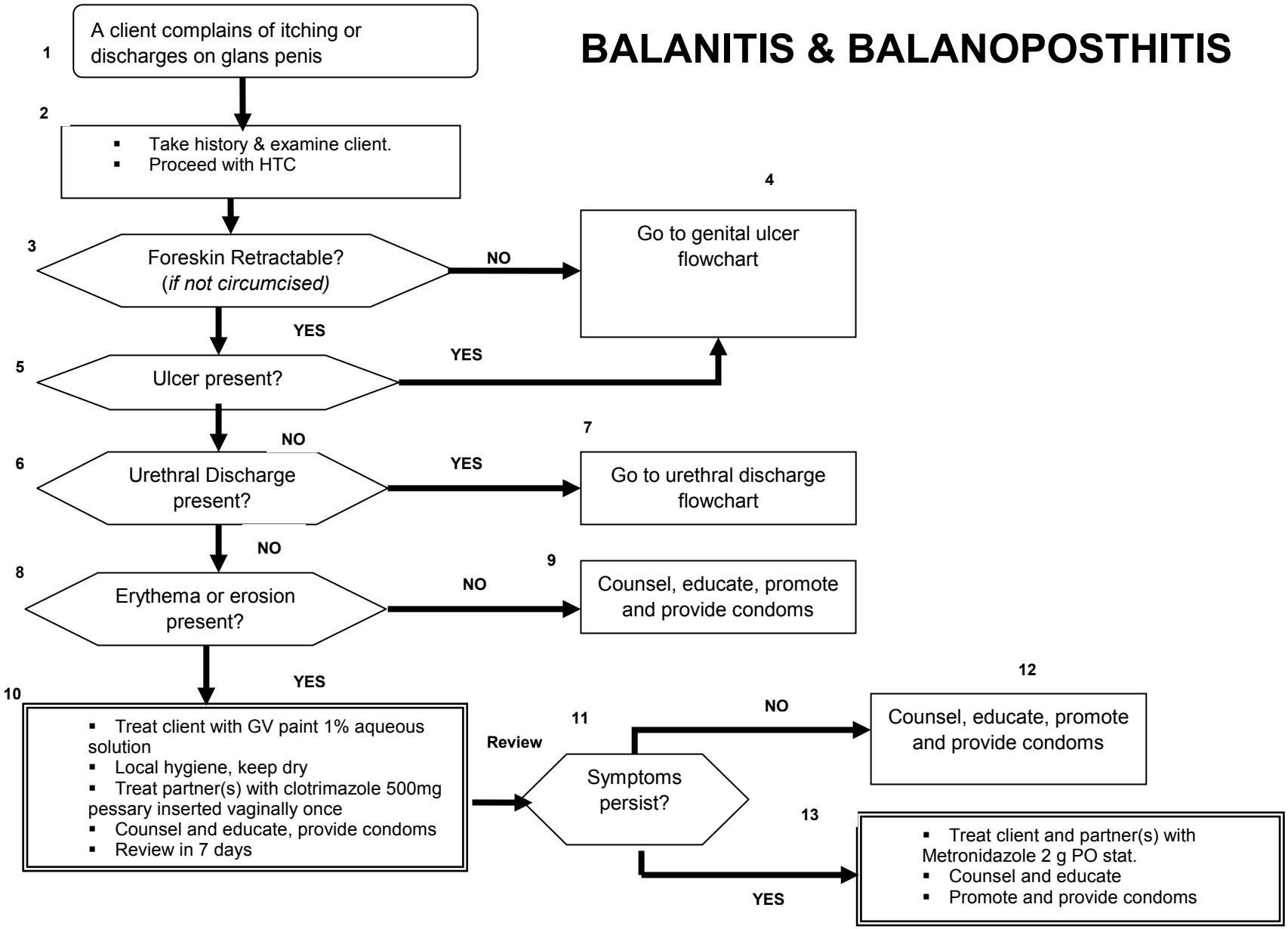
- Balanitis is often due to fungal infection. Immuno-suppressed persons are more prone to develop candida infection. Males with recurrent candidal Balanitis should be investigated for diabetes and HIV infection.
- Trichomonas Balanitis may occur in men.
- If a person has developed a rash on the genitals after taking some kind of medication, he may be allergic to the medication.

CASE STUDY 10

1. A man comes to you complaining that he has itchiness of the glans penis. You follow the flowchart and take a history and examine him. In the history you note that he has not had sexual contact with anyone other than his wife for at least a year. On examination you find only some redness of the glans penis. Outline your management of this patient.

2. A man comes to you with a history of itchiness of the glans penis. You follow the flowchart and treat him with gentian violet. He returns in two weeks stating that he is still not better. When you ask him if he has had sex, he says that he has been having sex with only his wife and has been using condoms. Outline your management of this patient

BALANITIS & BALANOPOSTHITIS



NEONATAL CONJUNCTIVIS - NC

Introduction

Neonatal conjunctivitis (*Opthalmia Neonatorum*) is a conjunctival inflammation occurring within the first 10 days of life and it can lead to blindness when caused by *Neisseria gonorrhea*. The most important sexually transmitted pathogens which cause *Opthalmia Neonatorum* are *Neisseria gonorrhea* and *Chlamydia Trachomatis*, which is transmitted in Utero if an infected woman is not treated during pregnancy. Other causes are *Staphylococcus Aureus*, *Streptococcus Pneumoniae, Heamophilus species* and *Pseudomonas* species. Newborn babies generally present with redness and swelling of eyelids or 'sticky eyes', or because of discharge from the eye(s).

Neonatal conjunctivitis is an extremely serious condition which may lead to blindness if not appropriately managed. It is therefore recommended that the infant is referred immediately if the condition can not be managed at primary health care level to a Central Hospital where appropriate treatment can be administered by a Paediatrician.

Management of Neonatal conjunctivitis using the flowchart

Box 1 The starting point of this flowchart is a neonate with discharge in his/her eyes

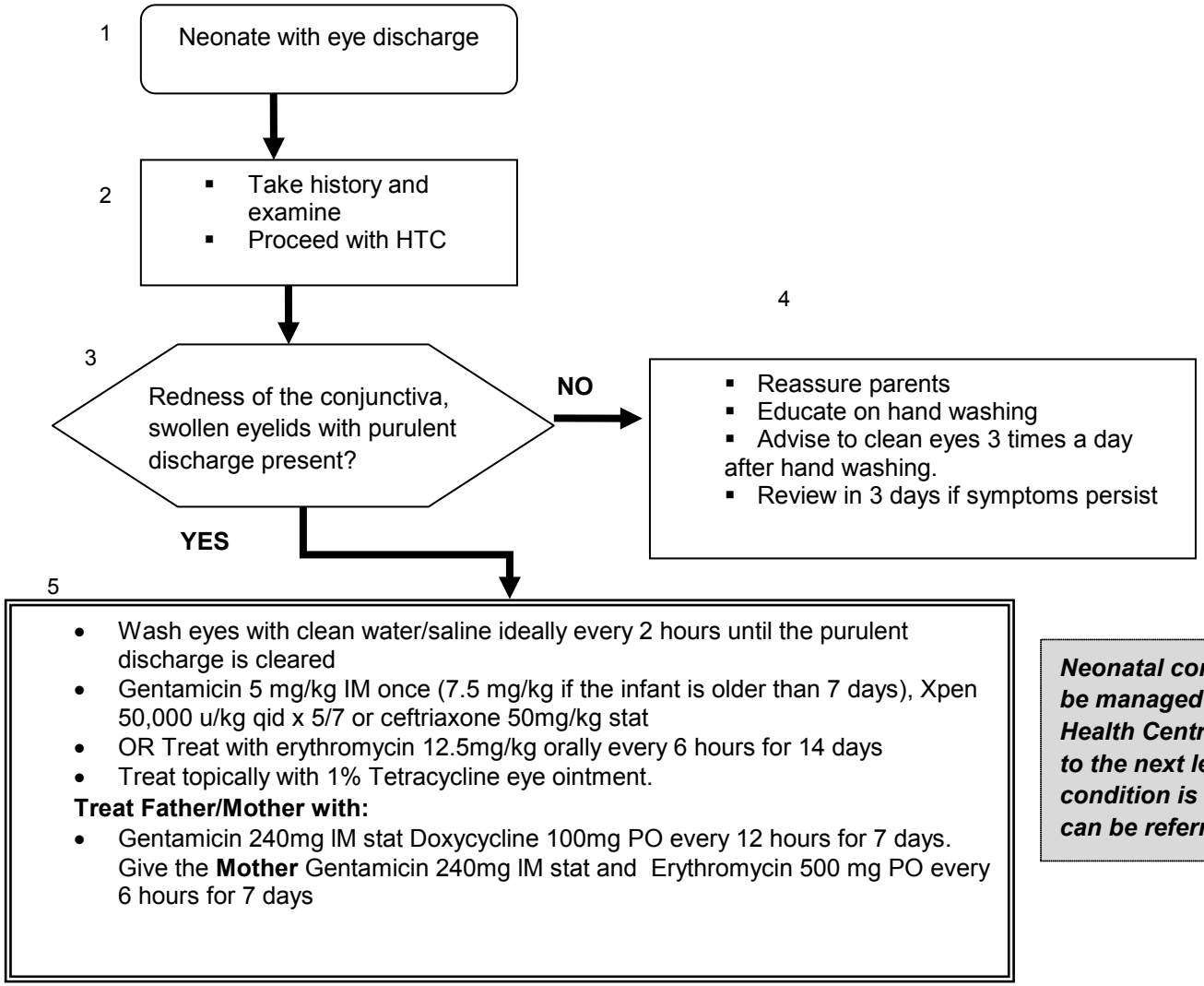
Box 2 Take a history from both parents if possible, specifically asking for history of Urethral Discharge or Abnormal Vaginal Discharge to find evidence of Chlamydia or Gonorrhoea.

Box 3 Examine eyes and observe purulent discharge; if not; go to **box 4**. If found go to **box 5**

Box 4 Reassure parents and advise on eye care for infant and hygiene measures.

Box 5 Carefully wash both eyes with clean water / saline; ideally every 2 hours. Use clean cotton wool and swipe from the outside of the eye towards the nose. Treat infant with Gentamicin 5 mg/kg single dose (7.5 mg/kg if the infant is older than 7 days) and ertythromycin 12.5mg/kg every 6 hours for 5 days (i.e: treat for Neonatal sepsis). Apply Tetracycline l % eye ointment/drops in both eyes every 8 hours until symptoms are cleared. The parents should receive treatment for Chlamydia and Gonorrhoea with Gentamicin 240 mg IM stat and Doxycycline* 100 mg every 12 hours for 7 days (Mothers should be given Erythromycin 500mg PO every 6 hours for 7 days rather than Doxycycline).

NEONATAL CONJUNCTIVITIS



Neonatal conjunctivitis can be managed at primary Health Centre before referral to the next level. Only if the condition is severe the child can be referred.

Section 4:

Education, Counselling and Extending to Partners & Communities

Introduction

The principles of good verbal and non-verbal communication (ROLES and CLEARR) reviewed in the chapter INTERACTING WITH COLLEAGUES, CLIENTS AND OTHERS on page 16 are fundamental to effective health education and counselling. They should be used **throughout** the interaction with clients and colleagues.

Though similar, education and counselling are somewhat different. Health **education** with STI clients involves learning from the client what they already know and do, and then tailoring additional practical information to be relevant to the situation of the client. Such information might include the name of the syndrome, consequences if untreated, symptoms, treatment and prevention. This merges with the process of **counselling** which is a process in which one person helps another solve a problem. The counsellor does not solve the problem himself or herself but rather helps the person being counselled to consider his or her options in a systematic manner. STI counselling would involve a whole range of skills from listening to the client's explanation of how the STI has affected his or her marriage or social life, to helping the client make some decisions about behaviour change.

The service provider should ensure that the client understands a variety of issues related to the STI before he or she leaves the clinic. The following nine issues should be discussed with every client by checking with them what they already know and do:

1. The **nature of the infection** and possible complications, including increased risk of contracting or transmitting HIV;
2. **How the client became infected**;
3. The possibility of **asymptomatic infection**, particularly in women;
4. The importance of **treatment compliance** to ensure cure;
5. The importance of **abstinence from unsafe sex** until cured;
6. The need to return for the **follow-up** visit;
7. How to **use a condom**;
8. How to **prevent re-infection** using safe sex practices;
9. The importance of **partner notification**.
10. Issues related to HTC and VCT

These will be dealt with briefly in this chapter, but issues 8 and 9 will be dealt with more fully in the following chapters on the involvement of sexual partners. **In this section only those issues that deal with the client's own independent knowledge and actions will be reviewed.**

Always, <u>always</u>, start by reviewing the client's knowledge

It can never be stressed too much that it is pointless to provide information or education without first checking what the client believes and knows, and what their situation is. Otherwise the information is likely to be irrelevant or of no interest to the client.

Always, always, communicate interactively

It can also never be stressed too much that education can never take place without paying attention to an interactive process with the client whereby the provider raises questions that allow the client to relate to his or her own reality and knowledge.

The Possibility of HIV Infection

A particularly difficult problem for the service provider is the knowledge that **a large proportion of people who present with symptoms of an STI may also be infected with HIV**. Although neither the client nor the provider may know the client's HIV status, the information on treatment and prevention of STIs should consider the strong possibility of the client being HIV-infected. Information on Voluntary Counselling and Testing (VCT) and HIV testing and counselling (HTC) should therefore be included in educating the client about STIs. It should be stressed that **you cannot tell if someone is HIV infected by how he or she looks**. People who have been infected with HIV may look strong, healthy, fat or young.

All clients and their partners should be encouraged and referred

to a trained VCT counsellor.

Voluntary Counselling and Testing / HIV Testing and Counselling (HTC)

HIV Testing and Counselling and VCT have shown to have a role in both HIV prevention and, for people with HIV infection, as an entry point to care. VCT provides people with an opportunity to learn and accept their HIV serostatus in a confidential environment with counselling and referral for ongoing emotional support and medical care. People who have been tested HIV positive can benefit from earlier appropriate medical care and interventions to prevent HIV-associated illnesses. Pregnant women who are aware of their HIV status can prevent transmission to their infants. Knowledge of HIV status can also help people to make decisions to protect themselves and their sexual partners from infection. Recent studies have indicated that VCT is a cost-effective intervention in preventing HIV transmission.

HIV counselling has been defined as '*a confidential dialogue between a client and a service provider aimed at enabling the client to cope with stress and make personal decisions about HIV/AIDS'*. The counselling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour.

The service provider's communication skills, and sensitive,

non-judgemental attitude are essential to good counselling

In some settings, HIV counselling is available without testing. This may help promote changes in sexual risk behaviour.

VCT is an entry point for

Prevention and Care

Medical Care

Preventing Mother to Child Transmission

Ongoing emotional and spiritual care

Social Support

The VCT process consists of pre-test, post-test and follow up counselling. It can be adapted to the need of the client and the setting in which it is delivered. VCT services should be provided according to the existing National VCT guidelines.

Why are education and counselling difficult?

> 'To counsel well, providers need to be empathetic, non-judgmental, honest, and respectful of patients'

Population Reports, Counselling Guide, J-36, December 1987.

As will be remembered from the case study in the chapter on interaction (page 16), education and counselling are difficult areas of STI management for both patients and service providers. If a service provider seems contemptuous or judgmental—or just too busy—patients may be reluctant to divulge personal information about sexual activities. Because of the stigma attached to STI, patients are embarrassed about their symptoms. They may have difficulty talking about their sexual behaviour and may have heard about or been treated by service providers who branded them as 'sinners', refused to provide treatment, discussed personal information in public waiting areas, or otherwise embarrassed or humiliated them.

The difficulties of a clinic setting

Perhaps most importantly, the session with a client is inevitably away from the pressures and influences that determine people's ways of interacting. Often a person will be unable to articulate why it is hard to communicate with a partner, or even say that it is difficult. In real life, though, each particular relationship has its own history and conventions about communication, and it is impossible for a service provider to determine these in advance. The only way is to help the client understand the need to have safer sex, to continue treatment, and to help them communicate with their sexual partner(s) about safer sex and being treated for STIs. This is done by a mixture of listening, empathy, review and discussion.

Counselling in the context of individual education

Counselling is typically aimed at helping the client manage difficult feelings or make decisions about behaviour and sexual interaction. Because behaviour and interaction involves more than the client themselves, it is important to realise the need to help the client relate to the realities of their situations and to their sexual partners. These aspects will be dealt with more fully in the chapters on Involvement of Sexual Partners. The counsellor's job is to help the client take the following steps:

- Identify any problem
- Review the causes and consequences of the problem
- Generate a list of possible solutions to the problem
- Review the pros and cons of each possible solution
- Decide on a course of action
- Commit to a course of action

Effective counselling is an important part of the prevention and management of STIs. It can help the client identify the source of the problem, as in the case of a woman who has lower abdominal pain but does not know that it comes from an STI transmitted to her by her husband.

Counselling can also help clients think through different solutions to a problem, such as how to achieve safer sex with a boyfriend.

The aspects of counselling that affect the involvement of partners in safer sex are more fully explored later in the chapter on Page 120. In this chapter, only those aspects of counselling that relate to the individual alone are discussed. Techniques of safer sex are also discussed in the chapter on Page 120 and should be referred to in determining the client's knowledge concerning safe sex.

Risk Assessment

Helping the client determine his or her level of risk relative to STIs may help the client decide to take greater precautions. Risk assessment is based on the following factors:

- the client's own sexual behaviour;
- the partner(s)'s sexual behaviour;
- The client's protective behaviour.

Some clients may be aware of the risks they are taking but feel unable to do anything about it. By asking three simple questions, the client may be able to find their own way forward:

- What do you see as your risks?
- What do you think you could do to reduce those risks?
- What are the constraints you might face in reducing the risks?

It is important to help the client realise that even one little risk reduction is important.

Others may not have realised they were taking risks, or may have thought their methods of self-protection were adequate when they are not. It is important to help the client accurately assess the level of risk without terrifying him or her! A helpful list of questions is supplied in

APPENDIX 6: ASSESSING RISK IN SEXUAL INTERACTIONS.

The Nature of the Infection

Check what the client knows about their condition.

Explain to all clients with STIs that STIs are acquired and spread through sexual intercourse. Be careful in talking with women who have pelvic inflammatory disease or genitourinary symptoms as these conditions are not always caused by STIs.

Tell the client what syndrome he or she is being treated for. Explain that the symptoms he or she has may be caused by several different organisms and so the treatment is not just for one disease. Explain that the treatment being given can kill all the organisms causing the symptoms, except in the case of herpes or genital warts. In the case of herpes and genital warts, explain that the symptoms might return after treatment.

Periodically check the client's understanding of what you have discussed by asking the him or her to restate the main points for attention.

How the client became infected

Check whether the client knows how they became infected.

Clients with STI should be helped to understand how a person acquires the infection. The infection is acquired through sexual intercourse. Your client, unless he/she is a faithful spouse, has become infected through his/her own sexual behaviour and by engaging in unsafe sexual acts. All clients should understand that HIV infection, an incurable disease which leads to the death of infected persons, is also acquired and transmitted through sexual intercourse.

The possibility of asymptomatic infection

Check whether the client knows that STIs are often either asymptomatic or that people may not be aware of symptoms that are present.

Clients should be helped to understand that only a small proportion of people who have STIs also have symptoms. Tell the client that persons with asymptomatic infections can still spread the disease and that asymptomatic infections have the same long-term consequences as symptomatic infections. In addition, if the asymptomatic partner does not receive treatment, he or she will re-infect the other partner.

It is particularly hard for women to notice symptoms, and even if they do have symptoms some women believe that the sensations or the discharge they might experience are in some way 'normal'. It is therefore very important to realise that you cannot tell from the look of a person whether or not they have an STI or if they are infected with HIV. There are many people who believe that by having sex with someone who looks 'young', or 'fresh', or 'healthy' that they are safe from STIs and AIDS. This is a very risky belief indeed.

Treatment Compliance and Follow-up

Check what the client knows about taking medicine, whether they know they have to take the full course, whether they are taking other treatments, and whether they have any concerns about treatment.
Tell the client the **names**, **doses,** **time course** and **side effects** of each of the drugs you prescribe. Explain that

- if the full course is not taken, resistance to the drugs may develop; this will make it harder to treat future infections.
- the full dose of each medication should be taken for the specified period.
- Drugs should not be shared with others. Separate doses are required for every person needing treatment.
- Sexual partners of the client may require different or additional drug treatment because they may have additional or different infections.
- Side effects should be reported immediately.

Check if the client knows he or she can expect to see symptoms decrease or disappear. Many clients lose confidence in the effectiveness of the drugs if symptoms do not disappear quickly. As a result, they may quit taking the drug before it has a chance to clear the symptoms. Also advise clients not to add drugs obtained from other sources to the treatment regimen as this can lead to toxicity. If the symptoms worsen prior to the follow-up appointment, the client should come to the clinic immediately for evaluation and possible referral. All clients should be encouraged to keep their follow-up appointments so that the provider can be assured that the treatment has been successful.

Periodically check the client's understanding of what you have discussed by asking the him or her to restate the main points for attention.

Abstinence from Unsafe Sex Until Cured

Check with clients whether they know they should abstain from unsafe sex until they have finished the full course of treatment and all symptoms have disappeared. Warn the client that if he or she does not wait, they may give their partner the STI if they have unsafe sex. If the client also has HIV, unprotected sexual activity while symptomatic will also greatly increase the likelihood of their spreading HIV to their partner. If symptoms of the STI remain, despite completing the full course of treatment, the client should refrain from unprotected sexual activity and return to the clinic immediately for evaluation and possible referral.

Review with clients the difficulties they may have in abstinence from unsafe sex.

Return for follow up examination

Check whether the client knows how they should return for follow-up examination.

It is important that all persons treated for STI should have a follow up health assessment. At this follow up, patient should be re-assessed and health education and counselling reinforced. Explain to your patients that if they still have symptoms they can get more medicine to cure their infection.

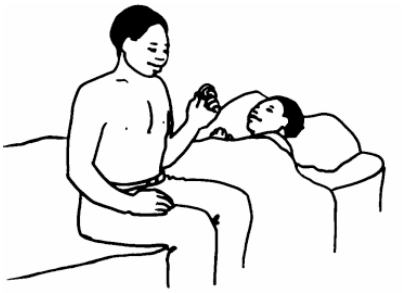
Condom Use

Check with clients whether they know how to use a condom, whether they use them regularly. Review with them their attitudes to condom use and the difficulties they may have in communicating with their partners about condom use. Refer to the chapter INVOLVING SEXUAL PARTNERS IN TREATMENT **and at the chapter** INVOLVING SEXUAL PARTNERS IN SAFER SEX **in order to look at some of the issues behind such communication.**

All clients should be aware that STIs are preventable infections and prevention may be achieved by using condoms. Condoms help people have 'safer sex' by preventing contact with the vaginal fluids, semen and blood of their partner. Using condoms is particularly important if either the client or the partner is at high risk of HIV and STI because of their high number of partners and frequency of unprotected sex.

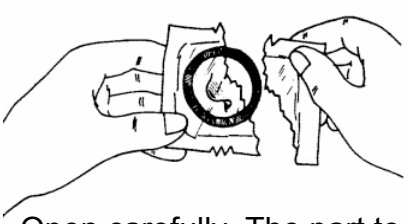
A series of pictures illustrating condom use follows on the next page. There is also a set of pictures on Condom Care in the Appendices.

HOW TO USE A CONDOM



Agree to use a condom with your partner.
REMEMBER: Natural vaginal lubrication resulting from arousal is always best.
Avoid 'Dry Sex' to avoid condom breaks!

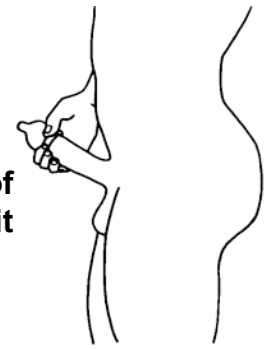
Don't put a condom on a soft penis!

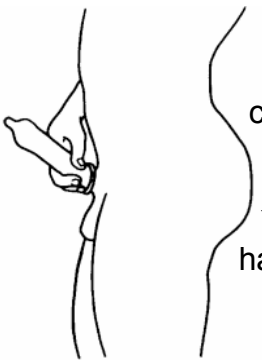


Open carefully. The part to be unrolled must be on the outside. DON'T unroll it before putting it on!

Put condom on BEFORE touching partner with penis.

Hold on to the top of the condom. Place it on the hard penis.

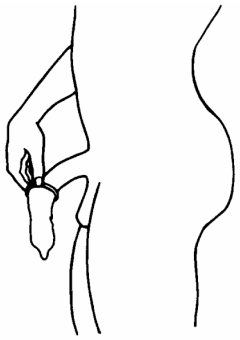


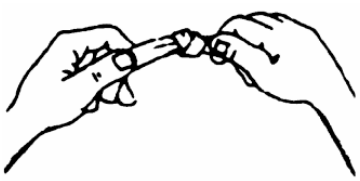


Unroll the condom all the way.

You can now have sex safely.

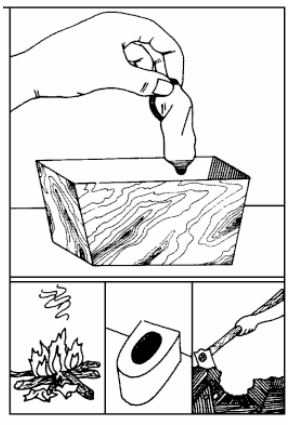
After ejaculation, hold condom at the base of the penis so it does not slip off. Pull out of your partner before penis becomes soft.





Tie up the condom before throwing it away to avoid spillage.

Throw the used condom in a latrine, or burn it or bury it. Do not try to re-use a condom.



CASE STUDY 11

1. A health worker was overheard telling a client with STI the following: “If you have sex again with bar-girls, you will get AIDS and die and your wife will get it too!”

   What are the dangers of using this approach? What would be a better approach?

2. A male client comes to you saying that he has been told that he has an incurable disease. When you take a history he informs you that he has been told he has genital herpes. He is quite upset and anxious and feels that he will die of AIDS now. When you examine him you are unable to find anything wrong with him except for some scarring on the foreskin caused by healed lesions of genital herpes.

   How would you counsel this patient?

3. Before providing education, what should you do to ensure that anything you say is relevant to the situation of the client?

EXERCISE 5

With a group:

Develop practical guidelines to use in the clinic situation for educating and counselling a client with STI. Keep in mind that you do not have much time to carry out this activity in the clinic. However it is a very important aspect in the management of persons with STI and should always be carried out.

INVOLVING SEXUAL PARTNERS IN TREATMENT

Introduction

Throughout this Handbook, it has been emphasised that the client with an STI comes to the clinic they are not just coming with a problem of their genitals. They are coming with a series of problems that are to do with their relationships with others and their concerns about themselves. Discussion of prevention can therefore never be outside of the context of how they review things with their sexual partners. This chapter looks at how to help clients do this.

From a public health perspective, the importance of partner notification and treatment is obvious. The client's current and recent partners must be involved in the treatment for the following reasons:

- To ensure that the partner receives treatment for possible STIs to avoid the adverse consequences of an STI
- To prevent the spread of the disease by the untreated partner, and
- To ensure that the client is not re-infected after treatment

From the client's standpoint, however, the issue may be more complicated.

Concerns, beliefs & expectations

Many clients will have reflected on their problems arising as a result of having an STI, and have some of the following **concerns**:

- worry about sexual partner being angry or being blamed for unfaithfulness;
- disappointment, anger or suspicion about sexual partner(s);
- embarrassment, shame, pain and worry;
- concern about talking with sexual partners;
- being found out;
- whether they will be cured;
- whether they will be treated at the clinic with respect;
- whether their illness is due to HIV;
- whether their treatment at another source will be found out and they will be blamed;
- worry about being asked to bring their sexual partner(s)

They may also have a number of **beliefs** about treatment or about STIs. They may not **know** how they were infected or even what STIs are. They may have a series of **expectations** about being cured quickly. They may think that it is easy to treat STIs as they arise and thus have an **attitude** that they can continue practising unsafe sex. They may also have beliefs about having sex with people that appear to them to be healthy, fit and strong.

Effect of these concerns

All of the client's concerns, expectations, attitudes and beliefs can have a profound effect on the compliance of the client with the treatment provided, their willingness to discuss things with their sexual partners, their ability to bring the sexual partner for treatment, their willingness to try to practice safer sex, and their seeking of treatment with other service providers or healers.

Sometimes these beliefs are simply due to inadequate knowledge, and their concerns may exist because they have not been given an opportunity to reflect objectively on their situations.

Points for the Client's Consideration

The person from whom the client contracted the STI and any subsequent sexual partners are called *contacts.* It may be difficult for the client to identify from whom he or she contracted the disease.

Areas that should be included for consideration when raising the issue of how to communicate with such contacts are:

- the marriage or relationship;
- the client's or sexual partner's reputation in the family and community
- the client's sexual life;
- the prospect of bearing children;
- the client's overall psychological well being.

Before reviewing with the client how to talk to the sexual partner, you should first find out if all the people with whom the client has had sexual intercourse in the last three months already knows he or she has an STI and if they know the importance of treatment and of preventing future infections.

The story of the unclean hand

In talking with the client about communicating with partners, you should explain that treatment of all sexual partners is very important as they themselves might be infected, and continue to re-infect the client even after the client is cured.

"The Story of the Unclean Hand" is a good way to explain to the client the need for partner referral. It is an easily remembered explanation which the client may also want to use when telling the contact about the need for STI treatment. The explanation is as follows:

> ***If both your hands are dirty, and you wash one, as soon as your hands touch each other the dirty hand will make the clean hand dirty again.***

This helps to show that sexual partner(s) must also receive treatment otherwise the clients risk becoming infected again and possibly developing complications. You should also explain that the other sexual partners may infect others or develop further complications because of lack of treatment, and that the result would be even more spread of the disease because their sexual contacts could be re-infected and they would then infect even more people.

You will be building up to helping the client review the important pieces of information they will want to explain to their sexual partners. Always point out the big advantage to your client of doing this: **they do not need to reveal to the service provider the identities of their sexual partners because it is up to them to reach each sexual partner and pass on the information.** When talking to his or her partner, the client should be prepared to explain these points:

- how the client was exposed and the risk of infection;

- where to get treatment;
- why the contact should avoid sexual activity until counselled and/or treated;
- that the partner may be infected, **even if he or she does not show symptoms**. Therefore, all recent sexual partners must come for treatment, whether they have symptoms or not;
- many STIs can cause serious or potentially life threatening complications if they are not treated;
- the infected person will continue to infect others with whom he/she has sexual intercourse if not treated.

How the client can tell each type of sexual partner

As discussed above, telling sexual partners that they may have been exposed to an STI can be very stressful for the client for a variety of reasons. It may help the client to contemplate different strategies for different partners, depending on the client's relationship to the partner. For example, telling one's wife might require much more explanation than telling a commercial sex worker.

In all instances it is important to remember that the process through which you will guide the client is to help them see that there are possible positive approaches to talking with partners.

At no time will you be telling the client what to do.

The provider can assist the client in selecting the best way of telling various partners by going through the following steps:

1. Ask the client what options he or she has considered.
2. Add to this list if any of the strategies discussed below or others you have thought of might be appropriate to the client's situation.
3. Have the client consider the pros and cons of the different options.
4. Ask the client to choose which option they prefer based on the above assessment. If the client is having a hard time choosing, help them decide by further discussing the pros and cons.

The options that are discussed should thus always be in the context of there being many possible other options in methods of telling their sexual partners. You should tell the client that the client may think of their own solutions.

The provider should not tell the client which option to choose but rather should assist the client in making his or her own choice. It should also be clear to the client that they will be weighing the risks of telling the partner against the risks that result if they do not tell the partner.

Finally they should be aware that **all** partners should, if at all possible, be contacted by them.

The Snake Story

Sometimes clients will be extremely angry with the partner and will want to focus on the partner's infidelity or lack of love. This may interfere with the client telling the partner about his or her possible exposure to an STI. The following story may help the client focus on the need for treatment, regardless of the other issues in the relationship:

> *If you find that a snake has entered your house, you are not going to start calling everyone and try to find out who is to blame for leaving the doors or windows open, and then having a long and heated argument about it. You are going to kill the snake*.

The following sections discuss alternatives for telling different types of sexual partners about their possible exposure to an STI.

A Married Person Who is Afraid to Tell His or Her Spouse

The following points could be discussed with a married person who contracted an STI through an extramarital relationship and is afraid to tell his or her spouse:

1. The client could acknowledge his or her mistake and take responsibility for exposing the spouse to an STI. He or she could apologise to the partner, ask for forgiveness and understanding and ask the spouse to work with him or her to solve the problem between them.
2. The client could emphasise that he or she is informing the spouse out of concern for the spouse's health and because he or she wants them both to get the needed treatment to avoid further medical complications.
3. If the client continues to be afraid to tell the spouse, ask him to weigh the chances of the spouse divorcing him against the consequences of the un-cured STI for the spouse and the possibility of re-infection for himself.
4. If the client strongly resists the idea of telling the spouse, suggest he or she give the partner referral slip to the spouse and ask him or her to go to the clinic for treatment. The provider can then educate the spouse about the STI when he or she presents for treatment.
5. Another alternative would be for the client to return to the clinic with the spouse so that the provider can discuss the problem with the two of them together.

In a polygamous marriage, either the client or the spouse should notify the other wives.

A Married Person Telling Extramarital Sexual Contacts

Some clients may express resistance to the idea of notifying extramarital sexual contacts. The client may blame the contact for spreading the infection and therefore feel that the contact "deserves what they get." Other possibilities are that the client does not know where the person could be found again or the contact lives in another town. Whatever the reasons, remind the client of the importance of treatment for the contact to avoid the adverse consequences of the STI and to avoid spreading the disease to others. If the contact lives out of town, the client could send the partner notification slip and a letter to inform the contact..

Single Person Telling Sexual Partners

The type of sexual relationship the client has with the contact will influence how they tell the sexual partner. If the single person has a steady relationship with the partner, he or she can probably approach partner notification in much the same way as the married person telling a spouse. If the relationship is casual, but the client knows how to contact the person, the client should be encouraged to do so. This can be done fairly simply by giving the contact the partner notification slip and telling him or her to go for treatment.

Remind the client that even if one of the sexual partners is asymptomatic, they may still be infected and must be treated.

How to Fill Out a Partner Notification Slip

Partner notification slips should contain the following information:

1. Date of issue
2. Name of issuing clinic
3. Identifying number for the index client. (This is helpful only if numbered records are kept at the clinic. It allows the provider to find the details of the index client's visit.)
4. Coded Index-client diagnosis. (Codes are shown below). Including a coded diagnosis is essential since the sexual partner coming to the clinic may not know the details of the index client's diagnosis. Using codes also helps reduce the sexual partner's embarrassment when he or she presents the card at the clinic.

If you have a numbering system for partner notification slips, give the client the appropriate number of slips to pass on to his/her sexual partners. If pre-printed slips are not available, a rubber stamp can be developed for use with plain paper. If neither of the above are available, hand-written slips are acceptable.

An example of a pre-printed partner notification slip is shown below.

CHIDZIWITSO
(CHIMANYISKO)
Chonde bwelani ndi kalata iyi mwansanga ku chipatala cha pafupi:
(Chonde zani luwilo na kalata iyi kuchipatala chapafupi:)

ISSUING CLINIC .....
CLASSIF .....
CLIENT NO .....
DATE

The accepted codes for use in Malawi are as follows:

GUD	Genital Ulcer Disease
UD	Urethral Discharge
PRUD	Persistent / Recurrent Urethral Discharge
AVD	Abnormal Vaginal Discharge
LAP	Lower abdominal Pain in Women
SS	Scrotal swelling/pain
BU	Inguinal Bubo
NC	Neonatal Conjunctivitis
BA	Balanitis

CASE STUDY 12

1. A male patient comes to your clinic with a contact card. He is rather upset that he has been told to come here as he has "no symptoms or signs of anything". You look at the card and note that the index patient was treated by you 4 days ago for a genital ulcer. What will be your management of this contact?
2. A female patient attends your clinic with a contact card. The index case was treated at your clinic for a genital ulcer. When you examine her, you find no evidence of genital ulcers nor a bubo, but you notice that she has a thick yellow vaginal discharge. Give an outline of how you would manage her.
3. A male attends your clinic with a contact slip which states that the female index patient was treated for vaginal discharge. How will you manage him now?

Once it is agreed that the client should discuss with his or her sexual partner the need for treatment, it is important to look at communications between the client and his/her partner(s) about safer sex.

The most important factor for the service provider to take into consideration is the considerable difficulty people have in talking with sexual partners about sex at all—let alone safer sex. It is at this point that it is always useful for you yourself to consider the difficulties you yourself may have had in discussing sex or times when you wish you had raised the issue of safer sex. If you reflect on these, it will help you understand the complex and difficult situation of the client, and on the difficulty of giving simplistic 'messages' about achieving safer sex.

In fact, most sex is a reflection of some kind of relationship between people beyond the merely physical. Attraction, interaction and trust are nearly always involved in some measure. It is sometimes hard to know how to define sexual interaction as the spectrum of interactions is so great, and people can have orgasms merely by thinking of particular situations or items—let alone being involved in close bodily contact.

As a result a lot of discussion about sex is difficult precisely because it is so hard to define, and the multitude of concerns people have in a sexual relationship may not always be clear even to the people themselves. Furthermore, they may have been told by others that talking about sex is wrong, or that the sexual act is 'dirty'.

The point of focus in any discussion about safer sex is therefore not the sexual act itself, but the nature of the relationship of the client with the sexual partner(s) and the ability of the client to achieve safer sex through any form of communication—even if it is non-verbal.

For example, the client may learn to stimulate his or her partner in an entirely new way that will lead to sexual satisfaction for both and which they will then be happy to continue without the need for discussing it.

"Safer sex" is not just about making sex safer but also about improving the quality of sexual relationships so that both participants can enjoy the relationship without fear of negative consequences. Thus, education about safer sex is based on trust, not fear.

It should be clear in any event that it is pointless to try just to tell the client to stop being sexually active. This is impractical for most people and may lead the client to think that the provider is judgmental or naive.

Techniques

Beyond the need to find ways of communicating with their partner(s), clients will need to have an understanding of some possible techniques for safer sex. Safer sex techniques should be discussed with all STI clients. As usual in any communication **check first with the client whether they understand what safer sex is, whether they have tried or know of any methods of safer sex, and, if they do, whether they have any concerns about adopting such methods.**

Techniques for safer sex include:

- abstinence,
- use of condoms,
- mutual faithfulness of uninfected partners,
- use of non-penetrative sexual techniques (such as thigh sex, massage or mutual masturbation), and
- decrease in the number of sexual partners.

However, you can encourage any forms of sexual expression in which the risk of STI transmission is minimised. There are many options for safer sex and partners will make a choice based on what is most pleasurable and acceptable to them both.

Touch in the form of caressing, massaging and rubbing one another is one way to receive love and sexual pleasure. We can learn ourselves, or teach others, how enjoyable sex can be. Many parts of the body, apart from the genitals, are erogenous zones (i.e. giving rise to sexual excitement)—the breasts, buttocks, thighs, lips and even ears. Foreplay is often seen as preliminary to penetrative sex, however it can be a very satisfying form of sexual expression without leading to penetrative sex.

Thigh sex where ejaculation occurs against a woman's thighs or mutual masturbation are also alternatives to penetrative sex.

Condoms

Most clients will already know about condoms, but it is always important to check the client's knowledge about, attitudes to and usage of condoms.

The subject of condom use may be challenging for both the provider and the client. A very large number of people find that sex without a condom is more pleasurable than with a condom, they take risks in order to achieve this pleasure, and many have great difficulties in discussing condom use without embarrassment, shame or fear.

Studies carried out in Malawi in 1996 have shown that many health workers, like other community members, have difficulty with the idea of using condoms with their spouses. Some of the reasons cited for avoiding condoms are listed below:

- In general, people are afraid to introduce the topic of condoms to their spouses for fear of being accused of unfaithfulness.
- Wives believed that if they suggested condom use, their husbands would be suspicious, surprised and angry.
- Husbands believed that if they introduced the condom, the wife would feel pained, hurt, bitter, doubtful, disappointed and worried. Husbands fear that the woman might present this problem to her *ankhoswe* because of the suspicion of extramarital sexual relations.

In addition to the fear of marital disruption, many people, including health workers and STI clients, have negative attitudes toward condoms, either because of actual experiences or because of what they have heard from others. Some of the common complaints about condoms are listed below:

- Some say condoms make sexual intercourse painful;
- Others say that it causes a man to take a long to ejaculate;
- Some say they do not experience 'body heat' with condoms;
- Some women report that they 'missed the feeling of the sperms inside;'
- Some people found it frustrating to have to stop to put the condom on in the while in the middle of sexual pleasure

It is quite possible that the client's sexual partner(s) as well as the client have similar feelings about condoms, so it will not be sufficient to try to persuade the client alone to use them. It is always important to establish whether the client is comfortable about reviewing condom use with the partner(s).

Thus the provider can help the client consider ways to overcome the key problems suggested by the above findings, and then help the client see how these same ways can be reviewed with the partner(s). If you have used condoms yourself, perhaps you can help the client by offering suggestions you know to have worked for you.

'Breaking the Ice'

Whatever the approach, it is clear that a central issue for many partners is the one of trust—especially if a marital or long-term relationship is involved. However, it is quite often true that the partner is just as concerned to use a condom, but has not discussed this because of fear of raising the subject. 'Breaking the ice' is often successful.

For some, a method of breaking the ice without causing offence that has worked is that the client could present the condom as a prescription from the health worker at the clinic. Or, the client could tell the partner he or she wants to use condoms out of love and concern for the partner. The client might also explain that he/she has been told at the clinic that a condom can be used to enhance sexual pleasure—either through prolonging

intercourse, or as a method of stimulation when the woman could put the condom on the man as part of foreplay.

After consideration, some clients may decide they do not want to use condoms, despite their benefits in protecting against STIs and AIDS. These clients should receive detailed education on "safer sex," as discussed in the section below.

> Keep reminding the client that a person who looks absolutely healthy and displays no visible symptoms of any illness may still be infected with an STI including HIV.

Clients who do not want to use condoms

For clients who do **not want** to use condoms explain the following options:

- Avoid sexual intercourse with all sexual partners until they are cured.
- Express intimate sexual feelings through non-penetrative sex.
- Explore the possibility that a desire for personal satisfaction may not be the only satisfaction. Sexual partners may derive more pleasure from each other when they are relaxed in knowing their sex is safer.
- After the clients are cured and want to resume sex, if all partners are no longer infected, only have sex with each other, or if unmarried stick to one uninfected sexual partner.

Clients who want to use condoms

For clients who **want to use** condoms explain the following options:

- Use the condom correctly every time you have sexual intercourse.
- Use the condom with all your sexual partners every time you have sexual intercourse.
- Use the condom in ways that will enhance your sexual pleasure and that of your sexual partner. The ways to enhance sexual pleasure depends on the individual's customs and beliefs about having sex and should be explored by each individual accordingly.

> Remind the client that a person who looks absolutely healthy and displays no visible symptoms of any illness may still be infected with an STI including HIV.

You need to know and be open to all the options, no matter what her/his own opinions are in order to help the client chose the best one for her/himself.

Handy Tips for Proper Condom Use

See the illustrations on page 110 and in APPENDIX 7: CONDOM CARE on page 147.

Check with clients who think they may want to use condoms that they know the correct way of putting on a condom, using a demonstration penis. **All clients should be offered a supply of condoms**. To increase the likelihood that clients will actually use the condom during sexual activity, emphasise the following points:

- Have a condom ready before you need it;
- Use a condom with every act of intercourse unless you are in a mutually monogamous relationship;
- Agree on condom use with your partner.

- **REMEMBER**: Natural vaginal lubrication resulting from arousal is always best. Avoid 'Dry Sex' to avoid condom breaks!
- Check the condom packet for holes. Make sure there is a vacuum in the packet by palpating the condom. Do not use the condom if the packet has a hole or the vacuum cannot be felt.
- Open the packet using the V-notch. Use the hands to tear the packet, not the teeth.
- Roll the condom onto the penis after the penis has become erect.
- Pinch the tip of the condom with the thumb and finger to expel air before putting it on. Make sure the part to be unrolled is on the outside.
- If the man is not circumcised, the foreskin should be retracted before putting the condom on.
- Do not use oil or oil-based lubricants such as petroleum jelly, because they may damage the condom. (Water-based lubricants, such as glycerine and K-Y Jelly are safe. Spermicidal foam is safe);
- Hold the rim of the condom when you withdraw after ejaculation;
- Throw the used condom away or bury it so that children cannot play with it; Do not reuse condoms;
- Store condoms in a dry, cool place. Do not store condoms in wallets.

The "Condom-Friendly" Clinic

Health providers should ensure that their clinics are "condom-friendly," i.e., that clients have easy access to condoms. The following suggestions can be implemented to increase condom accessibility:

- Condoms should be located where clients have access with minimal constraints and embarrassment. Condoms may be offered by the clinician and condoms may be put in a toilet where the client can help himself or herself in privacy.
- Condom educational materials and information should be provided to each STI client. They should also be available in the waiting room.
- The clinic should have a space where clients can be counselled and taught correct condom use skills.
- An adequate supply of condoms should always be kept on hand in the clinic. This will support the provider's message about the importance of condoms.
- All clinic staff should be made aware of other sources of free and subsidised condoms in the community. They should be prepared to advise clients about these sources.

Counselling tips

In conclusion to this section, here are some counselling tips to help clients develop their options and make informed choices about their sexual life.

Ask the client to explore her/his own feelings concerning condom use , and to consider ways to deal with their fears concerning possible consequences of introducing condom use to their sexual partners. If the client is afraid their spouse will accuse them of extra-marital sex, and problems will occur in their marriage, they can balance that concern against the risk of STI and HIV.

Help them explore the available options and to chose the best for themselves and their sexual partners.

Tell the client how the condom works to prevent the spread of STI.

Explain and encourage the importance of open communication between sexual partners concerning condoms and sexuality.

Explain possible ways to introduce the condom to their spouse. For example, present the condom as a prescription from the health worker at the clinic; if the client is worried about disrupting their marriage because of extra-marital sex, then suggest that the client apologises to her/his spouse for making a mistake. The client can tell his/her spouse that he/she is introducing the use of a condom because of his/her love and concern.

Help the client to explore acceptable ways of enhancing sexual pleasure when using the condom, for example, having more foreplay, asking the woman to put the condom on the man's penis as part of foreplay, discussing with the sexual partner different ways of pleasing each other.

Harmful Sexual Practises

Sexual abuse of children is becoming a serious social and medical problem in Malawi, requiring the attention of service providers who deliver social and health services. The treatment of child-victims is an important aspect of comprehensive health care.

Service providers should be aware of the possible link between sexual abuse and STIs in children and adolescents. Children and adolescents with STIs should not be assumed to have acquired infection from non-sexual contact.

Rape: un-consensual sex between adults

Defilement: sexual intercourse with a person below the age of 13

In cases of rape, defilement or (suspected) abuse the following should be done:

- A thorough physical examination
- Assessment of the mental status of the client
- Counselling - Trauma/Stress counselling and guidance for help/support
- Refer to the nearest police station (if the client has not been there yet)
- At health centre level, refer to the District Hospital for further examination (HIV status, high vaginal swabs) and an official report
- Provide treatment when indicated

The following harmful practices can endanger the lives of people and lead to disease, disability and death and therefore should be discouraged:

- Inheritance of a wife or husband
- Practice of Fisi (hiring of a man for sex and conception)
- Death rituals (hiring of a man for the widow to drive out the spirits)
- Use of traditional herbs to induce labour
- Insertion of herbs or plants in the vagina for dry sex

- Performance of traditional circumcision under un-sterile conditions
- Male or female prostitution
- Postpartum abstinence which predisposes a man to promiscuity
- Traditional treatment of genital warts and haemorrhoids (eg. By cutting)
- Polygamy
- Kuchotsa Fumbi (sex without consent after first menarche for initiation)

EXERCISE 6

1. Identify culturally acceptable means of safer sexual behaviour
2. Discuss 5 strategies to promote safer sex
3. Identify harmful cultural sexual practises

Every Service Provider is also a human being. And as human beings you face the same difficulties as the people to whom you provide advice. You have the same difficulties in human and sexual relationships, the same types of family quarrel, the same types of conflict with others, the same range of concerns. If you counsel people about STIs and safer sexual practice, the options you offer people to consider are the same options you yourself face in your own relationships.

It is by understanding this every time that you discuss options for behaviour with a client that you can come to empathise with the difficulties people face, and how it is that people can best come to decisions.

Throughout this book, the stress has been on blurring the boundaries between being a service provider and being simply human. Often you have been asked to reflect back on your own experiences in life in order to develop good working practice. Now you are being asked to reflect on your experience in work to reflect on your life as members of a community.

There are several possible areas for your consideration:

- Coping with your personal relationships;
- Using your own problems to understand others' problems;
- Stimulating discussion on difficult issues in your community;
- Introducing education;
- Helping people look at their own responsibilities for sexual and reproductive health;
- Thinking out your relationships to other people who provide services or resources for sexual and reproductive health.

Coping with your personal relationships

Health workers are just as susceptible to the sexual routes of HIV and STI infection and just as vulnerable to the consequences of those infections as the members of the communities around them. It is now well understood that social forces are more powerful than knowledge and information in determining the ability of people to practice safer sex. These social forces are as powerful for you as they are for anyone else in the community. This is one aspect of the link of your personal life to community life.

You may also have found that you have been approached in your community by other members of their communities, to assist them on health problems. You may have been asked for drugs, or condoms or advice. You may be pressured by relatives to give them special favours in your unit.

There are no simple guidelines for any service providers on how to deal with these issues. However, there are many ways of turning these issues to your advantage.

Use your own problems to understand others' problems

Your own problems in terms of your different sexual and gender relationships give you insights into the ways in which other people may have difficulties about these things. It may help you to start thinking of attitudes, practices and beliefs that are condoned in your community but which you may now want to change. You will only be able to change

these things by raising them as issues in the various forums a community provides for discussion.

The same goes for the pressures on you to do things for others outside of your work. How do these things cause you to reflect on what has to change in the community for better sexual and reproductive health?

Stimulating discussion

There are possibly many more forums for opening debate and discussion than you might at first think. The way into this is by thinking of all those places where you stop for a while and spend time in chatting.

If you are a woman, how much time do you spend at the hair-dresser's? Two hours? In those hours what do you discuss? How many other women go to the same hairdresser? How will the views of the hairdresser enter into any conversation?

Whether you are a man or a woman, there will be several instances during every day in which you get together with others and discuss things in a relaxed way.

You will quickly see the importance of such forums for discussion. Here you can reveal things that irritate you as a human being (relationships with a sexual partner, men's attitudes, beliefs about sexual education, anger at the way girls are treated in school) and you can raise the possibilities that these things might change. You can ask questions about what it might take to change them.

In this way you are planting questions in the minds of people. Once questions are there, people can then review the issues in their own ways. You may then find that people are beginning to develop ideas on how to do it.

You should never take part in these conversations as a health worker. You do so as a member of the community with concerns about the community way of life—but as one with a lot of knowledge about realities.

What are the other forums for such types of discussion?

- Washing places
- Shops
- Offices
- Bars
- Schools (parent/ teacher committees)
- Church meetings

You will also be asked many times to give talks. Instead of giving talks, why not seize the opportunity to open up discussions about people's concerns instead? Thus if you are asked to go to a school for a talk, why not spend the time by asking the pupils what their concerns are about sex?

GATHER and information

It is when you have opened up discussions that involve people that you will then find ways of helping people with greater knowledge. It is important that they create the openings so that any knowledge you provide is relevant to their stated concerns and the context of a problem. Such an approach also helps you to avoid telling people what they know already.

You are already aware of many areas in which people's knowledge may be inadequate. These might include:

- That most times you have an STI there are no symptoms.
- That it is important to treat symptoms of STIs early.
- That HIV is a real risk in sex with people who may look very fit, healthy and young.
- That condoms are effective in preventing HIV transmission.

You may also want to improve people's understandings of several key areas such as

- Safer and more pleasurable sex.
- The ways in which you are improving your clinic.
- The use of drugs for STIs, and development of resistance if poorly used.
- The importance of treating sexual partners if you have an STI.

However, people will never be interested unless they are already talking about a problem that is related to the areas you would like to explore.

If you use the GATHER process, and the principles of communication provided earlier in this book, you will be able to create the right environment for education.

Helping others look at responsibilities

You will find in these discussions that people hate the idea of change. This may be in spite of their desire to have a different type of life. It is for this reason that you may want to look at the ways in which people who lead opinion or are outspoken in your community may wish to review their responsibilities.

Could you, for example, go to them and say that in your discussions with many people there are particular concerns about sexual and gender interaction? Could you ask them to consider how the situation may change?

Remember:

It is always better to pose questions and let people figure out ways of doing things. If only one person does the suggesting, the ideas may not be owned by the others. Encouraging others to solve problems recognises that they have skills and expertise in thinking things through in ways you may never have imagined. In this way people can think together to reach innovative and locally relevant solutions to problems.

Relations with other types of provider

It is relatively easy to get along with other types of service providers when everything is going well. One of the troubling areas is when you see bad practice. For example, you may see traders selling antibiotics in the wrong doses from market stalls. Or you may be aware of a particular healer who is abusing their position to deceive people.

It is probable that your own direct action will not be useful. In such situations, as with the others, it may be that you can find ways of raising questions about these activities. For example, if people are preferring to buy their drugs at the stall, how would you get people to raise questions as to whether this is right?

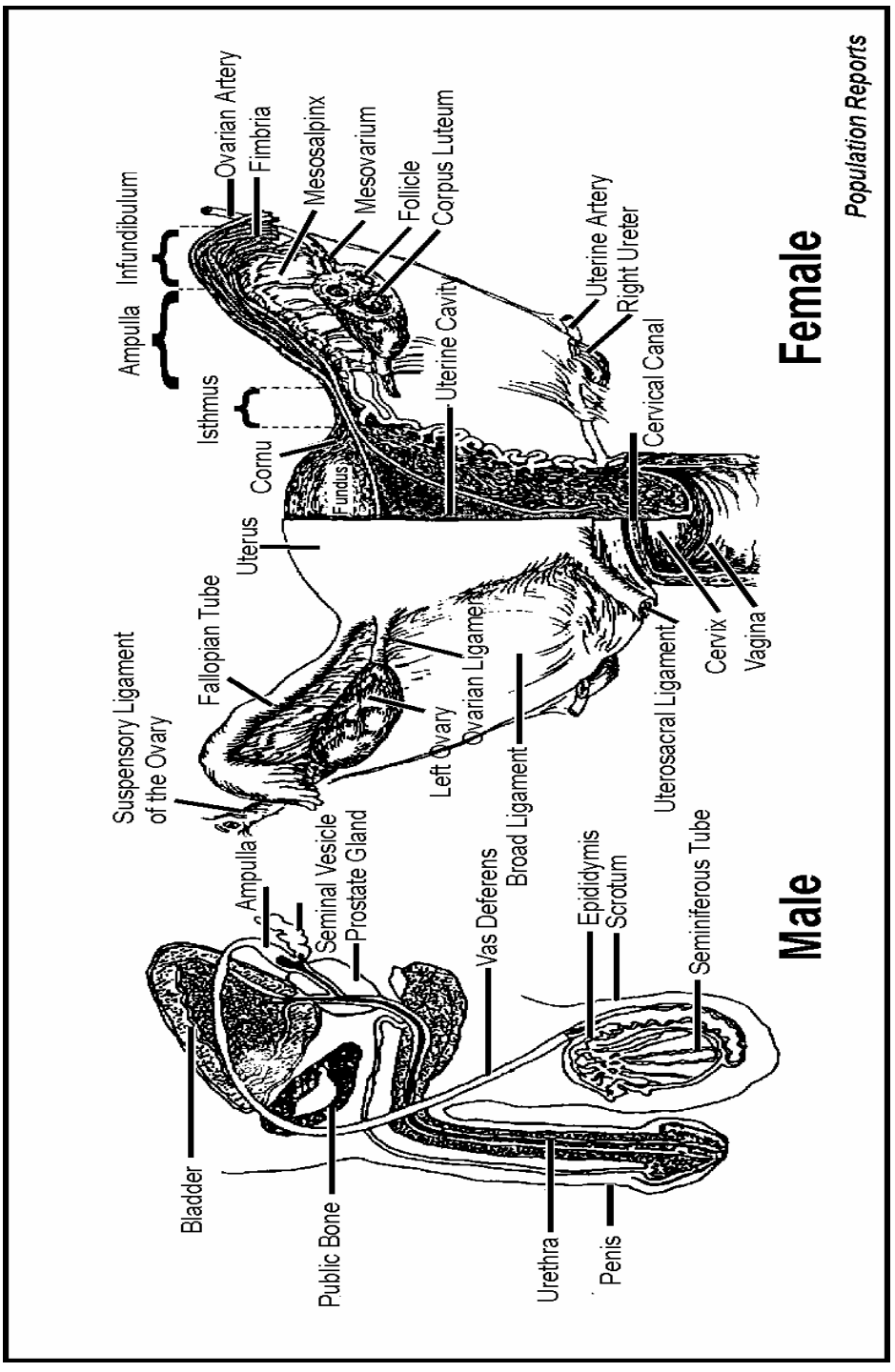
Conclusion

AIDS and STIs have revealed many weaknesses in contemporary societies. These diseases are not just medical problems but occur as part of the social and psychological fabric of the community. They have revealed weaknesses in our capacities to care for, interact with and even think about people—whether they are men or women, whether they have AIDS or not, whether they are young or old. Thus they have revealed that when women are in a weak position in society they can be misused and few will complain. They have revealed that sex with children is also more common than we may have thought. They have revealed that young people need to know a great deal more about sex so that they can cope when pressure is put on them to have sex or when they are wanting to have sex. They have revealed that many of our preconceptions about sexual behaviour have been simply wrong. They have revealed the ease with which prejudice about sexual practice and about AIDS can be so harmful. They have revealed the co-existence of shame about behaviour and the lack of desire to do something about it.

Health providers are in the unique position of being able to help community members look beyond the medical reality of the disease to the underlying causes and consequences of these diseases. They are well-respected and are seen to be knowledgeable about the causes and consequences of major health problems such as STIs and AIDS. Thus, they can use their position to help other community members consider the underlying causes of these health problems. As we all begin to consider these issues more thoroughly for ourselves, we can begin to think of solutions to the problems of STIs and AIDS that will work for us, given our religious convictions, our culture and our resources.

If we can learn to question the ways in which we ourselves and others interact with respect to sex and gender, if we can learn to question the roles we give one another, much can be done to diminish the impacts of AIDS and HIV. Our responsibility is to raise these questions both at work and in the communities of which we are a part.

APPENDIX 1:
DIAGRAMS OF REPRODUCTIVE TRACTS



APPENDIX 2: COMMON SEXUALLY TRANSMITTED INFECTIONS

This appendix is designed to give a very quick reference to the diseases underlying the syndromes. It covers:

- Causative Organisms
- Clinical Presentation
- Complications
- Treatment

Throughout, always remember that only a minority of people with STIs have symptoms of infection.

CHANCROID

CAUSE: Haemophilus ducreyi

INCUBATION PERIOD: 3-7 days

SIGNS/SYMPTOMS:

Ulcers
- usually more than one
- can become large
- irregular edges, soft base
- painful, bleed easily

Lymph nodes
- painful
- may develop into abscesses

TREATMENT: Erythromycin 250 mg orally every 8 hours for 5 days

HERPES

NB. New-born babies may be affected if the mother has active disease at the time of delivery.

CAUSE: Herpes simplex virus

INCUBATION PERIOD: 2-20 days

SIGNS/SYMPTOMS:

Ulcers
- small, start off as blisters
- Usually itchy and painful
- heal within 10 -14 days
- Usually recur, on average 5x/year

Lymph nodes
- rarely swollen/tender

TREATMENT: No cure, but symptoms may be relieved by using:
Acyclovir (Zovirax) 800 mg every 12 hours for 5 days *or*
Acyclovir cream 5% apply on lesions every 12 hours for 5 days
For secondary infections—Bactrim
Lesions must be kept clean and dry

GENITAL WARTS

CAUSE: Papilloma virus

INCUBATION PERIOD: 1-6 months

SIGNS/SYMPTOMS: Warts, i.e. fleshy outgrowths—number varies

TREATMENT: **Chemical treatment:**

i. Compound podophyllin paint weekly. Apply carefully and sparingly to lesions, avoiding normal tissue. Wash off after 1-4 hours. If applied to vaginal, vulvar, anal, or meatal surfaces, they should be allowed to dry before coming into contact with normal epithelium. If there is no improvement after 4-6 weeks, consider alternative treatments.

   Podophyllin paint is toxic and should not be used in large amounts. Large areas should be treated sequentially. Podophyllin paint is contra-indicated during pregnancy and lactation.

ii. Silver nitrate stick applied daily. This can be used during pregnancy and lactation as an alternative to Podophyllin paint.

Physical removal:

i. Liquid nitrogen
ii. Electrocautery
iii. Surgical removal

Caution: Cutting away the warts (with scissors or razors) in the outpatient setting is contra-indicated since it results in excessive bleeding.

GRANULOMA INGUINALE

NB Very rare in Malawi

CAUSE: Calymmatobacterium granulomatis

SIGNS/SYMPTOMS: Ulcers - large, velvety, usually non-painful

TREATMENT: Doxycycline 100 mg orally every 12 hours for 14 days
(Erythromycin in pregnant or lactating women, 500 mg orally every 6 hours for 14 days

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TRICHOMONIASIS

NB Extremely common in Malawi

CAUSE: Trichomonas vaginalis

SIGNS/SYMPTOMS:

In women:
- vaginal discharge—frothy, foul smelling
- inflamed vagina, vulva, perineum, inner thighs

In men:
- usually asymptomatic
- may cause urethral discharge or balanitis

TREATMENT: Metronidazole 2 grams orally stat dose

BACTERIAL VAGINOSIS

CAUSE: Gardnerella vaginalis

SIGNS/SYMPTOMS: Grey, vaginal discharge

TREATMENT: Metronidazole 2 grams orally stat dose or,
400-500 mg orally every 8 hours for 7 days.

CANDIDA ALBICANS

N.B. *The organism is opportunistic and not usually a sexually transmitted disease—under certain circumstances an infection may develop:*

- *during pregnancy*
- *while using oral contraceptives*
- *in diabetes*
- *while using antibiotics*

CAUSE: Candida albicans

SIGNS/SYMPTOMS: In women:
- Vaginal discharge—white, cheesy
- Vulvo-vaginal inflammation

In men:
- Erythematous rash—very itchy

TREATMENT: In women:
Clotrimazole 500mg pessary intra-vaginally single dose.
Gentian Violet (GV) paint to the vaginal walls, cervix, and vulva daily for 7 days

In men:
Gentian violet topical application daily for 7 days, or
Clotrimazole cream every 12 hours for 7 days

Note: Diflucan (fluconazole) 150 mg oral tab STAT may be given instead of clotrimazole and GV paint when available

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LYMPHOGRANULOMA VENEREUM

CAUSE: Chlamydia trachomatis (L serovars)

INCUBATION PERIOD: 1 - 6 weeks

SIGN/SYMPTOMS

Ulcer - usually one
- Small, painless, often unnoticed

Lymph nodes
- Painful
- may develop into abscesses (buboes)—may be presenting symptom

TREATMENT: Doxycycline 100 mg orally every 12 hours for 14 days
(Erythromycin in pregnant and lactating women, 500 mg orally every 6 hours for 14 days)

GONORRHOEA

CAUSE: Neisseria gonorrhoea—infects the urethra, cervix

INCUBATION PERIOD: 1 - 4 days

SIGNS/SYMPTOMS:

Commonest
- Discharge (purulent, profuse)—vaginal in women, urethral in men
- burning on micturition

Others include
- conjunctivitis
- arthritis
- pharyngitis
- peri-anal itching

COMPLICATIONS:

Women
- Bartholin's abscess
- pelvic inflammatory disease
- infertility
- ectopic pregnancy

Men
- urethral stricture
- epididymo-orchitis
- Prostatitis

New born babies
- Conjunctivitis

TREATMENT: Gentamicin 240 mg IM stat dose ***or***
Ciprofloxacin 500 mg orally stat dose

NON-GONOCOCCAL URETHRITIS/CERVICITIS

Main differences between Gonorrhoea and NGU:
- symptoms of NGU tend to be less severe
- the incubation period of NGU is much longer (1-3 weeks) that of gonorrhoea (1-4 days)

N.B.: *NGU and Gonorrhoea often occur concomitantly*

A patient presenting with a discharge must be given treatment for both infections unless there is laboratory evidence that there is only NGU or Gonorrhoea.

CAUSE: Chlamydia trachomatis (most common)
Ureaplasma urealyticum

INCUBATION PERIOD: 1-3 weeks

SIGNS/SYMPTOMS: As in gonorrhoea BUT the discharge is usually scanty, thin, clear

COMPLICATIONS: As in gonorrhoea, Reiter's disease (i.e. non-specific urethra-balanitis)

TREATMENT: Doxycycline 100 mg orally every 12 hours for 7 days
Erythromycin in pregnant and lactating women, 500 mg orally every 6 hours for 7 days

SYPHILIS

CAUSE: Treponema Pallidum

Untreated infections may pass through four stages:

- primary syphilis
- secondary syphilis
- latent syphilis
- tertiary syphilis

INCUBATION PERIOD: 9 - 90 days

PRIMARY SYPHILIS

N.B. People are infectious during this phase

SIGNS/SYMPTOMS:

Ulcer(s) - one or more
- Small, usually painless
- Clear edges, hard base
- does not bleed easily

Lymph nodes
- Often bilateral
- Painless, matted

TREATMENT: Benzathine penicillin 2.4 MU IM stat dose

SECONDARY SYPHILIS

N.B. People are infectious during this phase

SIGNS/SYMPTOMS:
- rash
- condylomata lata
- Mucous patches
- generalised illness

These appear 6-8 weeks after the appearance of the primary ulcer

TREATMENT: Benzathine penicillin 2.4 MU IM stat once weekly for 3 weeks

If the client is allergic to Penicillin: Doxycycline 100 mg every 12 hours for 30 days, if the client is allergic to penicillin, and also pregnant or lactating: Erythromycin 500 mg every 6 hours for 30 days.

LATENT SYPHILIS

The organism is still alive but is in a latent phase.

There are no signs nor symptoms and the person is NOT infectious.

TREATMENT: **Early latent phase** (time since acquisition of disease is less than 2 years): Treat as Secondary syphilis

Late latent phase (time since acquisition of disease is over 2 years):

Benzathine penicillin 2.4 MU IM weekly intervals of 3 weeks. If the client is allergic to penicillin Doxycycline 100 mg every 12 hours for 30 days or if client is both allergic to penicillin and pregnant or lactating, erythromycin 500 mg every 6 hours for 30 days.

As latent syphilis may not be detected easily in our Malawi context, and therefore the duration of disease is difficult to determine, it is advisable to treat all latent syphilis as LATE latent syphilis

TERTIARY SYPHILIS

SIGN/SYMPTOMS:
- Gumma (sores)
- Cardiovascular pathology
- Central nervous system disorders

TREATMENT: If nervous system is not involved then treat as in LATE LATENT syphilis

Neuro-syphilis is treated with:

Aqueous Benzyl Penicillin 3 MU IV every 4 hours for 14 days followed by Benzathine penicillin 2.4 MU IM at weekly intervals for 3 weeks. If the client is allergic to penicillin treat with Doxycycline 100 mg every 12 hours for 30 days. If the client is allergic to penicillin and pregnant or lactating treat with Erythromycin 500 mg every 6 hours for 30 days.

CONGENITAL SYPHILIS

Children under the age of 2 usually respond well to adequate doses of penicillin, but recovery may be slow in seriously ill children

SIGNS/SYMPTOMS: Snuffles (often bloody), syphilic rash (maculo-papular with small spots) most severe on hands and feet, hepatosplenomegaly and periostitis.

TREATMENT: Benzathine penicillin 50,000 units/kg IM stat; repeat after 1 week

If maternal treatment for Syphilis was inadequate (eg. Erythromycin in case of Penicillin allergy), unknown, or was completed less than 4 weeks before delivery, the infant should be treated for congenital syphilis at birth, regardless of the presence of symptoms.

TESTS FOR SYPHILIS

SCREENING TESTS:
VDRL (Venereal Disease Research Lab.)
RPR (Rapid Plasma Reagent)
Determine Syphilis Rapid test

SPECIFIC TESTS:
TPHA (Treponema Pallidum Haemagglutination)
FTA-ABS (Fluorescent Treponemal Antibody test)
MHA-TP

APPENDIX 3: GLOSSARY

Asymptomatic	Without symptoms.
Carrier	One who harbours infections micro-organisms without showing signs and symptoms.
Client management	A process through which the provider addresses both the presenting medical problem and the psycho-social issues related to that problem.
Contact	A person known or believed to have been exposed to an infectious disease.
Contact Tracing	Means of identifying sexual contacts of the index client so that they can get early treatment, thereby controlling the spread of STIs.
Defilement	Sexual intercourse with a person below the age of 13
Index Client	The person who comes to the health facility with signs and symptoms of STIs.
Partner Notification	The process of informing the sexual partner(s) of an STI client to come for treatment. Is done by the client rather than health centre staff.
Primary Sexual Contact	The person from whom the index client acquired the infection.
Rape	un-consensual sex between adults
Secondary Sexual Contact	The person or persons that the index client has had sex with since contracting the STI, who may have been infected by the client.
Screening	The process of examining and testing a client for the possibility of a disease.
Sexual Partner	Any person with whom one has had sex.
Syndrome	A group of signs and symptoms.
Syndromic Approach to STI	An approach to the diagnosis and treatment of clients with STIs using commonly occurring signs and symptoms (syndromes) rather than laboratory tests.
VCT	Voluntary Counselling and Testing
Youth Friendly Services	High quality health services that are relevant, accessible, attractive, affordable, appropriate and acceptable to the youth

APPENDIX 4: DRUG INFORMATION

1. BENZATHINE PENICILLIN (PENILENTE/BICILLIN)

Benzathine Penicillin is a long-acting intra-muscular form of penicillin. Usually used in doses of 2.4 Mu (8ml) as a stat dose or weekly x 3. It should never be given intravenously.

INDICATIONS Genitourinary Diseases.

SIDE EFFECTS

- Painful at injection site. (Swirl to dissolve the contents of the vial, don't shake)
- Skin rashes, diarrhoea
- Allergic reaction is serious due to prolonged action.

CLIENT INFORMATION: Can be used in pregnancy and lactation.

CONTRAINDICATIONS: If there is any history of allergies.

2. DOXYCYCLINE

Doxycycline is a broad spectrum antibiotic of the tetracycline group. It is preferred to other tetracyclines as it is better absorbed, can be taken daily or twice daily and has fewer side effects. It comes in capsules of 100 mg.

INDICATIONS Urethral Discharge and Genitourinary Symptoms, PID, swollen tender inguinal lymph nodes (Bubo), swollen tender testes (scrotal swelling).

SIDE EFFECTS Nausea, vomiting, flatulence.
Discoloration of teeth and retardation of bone growth in children.

CLIENT INFORMATION: Can be taken with food.

CONTRAINDICATIONS: Contraindicated in pregnancy, lactation and children under 8 years.

Erythromycin should be used as an alternative in pregnancy.

NOTE: Erythromycin may fail in preventing congenital infections.

INTERACTIONS:

- May reduce the effect of oral contraceptives.
- Absorption of doxycycline is reduced in the presence of antacids and iron, magnesium, calcium or zinc supplements.
- Carbamazepine (tegretol) and phenytoin may lower the blood level of doxycycline.
- Avoid use in clients taking diuretics.

3. ERYTHROMYCIN

- Erythromycin covers almost the same spectrum as penicillin.
- It is a useful alternative for penicillin-allergic clients and in management of STIs in pregnancy.
- It comes in 250mg tablets/capsules.

INDICATIONS

- Alternate choice for Benzathine Penicillin where there is penicillin allergy, genital ulcers, PID.
- In pregnancy used in place of Doxycycline.

SIDE EFFECTS

- Nausea, vomiting, diarrhoea, cramps (dose related).
- Serious cholestatic jaundice.
- Possible oral contraceptive failure.

CLIENT INFORMATION

Recommended alternative in pregnancy and lactation.

CONTRAINDICATIONS

Contraindicated in liver disease.

INTERACTIONS

- Raises the serum levels of carbamazepine (Tegretol), theophylline.
- Reduces the effects of penicillin.
- Increased tendency to bleeding with Warfarin.

NOTE If Erythromycin is used for the treatment of syphilis in pregnant women who are allergic to Penicillin, congenital syphilis may not be prevented and the newborn should be treated, regardless of the presence of symptoms with: Benzathine Penicillin 50,000 units/ kg IM in a single dose.

4. GENTAMICIN

Gentamicin is in the group of aminoglycolides. Preparation, 40mg/2 mls, 80mg/2mls vials administered IM.

INDICATIONS

Antibiotic mainly used for Gram-negative Bacteria

SIDE EFFECTS

- In extreme high doses can cause hearing impairment.
- Renal impairment.

CLIENT INFORMATION

Well tolerated in pregnancy

CONTRAINDICATION

Not known

5. METRONIDAZOLE (FLAGYL)

- Metronidazole is an antibiotic effective against anaerobic bacteria and certain protozoa, e.g., *Trichomonas vaginalis.*
- It is useful in the treatment of some STIs and gynaecological infections. A stat dose is given in the management of vaginal discharges, but PID is treated with smaller doses over 5 - 10 days.
- It comes in tablets of 200mg and 400mg.

INDICATIONS

- GUS, lower abdominal pain.
- Metallic taste in mouth.
- Rash urticaria, itching.
- Headache and dizziness.
- Candida overgrowth.

CLIENT INFORMATION

- Causes discoloration of urine.
- Should be taken with or directly after meals.
- Do not take alcohol for 48 hours after last dose.

CONTRAINDICATIONS

- Contraindicated in the 1st trimester of pregnancy and during lactation.
- Avoid in epileptics or clients with decreased cardiac function.

INTERACTIONS

- Raises the blood levels of Phenytoin and Warfarin.
- Phenobarbitol reduces the side effects of metronidazole.
- Interacts with alcohol to cause flushing, sweating, abdominal cramps, nausea and vomiting.

6. CLOTRIMAZOLE

In preparation vaginal 500mg pessaries or CREAM.

INDICATION: AVD (to cover candidacies)

SIDE EFFECTS realatively rare.

DOSE/ADMINISTRATION Insert one pessaries single dose. Dose may be doubled or adjusted for severe infections.

NOTES Patients should be carefully advised on use of the applicator.

7. ACYCLOVIR

Acyclovir is used to treat herpes infection of the genitals and skin. It does not cure herpes infections but decreases pain and itching and promotes healing.

INDICATION: Herpes Simplex Virus

SIDE EFFECTS: burning and itching when ointment is applied. Headache, upset stomach, vomiting and loose stools

DOSE /ADMINISTATION 400 mg every 12 hours for 5 days, or topic ointment 5% every 12 hours applied on sores for 5 days.

8. AZITHROMYCIN

Azithromycin is a micolide with activity against both gram positive and gram negative organisms. Good tissue concentration and longer tissue half life.

INDICATION: Syphilis, chancroid, Urethral discharge/ LGV

SIDE EFFECTS: Fewer GIT upsets (stomach, vomiting and loose stools)

DOSE /ADMINISTATION: Single dose of 2g preferred for most STIs.

APPENDIX 5: BASIC INFECTION PREVENTION METHODS

Antiseptic measures

Prevention of infection by killing or inhibiting the growth of micro-organisms on skin and other body tissues, using chemicals.

Hand washing

May be the single most important infection prevention procedure. Washing with plain soap or detergent.

Gloving

As a precaution, gloves should be worn by all staff prior to contact with blood and body fluids from any client.

Decontamination

Is the first step in handling soiled equipment, instruments, reusable gloves and other items. Decontamination makes objects safer to handle for staff before cleaning them.

Cleaning

Crucial step in providing safe infection-free equipment and instruments. A thorough cleaning of equipment and instruments with detergent and water physically removes organic material such as secretions or oil.

High-Level Disinfection (HLD)

When sterilisation is not suitable, high level disinfection is the only acceptable alternative. HLD destroys micro-organisms including HBV and HIV but does not kill bacterial endospores and thus will not achieve sterilisation. HLD boiling for 20 minutes or chemicals.

Sterilisation

Completely destroys all micro-organisms done after decontamination, can use chemical or steam under pressure.

Principles of Universal Precautions in Infection Prevention

1. Assume all blood and other body fluids to be infectious.
2. Clean and cover any sores or cuts on your hands with waterproof plaster.
3. Wash your hands with soap and water after your work with one client and before you start with the next one.
4. Wash after an accidental exposure to blood, semen, vaginal and body fluids containing blood.
5. Wear gloves any time contact with blood, semen, vaginal secretions and body fluids or pus is likely.
6. Take extra precautions to avoid getting stabbed with needles, blades or sharp instruments.
    - Put needles and blades in a container immediately after use.
    - Do not detach needles from syringes at this step.
    - Never recap needles.
7. Decontaminate all reusable instruments immediately after use.
8. Thoroughly clean all reusable instruments after decontaminating.
9. Correctly disinfect or sterilise all reusable instruments after decontaminating and cleaning them.
10. Immediately clean-up any spills of body fluids/blood using 0.5% chlorine solution.
11. Dispose of contaminated rubbish in a container that has a tight cover and burn or bury it.

12. Handle dirty linen correctly.

APPENDIX 6: ASSESSING RISK IN SEXUAL INTERACTIONS

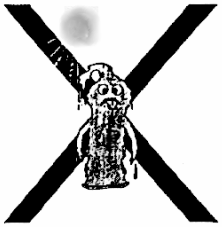
A helpful outline of questions to ask when helping a client's to review the risks in their sexual lives appears below.

1. Do you practice safe sex?
2. What do you mean by safe sex?
3. How many sexual partners have you had in the past year?
4. Have you practised safe sex with all of them?
5. Do you practice safe sex every time you have sex?
6. What causes you not to have safe sex if you don't?
7. Have you had any other STI in the past year?
8. Which of these sexual activities have you tried?
    - vaginal intercourse, insertive or receptive;
    - anal intercourse, insertive or receptive;
    - oral intercourse, insertive or receptive;
    - non-penetrative activities, such as masturbation (alone or with a partner)?

Check the client's knowledge of which of these needed protection, and whether they were protected when necessary.

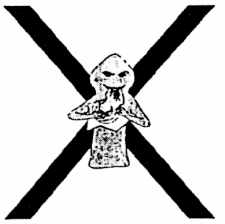
1. Have you had vaginal intercourse during your or your partner's menstrual period? Was it protected?
2. Have you ever been raped or forced to have unprotected sex when you didn't want it?
3. Have you ever exchanged unprotected sex for money, goods, or drugs (include both giving and receiving)?

APPENDIX 7: CONDOM CARE



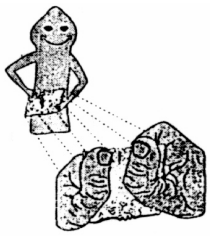
Do NOT keep your condom in a tight pocket, or in your wallet for a long period—it's too hot. Do NOT use condoms which are dry, dirty, brittle, yellowed, sticky, melted or damaged.

INSTEAD...
Condoms should be stored in a cool, dark, dry place away from sunlight, moisture and heat.



Do NOT use your teeth or other sharp objects to open the package—it may tear the condom.

INSTEAD...
Tear the condom open carefully using the guides in the package.



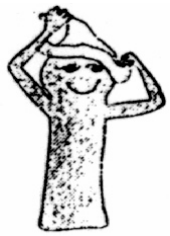
Do NOT use grease, oils, lotions, or petroleum jelly to make condoms slippery—the oils cause the condom to break.

INSTEAD...
It is ALWAYS PREFERABLE to ensure that woman partners are naturally lubricated and moist before vaginal sex.

In dry sex the condom may break.

Do NOT pull the condom tight over the head of the penis—it may cause the condom to burst.

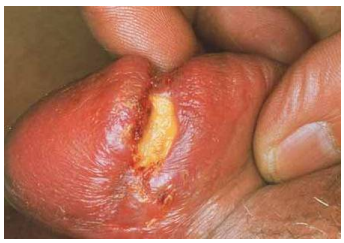
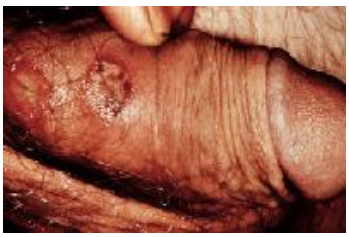
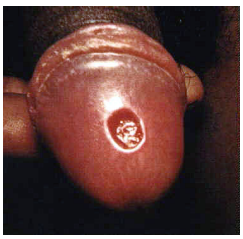
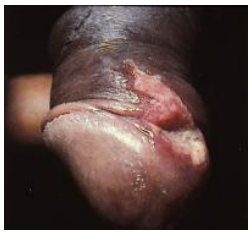
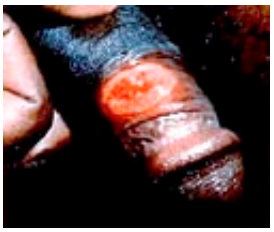
INSTEAD...
Squeeze the air out of the tip of the condom as you put it on to leave space for the semen to collect.

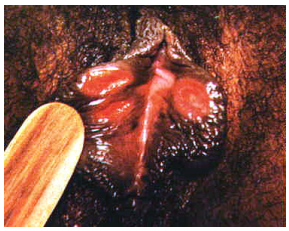
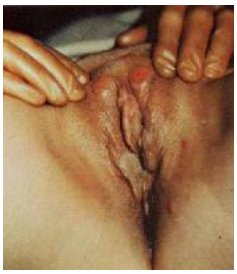


Only use a condom one time and then dispose of it properly. Keep plenty of fresh condoms available.

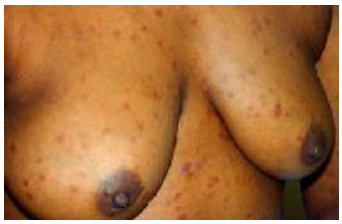
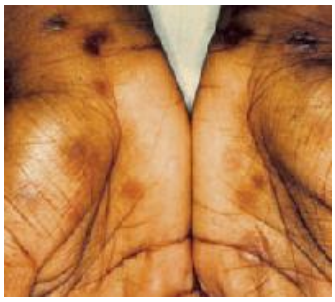
Other instructions for condom use are on page 110

GENITAL ULCER DISEASE

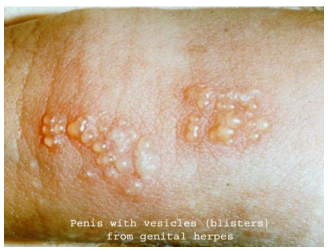






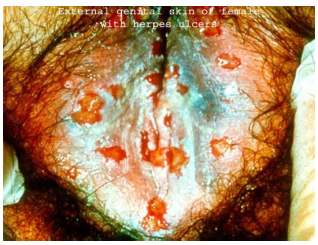



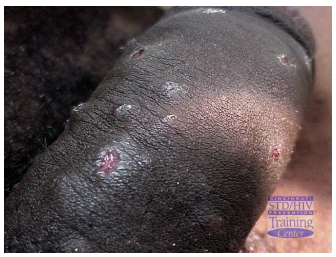
Syphilic rash – secondary syphilis

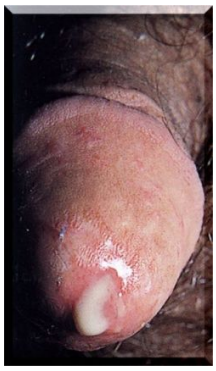
GENITAL HERPES

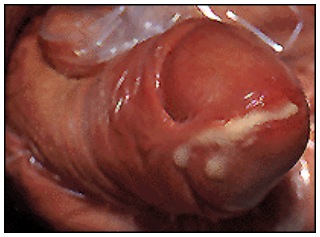




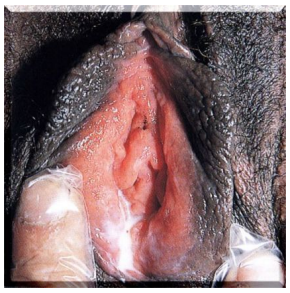


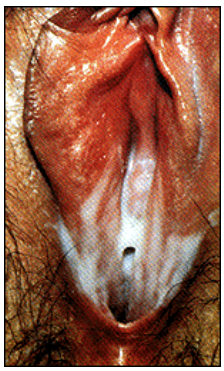
URETHRAL DISCHARGE IN MEN





ABNORMAL VAGINAL DISCHARGE





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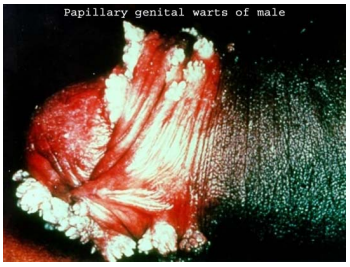
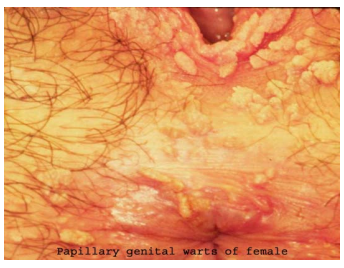
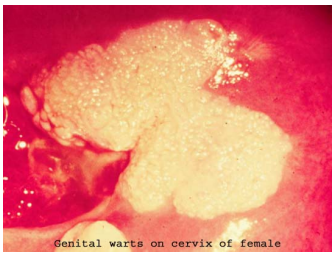
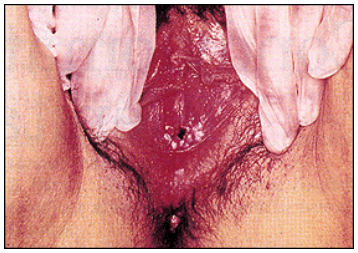
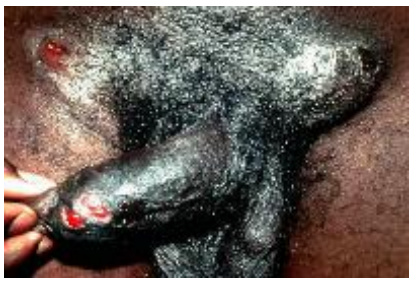


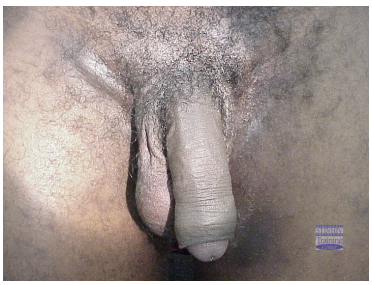




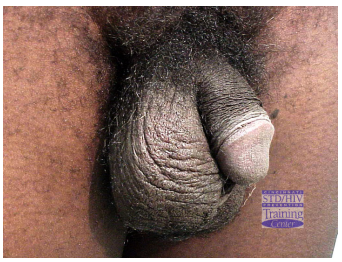


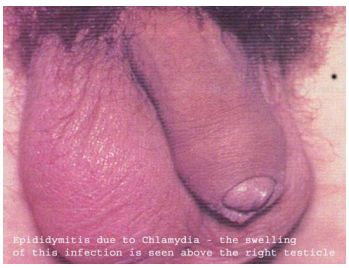
BUBO

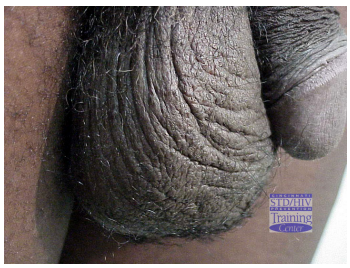




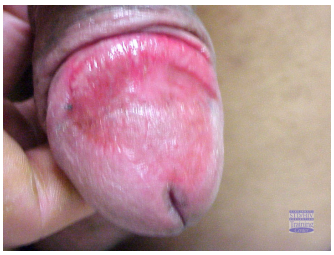
SCROTAL SWELLING

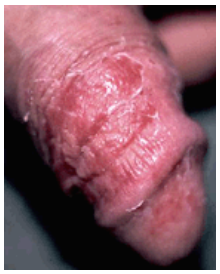




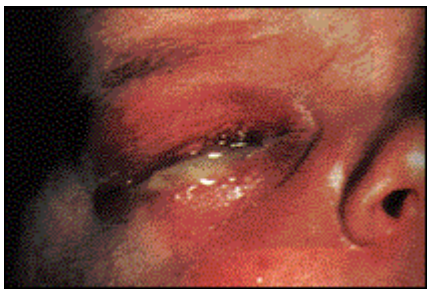


BALANITIS





NEONATAL CONJUNCTIVITIS



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