

# **STI CASE MANAGEMENT**

**THE SYNDROMIC APPROACH FOR PRIMARY HEALTH CARE SETTINGS  
FACILITATOR'S VERSION**



**WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR THE WESTERN PACIFIC  
MANILA 2001**

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World Health Organization  
Regional Office for the Western Pacific  
Manila  
2001

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# **STI CASE MANAGEMENT**

## ***THE SYNDROMIC APPROACH FOR PRIMARY HEALTH CARE SETTINGS***

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### **FACILITATOR'S VERSION**

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# FOREWORD

The World Health Organization estimates that 30 million new curable sexually transmitted infections (STIs) occur each year in the Western Pacific Region. The medical and social consequences of these infections place a heavy burden on health services and on communities.

As with many health programmes, we all share a feeling of urgency when we approach the problem of curable STIs. The potentially explosive nature of HIV epidemics adds to this urgency because of the role STIs play in facilitating the transmission of HIV. In communities where sexual contact is the predominant way HIV is transmitted, STI prevention and control can have a dramatic impact on reducing HIV transmission.

The World Health Organization endorses the syndromic approach to STI case management. It is simple, cost-effective and applicable at the primary health care level. Once patients come to a health facility with a suspected STI, health care workers can use the syndromic approach to give treatment quickly, using the most effective and standardized treatment regimens. In addition, health care workers are encouraged to deliver effective health education aimed at improving patient compliance with therapy and at reducing the patient's high-risk behaviour.

This publication is designed to be used in training all members of the health care team working at the primary health care level, where proper STI care is urgently needed. Care should be made available to the majority of people in the community where they live or work, rather than through specialized health services.

By using the syndromic approach in managing cases, you will be able to offer effective STI care and will also help to accelerate efforts to address the problem of curable STIs in the Western Pacific Region.

*Shigeru Omi*

Shigeru Omi, MD, Ph.D.  
Regional Director

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# **INTRODUCTION**

Welcome to this package of training materials designed to help primary health care workers to improve their management of STD cases. The syndromic approach advocated by this training package is based on sound public health thinking, and has been shown to contribute towards efforts to control STD infection and prevent HIV transmission.

Your work as a facilitator or training coordinator will introduce this new approach to diagnosing and treating STD patients. The training sessions you will facilitate are an integral part of a renewed national commitment to addressing STD service delivery. This commitment is based on an interest in preventing HIV infections and in addressing the problems of curable STDs.

Thank you for helping to introduce the syndromic approach to STD case management in your country.

## **THE STRUCTURE OF THE FACILITATOR'S VERSION**

At the beginning of each module in the Facilitator's Version, there is a section where the learning objectives are listed. Two types of learning objectives are given, objectives for knowledge gain and objectives for skills acquired. In order for training participants to become proficient in using the syndromic approach for STD case management, they will need a balance of both knowledge and practical skills. For participants to build their skills, they must practice the "how to" aspects of the training. In this package, this need is addressed primarily through open discussion and role-playing.

The first section of each module will also include a suggested time-frame for completing the training session, a supplies and equipment list, and, in one case, suggested ice-breaking activities to choose from.

Each module is supplemented by notes in the margin for the facilitator. These notes will include suggested interactive questions, sometimes with discussion points, to help you guide the discussion that you will hopefully stimulate, as well

as other information we hope you will find useful as you facilitate a training session.

Exercises and activities are included at the end of each module, followed by answers to the written questions.

## **WHO IS THIS TRAINING DESIGNED FOR?**

The training package is designed for a wide range of different types of health care workers who are based in a primary health care setting. It is always a good idea to tailor the training to the needs of the participants attending your sessions. Although we do not suggest that you eliminate any module, it may be possible to emphasize some modules and de-emphasize others.

To emphasize a module, you should plan to exceed the recommended time indicated so that there is more time for participation. This could be in the form of more or longer open discussions, or you could conduct several rounds of role-plays. This will reinforce the skill-building aspects of the module.

To de-emphasize a module, we suggest you cut the recommended time indicated at the beginning of the module by at least one quarter, and be selective about using the interactive questions suggested in the margin as well as the exercises, role plays and activities at the end of the module.

# THE STRUCTURE OF TRAINING ACTIVITIES

Given below are two different suggested structures for training sessions. Sample course schedule #1 is for a three-day course designed for health care workers. Sample course schedule #2 is designed to fit within the time private practitioners typically have available. It uses half-day sessions and could either be completed intensively in one week or broken into two sessions per week spread out over two weeks. For the second course, participants are expected to do the written questions in their own time after concluding each half-day session.

SAMPLE COURSE SCHEDULE #1		
Day	Number of classroom hours	Schedule and session description
1	6	Morning: Pre-test Module 1: facilitated session
2	8	Afternoon: Module 2: facilitated session Morning: Module 3: facilitated session
3	6	Afternoon: Module 4: facilitated session Morning: Module 5: facilitated session Afternoon: Module 6: facilitated session Post-test and training evaluation

<b>SAMPLE COURSE SCHEDULE #2</b>		
<b>Day</b>	<b>Number of classroom hours</b>	<b>Schedule and Session Description</b>
1	3	Pre-test Module 1: facilitated session
2	4	Module 2 and 3: facilitated session
3	4	Module 4: facilitated session
4	4	Module 5 and 6: facilitated sessions Post-test and training evaluation

If you can include a practicum component in the course, this will require some additional planning. A practicum component usually means that a facilitator or instructor observes trainees using their new skills while caring for actual STD patients. The advantage is that the facilitator can give the trainee immediate feedback about their skills, and at the same time encourage them in their efforts to master these skills. It is the ideal way to organize a training. It can also be useful for evaluation purposes (see pages 10-12).

Practicum can be added to follow the three days described in sample course schedule #1 immediately. It is best to do the practicum in a setting where there are several STD patients seen per day so that training participants can practise their skills several times with different patients in a relatively short period of time. For sample course schedule #2, the practicum component could be accomplished with the facilitator offering to making periodic visits to the practitioner's health centre to discuss recent cases and respond to their skills development issues.

# PREPARING FOR THE TRAINING

The first thing you need to do to is to read through the training package carefully to familiarize yourself with the module contents and the suggested instructional methods, facilitating questions, in-class written questions, role-plays and activities. You may also want to gather some additional materials, such as the national STD case management guidelines and any available data on STD rates. If you are the lead facilitator for the course and must familiarize yourself with Modules 1 through 6, please plan ample preparation time.

When preparing to conduct training sessions, it is a good idea to investigate what other training your participants may have had prior to attending your sessions. This can also be a good opportunity to explore possibilities for collaborating with other health programmes or community-based activities that may have similar interests in upgrading STD services.

Ideally, the work of the training facilitator is based on an existing training plan. Such a plan will clarify several issues that may fall under the facilitator's responsibility. Some of the topics that may be addressed in such a plan include:


- Which group of health care workers are the priority for training and what are their particular training needs?
- What human and financial resources exist for training and how can they be used?
- What type of activities can serve as follow-up to the training, including supervision or intermittent refresher training?
- How will the training programme be monitored or evaluated?

This training package is designed to be used with groups of up to 30 participants at a time. The quality of the training will suffer if the group of participants is larger.

When planning the administrative aspects and logistics for the training session, there are several key issues you can expect to encounter, including:

- Budget: Is it adequate?  
Will the funds be available ahead of time?
- Participants: Have the desired qualifications and position or role of the participants been determined?  
Are they being invited or identified according to these qualifications?  
Are participants invited with sufficient lead time for them to arrange their schedules to attend?
- Venue: Is the venue adequate in terms of size, ventilation and temperature, lighting, noise level, seating, etc.?
- Materials: Are there sufficient materials for the number of participants expected?
- Facilitator(s): Have the desired qualifications and role of the facilitator(s) been determined?

Finally, it is frequently appropriate to give out certificates of participation in this training course. A sample certificate is shown below.



This is to Certify that

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has attested and successfully completed a course in  
**SYNDROMIC STD CASE MANAGEMENT**  
held in the  
Central Majestic Hotel  
from May 1 to 3, 1997

<hr style="width: 80%; margin: 0 auto;"/> <p>PROGRAMME MANAGER NATIONAL STD/AIDS PROGRAMME</p>	<hr style="width: 80%; margin: 0 auto;"/> <p>TRAINING COORDINATOR</p>
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# TRAINING METHODS

There are several different training methods used in this training package. Experience with these methods suggests that there are some key points that are useful to improve their effectiveness, and these are summarized below.

## KEY POINTS FOR MAKING EFFECTIVE PRESENTATIONS

- Before starting, **announce the schedule for the session** so participants will know how long it will last.
- **Speak loudly or use a microphone system** so that all participants can hear the presentation easily.
- **Lower the lighting** in the room while using an overhead projector, but leave enough light so that participants can read their own documents and write notes. Moderate lighting also helps keep participants from becoming sleepy.
- **Avoid moving around or making many gestures** while you are presenting because this can distract participants.
- **Speak slower** than normal conversation speed.
- **Offer frequent opportunities for participants to ask questions** or request clarification.
- **Look at participant's faces and posture** to detect problems such as lack of understanding or boredom.
- **Use icebreaking activities** to refocus the participants' attention during the session if necessary.
- While using the facilitating questions or group exercise techniques, **encourage participants to openly share their opinions** and their understanding of the material they are learning.
- **Avoid interrupting or criticising participants** who respond to a facilitating question or who are participating in a group exercise.
- **Allow a short silent pause after presenting** a new idea or after completing an exercise to help participants to think about the information they have just learned.

## KEY POINTS FOR FACILITATING GROUP DISCUSSIONS

- **Establish your role** as the facilitator or discussion leader at the beginning of the training but avoid being seen as an inaccessible “expert”, because this can suppress group discussion.
- **Remain free of personal or emotional involvement** in the discussion and maintain your neutrality throughout the session.
- **Create an environment where people can express their views** without fear of a negative response from others.
- Be ready to **listen** to participants without interrupting.
- Be prepared to **wait** for participants to start expressing their ideas.
- **Encourage** participants to express different points of view.
- **If participation is sluggish**, particularly at the beginning when participants do not know each other, it can be helpful to ask a question and give participants two to three minutes to prepare individual written responses, then ask each participant in turn to share their views with the group.

## KEY POINTS FOR RUNNING A ROLE-PLAY EXERCISE

- Briefly **outline the purpose** of the role-play exercise, emphasizing its importance for skill-building.
- **Quickly identify role-play teams** composed of a provider, a patient and an observer.
- Ask participants to **read the descriptions** for all three roles.
- **Briefly outline the steps and timing** of the role-play exercise.
- Discuss the type of feedback that will be given after the role-play and confirm that participants **agree in advance**

to this type of feedback. Feedback that is asked for, rather than imposed, is more productive.

- If you have any, **give your feedback after the the participants** have finished giving their feedback to the person acting in the provider role.

## KEY POINTS FOR GIVING FEEDBACK

- **Make the feedback specific.** “I liked it” is not as helpful as “I liked the way you helped the patient start thinking about referring his sexual contacts.”
- **Make positive statements** before you provide suggestions for improvement. Encouragement is a powerful force for change.
- **Be descriptive and give clear suggestions** rather than being judgemental. “It made me feel confused when you...” and “I think it would be easier to understand if you...” are better than “your presentation was disorganized.”
- **Focus on behaviour** that can be changed. “You interrupted the patient frequently” rather than “you were rude to the patient.”
- **Be tentative** rather than absolute. “You seem unconcerned about this problem” rather than “You don’t care what happens.”
- **Inform or suggest** rather than command. “He was waiting for you to write down the drug instructions” and “you might want to think about writing down the drug instructions” are better than “you should have given him written instructions.”
- **Verify feedback.** In a group, you can check with the others for the accuracy of comments and whether an impression is shared.

# EVALUATING THE TRAINING

Usually the first step in evaluating a training course is to summarize the numbers of individuals who complete the training and describe some of their characteristics. Two sample forms for collecting this information are included in the annex (Training Participant Learning Assessment and the Summary Report for Syndromic Approach Training Course).

It will also be useful to assess how effective the training was. It is best not to base any assessment on what participants have written in their personal copy of the modules. Their copy is a personal learning aid and reference set. Indeed, we suggest that you only look through someone's copy if they have asked you to do so.

A written Pre-test/Post-test is included in the annex as one option for assessing the knowledge gained by the end of the course. However, this evaluation tool does not reveal the progress participants have made in building the skills they must use to use the syndromic approach effectively.

By the end of the training programme, participants should be fully confident about history-taking and examination, and using flow-charts for diagnosis and treatment. However, they may need to develop and refine their communication and education skills over a number of months. Similarly, it will take time for staff to identify the effectiveness of their approach to partner management, which will depend on the number of partners who attend for treatment.

Below are two suggestions for further evaluating the effectiveness of the training in terms of both knowledge and skills. You might find one or both of these a useful basis to design your own evaluation.

## A REVIEW MEETING

This is a useful short-term assessment tool. You can use it both to assess trainee skills and competencies off-the-job and to review the training programme.

The basis of your assessment could be a series of role-play case studies, in which trainees would take turns to observe and take part. You could provide observation checklists or ask them to create their own, which gives them a sense of 'ownership' of the skills. For example:

- ask the trainee to list their main responsibilities in syndromic management;
- ask groups of trainees to discuss and agree the main skills and standards of behaviour for each responsibility; or
- ask trainees to rank their own performance on a scale of 5, with (1) as excellent and (5) as poor for each standard.

Having done this, trainees can practise role-playing a case-study you give them. In giving your feedback on the role-plays, you could compare your assessment with the trainee's own assessment. Trainees could then each devise a personal development plan, listing their strengths (things to continue doing) and weaknesses (things they still want to improve).

Emphasize that learning never stops just because a course finishes, and that you hope each person will continue both to improve their own skills and also their work as part of a team.

You could also use the meeting to:

- ask trainees to report any experience with syndromic diagnosis and case management;
- clarify any questions that remain;
- explore how the training has reassured people about the effectiveness of syndromic diagnosis and case management;
- help to resolve any continuing problems; or
- ask the trainees for feedback on the training programme so that you can improve it in the future.

Finally, keep a record of everything that you have to resolve as the training progresses so that, each time the training programme is offered, you can ensure the most effective learning experience possible.

## **WORK OBSERVATION**

It is at the work place that each trainee must apply their skills, so it is particularly helpful to conduct a further assessment there. Facilitators or supervisors may be able to do this using the following approach:

- Devise a checklist of observable skills and standards for each responsibility.

- Tell the trainee when the observation assessment will happen and how you will do it.
- At the observation session, respect the patient's feelings and only observe if he or she is comfortable with your presence.
- Do not interfere with the process you are observing.
- Make short notes that you can expand on soon afterwards.
- Look for flip-charts and evidence that the trainee (provider) has made the best use of available resources.

We must accept that actual patients will always offer situations and problems that are much more challenging than anything we can prepare for. So, if possible, give the trainee feedback on their skills and help them to identify how they can improve on any remaining weak areas.

## **MODULE 1**

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### **THE PUBLIC HEALTH SIGNIFICANCE OF STD FACILITATOR'S VERSION**

**TIME FRAME** 1.5 hours

#### **SUPPLIES AND**

- EQUIPMENT**
- Flip-chart and flip-chart paper
  - Markers (ideally in two or three colours)
  - Tape (for posting pieces of flip-chart paper on wall)
  - Overhead projector and overhead set, or Flip-chart version of overheads
  - Extra pens or pencils and paper for participants

## TIPS

- We suggest that you quickly set the tone to ensure a high level of participation from participants later on. A good way is to start by introducing yourself and asking each participant to introduce him or herself.
- After this, together with the group of participants, you could develop some “Rules of Participation” as described in the box.
- Then we also encourage you to do an icebreaker activity. There are two different icebreakers included on the next page, or perhaps there are other icebreaker activities you already know of.

## RULES OF PARTICIPATION ACTIVITY

On a piece of flip-chart paper, write “Rules of Participation” at the top. Ask participants to mention some rules of participation they would like to have for themselves while they are in the training room. You can either ask participants to vote on items or only list those which are agreed to by all. Some rules may be listed that apply to the facilitators.

### **SAMPLE RULES OF PARTICIPATION**

- No smoking.
- Participants will ask questions freely at any time.
- Each participant will try to include his or her views or experience during each open discussion opportunity.
- 100% participation for all group exercises.
- 100% participation for all individual written exercises.
- Facilitators keep to allotted time schedule.
- Participants and corresponding facilitators arrive in time for the beginning of each session.
- Facilitators speak clearly so everyone can hear.
- Feedback is given in a constructive fashion.

## **ICEBREAKING ACTIVITIES**

Before beginning the training session, we suggest that you conduct an icebreaking exercise to encourage participants to become comfortable with each other and with the facilitator. Some simple activities are described below.

### **ICEBREAKER #1 — INTRODUCTIONS**

**Time allocation:** approximately 25 minutes

1. Ask all participants to select a partner for this introduction. The partner will ideally be someone they have never met before. Give the participants 10 minutes to interview each other so that they can introduce their partner to the rest of the group. Give each participant approximately one minute to introduce his or her partner.

### **ICEBREAKER #2 — THE NAME GAME**

**Time allocation:** approximately 15 minutes

1. Ask all players to form a large circle (if the group is too large, form two or more circles of at least 10 people in each).
2. Identify a volunteer to start the game and this first volunteer says his or her name.
3. Proceeding in a clockwise fashion, repeat the previous names that have been given and add your own to the end of the list.
4. By the end of the circle, the last person will have to try to remember the names of all others in the circle.

# LEARNING OBJECTIVES FOR MODULE 1

KNOWLEDGE GAIN	SKILLS ACQUIRED
<ul style="list-style-type: none"> <li>• Identify how STDs are transmitted and the factors that influence transmission.</li> <li>• Appreciate the complications that can result from untreated STDs.</li> <li>• Explore the extent of STDs, the true level of infection in a population, and why these are sometimes difficult to see from statistics.</li> <li>• Understand how STDs are linked with the spread of HIV.</li> <li>• Explain why the control of STD is so difficult, and what must be done to achieve control.</li> </ul>	<ul style="list-style-type: none"> <li>• Talk about STD rates in your country or area and explain why these rates may or may not reflect the true STD burden</li> </ul> <p>Explain some of the serious consequences and complications that can arise if STDs are left undiagnosed and untreated.</p> <p>Describe the two-way link between STDs and the spread of HIV and explain why STD control is important for HIV prevention.</p>

## **MODULE 1**

### **THE PUBLIC HEALTH SIGNIFICANCE OF STD**

**S**exually transmitted diseases (STDs) are very common. The most widely known are gonorrhoea, syphilis and AIDS (HIV infection), but there are more than 20 others. According to current WHO estimates, there are more than 333 million new cases of curable STDs every year throughout the world. About one million new infections occur every day. The relationship between HIV and other STDs makes it even more urgent to prevent and control curable STDs.

This training module includes information about the impact of the STD epidemic. It discusses how STDs are transmitted, and the biological and behavioural, or social, factors that influence their transmission. Complications of STDs and the links between curable STDs and HIV transmission are described. The module ends by discussing factors that are important in controlling and preventing STDs, and how STD control can be improved.

#### **CONTENTS**

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The Challenge of Controlling and Preventing STD	13
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# STD TRANSMISSION

Facilitating question:  
» *How aware are people in your community of the causes of STDs including HIV?*

## How STDs are Transmitted

- Unprotected penetrative sexual intercourse
- Mother-to-child either:
  - during pregnancy, or
  - at delivery, or
  - after birth (HIV only), or
  - through breast-milk (HIV only)
- Transfusions or other contact with blood or blood-products

Not every act of unprotected sexual intercourse results in an STD being passed from an infected individual to their partner. Whether or not a person becomes infected with an STD is influenced by many factors, biological and behavioural.

## BIOLOGICAL FACTORS THAT INFLUENCE STD TRANSMISSION

### WOMEN

There are two important biological features that make it easy for a woman to become infected with an STD:

- the large mucosal surface of the vagina, and
- cervical ectopy in younger women.

Infections can enter the body most easily through a mucosal surface, thus the woman has a larger area through which she can become infected if she has sexual intercourse with a partner who has an STD. Cervical ectopy describes the situation where cells that more readily allow infections to occur are found on the surface of the cervix. This is normal for younger women and makes them more vulnerable to STD infection than older women.

## **MEN**

Uncircumcised men are more likely to get an STD than circumcised men. It is more difficult for uncircumcised men to protect the inside surface of their foreskin from contact with bodily fluids.

## **BEHAVIOURAL FACTORS THAT INFLUENCE STD TRANSMISSION**

Many behavioural factors may affect the chance of getting infected with an STD during sexual intercourse. Behaviours that increase the chance of infection are called 'risky'. Risky behaviours make it more likely that a person will come into contact with an individual infected with an STD. The risk is increased if a condom is not used while having penetrative vaginal or anal intercourse.

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*High-risk behaviour for STD transmission is behaviour that potentially exposes individuals to infected blood, semen, vaginal fluid or genital lesions.*

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## **PERSONAL SEXUAL BEHAVIOURS**

Personal sexual behaviours that are risky include:

- changing of sexual partner frequently;
- having more than one sexual partner;
- having sex with casual partners, sex workers or their clients;
- previous STD infection(s) in the past year;
- exchanging sex for money, goods or favours,
- exchanging sex drugs for drugs or drugs for sex; and
- using vaginal drying agents.

Recent or frequent change of sexual partner, having more than one sexual partner or having casual sex or sex with sex workers or their clients make it more likely that a person will come into contact with someone who has an STD.

If a person has had an STD in the past year, they may be at risk from getting infected in the same way as before if they have not been able to change their behaviours. Exchanging sex for money characterizes a wide range of different people; it includes those who call themselves sex workers (or prostitutes) as well as the people who purchase sex from them (customers or clients). It may also include people who do not call themselves sex workers but who may be giving or receiving something of value in exchange for sex. This

# Risky Behaviours

- **Personal sexual behaviour**
  - Changing sexual partner frequently
  - Having more than one sexual partner
  - Having sex with casual partners, sex workers or their clients
  - Previous STD infection(s) in the past year
  - Exchanging sex for money, goods or favours
  - Exchanging sex for drugs, or drugs for sex
  - Using vaginal drying agents
- **Other personal behaviours associated with risk**
  - Skin-piercing
  - Alcohol or other drugs before or during sex
  - Blood transfusion
- **Partner(s) behaviour**
  - has sex with others
  - has STD
  - is HIV-positive
  - injects drugs
  - has sex with other men (male partner)

behaviour is risky because these individuals tend to get infected with or transmit STD infections relatively frequently. Use of drying agents refers to a wide range of practices. In some areas of the world, women insert herbs or other substances into the vagina to achieve a drying or tightening effect. This can result in vaginal irritation, which can cause small breaks in the vaginal wall that facilitate STD transmission.

## **OTHER PERSONAL RISK FACTORS**

Other personal behaviours that are risky include:

- skin-piercing;
- alcohol or other drugs before or during sex; and
- blood transfusion.

Skin-piercing refers to a wide range of practices including using unsterile needles to give injections or tattoos, scarification or body-piercing and circumcision using shared knives. Alcohol or drug use may affect condom use. Blood transfusion information should be specified by year. Transfusions that occurred prior to 1988 are not generally considered to be problematic.

Facilitating questions:

» *Is there anything that surprised you as a factor that influences transmission?*

» *Do any of these factors apply to patients in your region?*

» *Are there any other factors in your region that we have not included in the list?*

## **PARTNER(S) BEHAVIOUR**

Even if an individual has no risky behaviours, they may be at risk if their partner:

- has sex with others;
- has STD;
- is HIV-positive; injects drugs; or
- has sex with other men (male partner).

If the partner has one of these behaviours, he or she is more exposed or more susceptible to STD infection, and thus more likely to transmit an STD.

## PROTECTIVE BEHAVIOUR

<b>Protective Behaviours — Behaviours That Reduce Risk</b>
<ul style="list-style-type: none"><li>• Using condoms</li><li>• Low-risk sexual activities for example, mutual masturbation</li></ul>

Protective behaviour reduces the risk of becoming infected with an STD. Condom use reduces the risk of STD infection by preventing contact with vaginal fluids, semen or blood. Used properly, condoms are up to 95% effective at preventing the transmission of STDs. Sexual practices such as penetrative vaginal and anal intercourse are high risk, so practices which avoid the exchange of bodily fluids, such as mutual masturbation, are of considerably lower risk.

In many cases, you will find out about personal behaviour while you are interviewing a patient. How to use this information as you manage patients will be discussed in Modules 3 and 5.

Facilitating questions:

» *Please re-read the list of possible factors involved in STD transmission. If you were the STD programme manager for your country, which factors would you think were the most important to consider for your programme. Why?*

» *What do you think people in your community do when they think they may have an STD? Do they go to a health centre first? Why might they go elsewhere?*

## VULNERABLE GROUPS

Vulnerable Groups
<ul style="list-style-type: none"><li>• Sexually active teenage girls</li><li>• Women or men who have several sexual partners</li><li>• Sex workers and their clients</li><li>• Men or women whose jobs separate them from their regular sexual partners for long periods of time</li></ul>

Facilitating questions:

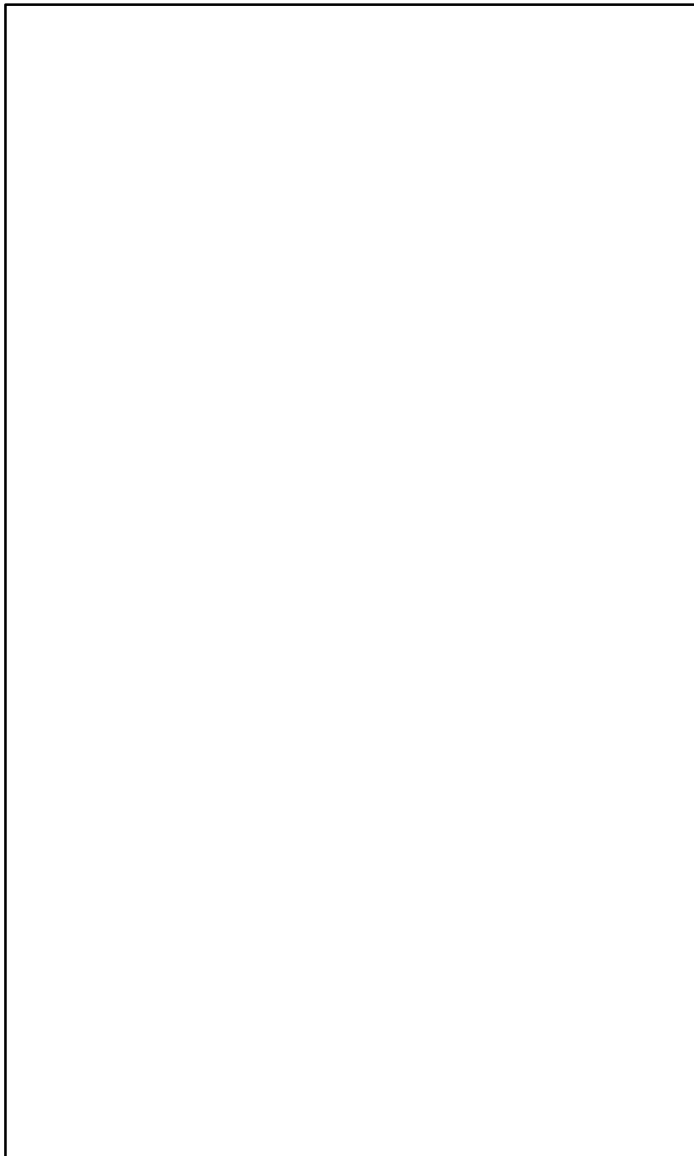
» *What are health worker and community attitudes towards people who they think are members of these groups? What are their attitudes towards anyone who has an STD?*

» *What kind of health services can these different people use? This can include modern or traditional providers. Why do you think they choose these services?*

In most communities there are groups of people who are particularly vulnerable to STDs either because they are exposed to infected partners more frequently, or because they are more susceptible to getting infected each time they are exposed. For various reasons, these people hesitate to go to health facilities for treatment. Special efforts may be needed to reach them and to make services available and acceptable to them.

## COMPLICATIONS OF STD INFECTIONS

All the following complications can be avoided if the correct treatment is provided before they develop.



*Infertility is one possible consequence of STD infection and it is preventable when curable infections are treated promptly and effectively.*

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***PID and infertility***  
*Without treatment, 55% to 85% of women with PID may become infertile. Many women may lose their fertility without ever realizing that they had PID.*

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### **Principal Complications of STD Infections in Women and Children**

- Chronic abdominal pain
- Pelvic inflammatory disease (PID)
- Infertility
- Death due to sepsis, ectopic pregnancy or cervical cancer
- Spontaneous abortion, stillbirth or perinatal death
- Potentially blinding eye infections or pneumonia in infants

---

***PID and ectopic pregnancy***  
*Pelvic inflammatory disease increases the risk that a pregnancy will be ectopic by 7 to 10 times.*

---

Pelvic inflammatory disease (PID) is inflammation of the uterus, fallopian tubes and ovaries. Sometimes PID spreads throughout the lower abdomen. The main causes of pelvic inflammatory disease in women are gonorrhoea and chlamydia. The pain from PID is often the first symptom that women notice. If the fallopian tubes are already damaged when the women starts to feel pain, this damage is irreversible.

Because PID permanently scars and narrows the fallopian tubes, it increases the risk of ectopic pregnancy — a condition that can be fatal to women. If the pregnancy implants in the fallopian tube, the tube can rupture, causing extensive haemorrhage. Ectopic pregnancies cause an estimated 1% to 5% of all maternal deaths.

Gonorrhoea and chlamydia can also cause eye infections and pneumonia in the newborn. A syphilis infection during pregnancy can spread through the placenta and infect the fetus. Up to 40% of syphilitic pregnancies end in spontaneous abortion, stillbirth, or perinatal death. This is particularly serious when the maternal syphilis infection is untreated during the first 20 weeks of pregnancy.

*In a number of countries, ophthalmia neonatorum afflicts 5% of the newborn. Without treatment, ophthalmia neonatorum permanently damages the vision of 1% to 6% of affected infants. Chlamydia may also spread to the lungs of the newborn, and lead to chlamydial pneumonia.*

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## **MEN**

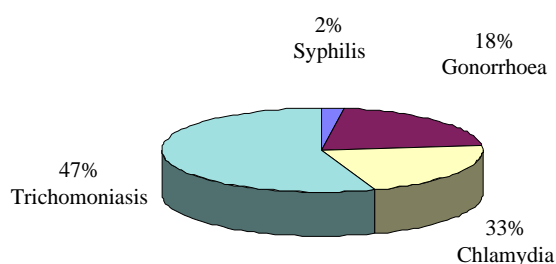
<b>Principal Consequences of STD Infections in Men</b>
<ul style="list-style-type: none"> <li>● Urethral stricture</li> <li>● Infertility</li> </ul>

Facilitating questions:

- » *What does this information mean for the kinds of services you provide and the kinds of patients you see?*
- » *What are some other social or economic consequences of STD infection in your region or area?*
- » *In your region, what happens to a woman or a man who becomes infertile because of STD infection?*
- » *What happens when there are problems with a pregnancy or with the newborn because of STD infection?*

Gonorrhoea and chlamydia can lead to serious complications in men. An infection can spread from the urethra (where it is known as urethritis) to the epididymis (where it is known as epididymitis). This can cause urethral stricture and infertility.

### Estimated Number of New Curable STD Infections Among Adults Age 15-49 Western Pacific Region, 1995



Total number of new curable STD infections for the Western Pacific Region is approximately 30 million per year.

» Are any of these rates surprising to you? Why are they surprising?  
» Are you aware of any other STD rates that you would like to add to the information presented here? Where are the most important gaps in information?

The World Health Organization estimates that 30 million new cases of curable STDs occurred in the Western Pacific Region in 1995. This estimate was based on a review of all available STD studies.

## HOW ACCURATE ARE STD STATISTICS?

Estimates for STDs are typically higher than national STD reports because these reports under-represent the true number of people infected with curable STDs.

Statistics on STDs are frequently based on the numbers of people attending health facilities for treatment. These case reports tend to underestimate the true amount of STD infection in the general population for several reasons, including:

- lack of symptoms, so people don't go for treatment;
- health facilities are too far away; and
- use of alternative health care providers, such as pharmacists and traditional healers, who do not report case numbers.

The amount of bias in STD case reports is different for the different STD infections. For example, 70% of women and up to 70% of men infected with chlamydia may not have symptoms, and up to 80% of women and up to 70% of men infected with gonorrhoea may also be asymptomatic. Where STD case reporting is done, multiple infections like co-infection

Facilitating questions:

## Reasons for Underestimating STD Frequency

- Men and women with STD may have no symptoms so they do not seek treatment.
- Clinics that report STD cases may not be easy to reach.
- People with STD may go to alternative health care providers.

with gonorrhoea and chlamydia are frequently documented as only one infection.

In some countries, the primary sources of STD care used by most people are not the government health services. Other sources of care include pharmacists, traditional healers, drug sellers, herbalists, private doctors or private STD clinics. These types of services commonly do not report their STD cases to national authorities.



## THE HIV/AIDS EPIDEMIC

Infection with human immunodeficiency virus (HIV), which causes AIDS, is spread by the same behaviour as other STDs. There is as yet no cure for AIDS, and it is fatal.

The table below shows the estimated number of HIV infections occurring in selected countries for the year 1996.

- By 1995, WHO estimated that a total of 18.5 million adults and about 1.5 million children worldwide had been infected with HIV.
- The proportion of cases in women is increasing.

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*The World Health Organization predicts that the HIV/AIDS epidemic will grow very quickly in Asian countries. The number of HIV infections in Asia is expected to double by the year 2001.*

---

## Estimated HIV Prevalence for Selected Countries of the Western Pacific Region, 1996

Country	WHO estimated HIV infection in adults age 15-49	
	Number	% of adults age 15-49
Australia	11 000	0.113
Cambodia	96 300	1.974
China	50 000	0.007
Japan	5 000	0.008
Malaysia	55 000	0.530
New Zealand	1 200	0.064
Papua New Guinea	4 500	0.203
Philippines	17 500	0.035
Republic of Korea	2 500	0.009
Viet Nam	57 000	0.203

- By the year 2000, it is projected that a cumulative total of 30 to 40 million people will be infected and that approximately 90% of them will be living in the developing world.
- During the year 2000, it is projected that two million people will become infected with HIV.

## THE LINK BETWEEN STD AND HIV/AIDS

Human immunodeficiency virus is passed from one person to another more easily when one or both people are infected with another STD. The STDs that are particularly important in this interaction are chancroid, chlamydia, gonorrhoea, syphilis and trichomoniasis. Depending on which infection it is, these STDs can make it two to nine times more likely that someone will be infected with HIV when exposed to the virus.

Even non-ulcerative STD infections can increase the risk of getting infected with HIV. This may be because STD infection increases the number of white blood cells in the genital tract. White blood cells are both targets and sources of HIV. Another reason could be that genital inflammation associated with these STDs can cause microscopic cuts in genital tissues, creating potential sites where HIV can enter the body.

The problem of non-ulcerative STDs is thought to be important because these STDs are more common than ulcerative STDs, and therefore might be associated with more HIV infection. This is of great potential concern in the Western Pacific Region, where non-ulcerative STDs are believed to be quite common.

Research is beginning to show that STD control can have a powerful effect on the HIV epidemic. Also, treating people with STDs provides a valuable opportunity for health care workers to reach individuals whose infections and sexual behaviour put them at high risk of acquiring HIV.

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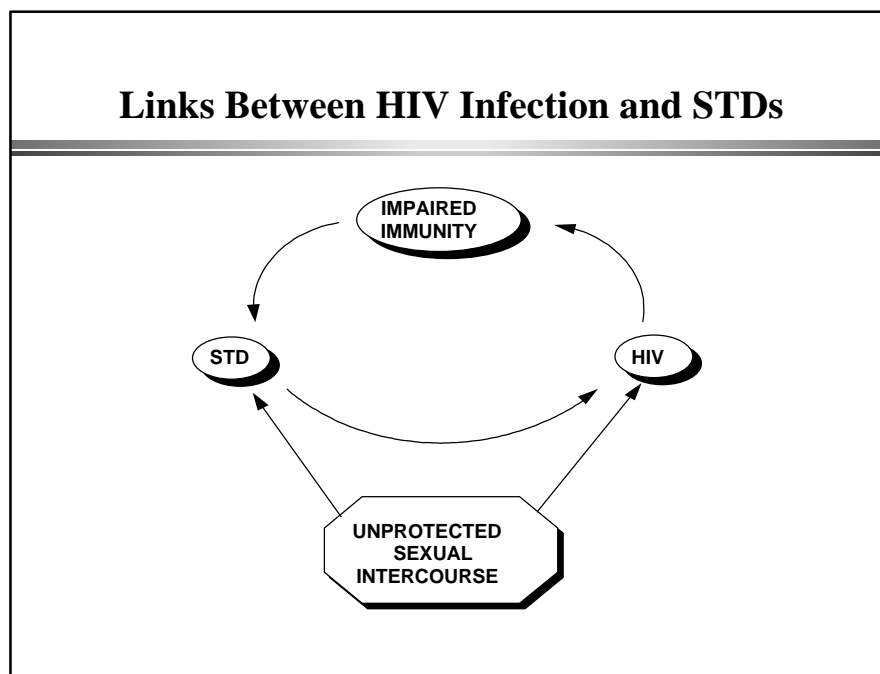
*Improved  
STD  
services can  
have a  
direct and  
powerful  
impact on  
the AIDS  
epidemic.*

---

***A Successful STD Rural Health Programme***

*A recent study conducted in a rural area indicated that a comprehensive STD programme based on the syndromic approach to STD case management reduced the HIV incidence in the community by 42% over a two-year period.*

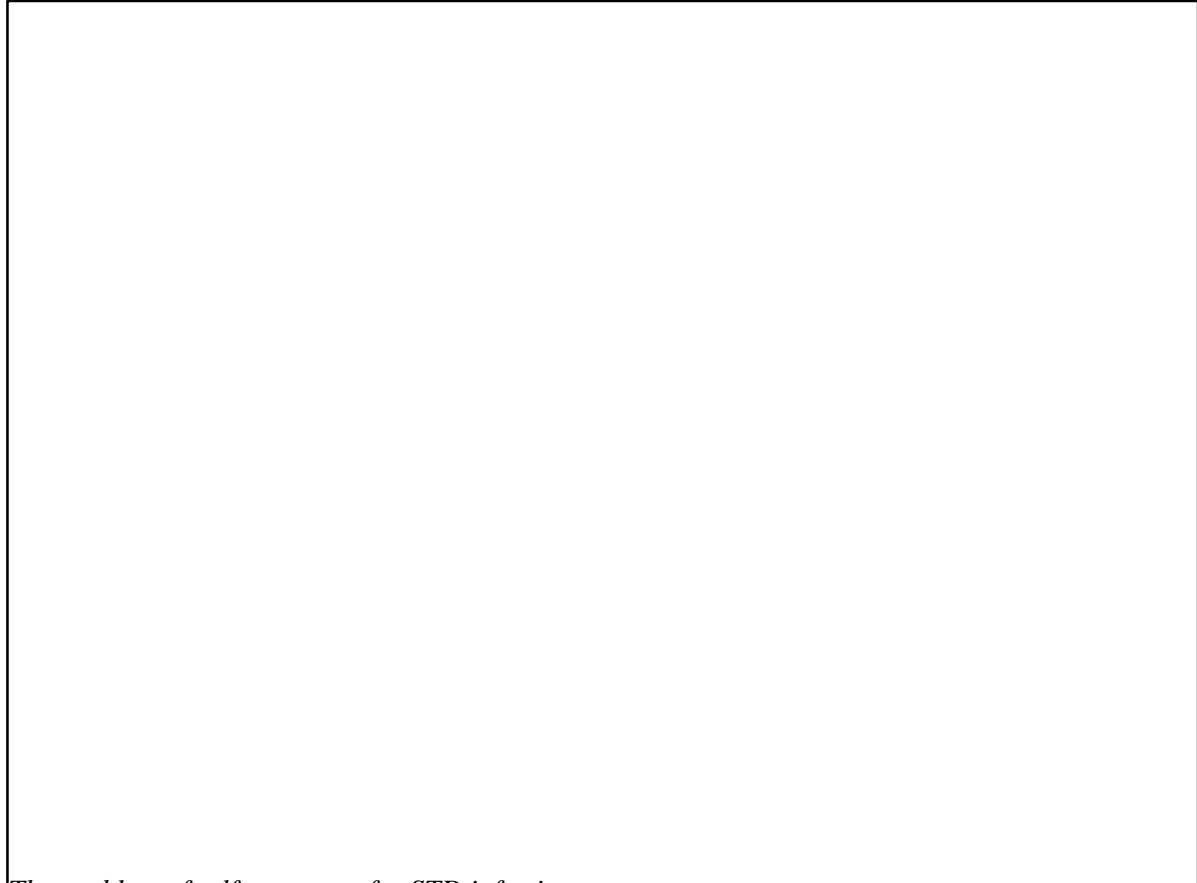
**THE LINKS BETWEEN HIV INFECTION AND STDs**




---

*Among the STDs that have been shown to increase the risk of HIV, those STD that cause genital ulcers, which includes syphilis and chancroid, have been shown to have the most dramatic impact on HIV infection.*

While STD infections increase the risk of infection with HIV, it is also true that a person infected with HIV is more vulnerable to getting multiple STD infections. Changes in the bodies of HIV-infected individuals make them more vulnerable to infection in general. They may also be more resistant to STD treatment and their infection may take longer to resolve.



*The problem of self-treatment for STD infections.*

# THE CHALLENGE OF CONTROLLING AND PREVENTING STDs

## FACTORS THAT INFLUENCE DELIVERY OF EFFECTIVE STD CARE

Delivery of STD Care is Affected by:

- Social factors
- Lack of symptoms
- Incomplete treatment
- Treatment of partners

### SOCIAL FACTORS

There are a number of social factors that affect whether or not people obtain effective treatment for curable STD infections, including:

- lack of appropriate health facilities;
- health facilities are too expensive;
- health facilities are too far away;
- health facilities do not have effective drugs;
- people prefer to try alternative health providers such as traditional healers first; and
- the social stigma attached to STDs make people tend to hide what they feel is shameful, and therefore they hesitate to seek treatment.

---

*People frequently avoid going to health centres. They prefer to go directly to drug sellers, including pharmacies, for treatment. This is a widespread problem for STD case management and worsens the problem of antibiotic resistance.*

---

## **LACK OF SYMPTOMS**

People may not know that they have an STD because there are no symptoms.

## **INCOMPLETE TREATMENT**

Treatment of an STD may not be completed, even after a person has gone to the health centre for care. Some of the reasons for this include:

- the treatment is too costly;
- the treatment takes many days to complete and the patient forgets it;
- the patient believes that partial treatment is enough to cure the infection, particularly when the symptoms disappear; and
- the patient has a low opinion of the services they received at the health centre.

## **TREATMENT OF PARTNERS**

It is important to treat the sexual partners of STD patients to prevent the continued spread of infection, or reinfection. However, partners may not be treated for many reasons, including:

- the patient feels uncomfortable or unable to inform their sexual partner(s) about an STD infection;
- sexual partner(s) do not accept treatment or are unwilling to go to the health centre for treatment;
- tracing sexual partner(s) is too difficult; and
- the patient cannot identify their sexual partner(s), for instance, if the patient is a sex worker.

## **MANAGEMENT OF STDs**

In order to reduce the spread of STD infection, practical management strategies must take into account the many aspects of controlling STDs.

*Asymptomatic STDs influence transmission because people do not realize they have a health problem and so do not seek treatment. Depending on the infection, up to 70% of men and 70 to 80% of women are asymptomatic while infected with an STD.*

---

## Preventing and Controlling STDs Involves:

- Early diagnosis and treatment
- Education of patient and partner(s)
- Promotion of condom use
- Targeting vulnerable groups

» *What makes STD control difficult ?*

- It is difficult to change sexual behaviour.
- Sex can be embarrassing to talk about.
- Many people with STDs have no symptoms.
- Treatment is not always simple and sometimes it is costly.

Facilitating question:

» *How can an STD programme overcome the problems you just described and what are some features of an improved programme for your region?*

### **EARLY DIAGNOSIS AND**

Early diagnosis and treatment helps to:

- reduce STD transmission from currently infected people to others; and
- reduce the chances of developing serious complications from the infection.

To achieve this, all patients with STDs need to be treated effectively during their first visit to a health facility. Ideally, this means that STD services should be available at all health facilities. In order for STD diagnosis and treatment activities to be most effective, health facilities need adequate supplies of the necessary drugs. Known sexual partners should be treated for STDs even if they are symptom-free, so patients need to be encouraged (and assisted, if appropriate) to inform sexual partners.

### **EDUCATION OF PATIENT AND PARTNER(S)**

It is important to encourage people to adopt safer sex practices, and to help those who are at risk because of their partner's behaviour. The aims of education for STD patients are to:

- support a change in a person's behaviour so that he or she will be cured of their infection;
- avoid infecting others; and
- remain free of infection in the future.

Facilitating question and discussion points:

## **PROMOTION OF CONDOM USE**

- If used correctly and consistently, condoms can help prevent the spread of STDs and HIV.

All sexually active people should know how to use condoms. Providers should check to make sure their STD patients are able to use condoms, so providers need to be comfortable with discussing condoms and demonstrating how to use them.

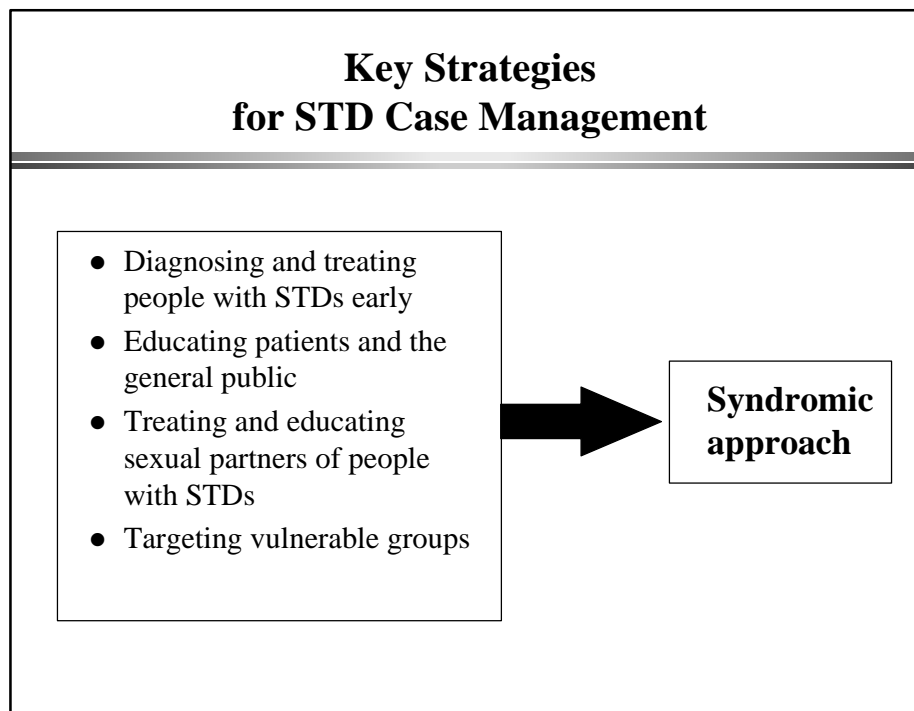
## **TARGETING VULNERABLE GROUPS**

- It is important to target STD service delivery for vulnerable groups.

In many places in the world, male or female sex workers and their clients run the highest risk of becoming infected. The stable or regular partners of these people are also at high risk of infection. Other vulnerable groups can include those working away from home, young people or those who use drugs. Vulnerable groups may have limited access to STD services, so these services need to be targeted to be effective.

## **THE SYNDROMIC APPROACH**

The syndromic approach to STD case management is designed to blend these strategies together to deliver comprehensive and integrated STD care.



# **REVIEW**

## **STD TRANSMISSION**

- STDs and HIV are transmitted in similar ways.
- There are many factors that influence STD transmission, and some people are at greater risk of becoming infected with an STD or of failing to get effective treatment.
- People with untreated STD infections can experience severe symptoms and sequelae or consequences.
- STDs can cause infertility in both men and women, ectopic pregnancy in women, problems with pregnancy and childbirth, and infections in the newborn.

## **STD RATES**

- STDs are a growing health burden for individuals and for health services.
- There are some groups that are particularly vulnerable to STD infection.
- In most countries, STDs are under-reported.

## **THE LINK BETWEEN STD AND HIV/AIDS**

- STDs are linked to the spread of AIDS. There is a strong link between having an STD (especially genital ulcers) and becoming HIV-positive. HIV infection may make people more susceptible to other STDs, and may make other STDs more resistant to treatment.
- Programmes that successfully treat STD infections promptly can have an impact on HIV transmission.

## **THE CHALLENGE OF CONTROLLING AND PREVENTING STDs**

- Features of an effective STD programme include prompt diagnosis and effective treatment, education to reinforce STD care and prevention, services extended to sexual partners of individuals with STDs, and targeting STD services to reach vulnerable groups.
- The syndromic approach is a practical answer to the problem of controlling STDs.





## **1.3 ACTIVITY**

### **STATISTICS PROJECT**

Having learned about STD and HIV rates for the region, it would be helpful to find out more about the statistics available for your country, region or community.

This activity is best done as a group project. If it is not possible for you to work with a group on this project, please discuss your findings with your colleagues and supervisor. Your facilitator or supervisor should be able to help you obtain any available statistics or records.

There are three steps to this project: gathering information, interpreting the information, and drawing conclusions.

#### **STEP 1 GATHERING INFORMATION**

- a) Think about what sort of information about STDs in your country or region would be useful to have, and why.
- b) Collect information on STD and HIV for your country, region or community. Approach your local health service for any reports they have on numbers of people seeking treatment for STD, and find out if any special surveys using laboratory tests have been done. Your facilitator, tutor or supervisor may be able to help you with statistics or other information.
- c) Collect any estimates about STDs or HIV. In some cases, this may be the only information available.

#### **STEP 2 INTERPRETING THE INFORMATION**

- d) According to the information you have gathered, who is most at risk for getting infected with STDs? Are particular groups more at risk than others?
- e) To what extent is this information useful, given your answers to the question in point a) above?
- f) How accurate do you consider the statistics (or estimates) to be?
- g) Do you think there is a tendency for the statistics to underestimate cases in women? Why do you think this is so? How much of a problem is this?

#### **STEP 3 DRAWING CONCLUSIONS**

- h) Make simple graphs or tables that show the information you have gathered.
- i) Make a list of conclusions that can be drawn from the information you have gathered.

# ANSWERS

## 1.1 QUESTION

Addressing the problem of asymptomatic STDs is perhaps one of the biggest challenges in delivering effective STD care. There are several approaches being tried or considered for different settings.

- a) Improve individual's ability to detect abnormal symptoms that may suggest STD infection and encourage them to go for a check up.
- b) Raise patient's awareness of behavioural risks and encourage them to go for a check up when they believe they may be infected (although some patients may overreact and come in for care when it is unnecessary).
- c) Provide regular periodic STD care to groups with high risk behaviour so that they can voluntarily take advantage of preventive STD services. An example of this would be a clinic visit twice a month for sex workers whether or not they currently have symptoms of STD.
- d) Provide periodic selective mass STD prophylaxis among groups of people with high risk behaviours. An example of this would be regular periodic penicillin G injections for sex workers. This is considered an experimental approach and has not yet been shown to be viable.

## 1.2 QUESTION

- a) Well done if you spotted our statement on page 10 that chancroid, chlamydia, gonorrhoea, syphilis and trichomoniasis may increase the risk of HIV transmission by two to nine times.

The risks for three of these conditions are listed below:

<b>Condition</b>	<b>Increases risk of HIV transmission by:</b>
Syphilis	3 to 9 times
Gonorrhoea	3 to 5 times
Chlamydia	3 to 5 times

Please note that this STD syndromic approach training package does not cover herpes, though it is associated with a doubled risk of HIV transmission. You should always encourage patients with this virus to avoid sexual activity when a herpes sore is present.

Why do you think there is such a range in the available figures? In part, the range can result from the sheer problems of this type of research.

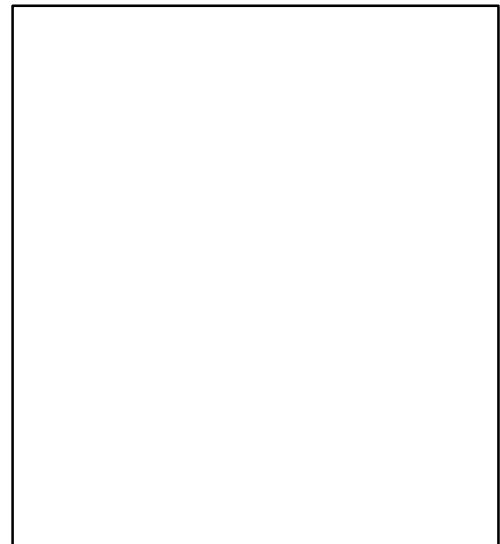
- b) There are two possible reasons why non-ulcer-causing STDs increase the risk of transmitting HIV:
  - The presence of STD viruses or bacteria in the bloodstream locally stimulate the body's immune system to increase the number of white blood cells, which are both targets and sources of HIV.
  - Genital inflammation may cause microscopic cuts that allow HIV to enter the body.
- c) HIV infection may affect transmission of STDs in two ways: by making an STD more resistant to treatment, and by making people more susceptible to STDs.

**STD Case Management —**  
*The Syndromic Approach*  
*for Primary Health Care Settings*

**MODULE 2**  

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**USING FLOW-CHARTS FOR SYNDROMIC MANAGEMENT**



**T**his module introduces syndromic case management, its advantages over the traditional approaches to STD management and the important features of syndromic management that make it useful in all health care situations.

Before starting this module, you should already have completed Module 1, so that you are familiar with the impact of the epidemic, and the challenge of reducing transmission of STDs.

Later modules will help you develop your understanding of the flow-charts much more, by working through each one in detail.

We suggest you keep a separate copy of the four basic flow-charts nearby while you are studying this module.

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**Remember:**  
*The quality of the  
syndromic case  
management approach  
depends on you.*

---

## CONTENTS

Traditional Approaches to STD Diagnosis	1
The Syndromic Approach to STD Case Management	3
Features of the Syndromic Approach	4
Review	14
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Answers	18

## **MODULE 2**

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### **USING FLOW-CHARTS FOR SYNDROMIC MANAGEMENT FACILITATOR'S VERSION**

**TIME FRAME:** 1 hour

**SUPPLIES AND**

**EQUIPMENT**

- Flip-chart and flip-chart
- Markers (ideally in two or three colours)
- Tape (for posting pieces of flip-chart paper on wall)
- Overhead projector and overhead set or  
Flip-chart version of overheads
- Extra pens or pencils and paper for participants

## LEARNING OBJECTIVES FOR MODULE 2

KNOWLEDGE GAIN	SKILLS ACQUIRED
<ul style="list-style-type: none"><li>• Describe the problems with using traditional approaches to treating patients with STDs.</li><li>• Describe the advantages that syndromic case management offers.</li><li>• Identify the main features and benefits of syndromic case management.</li><li>• Explain that there are different steps specified by flow-charts to diagnose an STD syndrome and treat patients.</li><li>• Identify your further learning needs, which will depend on your responsibilities as a member of a health care team.</li></ul>	<ul style="list-style-type: none"><li>• Be able to defend the syndromic approach to those who criticize it.</li></ul>

# TRADITIONAL APPROACHES TO STD DIAGNOSIS

## Two Traditional Approaches to STD Diagnosis

- *etiological diagnosis* uses laboratory tests to identify the causative agent
- *clinical diagnosis* uses clinical experience to identify symptoms which are typical for a specific STD

Health care providers generally use one of two approaches when they diagnose STDs: etiological diagnosis or clinical diagnosis. Etiological diagnosis enables the provider to make a precise diagnosis and treat their patient for the specific infection. However, many providers do not have the facilities to identify a causative agent, so they make a clinical diagnosis that relies heavily on their experience with similar cases in the past. In the diagnosis and treatment of STDs, both of these traditional approaches present a number of problems.

## Problems with Etiological Diagnosis

- Skilled personnel and sophisticated equipment are needed to identify the causative agent of an STD.
- Laboratory tests for diagnosis are expensive and time-consuming.
- Treatment does not begin until the results are obtained.
- Testing facilities are not available at the primary health care level where many people with an STD seek care.

» What problems can you see with identifying a causative agent before offering treatment? [Hint: In Module 1 we said that early, effective therapy was essential to control the spread of STDs.]

» What problems can you see with relying on a clinical diagnosis?

Facilitating question:

» Do any of these problems with etiological and clinical diagnosis apply in your health centre? If so, which ones?

Facilitating questions:

Etiological diagnosis is expensive and test results may take some time to arrive. These delays are a problem because:

- treatment does not start straight away;
- infected individuals continue to transmit the infection to others; and
- the patient's confidence in the provider may be reduced, which can affect the patient's willingness to finish treatment, return for follow-up, or refer sexual partners.

### **Problems with Clinical Diagnosis**

- Clinical diagnosis is only accurate for 50% of STD cases.
- Mixed infections are not usually considered.
- Mis-treated or untreated infections can lead to complications and continued transmission.

Using clinical diagnosis, the clinician treats one STD infection based on the clinical symptoms. However, different STD infections cause similar symptoms and the clinician may pick the wrong one to treat. In addition, mixed infections are common, and a patient who has multiple infections needs to be treated for each of them. Failure to treat one of the infections may lead to complications and the continued transmission of that STD.

# THE SYNDROMIC APPROACH TO STD CASE MANAGEMENT

## HOW THE SYNDROMIC APPROACH DIFFERS FROM TRADITIONAL APPROACHES

How is syndromic case management different from etiological diagnosis and from clinical diagnosis? What are its main features and what benefits does it offer? We will try to answer these questions before introducing the distinguishing tools of the syndromic approach — flow-charts.

### The Main Benefits of the Syndromic Approach

- Complete STD care is offered at the patient's first visit.
- Treatment is more widely and rapidly accessible.
- Patients are treated for possible mixed infection by addressing all the important causes of a syndrome.
- Prevention and compliance are addressed through education, partner referral and condom provision and promotion.

The principal feature and benefit of the syndromic approach is that STD services can be offered wherever the patient makes his or her initial visit, so patients do not have to go to specialized clinics or large hospitals. When drugs are available, patients can be treated at their first visit as well.

Another feature and benefit of the syndromic approach is that the possibility of mixed infections is addressed straight away.

Finally, the syndromic approach includes an opportunity for educating patients regarding partner referral and prevention of future STD episodes. Offering condoms and encouraging their use is also an integral part of STD case management.

## **FEATURES OF THE SYNDROMIC APPROACH**

### The Main Features of the Syndromic Approach

- Grouping the main infectious agents according to the clinical syndromes they cause
- Using flow-charts as tools
- Treating patients for all the important causes of a syndrome
- Educating patients, promoting condoms and emphasizing the importance of partner referral

In this module, we will discuss the first three features of syndromic management outlined above, the clinical syndromes, using flow-charts and treating for all causes of a syndrome. Patient and partner education will be discussed in later modules.

## **IDENTIFYING THE SYNDROMES**

A syndrome is a group of symptoms that patients describe, combined with the signs that providers observe during examination. Although STDs are caused by many different organisms, these organisms only cause a limited number of syndromes. Using the syndromic approach you can identify one of these syndromes and treat it accordingly.

The table below summarizes the signs and symptoms for four STD syndromes and their etiologies or causative agents.

<b>The Four Steps in Syndromic STD Case Management</b>
<ol style="list-style-type: none"><li>1. History-taking and examination</li><li>2. Syndromic diagnosis and treatment, using flow-charts</li><li>3. Education on safer sex, including condom promotion and provision</li><li>4. Management of sexual partners</li></ol>

## **USING FLOW-CHARTS**

Please have a copy of all the flow-charts with you as you begin this section.

## **WHAT IS A FLOW-CHART?**

A flow-chart is like a map that guides you through a series of decisions and actions. Each decision or action is enclosed in a box, with one or two routes leading out of it to another box, containing another decision or action.

The health care provider starts by asking the patient about their complaint and then refers to the relevant flow-chart. Beginning at the clinical problem box at the top, the health care provider works down through each level until they come to the end of a branch, called an exit path, where there is a suggested action to take.

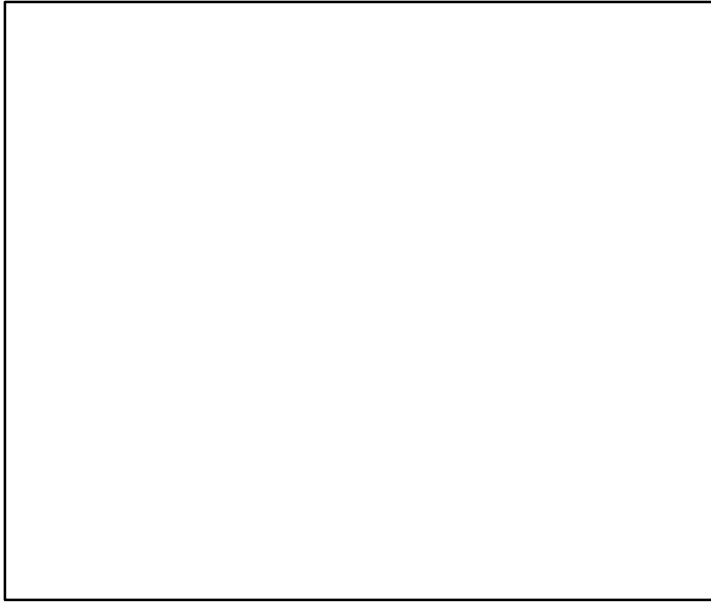
## **BENEFITS OF USING FLOW-CHARTS**

### **The Benefits of Using Flow-Charts**

- They can be used at any time in all types of health facilities.
- They suggest clear decisions.
- Most cases do not need to be referred.
- Standard treatment guidelines are established.

The different syndromes are easy to identify and so a flow-chart can be developed for each one. The flow-chart for a particular syndrome guides the health worker carefully through a series of actions and decisions that are appropriate for that syndrome. Providers who use a flow-chart will get clear guidance on how to treat patients for their condition or conditions.

Once trained, providers will find the flow-charts easy to use. A wide range of different types of health care workers at any health facility can manage STD cases effectively using the flow-charts.



*One of the benefits of using the syndromic approach is that patients are treated straight away.*

## **STEPS IN USING FLOW-CHARTS**

### **Steps in Using Flow-Charts**

- Determine the clinical problem – ask for patient’s presenting symptom
- Find the appropriate flow-chart by looking at the clinical problem box at the top
- Usually the flow-chart will ask you to take a history and examine the patient
- Use the results from the examination and history to make a decision – usually by choosing ‘yes’ or ‘no’
- Depending on your decision, there may be boxes to consider and more choices to make
- Follow the arrows, proceeding one step at a time until you reach the end of a branch, or exit path

---

#### **Remember:**

*Simply work through the flow-chart step by step. Be careful not to miss any steps.*

---



## TREATING ALL CAUSATIVE AGENTS

While a clinical or etiological diagnosis tries to identify one causative agent, syndromic diagnosis includes immediate treatment for all the most important causative agents.

This means that, if all the necessary drugs are available, syndromic treatment will quickly render the patient non-infectious so they can't transmit the infection to another person.

The box below describes a case-study to show how syndromic case management works. In this example, the provider identifies the most likely causes of a patient's symptoms and signs, and gives treatment for those infections that have serious complications or sequelae.

### *Urethral Discharge*

*A patient complains of a discharge from his penis. Upon examination, you confirm the discharge from the urethra.*

Urethral discharge syndrome is caused, most of the time, by gonorrhoea and/or chlamydial infection, so the treatment should be effective against both these causes.

*There are other causes of urethral discharge syndrome, such as infection with *Ureaplasma urealyticum* and *Trichomonas vaginalis*. Should the patient be treated for these causes as well?*

Not necessarily, because both are less common and do not lead to complications. Their treatment is not urgent. However, both gonorrhoea and chlamydial infection are common; not only can they cause complications, but they can facilitate HIV transmission. So it is essential to treat the patient for both of these infections.



## RESPONDING TO CRITICISMS OF THE SYNDROMIC APPROACH

We will try to answer the most commonly voiced criticisms made against the syndromic approach. If you completed Activity 2.3, you may already have thought about most of these points.

## The Most Common Criticisms of the Syndromic Approach

- The syndromic approach is not scientific.
- Syndromic diagnosis is too simple for a physician to use.
- The syndromic approach does not use a provider's clinical skills and experience.
- It would be better to treat first for the most common cause, and then if symptoms don't improve, treat for a second cause.
- The syndromic approach wastes a lot of drugs.
- The syndromic approach promotes the development of antibiotic resistance.
- Simple laboratory tests should be included.

### ***The syndromic approach isn't scientific***

On the contrary, it is based on epidemiological studies conducted throughout the industrialized and developing world. In order to evaluate the accuracy of syndromic diagnosis, a number of validation studies have been done comparing syndromic diagnosis with laboratory-assisted diagnosis. These studies found syndromic diagnosis to be similar to laboratory-assisted diagnosis, and hence accurate. As a result, syndromic diagnosis of STD has been adopted in many settings all over the world.

### ***Syndromic diagnosis is too simple for a physician to use - it is more appropriate for nurses.***

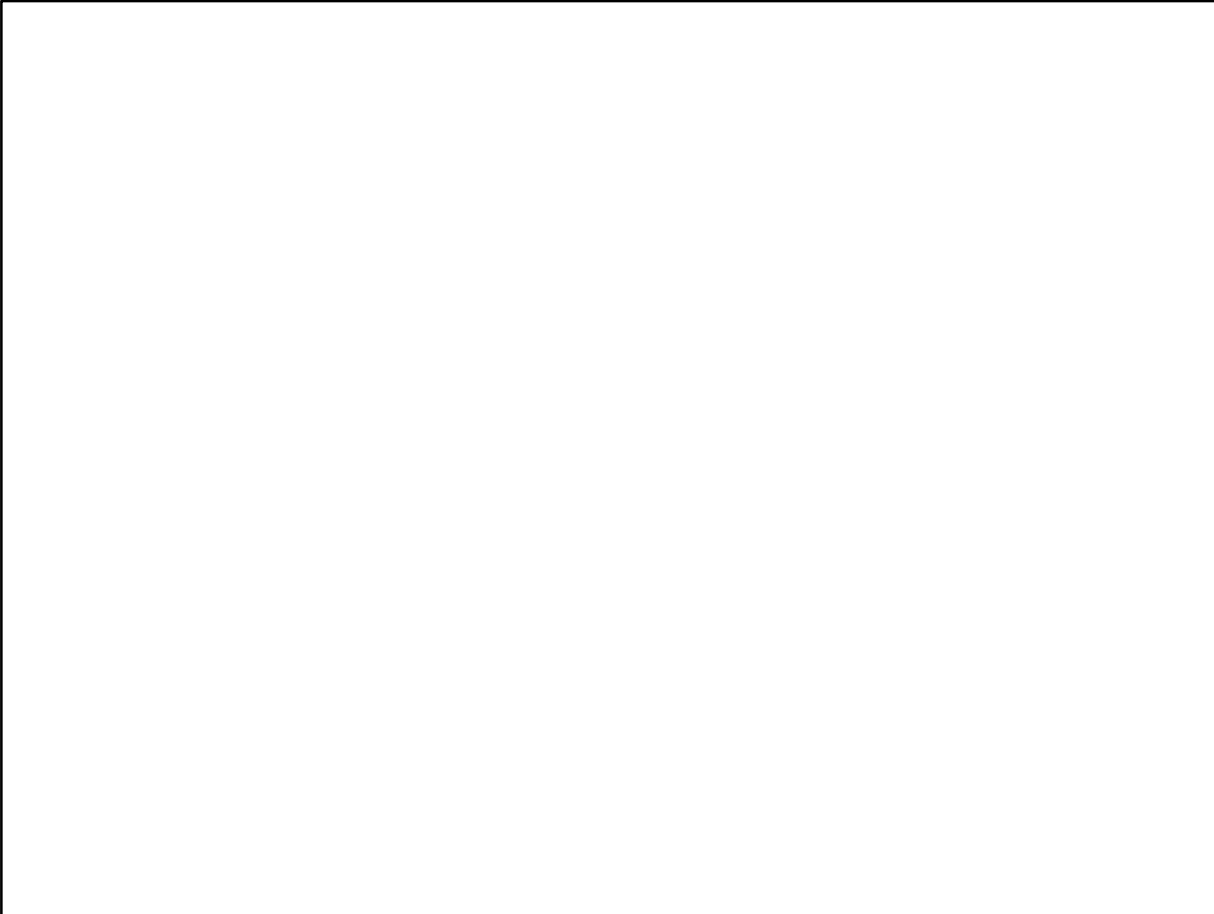
Simplicity does not prevent physicians from using other tools, such as a thermometer or a stethoscope. It is a great advantage for STD control if other service providers, in addition to doctors, can use the syndromic approach to make a diagnosis. A streamlined diagnosis and treatment process also frees up more time for health workers to offer education for behaviour change.

### ***The syndromic approach does not use a service provider's clinical skills and experience.***

Many clinicians rely heavily on their own clinical judgement. They find it difficult to accept that using a clinical judgement alone could be a problem. Not only do studies show that clinical diagnosis is accurate for only 50% of STD cases, but clinical diagnosis also misses mixed infections.

- Prepare pieces of flip-chart paper with the criticisms from activity 2.2 listed on each page. Allow participants to spend about ten minutes writing down their responses to the criticisms of the syndromic approach. Then go around the room and get each participant to give you up to two arguments for each of the criticisms. Write them out under each of the criticisms. Paste the criticisms and responses on the wall so they are all visible simultaneously.





*An example of inappropriate case management. It is likely that by using the proper flow-chart, the provider can treat straight away without waiting for results from diagnostic tests.*

***It would be better to treat the patient first for the most common cause and then, if the symptoms don't improve, treat for a second cause.***

Patients who are not cured by the first treatment may not return to the health centre and may even seek further treatment elsewhere, resulting in an inappropriate course of treatment. They may also become asymptomatic but still have an untreated STD, and if they have unprotected intercourse, they may spread the infection further.

***The syndromic approach wastes drugs, because patients are being over-treated***

In fact studies have shown that the syndromic approach makes STD care less expensive in the long run. The technology, skills and infrastructure needed to make an

etiological diagnosis are expensive. Failed treatment or a wrong clinical diagnosis that results in inappropriate or incomplete treatment make the cost of treating a patient higher because they have to be treated again, may develop complications and may continued to spread the infection.

***The syndromic approach promotes the development of antibiotic resistance.***

Antibiotic resistance emerges if people do not take enough antibiotic(s) to cure their infection(s) completely. With the syndromic approach, providers are encouraged to give standardized treatment using the most effective medications available for a given syndrome. Providers are also encouraged to use single dose therapy whenever possible thereby avoiding problems with patient compliance. Better communication between providers and patients makes it more likely that the patient will continue to take their medication as requested after they leave the health centre.

***Good, simple laboratory tests, such as Gram stain, should be included in STD diagnosis.***

When you include laboratory tests in the process, patients must wait for the results and may not return for treatment. Also, while they are waiting, they remain infectious and complications can occur. Gram stain is only justified when microscopy is readily available, quick and consistently accurate.

Facilitating question:

» We have finished Module 2. Do you still have any questions about syndromic case management of STDs?

» What benefits might syndromic case management bring to your health centre?

» Do you think it will be difficult to implement syndromic case management at your health centre?

# **REVIEW**

## **TRADITIONAL APPROACHES TO STD DIAGNOSIS**

- Even in a well-structured health system, there are problems with relying on etiological or clinical diagnosis of STDs.
- Etiological diagnosis is expensive and time-consuming; it requires special resources and frequently leads to delayed treatment.
- With clinical diagnosis, it is easy to misdiagnose some STDs and also to miss mixed infections.

## **THE SYNDROMIC APPROACH TO CASE MANAGEMENT**

- The syndromic approach to STD case management is the best approach for effectively controlling the spread of STDs, because it provides for early, effective treatment at a patient's first visit to a health facility.
- The main features of the syndromic approach are:
  - defining clinical syndromes that group together several potential causative agents;
  - using flow-charts that help the provider to identify the possible causes of a given syndrome;
  - treating patients promptly for all the important causes of the syndrome; and
  - ensuring that partners are treated, patients educated about treatment compliance and risk reduction, and condoms promoted.

## **USING FLOW-**

- Flow-charts are the basic tool of syndromic STD case management.
- Flow-charts are easy to use if followed step by step, so different kinds of health care providers can use them.

- Using flow-charts makes treatment prompt and more widely accessible.
- Flow-charts enable health care providers to include education and condom promotion in their treatment.

# QUESTIONS AND ACTIVITIES

## 2.1 QUESTION

How would you manage the treatment for genital ulcer syndrome? Tick the best option out of the list below:

Treat the patient for one cause only, and ask the patient to return if the sore doesn't get better, so you can then treat for the second cause.

Treat the patient for both conditions immediately.

Refer the patient for an etiological diagnosis.

## 2.2 ACTIVITY

### *Self-Study Project*

Below are some tips for your self-development as you continue to study.

1. Keep the flow-charts to hand at all times. If possible, place them on a desk or on a wall, where you can see them easily. A pocket version may be available.
2. Think about the benefits and challenges of implementing the syndromic approach for STD case management in your health centre. Discuss these points in the training session or arrange to discuss them with your supervisor.
3. If one of your colleagues is already using the syndromic approach, try to arrange to observe an STD examination. You might pick up valuable ideas that will make your own learning easier. Please remember that it is always best to ask the patient for his or her permission to observe the examination, and respect the patient's privacy at all times.

### **2.3 ACTIVITY**

When discussing syndromic diagnosis with others, we find that people tend to have similar concerns. Listed below are some of the comments we commonly hear. Please note down whether you agree or disagree with each one, and why.

'The syndromic approach isn't scientific.'

'Syndromic diagnosis is far too simple for a physician to use – it can even be used by nurses.'

'The syndromic approach fails to make use of a service provider's clinical skills and experience.'

'It would be better to treat the patient first for the most common cause and then, if the symptoms don't improve, treat for a second cause.'

'The syndromic approach results in a waste of drugs, because patients are being over-treated.'

'The syndromic approach promotes the development of antibiotic resistance.'

'Good, simple laboratory tests such as Gram stain should be included in STD diagnosis.'

# ANSWERS

## 2.1 QUESTION

Well done if you chose the second point, 'Treat the patient for both conditions immediately'. Clinically, it is not possible to distinguish the cause of a genital ulcer with any accuracy, so the safest option is prompt treatment for both causative agents, leaving the patient no longer infectious.

The first option presents problems typical of a clinical approach to diagnosis and treatment. If the patient is not cured by the first treatment, they may spread the infection. There is also a further risk that the patient might seek treatment elsewhere and be managed inadequately.

If you ticked the last option, 'Refer the patient for an etiological diagnosis', remember that we stressed the many problems that can arise from a delay in treatment — even when tests are available locally.

**STD Case Management—**  
*The Syndromic Approach*  
*for Primary Health Care Settings*

**MODULE 3**  

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**HISTORY-TAKING AND EXAMINATION**  
**FACILITATOR'S VERSION**

**TIME FRAME:** 2.5 hours

**SUPPLIES AND  
EQUIPMENT**

- Flip-chart and flip-chart
- Markers (ideally in two or three colours)
- Tape (for posting pieces of flip-chart paper on wall)
- Overhead projector and overhead set, or Flip-chart version of overheads
- Extra pens or pencils and paper for participants

## LEARNING OBJECTIVES FOR MODULE 3

KNOWLEDGE GAIN	SKILLS ACQUIRED
<ul style="list-style-type: none"> <li>• Identify the four areas of information to cover during the interview.</li> <li>• Recall the steps in conducting a clinical examination for men and women.</li> <li>• List both non-verbal and verbal communication skills.</li> <li>• Explain the value of using communication skills to gather information effectively, conduct a clinical examination and ensure patient compliance.</li> <li>• Describe the challenges of interviewing a patient with a suspected STD and the need to offer privacy and confidentiality.</li> <li>• Explain the importance of demonstrating your respect for each patient.</li> </ul>	<ul style="list-style-type: none"> <li>• Use the techniques, including several non-verbal skills, to establish rapport with a patient and begin a productive encounter.</li> <li>• Ask questions effectively, keeping them free of moral judgement, preserving confidentiality, and using clear words that patients understand.</li> <li>• Use verbal skills to respond to a patient's emotions appropriately.</li> <li>• Use open and closed questions appropriately and employ techniques to improve two-way communication with patients.</li> <li>• Conduct an efficient examination of both male and female patients.</li> <li>• Anticipate patients' anxiety and embarrassment, and acknowledge your own feelings.</li> </ul>

**The Syndromic Approach—  
STD Case Management  
for Primary Health Care Settings**

# MODULE 3

## HISTORY-TAKING AND EXAMINATION

This module focuses on two very important skills in syndromic diagnosis: history-taking and examination. This module will help you to refine your skills in communication and examination.

Even if you have a good deal of experience in interviewing patients, interviewing someone with symptoms of an STD can be difficult. Because these symptoms occur in the genital area and because patients must describe their sexual behaviour, embarrassment can make the encounter challenging. This training will help you to get all the information you need when taking a patient's history. It will also help you to carry out a physical examination.

It is important to recognize that history-taking and examination cannot be learned simply by studying. To reach an appropriate level of proficiency, you need to practise using your skills. The action plan at the end of the module suggests ways to build this experience. Practising these skills is the best way to gain the experience and confidence you need.

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# HISTORY-TAKING AND EXAMINATION

History-taking and examination are an important part of the syndromic approach because they lead to diagnosis and treatment, help you to assess the patient's risk of transmitting or contracting an STD in the future and help you find out about sexual partners who may also be infected and need treatment.

## The Aims of History-taking and Examination are to:

- Make an accurate and efficient syndromic STD diagnosis
- Define the patient's risk of transmitting or contracting STDs
- Find out about partners who may have been infected

---

*In order to use flow-charts effectively, you must be able to gather sufficient accurate information by refining your interviewing and examination skills.*

---

# EFFECTIVE FACE-TO-FACE COMMUNICATION

Communication skills are particularly important for health care providers who treat patients with STDs, as much of the information needed is sensitive or embarrassing and the patient may be ashamed to talk about it. Communication skills can be verbal or non-verbal, and are aimed at:

- establishing a rapport with the patient so that they feel comfortable talking about their problem; and
- obtaining as much relevant information as possible.

Good communication skills will help the patient to feel confident in the way you treat their problem.

Perhaps you have already thought about some of the difficulties involved with interviewing a patient with STD symptoms. Many people are already nervous about attending a health centre, these feeling can be even stronger for those who have symptoms in their genital area — for example, an ulcer or unusual discharge. How would you feel if you went to a health centre with such symptoms?

There are no right or wrong answers to this question. Some people will feel nervous, embarrassed, anxious, ashamed or even horrified. The strength of such feelings might depend on the patient's awareness of STDs or their beliefs about the cause of their symptoms, on their gender, age or social status, or even on whether or not they are familiar with the provider. The answers to this question could be as many and varied as the people who attend the health centre.

An important outcome of these anxious feelings is that people rarely present with the symptoms causing them the most concern. A patient with a genital ulcer or discharge will often complain of a headache or sore throat at first. Discovering the real symptoms depends on the skills, attitude and encouragement of the provider. The first step is to establish a good rapport with the patient. Once this is achieved, other verbal skills will help the provider to obtain all the information they need.

## **COMMUNICATION SKILLS FOR ESTABLISHING RAPPORT**

Communication skills for establishing rapport with patients are the first skills you will use when a patient comes to see you. They include:

- verbal skills — the way you talk to the patient and ask questions, and
- non-verbal skills — how you behave with the patient.

*While interacting  
with STD patients,  
the successful  
provider will be  
positive, friendly and  
able to empathize or  
see things from the  
patient's perspective.*

---

### *Swanti's Visit to Nurse Sukaro*

*Mrs. Sukaro is a nurse at the health centre in Swanti's home town. Nurse Sukaro has had a very busy morning and she is feeling very tired. She is still writing notes for the medical records and there is a records assistant standing nearby waiting for her to finish. Swanti enters the room. Nurse Sukaro glances briefly at Swanti and says "Just a moment". Swanti shuffles her feet while still standing and stares at the floor. When Nurse Sukaro finishes writing, she leans back in her chair, sighs and puts her hands on the desk. Then she looks up sharply at Swanti and asks: "What's your problem?"*

*Swanti stands still, looking at the ground and shuffling her feet nervously. The records assistant picks up her notes and leaves the room. Nurse Sukaro repeats her question impatiently.*

*"Well miss" responds Swanti, "I er... I haven't been feeling very well... er... it's my tummy, it's..."*

*"Goodness me! I haven't got all day!" says Nurse Sukaro. Swanti begins to cry.*

» *if you were Swanti, how would you feel?*

» *What is wrong with the way Nurse Sukaro behaves with Swanti?*

Nurse Sukaro's behaviour is likely to make anyone feel unimportant. But how each individual responds to Nurse Sukaro depends on their character. An assertive person might be angry with Nurse Sukaro, whereas a more shy person like Swanti might be scared. Given that Swanti already seems embarrassed by her symptoms, there's little likelihood of a successful interview.

So what did Nurse Sukaro do? Through open discussion, even more points than these may emerge:

- Nurse Sukaro doesn't greet the patient at all, or introduce herself.
- She barely looks at the patient for the first few minutes.
- She begins talking while someone else is still in the room.
- She speaks and behaves in an impatient, unfriendly manner.
- She shows no sympathy for the patient's embarrassment. Indeed, she becomes irritated towards the end of the conversation

*Swanti's visit to Nurse Sukaro.*

Facilitating question and discussion points:

## VERBAL SKILLS

### Verbal Skills

- Greet the patient
- Avoid common problems in verbal communication
- Ask 'open' and 'closed' questions effectively
- Prepare your response to patient emotions

## GREET THE PATIENT

The first step is to greet the patient in an appropriately friendly manner and introduce yourself. Some of the other ways you can make the patient welcome are described in the box below.

### How to Greet the Patient

- Use a welcoming tone of voice, smile.
- Introduce yourself.
- Offer the patient a seat.
- Make eye contact if culturally appropriate.
- Encourage the patient to talk by asking questions.
- Nod when the patient talks or say "mmm" or "tell me more".
- Be respectful and understanding.

How to continue to practise your skills:

Since non-verbal behaviour takes place all the time in daily life, you can readily develop or refine your interpersonal skills. Here are some suggestions:

- Often, non-verbal and verbal behaviour conflict, as when a colleague who looks tired or harassed tells you that he or she "is fine". Pay close attention to other people's non-verbal behaviour over the next few days. How often does it confirm what someone is saying? How often does it tell you something different about the person's feelings?

- Because non-verbal behaviour can be unconscious, we are not always aware of the messages that we are giving to other people. When you are talking to colleagues or friends, check your hands, facial expression and posture. What are they telling other people about your own feelings?

- With a group of peers, you can discuss how one can show feelings non-verbally. Think about showing tiredness, frustration, impatience, anger, joy or depression.

*Greeting the patient.*

### **COMMON PROBLEMS IN VERBAL COMMUNICATION**

There are several problems in verbal communication that occur often and that can make syndromic STD case management less effective. It is important to be aware of these problems so that you can avoid them as much as possible.

## How to Avoid Common Problems in Verbal Communication

- Always be polite.
- Use words that the patient can understand easily.
- Make your questions clear.
- Ask one question at a time.
- Avoid 'leading' questions.
- Avoid moral judgements.
- Ask the patient's permission to talk about sensitive topics.

When interviewing patients, always phrase your questions politely and be respectful. You should use words that the patient will understand easily. You will need to be careful using medical terms that may confuse the patient.

You should make your questions clear. This means the question should be specific enough so that the patient has a clear idea how to answer it. Another way to reduce confusion is to ask only one question at a time. Sometimes providers combine two questions into one because they feel rushed. This can be confusing if the patient misunderstands.

Another common problem is phrasing a question in such a way that it suggests a "right" answer. This is called a leading question and patients may answer in a certain way just because they want to agree with what they think is your view. Leading questions are sometimes hard to avoid but, wherever possible, you should let the patient's answers reveal their own views.

The wording of questions should ideally be free of moral judgements. If an STD patient feels you are judging them, they may become less responsive and you won't get all the information you need to treat them and their partners effectively. Educating for behaviour change may also be more difficult.

Finally, you should always ask the patient's permission to talk about sensitive topics. Asking questions about a medical history related to STD or about sexual behaviour can be very sensitive. Introducing your questions by asking permission helps patients to feel they can trust you with this very private information.



After completing Question 3.1 and Activity 3.2, we suggest you take about 20 minutes for an open discussion. For Activity 3.2, you might want to ask if these terms are acceptable for some people and not others. For example, if the provider is an older man and the patient is a young woman, the language may need to be different.

## ASKING OPEN AND CLOSED QUESTIONS

### Open and Closed Questions

- Open questions – patient can give a longer reply including the information he or she wants to include.

Examples:

“What is troubling you?”

“What kind of medicines are you taking at the moment?”

- Closed questions – patient answers in one word or a short phrase, often ‘yes’ or ‘no’.

Examples:

“Is the swelling painful?”

“Is your period late?”

“What is your age?”

Obtaining a patient’s medical and sexual history means you must gather accurate information in a short time. There are two approaches you can use, asking open questions and asking closed questions.

Open questions allow the patient to explain what is wrong or how they feel in their own words, and to tell you everything they think is important. Closed questions, on the other hand, ask the patient a more precise question that has a short answer, often yes or no, based on the words and ideas that the service provider has chosen to use.

#### *An interview using closed questions:*

*Patient: I have a pain in my tummy.*

*Provider: I'm sorry to hear that. Where is the pain?*

*Patient: Here.*

*Provider: Is the pain constant?*

*Patient: No.*

*Provider: Does it feel tender?*

*Patient: Yes.*

*Provider: When did the pain begin?*

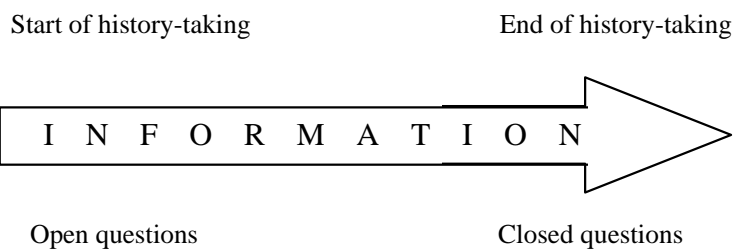
*Patient: Last week.*

***The same interview using open questions:***

*Patient: I have a pain in my tummy.  
Provider: I'm sorry to hear that. Tell me about this pain.  
Patient: Well, it started a week ago. At first I just felt tender down here, but sometimes it begins to hurt a lot. It hurts when I sit down or stand up — it isn't like my monthly pain at all.  
Provider: What else is troubling you?  
Patient: Well, there is one other thing. There's a funny kind of water that I don't usually get. It doesn't hurt but it's embarrassing.  
Provider: How are your periods?  
Patient: OK I think, I mean I'm regular, and they give me a little pain. But this is different.*

In the second example, the provider gathers more information by using open questions. Experts in interviewing STD patients also suggest that providers may need to ask “Anything else?” several times. This is because some patients are so embarrassed that they sometimes describe other unrelated symptoms, such as a headache, before they are comfortable enough to describe an STD-related symptom. Other patients are not sure which symptoms are related to STD and which are not. Giving them a chance to describe a range of complaints can frequently reveal useful information.

### **Gathering Information During History-taking**



How can you use the two types of questions? Patients often have trouble revealing information about their own sexuality, so open questions are helpful at the beginning to help patients feel more comfortable. Generally, you will gather much more information from an open question than from a closed one. There is also some danger of missing important information if you use closed questions early in the interview. Once you have used open questions to understand the patient's problem as he or she sees it, closed questions may be very helpful to draw out specific details that you need to know.



## NON-VERBAL SKILLS

Non-verbal skills include how you behave with the patient and the physical surroundings of where you interview the patient.

Non-Verbal Skills
<ul style="list-style-type: none"><li>● Provide the patient with privacy.</li><li>● Listen carefully to what the patient says.</li><li>● Sit if patient is sitting and watch how close you are to patient.</li></ul>

Facilitating questions and discussion point:

» *Consider your own working environment. To what extent can you interview patients in privacy?*

If participants think it will be difficult to provide somewhere private for the interview, encourage them to discuss this important issue with others in their health centre and with their supervisor.

» *What examples can participants share about observing non-verbal behaviour?*

» *Does anyone have a good example of non-verbal behaviour conflicting or confirming what someone says?*

## PROVIDE PRIVACY AND CONFIDENTIALITY

The key to effective non-verbal communication is to treat patients with respect. One of the principal ways this is done is by offering them privacy and confidentiality. Usually this means you make arrangements to use a quiet place for the interview, somewhere where you won't be disturbed. If it is not possible to interview patients inside an office, it can be helpful to use inexpensive barriers such as unattached walls, screens or curtains. You can also try to talk quietly while interviewing patients.



*Offering privacy and confidentiality in a typical primary health care clinic situation.*

### **LISTEN CAREFULLY TO THE PATIENT**

Patients are more responsive when providers show that they are listening. In many cultures, you can show your interest in what the patient is saying by leaning forward slightly towards him or her; you can also nod your head or comment occasionally to encourage them. Don't move about, write or interrupt while the patient is talking.

### **POSTURE**

It can be very helpful to match the patient's posture — sit if the patient is sitting and stand when the patient stands. You should think about how near you can be to a patient while still being sensitive to their privacy. Physical proximity between people varies from culture to culture. You should position yourself as close to the patient as is culturally acceptable. It is better for the health care provider to be next to a table or desk rather than behind one.

These points are simple and yet they can make the difference between gaining or losing a patient's trust or confidence.

## OTHER VERBAL COMMUNICATION SKILLS

### Six Useful Skills For Effective Verbal Communication

- Facilitating
- Directing
- Summarizing and checking
- Empathizing
- Reassuring
- Expressing partnership

Tip:

A good way to invite participants to discuss these skills is to ask if anyone can explain what each skill means. If participants cannot find the words to explain it, perhaps they can give an example from an experience they have had.

In addition to positive non-verbal behaviour and appropriate, respectful questioning, there are a number of additional skills which can be extremely useful when interviewing STD patients. They can help you to deal supportively with the patient's emotions as well as to gather information effectively.

Facilitating means using words, sounds or gestures to encourage patients to continue talking. Non-verbal facilitation includes nodding the head and raising the eyebrows as the patient is talking. The service provider can also use words, phrases or other sounds to encourage the patient to continue speaking.

#### *Spoken Facilitation*

*Patient: I'm not sure... it's embarrassing.*

*Provider: That's all right, I'm listening.*

*Patient: Well, it's that...*

*Provider: Yes?*

*Patient: There's this sore...*

Directing helps patients to sort out ideas and give information in a sequence. It is a useful approach when a patient is confused and doesn't know where to begin, or when they are talking quickly and mixing up issues that they are worried about. Direction is also a good way to allow patients to share their concerns and worries more easily.

### ***Direction***

*Patient: I don't know, it's been there for three weeks. What am I going to tell my husband? Will anyone have to know?*

*I mean, it is curable isn't it?*  
*Provider: Let's find out what the problem is first so we can deal with that. Then we can talk about your husband.*

Summarizing and checking allow you to verify that you have understood the patient correctly. To do this, you paraphrase what the patient has said, and ask if your summary is correct. Use this skill when the patient has mentioned a number of things that you want to confirm.

### ***Summarizing and Checking***

*Provider: (Summarizing) So you're worried what to say to your husband, and you feel very embarrassed about this condition. You want to know whether we can cure it.*

*(Checking) Have I got that right?*  
*Patient: That's right. What IS wrong with me?*

Showing empathy using words, sounds or gestures that show you understand is perhaps the most important skill of all when dealing with the patient's feelings. If you notice that a patient is tense or anxious, for example, you can express your empathy by commenting on what you have noticed. By showing empathy, you allow the patient to express his or her fears, and establish more open communication between the two of you. Like facilitation, it also encourages the patient to continue speaking.

### ***Empathy***

*Provider: I can see that this is worrying you a good deal.*

*Patient: Yes, it's been bothering me for over a week now. I'm worried sick.*

Reassurance is a useful way to show that you accept the patient's feelings and that the problem need not last forever. You indicate with words, sounds or gestures that the patient's anxiety can be addressed.

### *Reassurance*

*Provider: I can understand that you feel worried about symptoms like these. As soon as I find out what's wrong, we can try to begin treatment that will make you better.*

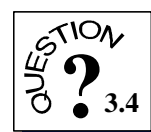
*Patient: That's good. So what else do you need to know?*

Expressing partnership confirms a commitment to help the patient. This commitment could be with the provider personally, as in the example below, or with the team of people in the health centre.

### *Partnership*

*Provider: You've done the right thing to come here for treatment. Before you leave I'll make quite sure you have all the information you need to prevent further infection. And we'll also talk about the best way to discuss this with your husband.*

*Patient: Oh thank you. I don't want this to happen again.*



Most experienced providers use one or more of these interviewing skills some of the time. The key to interviewing patients who may have an STD is to use all six skills most of the time. Question 3.4 will help you familiarize yourself with each of these skills.

## **GATHERING STD INFORMATION**

Improving your ability to collect patient history information is helpful because:

- it helps you to make a syndromic diagnosis of STD which is accurate and efficient, given the time you have available; and
- this information is also the starting point for partner referral and treatment, and for understanding the patient's behavioural risks of transmitting or contracting STDs in the future.

## The Information You Need

- General details about the patient
- Description of present illness
- Medical history
- Sexual history

In this section, we discuss the kind of information you will need to obtain as part of a patient's history. We hope that you will use the communication skills covered in the previous section as you gather this information. We will attempt to illustrate how these communication skills are an indispensable part of history-taking.

You can use the guide below to remember the types of questions to ask under each of these topics. The reasons for asking some of these questions will be clearer after you have studied Module 4, where the syndromic flow-charts are described in detail. For example a list of suggested questions for making a risk assessment are included there.

The history-taking guide can be adjusted to include other information that you consider to be valuable. For example, in some settings it may also be important to know whether or not male patients are circumcised or how many pregnancies female patients have had to be able to identify abortion or miscarriage.

Tip:

Instead of reading through all of the questions on the next page together with participants, another option is to give participants three to five minutes to read them on their own. Then ask participants if they have any questions or if there were any questions that surprised them.

# Guide for History-Taking

## General details

Age  
Number of children  
Locality or address  
Employment

## Present illness

Presenting complaints and duration

*For men only:*

If a urethral discharge — Pain while passing urine? Frequency?  
If scrotal swelling — History of trauma?

*For women only:*

If a vaginal discharge — Pain while passing urine? Frequency?  
Risk assessment positive (see note below)?  
Lower abdominal pain — Vaginal bleeding or discharge?  
Painful or difficult pregnancy or childbirth? Painful or difficult  
or irregular menstruation? Missed or overdue period?

*For men and women:*

If a genital ulcer — Is it painful? Recurrent? Appearance?  
Spontaneous onset?  
Other symptoms, such as itching or discomfort

## Medical history

Any past STD — Type? Dates? Any treatment and response?  
Results of any prior tests?  
Other illness — Type? Dates? Any treatment and response?  
Results of tests?  
Medications  
Drug allergies

## Sexual history

Currently active sexually?  
New sex partner in the last three months?  
Risk assessment (see note below)

**Note:** Risk assessment is a specific set of questions to ask female patients who complain of vaginal discharge. It is included in the flow-chart to help providers decide where the infection is localized. Risk assessment will be discussed in greater detail in Module 4.

## HOW TO ASK QUESTIONS

Next, you need to consider how you will ask questions to obtain this information. It would be easy to convert the information on the previous page into closed questions but that means asking a lot of questions, as shown in the case-study below. On the other hand, this same case-study also includes examples of how one or two open questions might encourage the patient to provide most of the information you need.

### *Taking a sexual history*

- Provider: I need to ask you a few very personal questions now ... about your sexuality. I know this is difficult to talk about, but I assure you no-one else will know.*
- Patient: Why does information about my sexuality matter to you?*
- Provider: That's a good question. It's partly to help me make sure I'm giving you the right treatment, and partly to help us know how many people might have the same infection. Is that OK?*
- Patient: ... Yes ... all right.*
- Provider: Have you been sexually active over the last 3 months or so?*
- Patient: Well, yes, I suppose so.*
- Provider: Tell me about that.*
- Patient: What do you want to know?*
- Provider: Oh, how often, who with, that sort of thing.*
- Patient: Well... I've got two boyfriends ... Well, there's another friend who I sleep with sometimes but he's usually away...*
- Provider: When did you last sleep with the friend who's away a lot?*
- Patient: I can't remember ... sometimes last month I suppose.*
- Provider: And what about your other boyfriends?*
- Patient: Well, Ro is my proper boyfriend. We spent the night together two nights ago ... well, we often do ...*
- Provider: What about your other boyfriend?*
- Patient: Well ... Ro doesn't know about the others.*
- Provider: That's all right. I promise he needn't know ... you're being very brave about all this.*
- Patient: Well .. I see him every Tuesday. Usually ... but I didn't see him last Tuesday because I was with my parents then.*
- Provider: Do you know if any of your boyfriends has a discharge at the moment?*
- Patient: No ... I mean I'm not sure, I don't know.*
- Provider: That's OK. Any other boyfriends in the last 3 months?*
- Patients: No.*
- Provider: That's fine. You've done very well, so now I can tell you what this discharge is ...*



## THE CLINICAL EXAMINATION

The purpose of a clinical examination is to confirm any STD symptoms the patient has described by checking for signs of STDs. This section explains what to do when examining male and female patients.

Examining the most private parts of a person's body requires tact, sensitivity and respect on the part of the provider. Patients may be embarrassed or uncomfortable. In this section, we summarize the steps for conducting a clinical examination in an efficient and professional manner. We suggest some ways to help the patient understand the importance of the examination and overcome his or her embarrassment. In this way, you can provide some reassurance to the patient.

### Some Features of a Clinical Examination

- Behave professionally before and during the examination.
- Conduct an efficient examination.
- Reassure the patient.

---

*This section focuses on examination for four STD syndromes.*

*It does not take account of STD such as scabies or lice — treatment of these should be routine.*

---

Facilitating questions and discussion points:

» *What resources do you think are needed to conduct an examination?*

To conduct an examination, you need:

- a well-lit, private room;
- an examination table for the patient to lie on for the examination, and a chair; and
- time! This may also limit the extent of the physical examination. Managing an STD patient can take anything from 5 to 15 minutes.

» *What fears do people have about being examined?*

Most patients will feel very shy about showing their genitals to another person, especially a member of the opposite sex. Some people may also feel ashamed of their symptoms, even though anxiety about the symptoms has brought them to the clinic.

» *What must you do in order to reassure all patients before an examination starts?*

Before examination it is important to reassure patients by telling them that you will ensure their privacy and confidentiality.

## PROFESSIONAL BEHAVIOUR

### Professional Behaviour During a Clinical Examination

- Ensure privacy at all times.
- Explain what you are going to do, and why it is important.
- Approach the examination in a confident way, never showing uncertainty or embarrassment.
- Never be rough or conduct an examination against someone's will.
- Use all the communication skills covered in this Module.

Patients may be shy and even reluctant to have their genitals examined. This can be especially true for women. To try to overcome this, professional behaviour for providers starts with assuring some degree of privacy during the examination. You should then explain what will happen during the examination and why it is important.

You should also give the impression that you are confident and capable yet still sensitive to the patient's needs and worries. Ideally, patients will also be able to choose to be examined by a provider of the same gender. Some providers may be embarrassed or worried about the examination themselves, particularly when they are first learning this procedure. It is important to avoid showing patients any feelings of uncertainty or embarrassment because this can also interfere with the process of obtaining information.

Unfortunately, sometimes providers are rough during an examination because they feel rushed to finish. This is counter-productive because it interferes with building a good relationship with the patient, which is important for STD case management. Even though an examination is important in order to arrive at a diagnosis, we must never force someone to be examined.

Finally, professional conduct means you are able to use the communication skills covered in this module to maintain a productive two-way conversation with patients.

## Steps for Examining Male Patients for STD Syndromes

1. Ask the patient to stand up and lower his pants 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 patient lies down.
2. Palpate the inguinal region feeling for the presence or absence of enlarged lymph nodes.
3. Palpate the scrotum, feeling for individual parts of the anatomy:
  - *testes*
  - *spermatic cord*
  - *epididymis*
4. Examine the penis, noting any rashes or sores. Then ask the patient to retract the foreskin if present, and look at the:
  - *glans penis*
  - *urethral meatus*
5. If you cannot see an obvious urethral discharge, ask the patient to milk the urethra in order to express any discharge
6. Record the presence or absence of:
  - *ulcers*
  - *urethral discharge, noting the colour and amount*

Facilitating question and discussion points:

» *A male patient is reluctant to be examined by a female service provider. What can you do or say to persuade this patient to agree to be examined?*

When a male patient is being examined by a woman, you can often have a male member of staff present in the room while you examine. If this does not work or is clearly not culturally acceptable, your only alternative is for a male provider conduct the examination.

*Male genitalia*

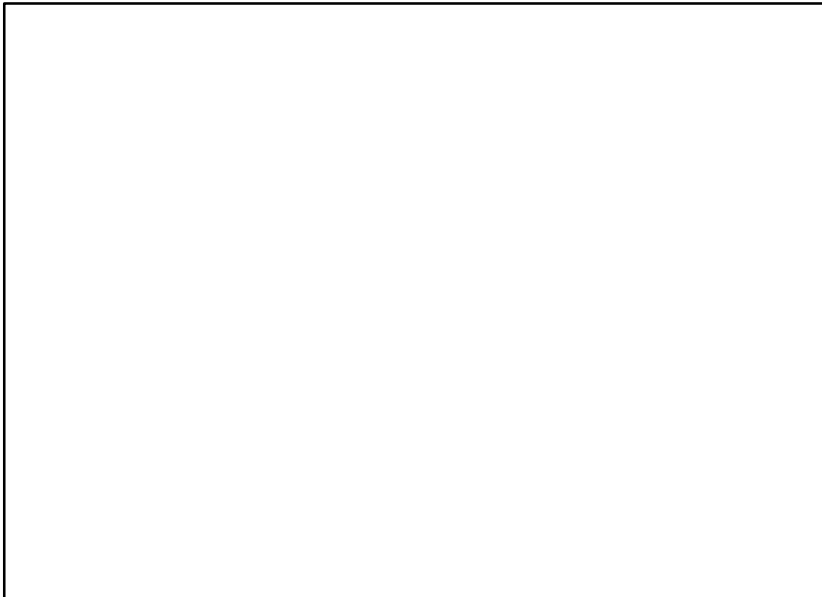
## Steps for Examining Female Patients for STD Syndromes

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

NOTE: Gloves are required only if you wish to conduct a vaginal or bimanual examination.



*Female genitalia #1*



*Female genitalia #2*

---

**IMPORTANT!**

***Syndromic diagnosis of STD in women requires inspection of the external genitals only, so gloves are not essential.***

---

Facilitating questions and discussion points:

» *A patient of the same gender as the service provider refuses to be examined, saying that he or she has clearly explained what is wrong already. What can you do or say to persuade the patient to agree to be examined?*

Remember that you cannot force any person to be examined. In this situation, both provider and patient are the same sex and we suggest that you:

- explain why you want to do the examination — to check his/her condition to make sure you give the right treatment; and
- emphasize that the examination will be brief and not painful.

» *A young woman is afraid to say anything, but communicates non-verbally that she is unhappy about being examined. What can you do or say to persuade this patient to agree to be examined?*

Whenever a female patient is being examined by a male provider, it is a good idea that someone else (a friend or female health care worker) is present. This will almost certainly make the situation more comfortable for the woman.

## **REVIEW**

## **HISTORY-TAKING AND EXAMINATION**

The aims of history-taking and examination are to:

- make an accurate and efficient syndromic STD diagnosis;
- define the patient's risk of transmitting or contracting STDs; and
- find out about partners who may have been infected.

## **EFFECTIVE FACE-TO-FACE COMMUNICATION**

Communication skills for establishing rapport include:

- verbal skills — the way we talk to the patient and ask questions; and
- non-verbal skills — how we behave when with patients.

Verbal skills include:

- always be polite;
- use words that the patient can understand easily;
- make your questions clear;
- ask one question at a time;
- avoid leading questions;
- avoid moral judgements; and
- ask the patient's permission to talk about sensitive topics.

The four non-verbal skills that help establish rapport are to:

- greet the patient;
- provide the patient with privacy;
- listen carefully to what the patient says; and
- sit if the patient is sitting and watch how close you are to the patient.

Questions can be open or closed. Use both kinds of question to obtain as much information as possible. It is better to start with open questions, then use closed questions to find out specific details.

Other verbal skills describe the way the health care provider talks to the patient, and include:

- facilitating;
- directing;
- summarizing and checking;
- empathizing;
- reassuring; and
- expressing partnership.

## **GATHERING INFORMATION FOR SYNDROMIC DIAGNOSIS OF STD**

### **HISTORY-TAKING**

It is important for syndromic diagnosis of STD to obtain as much information as possible.

Using a guide ensures that all the information needed is obtained.

History-taking is also important because it helps the health care provider to:

- assess the patient's risk of becoming infected again;
- find out about sexual partners who may need to be treated as well; and
- offer education about prevention of STDs, including condom promotion.

### **THE CLINICAL EXAMINATION**

Health care providers should behave professionally during a clinical examination by:

- ensuring privacy at all times;
- explaining what they are going to do, and why it is important;

- approaching the examination in a confident way, never showing uncertainty or embarrassment;
- never being rough or conducting an examination against someone's will; and
- using all the communication skills covered in this Module.

Following a check-list for clinical examinations will ensure that all the necessary information for syndromic diagnosis of STD is obtained.



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*Please take advantage of any opportunities you have to practise the skills you have learned in this module. The action plan on pages 34 to 36 will help you to do this.*

---

## QUESTIONS AND ACTIVITIES

### 3.1 QUESTION

There is something wrong with each of the six questions below. Consider how you would feel answering each one, and then note how you think it could be improved.

[At the start of the interview] "Name?"

"Tell me your medical history."

"How many sexual partners have you had, when and who are they?"

"Have you had sex with people other than your husband?"

"The symptoms only recur during your periods, don't they?"

"Are your menses normal?"

### 3.2 ACTIVITY

List down as many local language or popular terms you can think of for the following biomedical terms. Think about not just the term for the condition but also about other words or phrases that people can use to describe how it looks, feels, or smells.

Biomedical term	Local Language Term(s)
Vaginal discharge in women	
Urethral discharge in men	
Pain on urination	
Vaginal irritation	
Lower abdominal pain in women	
Pain on sexual intercourse	
Itching in the genital area	
Genital ulcers or open sores	
Failure to pass urine	
Gland swelling or buboes in the genital area	
Pain and swelling of the testicles	
[to a man] Will you please milk your urethra?	
[to a woman] Will you please spread your labia with your fingers?	

Questions for consideration:

Look at the list of local language terms that you wrote down in the activity above. Do you think you can use any local language terms in your practice? Why or why not?

Consider the words people use to describe different types of sexual activity, casual sex and sex workers.

### 3.3 QUESTION

If you are learning about open and closed questions for the first time, the questions that follow will help you to check your understanding of them.

- a) Please tick the box to indicate whether the question is OPEN or CLOSED.

	Open	Closed
Do you have a discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Are you married?	<input type="checkbox"/>	<input type="checkbox"/>
What is troubling you?	<input type="checkbox"/>	<input type="checkbox"/>
Is it painful?	<input type="checkbox"/>	<input type="checkbox"/>
Did you use a condom last time you had sex?	<input type="checkbox"/>	<input type="checkbox"/>
Is the discharge milky or clear?	<input type="checkbox"/>	<input type="checkbox"/>
What does the pain feel like?	<input type="checkbox"/>	<input type="checkbox"/>
Tell me about your periods.	<input type="checkbox"/>	<input type="checkbox"/>

b) Below are four statements. Tick the appropriate box to indicate which are TRUE and which are FALSE.

	True	False
Closed questions are very useful at the start of an interview.	<input type="checkbox"/>	<input type="checkbox"/>
Open questions enable the patient to respond with his or her own words and ideas – helping the service provider to better understand the patient.	<input type="checkbox"/>	<input type="checkbox"/>
A good medical interview starts with open questions and moves towards closed questions.	<input type="checkbox"/>	<input type="checkbox"/>
Closed questions enable you to rule out specific symptoms.	<input type="checkbox"/>	<input type="checkbox"/>

c) What kind of open question might be worth asking the patient several times, and why?

### 3.4 QUESTION

Please try to identify the different communication skills that the provider uses in the case-study below. Underline each example you find, and say which skill it is in the column on the right. The first one is underlined and identified for you.

<p>Nurse Singh: <u>Good morning. Please sit down... I am Nurse Singh and <u>you are?</u></u></p>	open question and facilitation
<p>Ramsa: <u>Al Ramsa.</u></p>	
<p>Nurse Singh: <u>How can I help you Mr Ramsa?</u></p>	
<p>Ramsa: <u>Well, I cut my arm yesterday while I was pulling out an old tree stump. Look, the cut's quite deep.</u></p>	
<p>Nurse Singh: <u>Oh, it's not too bad, but you did the right thing to come and get it cleaned up, Mr Ramsa. I can clean and dress it for you easily... Have you travelled a long way to take care of this arm?</u></p>	
<p>Ramsa: <u>Oh, I live 5 miles away, near Centerville</u></p>	
<p>Nurse Singh: <u>Fine. [Cleans and dresses the wound] Now, is there anything else bothering you Mr. Ramsa?</u></p>	
<p>Ramsa: <u>Well... there is something else [he laughs nervously].</u></p>	
<p>Nurse Singh: <u>I can see you feel a little embarrassed about this...</u></p>	
<p>Ramsa: <u>Yes I do... you see, it's my [leans forward and whispers]... it's my penis.</u></p>	
<p>Nurse Singh: <u>Yes?</u></p>	
<p>Ramsa: <u>Well, there's a... there's a sort of... sore on it.</u></p>	
<p>Nurse Singh: <u>And you're worried about this sore.</u></p>	
<p>Ramsa: <u>Yes I am. You see, I didn't cut myself or anything. It doesn't hurt but it doesn't look good. It's worrying me. I mean, one of my girlfriends said it's... well, it's a bad thing and she wouldn't go with me... I think it might have come from a bar girl, or maybe even one of my girlfriends.</u></p>	
<p>Nurse Singh: <u>Tell me about this sore.</u></p>	
<p>Ramsa: <u>What's to tell? It doesn't hurt... (shrugs).</u></p>	
<p>Nurse Singh: <u>How long have you had it?</u></p>	
<p>Ramsa: <u>Oh, a month or so I suppose. My uncle says it's nothing to worry about but I think it's from a woman... if I find out which one...</u></p>	
<p>Nurse Singh: <u>You're clearly anxious about where you got this sore, Mr. Ramsa, but I think we need to decide what it is first. I think we'll also need to talk about how to avoid it in the future... But first I'll need to examine the sore... [Patient looks surprised] I know this can be embarrassing but I need to do that in order to decide what's wrong. Is that all right with you?</u></p>	
<p>Ramsa: <u>Yes, I suppose so [reluctantly].</u></p>	
<p>Nurse Singh: <u>Before I can give you any treatment I must be sure...</u></p>	
<p>Ramsa: <u>It's going to be OK isn't it?</u></p>	
<p>Nurse Singh: <u>Oh yes, and I know we can help you to cure it. You need to prevent it happening again, but I'll tell you everything you need to know and help you decide what you're going to do about it. Is that OK?</u></p>	
<p>Ramsa: <u>Oh yes. .</u></p>	

## 3.5 ACTIVITY

### *Role-play Exercise for History-taking*

*The aims of this exercise are to:*

- *Practise communication skills for interviewing patients, so that you can interview real STD patients with more confidence*
- *Practise gathering the suggested relevant information listed on page 15*
- *Become more aware of your strengths in communication, and have a clear idea of any areas you want to improve*

The only way to refine your communication skills is to practise them, so this activity is a very important one.

The idea is that one person plays the role of an STD patient, while a second person plays the role of a provider. A third person observes the interaction and provides feedback to the provider. You can rotate the roles so that everyone has the chance to take on all three roles.

### ***The Patient's Role***

Your role is to take the part of an STD patient who is attending a health facility for treatment. Please decide who you are and what your character is. Spend some time answering the questions below to help define your character. Don't let your interviewer see these notes! Play the role of the patient as realistically as you can and respond honestly to your interviewer. Do not try to make it easy or difficult for the interviewer.

## Patient Characteristics

*What is your name?*

*Your gender and age?*

*Describe your personality: outgoing or shy, etc.*

*Describe your beliefs, religion, education, occupation.*

*What symptoms do you have? Anything else?*

*How many sexual partners do you have?*

*If you have just one sexual partner, do you know whether he/she has any other sexual partners?*

*How do you feel about the health facility you are visiting?*

*How do you feel about your symptoms, and about discussing them with someone else?*

After the role-play, you will be asked to give the interviewer feedback on how well he or she did. Here are some questions you can think about for this discussion:

- Concentrate especially on how you felt as the patient: did the interviewer make you feel comfortable, or put you at ease? How did he or she do this?
- Did your interviewer find out all the information about your character that you had written down?
- What questioning techniques did you respond to positively? Were there any techniques that you responded to negatively and why do you think this happened?

### **The Provider's Role**

The role-play should last about five minutes. During the exercise, be yourself. Try to use all the verbal and non-verbal skills explored in the module, while remaining aware of the patient's feelings and responding to these emotions. Try also to obtain as much appropriate information about the patient as you can in the time allotted.

While the 'patient' is working on defining his or her character, you can look over the checklist on the next page (the observer's role) to see the skills you are expected to practise.

During the interview, you might find it helpful to have your module open at page 15 as a reference. You may also have other reference tools available to use (e.g. the quick reference guide).

After the interview, you will receive feedback first from the patient and then from the observer. The observer will concentrate on your skills as listed on his or her check-list, while the patient will describe how he or she felt during the interview. He or she will also tell you if you missed anything important about him or her. After your interview, you can also think about and discuss what you would do differently the next time to help you conduct a more effective interview.

You may want to describe your experience related to one or more of the following issues:

- difficulties communicating with a patient of a different gender;
- discomfort with certain types of questions; and
- difficulties communicating with someone younger or older than you.

### ***The Observer's Role***

The observer's role is very important because you are going to give the 'interviewer' objective feedback on the skills they have demonstrated during the role-play. As you observe, use the check-list on the next page to make notes on what the interviewer does.

In giving feedback to the interviewer, try to be as objective and helpful as you can. Be clear about what he or she has done well, and explain why. Also, be willing to criticize the interviewer, but in a positive way; it is most useful to highlight the skills the interviewer may need to practise or refine further.

## OBSERVATION CHECK-LIST FOR ACTIVITY 3.5

Does the Interviewer...	Use this side for your notes
<i>Treat the patient with respect?</i>	
<i>Show he/she is listening by using appropriate non-verbal communication?</i>	
<i>Obtain the patient's permission to ask awkward, embarrassing questions?</i>	
<i>Deal effectively with the patient's emotions?</i>	
<i>Use mainly open questions, limiting the number of closed questions?</i>	
<p><i>Use any or all of the six verbal skills effectively?</i></p> <ul style="list-style-type: none"> <li>• Facilitation</li> <li>• Direction</li> <li>• Summarizing and checking</li> <li>• Empathy</li> <li>• Reassurance</li> <li>• Partnership</li> </ul>	
<p><i>Ask questions relating to the four areas of information required?</i></p> <ul style="list-style-type: none"> <li>• General details</li> <li>• Present illness</li> <li>• Medical history</li> <li>• Sexual history</li> </ul>	

### 3.6 ACTIVITY

#### **ACTION PLAN FOR HISTORY-TAKING AND EXAMINATION**

Role-plays are an effective way of practising skills when you are studying this material with a group. The others in your group will ideally be able to observe you practising these skills and have an opportunity to give you immediate feedback. This will help you to detect strengths and weaknesses in your approach. This action plan is an important way for you to start practising these skills.

First, please do the following activities. We suggest that you discuss these issues with your supervisor, co-workers or colleagues.

1. If you have already examined patients with STD, please list any problems that you had in the left-hand column below. Then, in the right-hand column, note how you overcame the problem, or how you could overcome it in the future. If you have never examined a patient for STD, what problems do you foresee (left column), and how might you overcome them (right column)?

<b>Problem</b>	<b>How overcome</b>

2. Discuss the facilities at your health centre: to what extent is it possible to offer STD patients privacy and confidentiality? If necessary, what can you do to improve this situation?

The only way you can master the skills we cover in this module is by practising them. The following activity you can do on your own over the next few weeks.

3. Practise history-taking and examination on actual patients. We suggest that you take notes on at least six history-taking encounters and six examinations. The form on the following page is intended to help you record your experience in a systematic fashion so that you can review it yourself or with your supervisor, a co-worker or colleague/trainer afterwards. The goal of this activity is for you to become confident in your interviewing and examination skills, so that your interaction with patients is more efficient and useful.

## ACTION PLAN RECORD OF HISTORY-TAKING AND EXAMINATION

Name of clinic: _____  Name of provider: _____	
	Use this column for your notes on <u>problems or successes</u> (in terms of diagnostic and communication skills)
<b>History taken on (date):</b>	
1.  2.  3.  4.  5.  6.	
<b>Examination carried out on (date):</b>	
1.  2.  3.  4.  5.  6.	

## ANSWERS

### 3.1 QUESTION

Don't worry if you found this activity difficult, especially if you have not had any previous training in interviewing. We wanted to raise these points:

***At the start of the interview: "Name?"***

This is not a friendly way to begin the interview. We should always be polite: "What is your name?" or "Tell me your name please". And why not introduce yourself to the client?

***"Tell me your medical history."***

This question is too vague. The patient does not know where to begin. They probably don't realize what a medical history is or what aspects of their history you want to know about. This question needs to be more precise.

***"How many sexual partners have you had, when, and who are they?"***

This is a difficult question to ask in most situations. However, in this case it is very problematic because there are really three separate questions. Ask only one question at a time. Alternatively, ask an open question first, for example "Can you tell me a bit about your sexual partner?" followed by "What about any others you have been with?" and see if the patient includes more of the details you need this way. Another tip: when you start asking deeply personal questions, begin by asking the patient's permission. Acknowledge that the question may be hard to answer—the patient will feel you understand his or her feelings better.

***"Have you had sex with people other than your husband?"***

This question suggests a moral judgement on the part of the service provider. We need to make our questions free of such judgements whenever possible.

***"The symptoms only recur during your periods, don't they?"***

This question puts words in the patient's mouth. This is known as a 'leading' question and questions like this should be avoided. "When do you get this problem?" or "What makes the problem worse?" would be better.

***"Are your menses normal?"***

The tip here is to avoid using medical expressions that the patient might not know or might misinterpret. The patient might think of normal menses quite differently to the provider. Better to ask the patient what is troubling them or how you can help them.

### 3.3 QUESTION

- a) If you remember that closed questions can be answered in one short phrase or with 'yes' and 'no', then this question should be easy. There are only three open questions:

Open    Closed

Do you have a discharge?

Are you married?

What is troubling you?

Is it painful?

Did you use a condom last time you had sex?

Is the discharge milky or clear?

What does the pain feel like?

Tell me about your periods.

- b) Below each true or false statement is followed by a brief explanation:

***Closed questions are very useful at the start of the interview.***

***FALSE***

Although closed questions require a specific answer, it is not true that they are useful at the start of the interview. On the contrary, you should avoid them, especially early in the interview.

***Open questions enable the patient to respond with their own words and ideas, and give the service provider a good understanding of their perceptions.***

***TRUE***

This is one of the benefits of using open questions at the start of the interview. They enable you to gather information quickly and efficiently, to collect important information you might otherwise have missed, and to learn about the patient's perceptions, concerns and language — all of which will be important later if you need to educate the patient about STDs.

***A good medical interview starts with open questions and moves towards closed questions.***

***TRUE***

Remember the interview process and the benefits of open questions that we described on page 7 to 9? The value of closed questions lies in checking or obtaining specific details later in the interview.

**Closed questions enable you to rule out specific symptoms.**

**TRUE**

By asking closed questions you can rule out specific symptoms — but remember to start with open questions at the beginning of the interview.

- c) Don't worry if you forgot this one. We were thinking of asking the patient a question like “Is anything more troubling you?” The reason why such questions are useful is that they allow the patient who feels nervous or anxious to work towards their main and most private concerns in their own way. Remember that many patients with STD symptoms will feel so embarrassed by them that they will feel reluctant to admit to such symptoms until you have demonstrated your willingness to listen and treat them with respect.

### 3.4 QUESTION

Below we have marked the passage and indicated the main skills that Nurse Singh is using. Please discuss your findings with a colleague or tutor if you are not sure about anything in this exercise. You might also like to discuss anything else that Nurse Singh could have said or done for this patient.

Nurse Singh: <i>Good morning. Please sit down... My name's Nurse Singh. <u>You are?</u></i>	Open question Facilitation
Ramsa: <i>Mr Ramsa.</i>	
Nurse Singh: <i><u>How can I help you Mr Ramsa?</u></i>	Open question
Ramsa: <i>Well, I cut my arm yesterday while I was pulling out an old tree stump. Look, the cut's quite deep.</i>	
Nurse Singh: <i><u>Oh, it's not too bad, but you did the right thing to come and get it cleaned up. Mr Ramsa. I can clean and dress it for you easily... Have you come far to have this dressed?</u></i>	Reassurance
Ramsa: <i>Oh, I live 5 miles away, near Centerville..</i>	
Nurse Singh: <i>Fine. <u>Now, is there anything else bothering you Mr Ramsa?</u></i>	Open Facilitation
Ramsa: <i>Well... there is something else.</i>	
Nurse Singh: <i><u>I can see you feel a little embarrassed about this...</u></i>	Empathy
Ramsa: <i>Yes I do... you see, it's my [leans forward and whispers]... it's my penis.</i>	
Nurse Singh: <i><u>Yes?</u></i>	Facilitation
Ramsa: <i>Well, there's a... there's a sort of... sore on it.</i>	
Nurse Singh: <i><u>And you're worried about this sore.</u></i>	Empathy/ Checking

Ramsa:	<i>Yes I am. You see, I didn't cut myself or anything. It doesn't hurt but it doesn't look good. It's worrying me. I mean, one of my girlfriends said it's... well, it's a bad thing and she wouldn't go with me... I think it might have come from a bar girl, or maybe even one of my girlfriends.</i>	
Nurse Singh:	<u>Tell me about this sore.</u>	Open question/ direction
Ramsa:	<i>What's to tell? It doesn't hurt...</i>	
Nurse Singh:	<u>How long have you had it?</u>	Closed, used to facilitate
Ramsa:	<i>Oh, a month or so I suppose. My uncle says it's nothing to worry about but I think it's from a woman... if I find out which one...</i>	
Nurse Singh:	<u>You're clearly anxious about where you got this sore, Mr. Ramsa, but I think we need to decide what it is first. I think we'll also need to talk about how to prevent it happening again... But first I'll need to examine the sore... [Patient looks surprised] I know this can be embarrassing but I need to do that in order to decide what's wrong. Is that all right with you?</u>	Direction  Reassurance/ checking
Ramsa:	<i>Yes, I suppose so (reluctantly).</i>	
Nurse Singh:	<u>Before I can give you any treatment I must be sure...</u>	Partnership
Ramsa:	<i>It's going to be OK isn't it?</i>	
Nurse Singh:	<u>Oh yes, and I know we can help you to cure it. You need to prevent it happening again, but I'll tell you everything you need to know and help you decide what you're going to do about it. Is that OK?</u>	Reassurance/ partnership checking
Ramsa:	<i>Oh yes.</i>	

**STD Case Management —**  
*The Syndromic Approach*  
*for Primary Health Care Settings*

**MODULE 4**  
**DIAGNOSIS AND TREATMENT**  
**FACILITATOR'S VERSION**

**TIME FRAME**      2.5 hours

**SUPPLIES AND**  
**EQUIPMENT**

- Flip-chart and flip-chart paper
- Markers (ideally in two or three colours)
- Tape (for posting pieces of flip-chart paper on wall)
- Overhead projector and overhead set, or Flip-chart version of overheads
- Extra pens or pencils and paper for participants

## LEARNING OBJECTIVES FOR MODULE 4

KNOWLEDGE GAIN	SKILLS ACQUIRED
<ul style="list-style-type: none"><li>• Remember and name the decisions and actions that constitute the four flow-charts to diagnose STD accurately.</li><li>• List the drug therapies and dosages for each diagnosis.</li><li>• Identify which drugs are recommended compared with those you have available in your health centre.</li><li>• Explain that patient education on a number of important issues and partner referral are a part of all the flow-charts.</li></ul>	<ul style="list-style-type: none"><li>• Use the four flow-charts to make a clinical diagnosis for a variety of case studies.</li><li>• Give the correct drug therapies and dosages for each diagnosis.</li></ul>

**STD Case Management —**  
*The Syndromic Approach*  
*for Primary Health Care Settings*

**MODULE 4**  
**DIAGNOSIS AND TREATMENT**

**T**his module provides you with a practical, step-by-step orientation to four different syndromic flow-charts.

For each flow-chart, a series of decisions and actions are described. A list of all the preferred drugs for each syndrome and WHO recommended doses is also included. Whenever possible, alternative drug therapies are suggested for situations where preferred drugs are unavailable or ineffective. Together with the facilitator for this course, you should select the most appropriate treatments for your setting and mark it by ticking the appropriate boxes in the drug choice list for each syndrome.

You will find this module easier if you have first studied Module 2, Using Flow-Charts for Syndromic Management, and Module 3, History-Taking and Examination. These two modules provide a broad overview of the techniques and skills you will use for syndromic case management.

**CONTENTS**

How to Use the Flow-Charts	2
Urethral Discharge Syndrome	4
Genital Ulcer Syndrome	7
Vaginal Discharge Syndrome	10
Lower Abdominal Pain Syndrome	15
Review	20
Questions and Activities	21
Answers	28



*A young woman sees health education posters related to STDs while waiting to be examined.*



## HOW TO USE THE FLOW-CHARTS

As you already know from Module 2, there is an entry point box at the top of each flow-chart, describing the complaint expressed by the patient. The entry point, in other words, is an STD-related symptom.

You should be able to pick the appropriate flow-chart as soon as the patient finishes describing their symptoms. As you move through the flow-chart, you will need to collect more information in order to make a diagnosis. This information is gained from history-taking and examination as described in Module 3, and may be different for each flow-chart.

At or near the end of each flow-chart, there are boxes indicating an appropriate action. There are boxes that include a diagnosis and will suggest that you choose treatment for one or more causes of the particular syndrome. When choosing treatment, you may need to consider alternative therapies for pregnant or lactating women. There may be other boxes that indicate you should be using a different flow-chart. There may be still other boxes that suggest the case be referred to address complications or that indicate the patient needs to return for a follow-up examination.

Specific drugs are not listed in the flow-charts because, in most cases, there are several drugs to choose from depending on patient characteristics and on the effectiveness and local cost of the drug. For each diagnosis included in the flow-charts, we have included a list of drugs that are recommended by WHO. National recommendations may differ from these recommendations, so please tick the box next to those drugs recommended by your country's national STD guidelines.

All flow-charts will include education for behaviour change, condom promotion, and partner referral and care. These topics are covered in more detail in Modules 5 and 6 but we will briefly describe them below.

In this course we refer to education as including the following topics:

- advising patients on the importance of complying with treatment, especially in completing a course of tablets;
- explaining how STD are transmitted and the possible complications of infection;
- advising the patient not to engage in sexual activity until completely cured; and
- talking about the patient's choices for making their sexual behaviour safer: abstaining from sexual activity, maintaining a mutually monogamous sexual relationship, engaging in non-penetrative sex or always using condoms.

In some situations, providers may be able to go beyond information-giving and help patients to understand their choices for changing their behaviour. For example, some people may not feel able to refuse a sexual relationship, and talking about this situation may help them find a way to reduce their risk of getting infected with an STD in the future.

Condom-use education is recommended for every person who comes to you with an STD-related complaint. It is advisable to do a step-by-step condom demonstration with each patient, followed by either giving the patient a supply of condoms or discussing where to get them.

Partner referral should be discussed with each patient diagnosed with an STD. After asking for the patient's help with identifying sexual partners, you will again use the skills covered in this course to care for people who come in as a partner of someone treated for STD.

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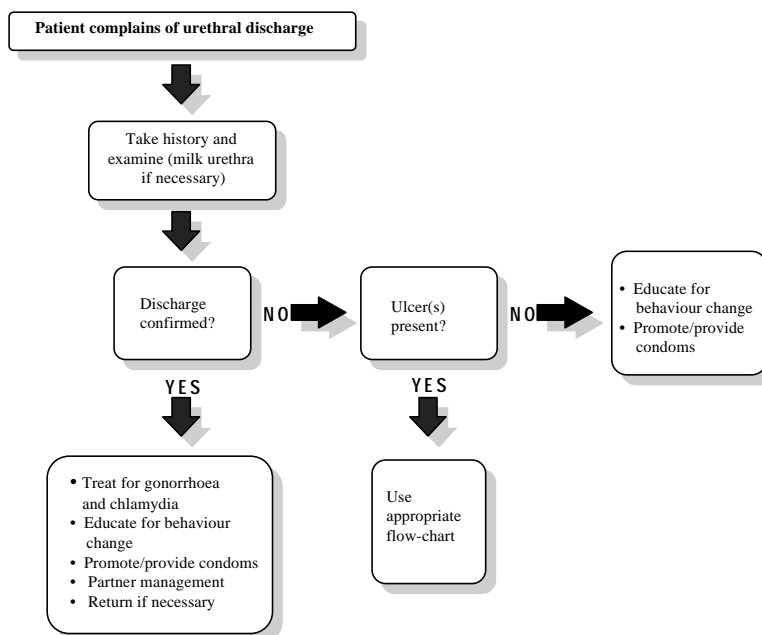
**REMEMBER:**  
*Always treat your patient with courtesy and respect. You must win their trust and confidence if you are to provide comprehensive and effective STD case management.*

---

# URETHRAL DISCHARGE SYNDROME

A man comes to your health centre complaining that he has noticed a discharge from his penis. You will use the flow-chart for urethral discharge.

## Flow-chart for Urethral Discharge Syndrome in Men



Take history and examine (milk urethra if necessary)

This box asks you to examine the patient to confirm that the patient has a urethral discharge and to see if any other STD is present.

Look at the external genitalia, not forgetting the inner surface of the foreskin and the parts normally covered by the foreskin. If you cannot see any discharge, ask the patient to squeeze the penis and milk the urethra. After examining the patient, go to the next box.

Discharge confirmed?

This box asks you whether or not there is a urethral discharge. If there is, go to the action box immediately below. If you cannot find a urethral discharge, proceed to the decision box on the right.

This box tells you how to manage this patient. Follow all the steps in the box to complete the patient's care. The diagnosis is given and you are encouraged to give immediate treatment for the infections you have identified. There is also a reminder that you need to offer education, promote condom use, and supply condoms or suggest where the patient can obtain them. Don't forget to ask the patient to return after one week if there is no improvement in symptoms after completing the treatment.

- Treat for gonorrhoea and chlamydia
- Educate for behaviour change
- Promote/provide condoms
- Partner management
- Return if necessary

Ulcer(s) present?

This box asks you to decide whether the patient also has a genital ulcer. If the patient has no evidence of any other STD, go to the next box on the right. If there is evidence of another STD, then go to the action box immediately below.

- Educate for behaviour change
- Promote/provide condoms

When you come to this box, you have not been able to confirm the presence of urethral discharge or any other STD. The patient may be worried about the possibility of having an STD as a result of taking part in risky sexual behaviour. This box suggests you reassure the patient, provide education and promote the use of condoms, including supplying them if you are able to.

Use appropriate flow-chart

If you come to this box and the patient has ulcers, simply turn to the flow-chart for genital ulcers.

Read the following case-study and ask participants to practise using the flow-chart to make a diagnosis and select a treatment regimen.

*For the last two days a middle-aged businessman has experienced pain when he passes urine. There is a slight watery discharge from the tip of his penis. His wife is in the village and he has not seen her for 3 months.*

Spends 5 to 10 minutes discussing the outcome of the case-study and checking to see if participants followed the correct pathway. Ask participants what drugs for urethral discharge syndrome are available in their health centre.

Case-study:

# Treatment for Gonorrhoea and Chlamydial Infection in Men

For **gonococcal urethritis**:

- ☐ CIPROFLOXACIN 500 mg in a single oral dose      OR
- ☐ CEFTRIAZONE 250 mg single i.m. dose              OR
- ☐ CEFIXIME 400 mg single oral dose                  OR
- ☐ SPECTINOMYCIN 2 g single i.m. dose

**NOTE:** In regions where Kanamycin and Cotrimoxazole show continuing efficacy in the treatment of gonorrhoea, these drugs may also be used:

- ☐ KANAMYCIN 2 g single i.m. dose, OR, when single dose therapy is not available:
- ☐ Trimethoprim 80 mg and Sulphamethoxazole 400 mg (COTRIMOXAZOLE) 10 tablets orally, once daily for 3 days.

PLUS

For the treatment of **chlamydial urethritis**:

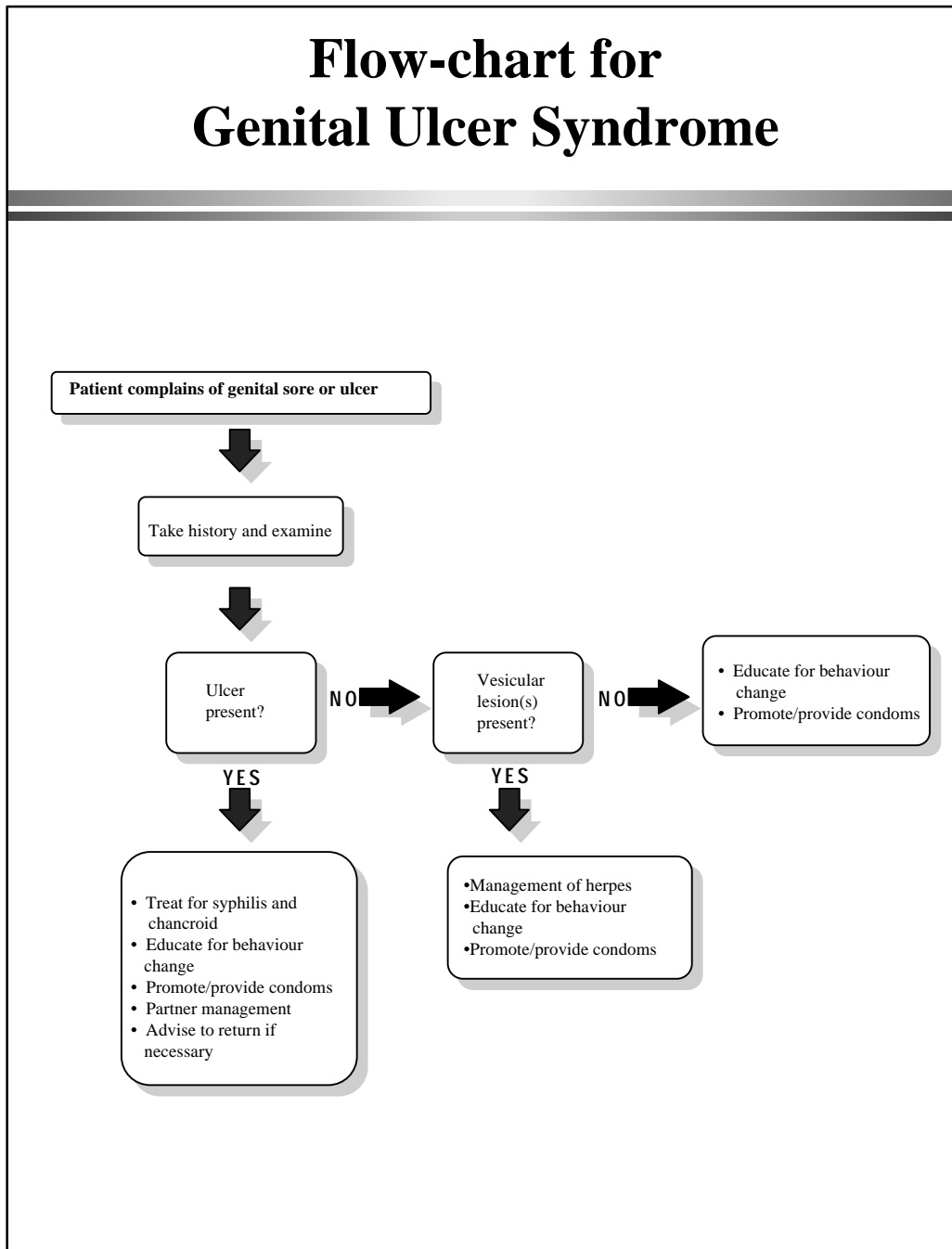
- ☐ DOXYCYCLINE 100 mg orally twice daily for 7 days      OR
- ☐ TETRACYCLINE 500 mg orally four times daily for 7 days

Alternatively, the following drugs may be used:

- ☐ Erythromycin 500 mg orally four times daily for 7 days      OR
- ☐ Sulfisoxazole 500 mg orally four times daily for 10 days (equivalent doses of other sulphonamides may also be used)

# GENITAL ULCER SYNDROME

A man or a woman comes to your health centre complaining that he or she has noticed a sore on the genitals. You will use the flow-chart for genital ulcer.



Take history and examine

This box asks you to examine the patient for genital ulcer and any other STD that may be present. An ulcer is a break in the skin or mucous membrane surface.

- In men, look at the external genitalia. Don't forget the inner surface of the foreskin and the parts it normally covers.
- In women, examine the skin of the external genitalia. Ask the patient to separate the labia so that you can look at the mucous surfaces for ulcers. If you have clean gloves available, you can separate the labia to examine the area yourself.

Ulcer present?

If there is a genital ulcer, go to the next box below. If you cannot find a genital ulcer, go to the box on the right.

- Treat for syphilis and chancroid
- Educate for behaviour change
- Promote/provide condoms
- Partner management
- Advise to return if necessary

This box tells you to treat your patient for both syphilis and chancroid. It also tells you to provide education, promote the use of condoms and ask the patient to return in seven days if symptoms have not improved.

You should advise the patient to take medication and discuss how he or she got this infection and what are its

complications.

Vesicular lesion(s) present?

If no ulcer is present, this box asks you to check and see if vesicular lesions are present. They look like a number of tiny blisters packed closely together, before they burst to form a small sore. If you can't see any such lesions, go to the box on the right. If they are present, go to the box immediately below.

- Educate for behaviour change
- Promote/provide condoms

At this point, you have not been able to confirm the presence of an STD. However, the patient may be worried about having an STD after taking part in risky sexual behaviour, so this box reminds you to reassure your patient, provide education, promote the use of condoms, and supply them if this is your policy.

Case-study:

Read the following case-study and ask participants to practise using the flow-chart to make a diagnosis and select a treatment regimen.

A young woman complains of a painful vulva. Her husband is her only partner. She appears ill and feverish. On examination, she has many small sores filled with a clear liquid on both labia majora and minora, and no visible ulcer.

Spend 5 to 10 minutes discussing the outcome of the case-study and checking to see if participants followed the correct pathway. Ask participants what drugs for genital ulcer syndrom are available in their health care.

---

**REMEMBER:**  
*Syndromic diagnosis of STD in women does not require internal examination, so gloves are not necessary.*

---

- Management of herpes
- Educate for behaviour change
- Promote/provide condoms

This box asks you to educate the patient on the management of herpes. You should assure the patient that, although the lesions cannot be cured, they will go away of their own accord, but might recur. Explain the importance of keeping the area clean and dry, and advise the patient not to have sexual contact while lesions are present but to wait until they heal.

## Treatment for Syphilis and Chancroid Infections

### For Syphilis:

BENZATHINE PENICILLIN G 2.4 million units intramuscularly at a single session (because of the volume of this dose, give it as two injections at separate sites)

For non-pregnant patients who are allergic to penicillin, use:

TETRACYCLINE 500 mg orally four times daily for 15 days OR

DOXYCYCLINE 100 mg orally twice daily for 15 days OR

ERYTHROMYCIN 500 mg orally four times daily for 10 days OR

SULFISOXAZOLE 500 mg orally four times daily for 10 days (equivalent doses of other sulphonamides may also be used).

**NOTE:** Ciprofloxacin, doxycycline and tetracycline should not be used during pregnancy or lactation

PLUS

### For Chancroid:

ERYTHROMYCIN 500 mg orally three times daily for 7 days

Alternatively, the following may be used:

CIPROFLOXACIN 500 mg single oral dose OR

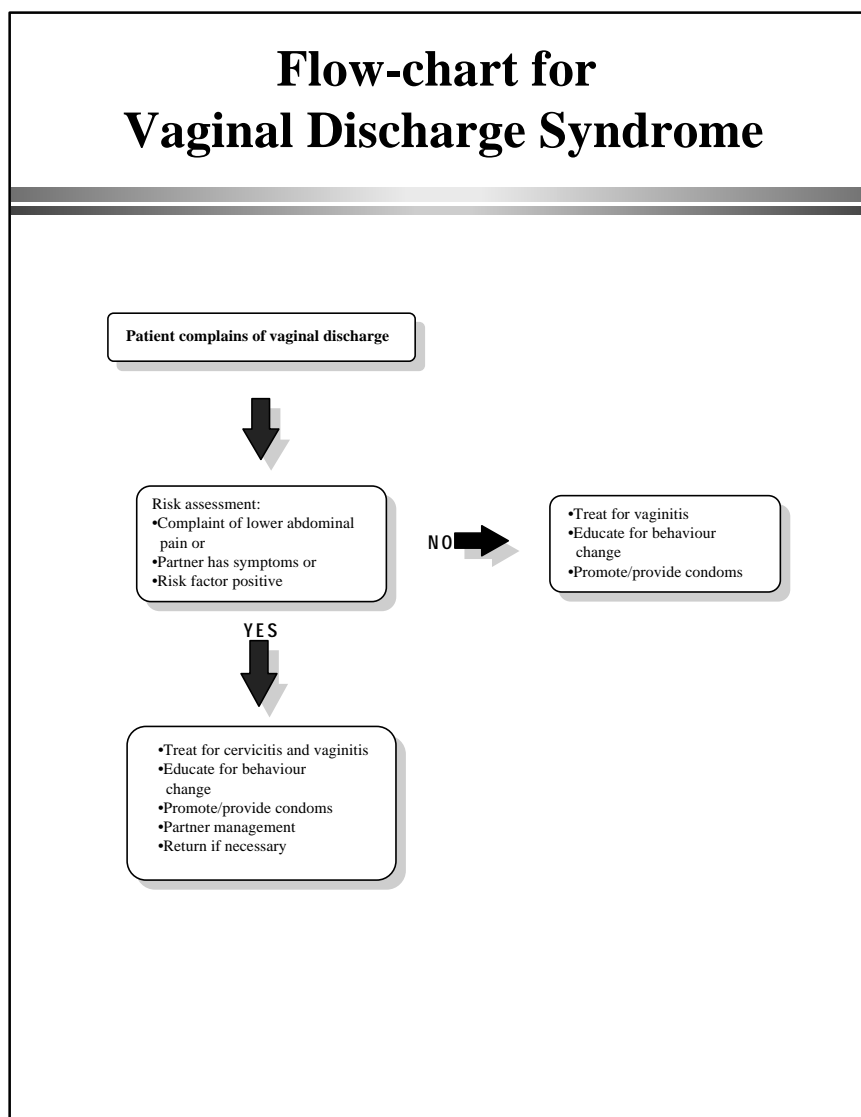
CEFTRIAXONE 250 mg single i.m. dose OR

SPECTINOMYCIN 2 g single i.m. dose or, in places where continuing efficacy has been demonstrated,

TRIMETHOPRIM 80 mg and Sulphamethoxazole 400 mg (COTRIMOXAZOLE) two tablets orally, twice daily for 7 days.

# VAGINAL DISCHARGE SYNDROME

It is normal for women to have some vaginal discharge. Women may notice an increase in vaginal discharge during certain phases of the menstrual cycle, during and after sexual



activity, or during pregnancy and lactation. Usually women complain of vaginal discharge when they think it is unusual for them or if it causes itching or discomfort. Women do not usually seek medical care for discharge that would be considered normal.

Women develop abnormal vaginal discharge if they have either vaginitis (infection of the vagina) or cervicitis (infection of the cervix), or both. It is useful to distinguish between these conditions because one of them, cervicitis, leads to serious complications. Therefore treating the patient's sexual partner(s) to avoid reinfection is a priority.

We can summarize the differences between vaginitis and cervicitis with the table below:

<b>Differences Between Vaginitis and Cervicitis</b>	
<b>Vaginitis</b>	<b>Cervicitis</b>
<ul style="list-style-type: none"> <li>• Caused by trichomoniasis, candidiasis and bacterial vaginosis</li> <li>• Most common cause of vaginal discharge</li> <li>• Easy to diagnose</li> <li>• Treatment of partner not necessary</li> </ul>	<ul style="list-style-type: none"> <li>• Caused by gonorrhoea and chlamydia</li> <li>• Less common cause of vaginal discharge</li> <li>• Difficult to diagnose</li> <li>• Need to treat partner</li> </ul>

Unfortunately, it is not easy to distinguish between cervicitis and vaginitis, especially when an internal examination is not possible. In the meantime, a good way to identify cervicitis is to ask certain questions, the answers to which indicate whether or not a woman is likely to have cervicitis. Some questions about risk factors are listed below.

Read the following cases-study and ask participants to practise using the flow-chart to make a diagnosis and select a treatment regimen.

*A 25-year old woman complains of a watery discharge. she has had this for two weeks and it is getting worse. She does not know whether or not her partner has a discharge because she has not seen him for two weeks. She has no other symptoms.*

Spend 5 to 10 minutes discussing the outcome of the case-study and checking to see if participants followed the correct pathway. Ask participants what drugs for vaginal discharge syndrome are available in their health centre.

---

**IMPORTANT:**  
*Think ahead of time about a good way to ask your patients about their risk factors. For example, a way to ask about a new sexual partner in the last three months could be...  
 "Have you had a new sexual partner since Christmas (or some other significant event)?"*

---

Case-study:

## Which Risk Factors Can You Ask About?

- Is the patient below 21 years old?
- Is the patient single?
- Has the patient had sexual intercourse with more than one person in the preceding three months?
- Has the patient had sexual intercourse with a new partner in the preceding three months?

If the patient answers “yes” to any one of the questions, she should be treated for both cervicitis and vaginitis

Risk assessment:  
•Complaint of lower abdominal pain or  
•Partner has symptoms or  
•Risk factor positive

As indicated in this box, there is no need to examine the patient. Instead, the provider asks the patient three questions:

1. Does the patient also have pain in the lower abdomen?
2. Does the patient's partner have any STD symptoms?
3. Do the patient's circumstances fit with any risk factors for cervicitis (risk factor positive)?

•Treat for vaginitis  
•Educate for behaviour change  
•Promote/provide condoms

If the patient answers 'yes' to any one of these questions, then she must be treated for both cervicitis and vaginitis.

•Treat for cervicitis and vaginitis  
•Educate for behaviour change  
•Promote/provide condoms  
•Partner management  
•Return if necessary

If the answer to all three questions is 'no', she can be treated for vaginitis alone.

# Treatment for Vaginitis Only

For **trichomoniasis and bacterial vaginosis:**

- ☞ METRONIDAZOLE 2 g as a single oral dose to be taken at the clinic under supervision OR
- ☞ METRONIDAZOLE 400-500 mg given orally twice daily for 7 days if single dose is not effective

**NOTE:** Do not prescribe Metronidazole in the 1st trimester of pregnancy, and warn the patient against drinking alcohol while taking it.

PLUS

For **vaginal candidiasis:**

- ☞ NYSTATIN 100 000 units (one pessary), inserted intravaginally once a day for 14 days OR
- ☞ MICONAZOLE or CLOTRIMAZOLE 200 mg, inserted into the vagina once a day for 3 days OR
- ☞ CLOTRIMAZOLE 500 mg, inserted into the vagina once only

PLUS

**NOTE:** There is no need to treat the patient's partner because vaginitis rarely has serious complications. In men, trichomoniasis usually resolves spontaneously.

# Treatment for both Cervicitis and Vaginitis

Treat the patient **for vaginitis**, as above

PLUS

For **gonococcal cervicitis**:

- CIPROFLOXACIN 500 mg in a single oral dose OR
- CEFTRIAXONE 250 mg single i.m. dose OR
- CEFIXIME 400 mg single oral dose OR
- SPECTINOMYCIN 2 g single i.m. dose

In regions where Kanamycin and Cotrimoxazole show continuing efficacy in the treatment of gonorrhoea, these drugs may also be used:

- KANAMYCIN 2 g single i.m. dose, OR, when single dose therapy is not available
- Trimethoprim 80 mg and Sulphamethoxazole 400 mg (COTRIMOXAZOLE) 10 tablets orally, once a day for 3 days.

PLUS

For **chlamydial cervicitis**:

- DOXYCYCLINE 100 mg orally twice daily for 7 days, OR
- TETRACYCLINE 500 mg orally 4 times daily for 7 days

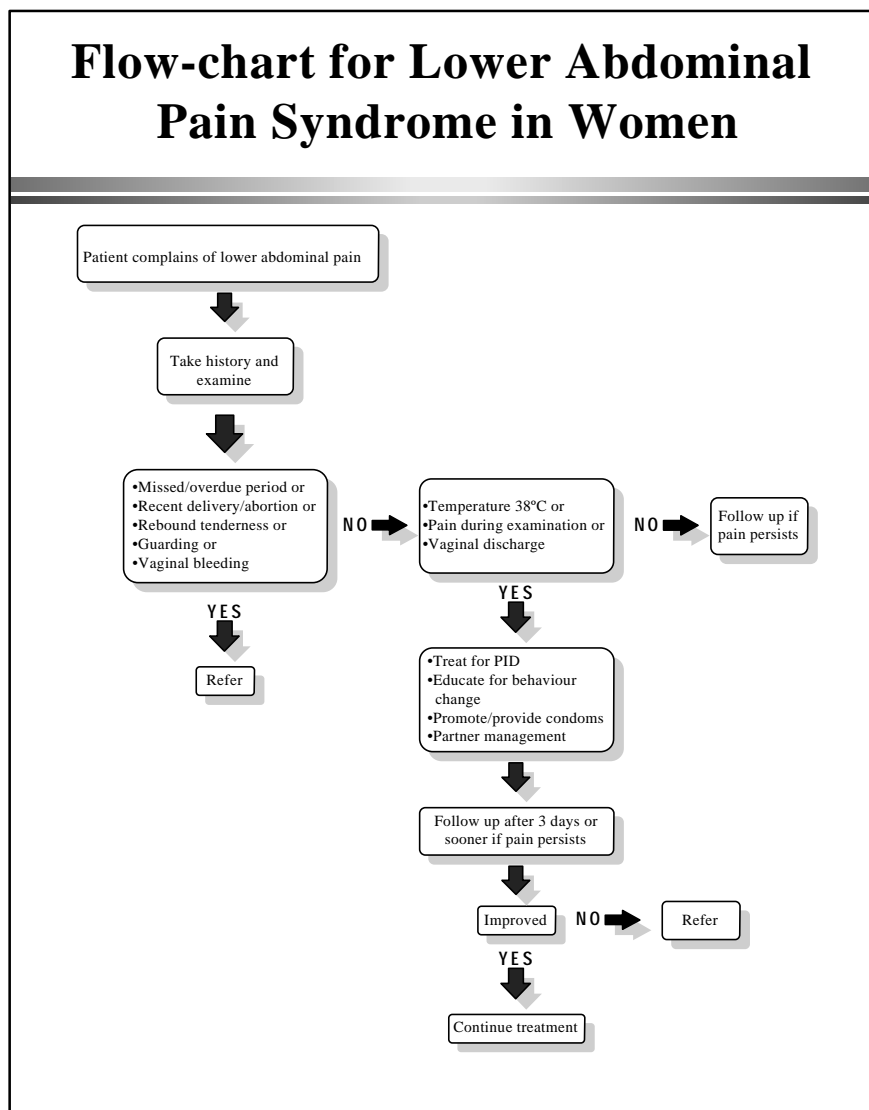
Alternatively, the following drugs may be used:

- ERYTHROMYCIN 500 mg orally 4 times daily for 7 days OR
- SULFISOXAZOLE 500 mg orally 4 times daily for 10 days (equivalent doses of other sulphonamides may also be used).

NOTE: Ciprofloxacin, doxycycline and tetracycline should not be used during pregnancy or lactation.

## LOWER ABDOMINAL PAIN SYNDROME

The term pelvic inflammatory disease (PID) refers to infections of the female upper genital tract: the uterus, fallopian tubes, ovaries or pelvic cavity. It occurs when infection goes up through the cervix. It can be caused by gonorrhoea, chlamydia or anaerobic bacteria.



Pelvic inflammatory disease includes endometritis, salpingitis, tubo-ovarian abscess and pelvic peritonitis. It can also lead to generalized peritonitis, a potentially fatal condition. Salpingitis may lead to a blocked fallopian tube, resulting in decreased fertility, or total infertility if both tubes are affected. It may also lead to partial tubal obstruction, allowing small spermatozoa to pass through, but not the larger fertilized ovum. The result can be a tubal or ectopic pregnancy outside of the uterus which will eventually rupture, causing massive intra-abdominal haemorrhage and, possibly, death.

Women with PID usually have a history of lower abdominal pain and of vaginal discharge. If a woman's symptoms include lower abdominal pain, you will use the flow-chart above.

Patient complains of lower abdominal pain

The entry point to this flow-chart is the symptom of lower abdominal pain. You can also use this flow-chart if the patient complains of both lower abdominal pain and vaginal discharge.

Take history and examine

This next box instructs you to take a history and examine your patient. While asking about history, you need to check for other symptoms, such as erratic bleeding, missed or overdue period, recent delivery or abortion. Erratic bleeding might be an early symptom of ectopic pregnancy. First, you should ask questions similar to these:

- Are there any problems with your periods?
- Do you have any vaginal bleeding?
- Have you had a miscarriage, abortion or delivery in the last six weeks?

Read the following case-study and ask participants to practise using the flow-chart to make a diagnosis and select a treatment regimen.

*A woman's partner has informed her that he has gonorrhoea. She has no discharge and no fever. She has pain in her left lower abdomen. On palpation, her abdomen is soft, with tenderness on the left side but no guarding. One week later, she returns at your request and is still tender on palpation.*

Spent 5 to 10 minutes discussing the outcome of the case-study and checking to see if participants followed the correct pathway. Ask participants what drugs for lower abdominal pain syndrome are available in their health centre.

Case-study:

### Checklist for Examining Lower Abdominal Pain Patients

- Temperature
- Palpate abdomen — tenderness, rebound tenderness, guarding, mass
- Vaginal bleeding
- Abnormal vaginal discharge

When examining the patient, you must first check their temperature. A high temperature indicates infection.

Palpate the abdomen for tenderness, rebound tenderness, guarding and detection of a mass. Abdominal palpation should first be superficial to detect pain on light palpation — this is known as tenderness.

Then make a careful and deep palpation. In the area where you found tenderness under light palpation, press down slowly and very gently and then release the pressure quickly. Any severe pain that results is known as rebound tenderness.

When the peritoneum is inflamed, upon palpation the abdominal muscles will become rigid and will not allow you to apply pressure. This is known as guarding. Guarding and rebound tenderness are features of peritonitis or an intra-abdominal abscess.

Light abdominal palpation will also enable you to detect a swelling or lump in the patient's abdomen. This is known as a mass. Upon deep palpation of the lower right and lower left abdomen, you might detect a tender mass deep in the pelvic cavity. This may be a tubo-ovarian abscess.

Also, you need to check for vaginal bleeding. This should alert you to the possibility of an ectopic pregnancy or abortion. Finally, you should check for abnormal vaginal discharge.



*How to conduct a physical examination without using a gynaecological table or a speculum.*

- Missed/overdue period or
- Recent delivery/abortion or
- Rebound tenderness or
- Guarding or
- Vaginal bleeding

This box lists the signs and symptoms for which you must refer the patient. If your examination or the patient's history suggest any of these signs or symptoms, move to the 'refer' box below.

If the patient has none of these signs and symptoms, move to the box on the right.

### Refer

This box asks you immediately to refer all patients who may have severe conditions to a facility where specialist gynaecological opinion and surgical treatment is available to treat:

- a pregnancy complication; or
- peritonitis or features of tubo-ovarian abscess.

- Temperature 38°C or
- Pain during examination or
- Vaginal discharge

This box requires you to make another decision, based on whether or not the patient has a fever of 38°C or more, or tenderness on light palpation, or vaginal discharge.

- If the patient has a fever, pain during examination, or vaginal discharge, treat her for PID as described in the action box below.
- If she has none of these, move to the next box on the right.

### Follow up if pain persists

If the patient has none of the warning symptoms and signs in the two earlier boxes where you were asked to examine and make a decision, reassure the patient and ask her to return if the pain persists.

- Treat for PID
- Educate for behaviour change
- Promote/provide condoms
- Partner management

Remember that, in treating for PID, you must give treatment simultaneously for gonococcal, chlamydial and anaerobic bacterial infection. You must also educate and counsel the patient if

necessary, promote and provide condoms, and discuss partner referral and treatment.

Follow up after 3 days or sooner if pain persists

This box requires that patients be seen three days after starting treatment, or sooner if pain persists. At this visit, take a history and examine the patient again.

If the patient is improved at the follow-up visit, continue the treatment for a total of 10 days. However, if at the follow-up visit, the patient is not improved, refer her for a gynaecological evaluation. Explore options for partner referral.

## Treatment for PID

### For gonorrhoea:

- ☐ CIPROFLOXACIN 500 mg in a single oral dose OR
- ☐ CEFTRIAXONE 250 mg single i.m. dose OR
- ☐ CEFIXIME 400 mg single oral dose OR
- ☐ SPECTINOMYCIN 2 g single i.m. dose

**NOTE:** In areas where Kanamycin and Cotrimoxazole continue to show efficacy in the treatment of gonorrhoea, these drugs may also be used:

- ☐ KANAMYCIN 2 g single i.m. dose, OR, where single dose therapy is not available:
- ☐ Trimethoprim 80 mg and Sulphamethoxazole 400 mg (COTRIMOXAZOLE) 10 tablets orally, once a day for 3 days, and then two tablets orally, twice daily for 10 days.

### For chlamydia:

- ☐ DOXYCYCLINE 100 mg orally, twice daily for 14 days, OR
- ☐ TETRACYCLINE 500 mg orally, 4 times daily for 14 days.
- ☐ Alternatively, the following drugs may be used:
- ☐ ERYTHROMYCIN 500 mg orally 4 times daily for 10 days, OR
- ☐ SULFISOXAZOLE 500 mg orally 4 times daily for 10 days (equivalent doses of other sulphonamides may also be used).

**NOTE:** Ciprofloxacin, Doxycycline and Tetracycline should not be used during pregnancy or lactation.

### For anaerobic bacterial infection:

- ☐ METRONIDAZOLE 400-500 mg orally, twice daily for 14 days
- NOTE:** Metronidazole should not be used in the first trimester of pregnancy. Also caution the patient to avoid alcohol while taking this treatment.

# REVIEW

## HOW TO USE THE FLOW-CHARTS

- Start at the top of the flow-chart, at the entry point box describing patient complaint.
- Gather the information needed for diagnosis.
- Make decisions based on information gathered and gather more information as required.
- Make a diagnosis.
- Choose the treatment that corresponds to the diagnosis.
- Offer education and condoms.
- Explore options for partner referral.



## FLOW CHARTS FOR FOUR SYNDROMES

A step-by-step orientation to the four flow-charts demonstrates how to work through each chart.

---

*The module contains lots of detail, so you now need time to put what you have read into practice. The next section contains case studies with questions and answers and an activity that will help you remember specific details in the flow chart and prepare for using them in your health centre.*

---

# QUESTIONS AND ACTIVITIES

## 4.1 QUESTIONS

- a) When is a vaginal discharge NOT a problem?
  
- b) For what syndrome is it useful to assess risk factors?

In assessing a patient's risk we need to take four factors into account. What are they?

What two extra questions must you ask in addition to the risk factors?

- c) On the next few pages are some short case-studies. For each one, please decide which flow-chart you would use, then read what happens when you take the patient's history and examine him or her. We will then ask you how to treat the patient.

**Kim**

*Kim, aged 22, attended the family planning clinic for her usual check-up while on the contraceptive pill. She tells the nurse about a yellow, itchy vaginal discharge that she has had for the past four days.*

Which flow-chart do you use?

*Kim says she has no abdominal pain or dysuria. She had her menses two weeks ago and it was normal. Shyly, she discloses that she had sex with an old school friend a week ago, and that she did not use a condom because she was on the pill. She last had sex with her regular boyfriend a month ago, as he is out of town.*

What is your diagnosis for Kim?

**Francis**

*An 18-year-old dock worker named Francis attends your clinic complaining that he had a discharge yesterday.*

Which flow-chart do you use?

*On examination, you can find no discharge, even after milking the urethra. However you do find an ulcer on his penis.*

What do you do now?

What do you treat this patient for?

***Puloka***

*Puloka, 24 years old, says that she began seeing Hopi, her new partner, three months ago. She is now experiencing a dull, persistent "belly bottom pain" which she thinks has been brought on by her excessive sexual activity with Hopi.*

Which flow-chart do you use?

*Puloka tells you that her periods are normal and she has never been pregnant. She thought that there might be some increase in what she considers to be normal vaginal discharge. On examination, she has no rebound tenderness or guarding, but clearly feels pain when you palpate the lower abdomen.*

What treatment do you give to Puloka?

What else do you discuss with her?

- d) Finally, below are four case-studies to give you more practise in diagnosing the cause or causes of vaginal discharge. Please decide whether you need to treat each woman for vaginitis only, or for both vaginitis and cervicitis.

***Maria***

*Maria moved in with her present partner four months ago. She is 22 years old. In addition to the discharge, she says her lower abdomen feels tender. Her partner has no symptoms.*

Treat for:

*Vaginitis only*

*Vaginitis and Cervicitis*



## 4.2 ACTIVITY

### *Preparing to use STD Flow-Charts in Your Health Centre*

Below we suggest some ways you can practise syndromic diagnosis using the flow-charts. Please adapt them according to what you most need to learn or practise, given your prior experience and learning.

1. Check what drugs are available and effective for each condition.

If you have not done so already, find out what drugs are available to treat each syndrome. Following this page are some forms you can use to write down which drugs are recommended in your country and for your health centre.

Make sure you have easy access to a list of the locally recommended drugs. You might, for example, write them on a piece of paper or card that you could keep on your desk, or use a permanent marker to tick the appropriate boxes on your quick reference guide.

2. Confirm the risk factors that you will use.

For specific places, the risk factors for vaginal discharge may need to be amended. Please consult your trainer on this matter if you haven't already done so.

3. Practise using the flow-charts.

Can you arrange to practise using the flow-charts with other health care workers? Here are some possibilities to consider:

- Act out managing different syndromes in pairs, remembering to ask the appropriate questions and include the necessary advice.
- A third person could observe you both, with Module 4 open at the appropriate pages to check that you do not leave anything out.
- If you do not have colleagues to work with, imagine a patient or recall an actual patient you had in the past, then work through what you would ask and do. Keep the flow-chart quick reference guide in front of you but the module closed. You could then read through the module to check how you have done.

As soon as you feel confident about using the flow-charts, arrange to practise syndromic diagnosis and treatment at your local health centre.

## DRUG TREATMENTS

### URETHRAL DISCHARGE SYNDROME

Gonococcal urethritis      **Treatment:** \_\_\_\_\_  
\_\_\_\_\_

plus      **Notes:** \_\_\_\_\_  
\_\_\_\_\_

Chlamydial urethritis      **Treatment:** \_\_\_\_\_  
\_\_\_\_\_

**Notes:** \_\_\_\_\_  
\_\_\_\_\_

### GENITAL ULCERS SYNDROME

Syphilis      **Treatment:** \_\_\_\_\_  
\_\_\_\_\_

plus      **Notes:** \_\_\_\_\_  
\_\_\_\_\_

Chancroid      **Treatment:** \_\_\_\_\_  
\_\_\_\_\_

**Notes:** \_\_\_\_\_  
\_\_\_\_\_

### VAGINAL DISCHARGE SYNDROME

***Risk assessment negative:***

Treat for Vaginitis:      **Treatment:** \_\_\_\_\_  
\_\_\_\_\_

Trichomoniasis,      \_\_\_\_\_  
\_\_\_\_\_

Bacterial vaginosis      **Note:** \_\_\_\_\_  
\_\_\_\_\_

plus      \_\_\_\_\_  
\_\_\_\_\_



# ANSWERS

## 4.1 QUESTIONS

If you are a clinician or have already worked with STDs, you may have found these questions very easy. On the other hand, if all this is new, it will take longer to reach the point where you feel confident about syndromic diagnosis, so don't worry if you found the questions difficult. Remember their purpose is to help you learn.

- a. Vaginal discharge is physiological or normal both during and after sexual activity, before, during and after a menstrual period, and during pregnancy and lactation. Remember that most women will not seek medical attention unless they perceive the discharge to be different or unusual in some way.
- b. An assessment of specific risk factors is made for vaginal discharge. Remember that the purpose is to decide whether the discharge is caused by vaginitis alone or by both vaginitis and cervicitis.

In assessing a patient's risk we need to take four factors into account:

- Below 21 years of age.
- Single.
- More than one partner in the last three months.
- A new partner in the last three months.

In some settings, there may be information available that can be used to adjust these risk factors to make them even more sensitive for identifying someone to be at risk for an STD infection.

In addition to the risk factors, you must also ask:

- Is the patient's partner symptomatic?
  - Does the patient have pain in the lower abdomen?

Remember that the patient should be treated for both cervicitis and vaginitis if the answer to one or more of these two questions or the four risk factors is yes.

- c. Case-studies:

### **Kim**

The correct flow-chart to use for Kim is vaginal discharge.

Well done if you wrote that Kim should be treated for both cervicitis and vaginitis. Why? Because she has had sex with more than one person in the last three months, which is one of the risk factors to take into account. She might also be positive on a second risk factor — sex with a new partner in the last three months. However, we can't be sure whether or not the 'old school friend' is a new sexual partner — and in any case only one positive risk factor is sufficient to treat Kim for both causes.

**Francis**

You are quite right to select the flow-chart for urethral discharge at first, because this is the symptom of which the patient complains.

Given the result of your examination, the flow-chart redirects you to the one for genital ulcer.

Examination has already confirmed that the patient has an ulcer, so you must treat him for both syphilis and chancroid.

**Puloka**

The correct flow-chart to use given Puloka's symptoms is the one for lower abdominal pain.

Upon examination, the pain in Puloka's lower abdomen suggests that she has pelvic inflammatory disease. She should be treated for gonorrhoea, chlamydia and anaerobic bacterial infection. The treatment WHO recommends for these is:

- Gonorrhoea                      Ciprofloxacin 500 mg in a single oral dose.
- Chlamydia                        Doxycycline 100 mg orally twice daily for 7 days.
- Anaerobic bacterial infection      Metronidazole 400-500 mg orally twice daily for 14 days.

Please remember that pain during examination is not the only decisive sign. Either an observed vaginal discharge or a temperature of 38°C (100.8°F), in addition to her given symptom of lower abdominal pain, would have been sufficient to lead to a diagnosis of PID.

**Remember:** In deciding whether to treat a woman with vaginal discharge for one or two causative agents, only one of the factors or questions need be positive.

**Maria**

Maria says that lower abdominal pain is one of her symptoms — so she needs treatment for both cervicitis and vaginitis.

**Palantina**

Palantina's case is more difficult. The information we have given suggests that she needs to be treated only for vaginitis because the risk factors are negative. But we haven't asked if her partner has any symptoms. To be sure of the appropriate treatment, we would need to complete the risk assessment first.

**Amy**

We know that Amy is less than 21 years old. This is one of the four risk factors, so we hope that you decided to treat her for both vaginitis and cervicitis.

**Rosi**

Rosi is the only person we can confidently treat for vaginitis alone, because none of the risk factors or questions apply in her case.

**STD Case Management—**  
*The Syndromic Approach*  
*for Primary Health Care Settings*

**MODULE 5**

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**EDUCATING THE PATIENT**  
**FACILITATOR'S VERSION**

**TIME FRAME:** 2.5 hours

**SUPPLIES AND**

**EQUIPMENT**

- Flip-chart and flip-chart paper
- Markers (ideally in two or three colours)
- Tape (for posting pieces of flip-chart paper on wall)
- Overhead projector and overhead set, or Flip-chart version of overheads
- Extra pens or pencils and paper for participants



## LEARNING OBJECTIVES FOR MODULE 5

KNOWLEDGE GAIN	SKILLS ACQUIRED
<ul style="list-style-type: none"><li>• Explain the differences between information-giving and education to encourage behaviour change.</li><li>• Explain why educating and motivating patients is vital in STD case management.</li><li>• Identify the main topics on which to educate STD patients.</li><li>• Identify six skills that will help you to educate and motivate patients.</li><li>• List the benefits of using condoms.</li><li>• Recall the basic steps for putting on condoms.</li></ul>	<ul style="list-style-type: none"><li>• Recognize and use a range of communications skills and a range of education skills for encouraging behaviour change in patients.</li><li>• Explain the benefits of using condoms to the patients.</li><li>• Demonstrate correct use of condom.</li></ul>

**STD Case Management—  
The Syndromic Approach  
for Primary Health Care Settings**

## **MODULE 5 EDUCATING THE PATIENT**

In this module, you will learn about educating patients to prevent STD infection. Education follows history-taking, examination and making a diagnosis, and is a fundamental part of STD case management.

The goals of patient education are to help the patient resolve any current infections, to prevent future infections and to make sure partners are treated and educated as well. In most health centres, staff don't have much time with each patient. This module will help you to use the time available for education as effectively as possible.

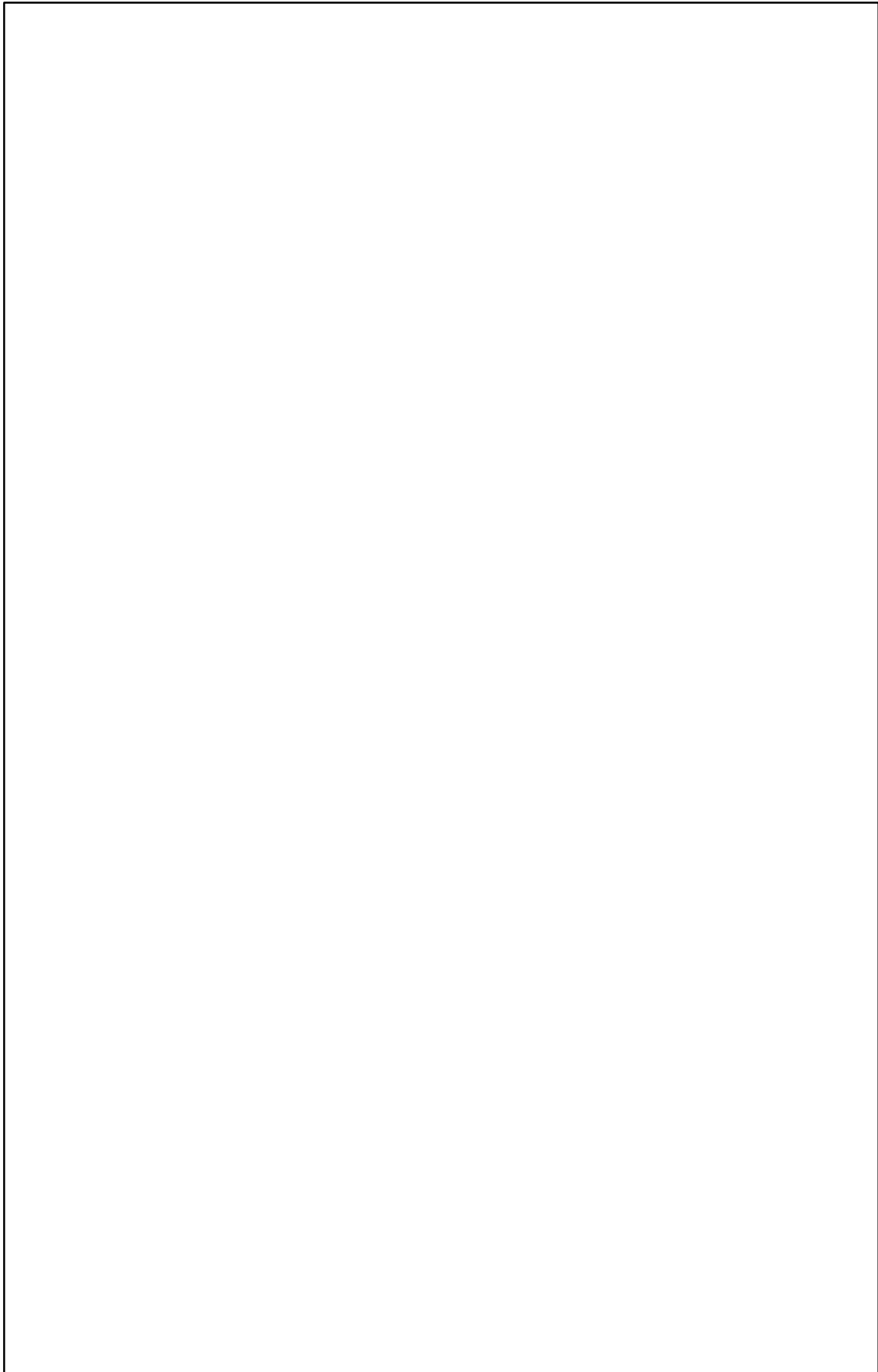
The interviewing skills we explored as part of history-taking are the starting point for educating patients. You might want to review these skills, which were covered in Module 3, before going further.

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*The benefits of changing behaviours that put individuals at risk for STD infection.*



## WHY EDUCATE?

Education makes STD treatment more effective because:

- patients are more likely to comply with treatment if they understand why it is important to do so; and
- the behaviour changes needed to prevent re-infection with STD usually need education, motivation and emotional support.

Patients with STDs need to make three essential decisions:

- to complete their treatment;
- to change any risky sexual behaviour; and
- to see that their sexual partners are treated.

In order for the patient to make these decisions for themselves, and to make changes in their behaviour that are long-lasting, the provider must:

- give the patient the information they need about their infection;
- help the patient to understand how STDs are transmitted and how to prevent them; and
- help the patient to understand how important it is that their sexual partners receive treatment and education as well.

Clinic visits are a good time for education, because patients want to learn about their infection and its prevention.

Facilitating question and discussion point:

*In educating patients with STD, what issues do you need to discuss or explore? In answering this question, you might find it helpful to refer to the flow-charts.*

In addition to the 3 issues listed to the left, with pregnant female, you may need to discuss the need to protect the baby.

## WHAT DOES EDUCATION INVOLVE?

### EDUCATING THE STD PATIENT INVOLVES MORE THAN JUST GIVING INFORMATION

Giving information is usually a one-way process where patients are given facts and told about the consequences of their infection. Often this is not enough to motivate them to change their behaviour. Nor does it focus on the patient's

questions, or make them want to talk about their own particular situation.

So, information is not enough to promote behaviour change. Each patient needs to be educated so they truly understand the nature of their infection, how they got it and how to avoid getting infected again. In fact, education is crucial to the success of the syndromic approach.

Compared to information-giving, education is a more in-depth process. Patients need to identify practical action they can take to prevent re-infection, for example. In order to change, the patient must understand and solve their own problems. They themselves must want and then decide to change. This helps to make the behaviour change long-lasting.

You can help this process of change by how you inform and educate your patients. It is very likely that you will be able to help patients change their behaviour. This is because health workers are often highly respected, and patients will listen to what they say, especially when the patient thinks they have an STD.

instead. We have chosen the term "education for behaviour change" to emphasize that the important feature of the interaction is its effect on the patient's decision to change his or her behaviour. The term used here also suggests that the interaction need not be lengthy, and that it is useful even if the provider only sees the patient only once.

Facilitating question:

There are many other reasons why providers continue an information-giving approach with patients, even if we all recognize it is not effective. What are some of the other reasons in your area, and in your culture?

### **Moving from Information-giving to Education**

- Patients often lack basic information.
- Information-giving alone is usually insufficient,  
**...so education for behaviour change is needed.**
- Education is part of an in-depth process of enabling someone to change.
- Patients need to identify practical action they can take.
- Education involves patients in understanding and solving their own problems.

Tip:

In this training package the term "education for behaviour change" is used to refer to a two-way interaction between the provider and the patient that helps patients to make behavioural changes that will reduce their risk of STD infection the future. In other training materials, the word "counselling" is used to describe this interaction

# EDUCATING TO PROMOTE BEHAVIOUR CHANGE

## Approaches for Encouraging Behaviour Change

- Ensure privacy and confidentiality.
- Build trust by listening and looking at patients.
- Make your messages as non-judgemental as possible.
- Use clear and simple language.
- Focus on the information and education needs of each patient.
- Choose a few important messages.
- Help patients to consider the benefits and costs of a new behaviour.
- Focus on realistic options for behaviour change.
- Make an agreement once the patient chooses to try a new behaviour.

## PRIVACY, CONFIDENTIALITY AND TRUST

Trust between the provider and the patient is encouraged when privacy and confidentiality are preserved. This is particularly true given the sensitive nature of STDs and sexual behaviour information. Trust is important for case management because it helps with all aspects of a provider-patient interaction. You can begin to build trust with your patients by listening carefully to them. It can also help to look your patient in the eye, if that is acceptable in your culture.

## NON-JUDGEMENTAL WORDING

Communicating judgements should be avoided as much as possible because they can have a very negative effect. You need to make your questions and messages to patients non-judgemental because usually STD patients feel upset, uneasy and possibly guilty about their behaviour or about being diagnosed with an STD. If a patient also feels looked down upon, or judged, they will feel even worse about their experience at the health centre. The box below contains some examples of phrases that are morally judgemental and some ways the wording could be changed to be non-judgemental.

Judgemental wording	Non-judgemental wording
<ul style="list-style-type: none"> <li>• Do you know that your bad behaviours puts you at risk for STDs?</li> <li>• So, I guess you have been with a “dirty” woman.</li> <li>• You should be ashamed at having sex when you are so young.</li> <li>• [to a sex worker] Well I am surprised you are still working while you are pregnant.</li> <li>• If you followed our religion and did not have “gay sex”, you would not have this problem.</li> <li>• One of you, either you or your husband, is not being faithful.</li> </ul>	<ul style="list-style-type: none"> <li>• Do you know that this behaviour can put you at risk for STDs?</li> <li>• Can you tell me how you think you may have become infected?</li> <li>• Having sex, even for young people, can put you at risk for STDs.</li> <li>• How long are you planning to work as your pregnancy progresses?</li> <li>• Having anal sex with another man without using a condom can put you at risk for STDs.</li> <li>• This illness can only be transmitted by sex. Can you tell me how you or your husband may have got it?</li> </ul>

## LANGUAGE

It is best to use clear and simple language, so that patients can understand you. You should not use medical terms that patients may not know. It can help to use descriptive words or phrases.

## INFORMATION AND EDUCATION NEEDS

As the patient’s situation changes, so their information and education needs vary. You can start to focus on the information and education needs of a patient by asking about their situation. Then you can identify what messages are most useful for them. Tailoring your messages to the patient’s needs will make these messages more effective.

## A FEW IMPORTANT MESSAGES

Limiting your messages to the most important is a practical approach because you will not usually have enough time to cover everything with a patient. It is also difficult for people to take in too much new information at one time. So, if you limit your messages the patients will be better able to focus on and remember the new information you are offering.

On a piece of flip-chart paper, create a grid similar to the one used on the next page and either you or the participants can select a behaviour to analyze. In many situations you will need to select a personal behaviour that will not cause embarrassment among participants. Some examples are: continuing versus stopping smoking, boiling versus not boiling drinking water, or wearing seatbelts. As a group, take 10 to 15 minutes to fill in the aspects of maintaining or changing the behaviour that are seen as benefits or costs.

Suggested activity:

Prioritizing means choosing three or four key messages that are potentially the most valuable for a patient given his or her particular circumstances and information and education needs.

## BENEFITS AND COSTS

Helping patients to consider the benefits and costs of a new behaviour is a practical way to encourage behaviour change. For example, continuing existing behaviour may have the benefit of being sexually enjoyable, but it may have the cost of getting infected with an STD. It is useful for patients to consider the benefits and costs of continuing their existing behaviour compared with changing behaviour. An example of the costs and benefits of using condoms is given below.

<i>Considering the Costs and Benefits of Using Condoms</i>			
<i>Existing behaviour (does not use condom)</i>		<i>Behaviour change (starts to use condoms)</i>	
<i>Benefit</i>	<i>Cost</i>	<i>Benefit</i>	<i>Cost</i>
<ul style="list-style-type: none"> <li>• <i>No change in behaviour</i></li> <li>• <i>Enjoys sex</i></li> <li>• <i>[for sex workers] Possibly more partners and more income</i></li> <li>• <i>Behaviour is socially acceptable</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Possible reinfection with STD and complications</i></li> <li>• <i>Possible HIV infection followed by death</i></li> <li>• <i>Regular partner possibly gets STD infection and complications</i></li> <li>• <i>Future children possibly get STD infection and complications</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Protects against STDs including HIV</i></li> <li>• <i>No chance* of infecting partner</i></li> <li>• <i>No chance of infecting children</i></li> </ul>	<ul style="list-style-type: none"> <li>• <i>Cost of condom</i></li> <li>• <i>Need to practise how to talk about using condoms</i></li> <li>• <i>Possibly reduces sensation or pleasure</i></li> <li>• <i>[for sex worker] Possibly fewer partners which may mean less income or poverty</i></li> </ul>
<p><i>* Condoms are up to 95% effective as a barrier against STD/HIV infection when used consistently and properly.</i></p>			

You may think that it is quicker to just tell patients about the benefits and costs of a particular sexual behaviour. This may be true. But it is much more encouraging if the patient identifies these things for themselves. Thinking through the issues helps patients to understand the consequences of their behaviour and to make a personal choice.

A good technique is to use questions to help patients think things through. An example is given below.

### *Mr Ang Considers his Choices*

#### **Background:**

*The Provider has already determined during the history-taking phase that Mr Ang has had a total of five sex partners in the last three months. Three of these partners were sex workers, one was a woman with whom he has a long-standing relationship, and the other was his wife. Mr Ang estimates that he uses condoms about half the time when he is with a sex worker, always when he is with his girlfriend, and never with his wife.*

*Provider: Mr Ang, I would like to spend a few minutes talking with you about how you might be able to avoid infection in the future.*

*Mr Ang: Well, I have been thinking of giving up going to girls [meaning sex workers], but I am not sure I can.*

*Provider: So you think it would be difficult?*

*Mr Ang: Yes, because I enjoy it and because my boss takes me with him to go to the brothel. But I am afraid of infecting my wife or my girlfriend. That would be horrible.*

*Provider: If you stop your visits to the brothel, what do you think would happen?*

*Mr Ang: Well, the only bad thing would be my relationship with my boss. I can't risk losing my job. That would be a disaster.*

*Provider: If you don't think it is possible for you to stop going to the brothel with your boss right away, there are some other choices you have. You could go less often. Or you can make sure you are always carrying condoms and go to a place where the girls are accustomed to using them. What do you think?*

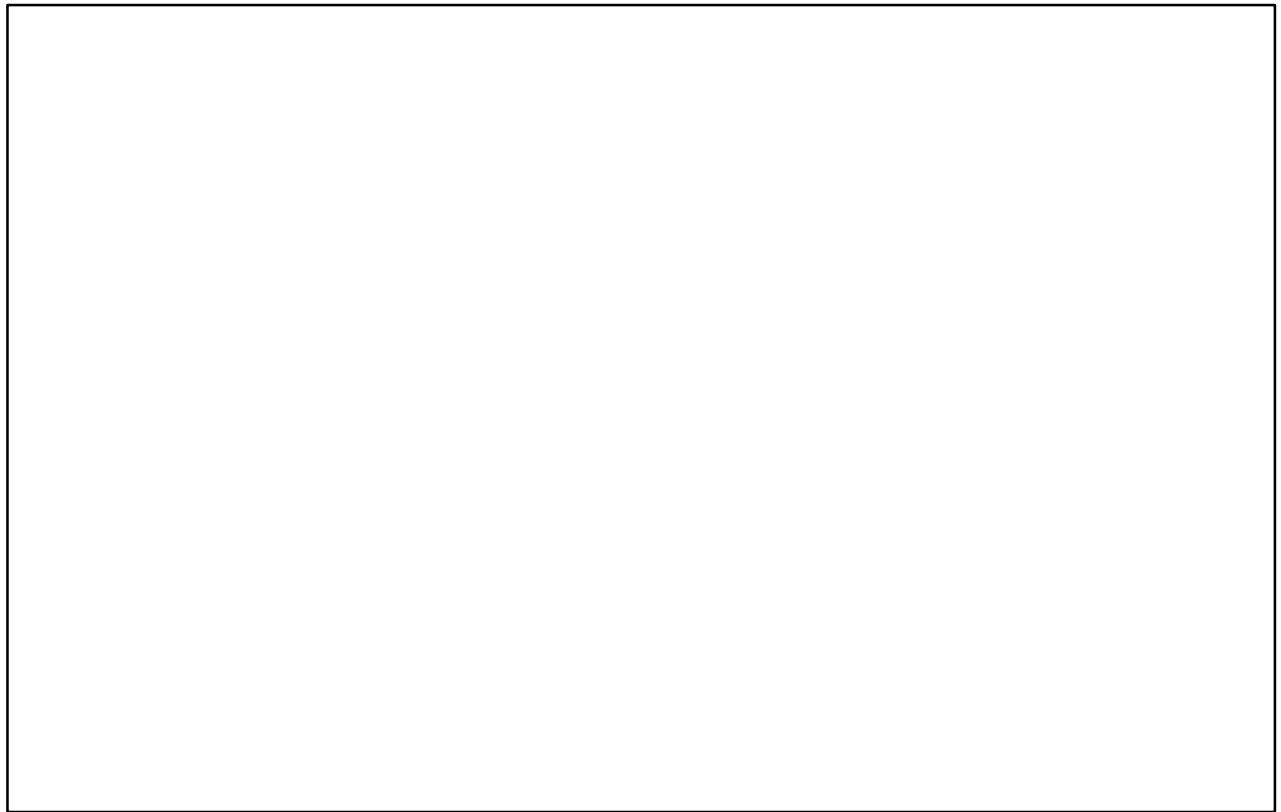
## **REALISTIC OPTIONS**

After thinking about the benefits and costs of specific behaviour, the patient needs to decide what change he or she will make. Encouraging patients to think about which options for behaviour change are realistic is also important and helps ensure the change is long-lasting.

Realistic options are those that take into account the reality of a patient's life, including barriers to behaviour change. The last statement made by the provider in the case of Mr Ang was a suggestion that is realistic given Mr Ang's situation.

Of course, mutual faithfulness, or not having sex at all, are the best options to prevent STD infections. But some patients

may be unable or unwilling to change their behaviour in this way. However, even in these cases, it may be possible for a patient to take some action to reduce the risks of further infections, as in the case of Mr Ang.



*Mr Ang and his boss changing their behaviours by using condoms correctly and consistently with their sexual partners.*

## **MAKE AN AGREEMENT**

After discussing realistic options for behaviour change, the patient needs to decide what they will do. Once the patient has made a choice, it is useful to make a verbal agreement about the changes he or she will make.

No matter how skilled you become in educating patients, some patients will choose not to change their behaviour. Try not to get discouraged when this happens. You are making an important contribution to a process of behaviour change

nevertheless. Your work with a patient may have a longer term effect. We know that there are many influences on behaviour change, and some people need to have the same or similar personal or educational experiences a number of times before changing their behaviour. Your contribution to this process is valuable whatever the results of a particular STD clinic visit.

## **TOPICS FOR EDUCATING PATIENTS**

### **Topics to Discuss with STD Patients**

- Explain the STD
- Explain the treatment
- Assess the behavioural risk
- Assess barriers to behaviour change
- Encourage choices to change behaviour
- Confirm decisions
- Talk about partners

If you have already taken the patient's behavioural history, you will be ready to move quickly through the information and education process.

### **EXPLAIN THE STD AND ITS TREATMENT**

While explaining the STD to the patient, it is best to use clear and simple language, and to avoid using medical terms. During this part of the conversation, you can also allow time for the patient to give you their understanding of the STD.

A patient needs to understand how they got the infection, or in other words that they became infected by having sexual intercourse with an infected partner. Patients also need to know about the consequences of their infection if it is not cured. It is good to make patients aware of the risks and consequences of their infection, but without making them fearful or causing panic.

## **Explaining the STD**

- Briefly describe which STD the patient has.
- Explain how the infection is passed, and what can happen if it is not cured.
- Ask the patient about his or her questions and concerns.

While you are explaining the STD, you should ask the patient about his or her questions and concerns. This will help you check that the patient has understood.

## **Explaining the STD Treatment**

- Briefly describe the necessary treatment.
- Give instructions on how to take the treatment.
- Explain and reassure about any common side-effects.
- Encourage the patient to take all their medication.
- Ask the patient about his or her questions and concerns.

As with any prescribing, you will describe the necessary treatment usually by naming the drug or drugs, and then give instructions on how to take it, including how much to take and for how long. It may be helpful to write down some key treatment details for the patient to take with them. If the patient cannot read, you might be able to use symbols for the key ideas. You can emphasize that to cure their STD, the patient must take all their medication and that treatment needs to be completed even if their symptoms disappear or they feel better.

It will help patients to respond appropriately when problems arise if you explain and reassure about any common side-effects.

Ask patients about their questions and concerns to check that they have understood. You may choose to ask the patient to repeat the treatment instructions as well.



## **ASSESS THE PATIENT'S RISK LEVEL**

After first recalling the information you learned from history-taking, you may need to ask the patient how they think they got the STD infection. If you already have this information, you may still want to ask about specific behavioural risk in greater detail to clarify the person's situation and needs. When there is plenty of time, you will be able to gather more information so that your educational approach will be appropriate to the patient's situation. When time is limited, you can perhaps identify a few key risk factors, based on your knowledge and experience of the local area.

### **How to Assess a Patient's Risk Level**

- Recall the information from history-taking.
- If necessary, ask the patient how they think they got infected.
- Ask about specific behaviours.
- Assess behaviours — are they “risky” or not?
- Identify behaviour changes that would reduce future STD risk.
- Check misconceptions about STD transmission and prevention.

***Risky and Protective Behaviours That  
Can Be Related to STD Infection***

***RISKY BEHAVIOURS***

***Personal sexual behaviour***

- *High number of sexual partners in past year*
- *Sex with new/different partner in past 3 months*
- *Other STD in past year*
- *Exchanged sex for money/goods/drugs (given or received)*
- *Use of substances to have “dry sex”*

***Other personal risk behaviours***

- *Skin-piercing*
- *Blood transfusion*
- *Injects drugs*
- *Drinks alcohol*

***Partner(s) sexual and other risk behaviours***

- *Partner has unprotected sex with others*
- *Partner injects drugs*
- *Male partner has sex with other men*

***PROTECTIVE BEHAVIOURS***

***Patient’s protective behaviour***

- *Condom use*
- *Low-risk or safer sexual activities in terms of STDs*
- *Only one mutually monogamous sexual relationship*

Please read through the list of behavioural factors related to STDs.

*Which issues are most relevant for the kind of patients you typically see?*

*Which issues are less important in your clinical practice as you try to assess an individual's risk of getting re-infected with an STD in the future?*

You will need to assess the behaviours you now know about and decide if they are risky or not. Risky behaviours are generally those that expose people to infected blood, semen, vaginal fluid or genital lesions. For some people however, their STD risk can be based on the risky behaviours of a stable sexual partner.

Although some risk behaviours can have a stronger effect on the chances of future STD infection than others, all patients diagnosed with STD can benefit from choosing to adopt safer sexual behaviours. In addition, those patients who are concerned about possible STD yet are diagnosed as infection-free, frequently acknowledge having a risk factor for STD that they can also choose to change.

Using this understanding of the patient’s risky behaviours, you should identify any behaviour changes that would reduce future STD risk.

Facilitating questions:

## PROMOTING RISK REDUCTION

### Safer Sex Options

- Limiting sexual partners to one monogamous relationship.
- Using condoms consistently and correctly.
- Replacing high-risk penetrative sex with low-risk non-penetrative sex.

Once you have assessed the patient's risk level, the next step is to help patients explore options for safer sex. The aim of safer sex is to protect people from coming into contact with semen, vaginal fluid, blood or genital lesions. In discussing safer sex with patients, it is good to begin by pointing out any safer sex options the patient is already practising. After this, you can then suggest specific ways to reduce their risk. Some patients are able to consider the option of having fewer sexual partners, or even sticking to just one monogamous partner.

Imagine a male patient tells you he has been periodically having unprotected vaginal or anal intercourse. If you suggest he stop this behaviour completely, he may think your suggestion is unrealistic, but he may be more receptive if you can discuss the possibility of starting to use condoms with him. Alternatively, you could suggest the possibility of substituting another behaviour for high-risk ones, like trying mutual masturbation instead.

With many patients, you can also discuss how safer sex to prevent STD infection relates to family planning. Condoms are a good method for both preventing pregnancy and STD infection, but at the same time you should emphasize that some of the other popular family planning methods (including the birth control pill, IUDs, and sterilization) do not protect against STD infection.

Whenever you are discussing sexual behaviour with a patient, check for misconceptions. Accurate information about the

*What are some common beliefs about protection against STD in your region?*

*Are there any other beliefs people have about STDs and how they are transmitted?*

Discussion points:

Misconceptions about STDs and how to protect against infection are common. Below is a list of some beliefs from around the world. Some beliefs may act as barriers to behaviour change. Participants may mention several others.

- Taking antibiotics before or after having unprotected sexual intercourse will prevent STD infection.
- You usually get STDs from toilet or towels.
- One STD can turn into another.
- You can only get one STD at a time.
- You can tell who has an STD or HIV by how he or she looks or feels.
- You can see if someone has an STD by looking closely at their genitals because people with STDs always have symptoms.
- STDs are only a problem for dirty or uneducated people or for people who have many sexual partners.
- Taking anti-malarials before or after sex prevents STDs.
- Urinating or douching after sex protects against STD.
- Only sex workers are at risk of an STD. Having sex for a bit of money once in a while is safe.
- All STDs, including HIV, are detected using the same diagnostic test.

Facilitating questions:

causes of STDs or how to prevent infection is often mixed with myths or rumours. Misinformation about STDs needs to be corrected, so that people can choose effective means to protect themselves from infection.

## **BARRIERS TO CHANGING BEHAVIOUR**

A health message is usually not enough to make people change their behaviour. There are many barriers that may make it difficult for people to consider changes. These barriers might arise from different aspects of the patient's life and experience.

<b>Factors that can Function as Barriers to Behaviour Change</b>
<ul style="list-style-type: none"><li>● Gender (male or female)</li><li>● Age</li><li>● Cultural practices</li><li>● Religion</li><li>● Poverty, social disruption and civil unrest</li></ul>

A health message is usually not enough to make people change their behaviour. There are many barriers that may make it difficult for people to consider changes. These barriers might arise from different aspects of the patient's life and experience.

Facilitating questions:

*What kinds of things would you describe as barriers to behaviour change in your region? Describe how the barriers operate.*

*What other barriers might apply? For instance, what rules or customs in your society can interfere with changing sexual behaviour?*

*Do these barriers vary between men and women, or between people of different ages?*

*An example of a barrier to effective condom use.*

## **GENDER**

Women often have little control over how they have sex, when, with whom, and under what circumstances. They are often unable to protect themselves, even if they want to. Some women may have access to condoms, for example, but cannot get men to use them.

Gender barriers also affect men. For example, a man may feel that he needs to have mistresses or girlfriends to be considered masculine by his peers. In some cultures, it may not be considered masculine to use a condom.

## **AGE**

Young people frequently find it difficult to find or take advantage of health services, including contraception and STD services. They may also have received inaccurate sex education.

## **CULTURAL PRACTICES**

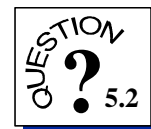
Cultural practices may help or hinder the patient's ability to change behaviour. The difference in age between a man and a woman at marriage, puberty rites, sexuality, child-rearing or the values of family and the community may all influence behaviour.

## **RELIGION**

Religious practices may influence the adoption and maintenance of safer sexual behaviour. Many religions discourage open discussion about sexuality and use of condoms, and this can be a barrier to behaviour change.

## **POVERTY, SOCIAL DISRUPTION AND CIVIL UNREST**

Circumstances beyond their control may push women and girls or boys into trading sex for money, food or even survival. Women may be pressured into having multiple sex partners as a way of supporting themselves and their children.



## **PATIENTS WHO GET RE-INFECTED WITH AN STD**

Patients who get re-infected with an STD need special attention and education. These patients have a higher risk of being infected with HIV, and they are also vulnerable to the serious consequences of long-term STD infection if it goes untreated for some time.

It is essential to spend more time with these patients. They may feel unable to make any changes in behaviour to reduce their risk of contracting an STD. You need to help them find easy changes that they can make and continue with for a long time. After succeeding in a few changes, they may be better able to make additional changes to reduce further their risk of STD infection.

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**Remember:**

*With all patients, the goal is to achieve realistic, long-lasting behaviour changes.*

---

## **THE NEED TO TREAT SEXUAL PARTNERS**

This is the theme of Module 6, so we will not discuss it in detail here. Remember that you should always tell your patient that it is important to treat all of his or her sexual partners. Your patient can be re-infected if partners are not treated, unless condoms are used all the time. Talk with your patient about ways to persuade their partners to come for treatment. Reassure the patient that you will continue to maintain their confidentiality.

## **BUILDING EDUCATIONAL SKILLS**

We have now covered the topics you will discuss with a patient, and why it is important to discuss behaviour change. You have learned that patients need to make three essential decisions:

- to complete their treatment;
- to change sexual behaviour; and
- to have sexual partners treated.

This section focuses on some practical techniques for communicating this information to patients.

## Six Educational Skills for Promoting Behaviour Change

- Explaining and instructing
- Modelling
- Reinforcing strengths patients already have
- Helping patients explore choices
- Rehearsing what the patient will say or do
- Reinforcing the patient's decisions

How do we encourage a patient's desire to change? First, it is important to use the communication skills that you developed while studying Module 3: open questions, facilitation, summarizing and checking, reassurance, direction, empathy and partnership. Please review or practise these skills again if you still feel uncertain about them.

You will find that these communication skills are important tools for educating and motivating behaviour change. They will help you to encourage patients to make choices and decisions. These skills will also help in coping with the emotional issues and shock that the patient may experience when they find out that they have an STD and how they became infected.

### EXPLAINING AND INSTRUCTING

Explaining means telling patients how or why something should be done. Instructing means telling patients what to do or how to do something, such as use a condom or take medication. These are skills that providers frequently use.

#### *Explanation and Instruction*

##### *Explanation:*

*"You have pain low in your tummy because of an infection passed to you during sexual intercourse ..."*

##### *Instruction:*

*"Remember to complete the whole course of tablets, to the very last one ..."*

Tip:

A good way to invite participants to discuss these skills is to ask if anyone can explain what each skill means. If participants cannot find the words to explain them, perhaps they can give examples from their own experience.

---

#### **IMPORTANT:**

*This course cannot train you to become a counsellor. If you have had training in educating or counselling patients, you should already have the above skills and more. If appropriate, please share your experience and help others to practise these skills.*

---

You may be able to improve these skills even further by checking that you are:

- asking patients what they already understand before explaining something in detail;
- discussing the patient's own ideas;
- communicating using clear and simple language;
- adapting your language and how quickly you say things to the needs of the patient; and
- asking if the patient has understood what you said.

*Swanti*

*Provider: Please don't worry Swanti, I'm going to help you all I can. Your illness is caused by an infection. Do you know how you got the infection?*

*Swanti: Well, I'm not sure but ... um ...*

*Provider: Yes?*

*Swanti: Well, perhaps it's something I ate?*

*Provider: I'm afraid not. This is going to be difficult news for you. ... You have pelvic inflammatory disease. It's a sexually transmitted disease. Do you know what that means?*

*Swanti: Well, that comes from touching dirty people ... but it can't be that.*

*Provider: You're right, it's not that... but perhaps you'll think this is worse. Illnesses like this one are only caused by having unprotected sex with someone else who has the same illness. Unprotected sex means sex without a condom.*

*Swanti: But I only make love with my husband. He's not ill ...*

*Provider: He doesn't necessarily have to feel ill, Swanti. People often don't. But if you've only been with him, then he must have passed the infection to you. And he must have got the infection ...*

*Swanti: From sex with someone else? No ... No.*

*Provider: You're very upset at this news, I can see. You need time to think about it.*

Notice how carefully the service provider is introducing news to Swanti. He or she is breaking the explanation into very small steps in order to be sensitive to Swanti's feelings.

## MODELLING

Modelling means giving examples of how the recommended behaviour has been successful for others who are similar to your patient. The box below shows the provider using this skill during Nguyen's interview.

### *Nguyen*

*Nguyen:* *Can't I ever have some fun without risking this again?*

*Provider:* *Of course you can have fun. It just needs to be a little different. It's hard to change, so let's talk about how you can be safer.*

*Nguyen:* *Are you saying there's something wrong with having a drink first and stuff?*

*Provider:* *Only because drinking tends to make people forgetful. It's hard enough to get used to a condom, but if you're drinking it's even harder to remember to use one and I've noticed more guys are being careful – and they still have their 'fun'. I've seen lots of guys lately who have decided to drink less and use a condom.*

*Nguyen:* *Well, I think I can probably try to keep a condom available and not drink too much so I lose control.*

You can use modelling to give examples from your own experience: "From my work I know ..." or "I have noticed that ...".

Why is giving positive examples so important? We know that if people are too fearful, they are unlikely to change their behaviour. Focusing on the positive things about a change is more effective for helping patients change their behaviour.

## REINFORCING STRENGTHS

Reinforcing strengths is when you point out a strength that you see in the patient. This is something that will help him or her recover or prevent the recurrence of STD infection. It encourages a patient to realize that they can help themselves.

### *Nguyen*

*Nguyen:* *OK, like I know it's important but ... I don't think I could get used to it at all ...*

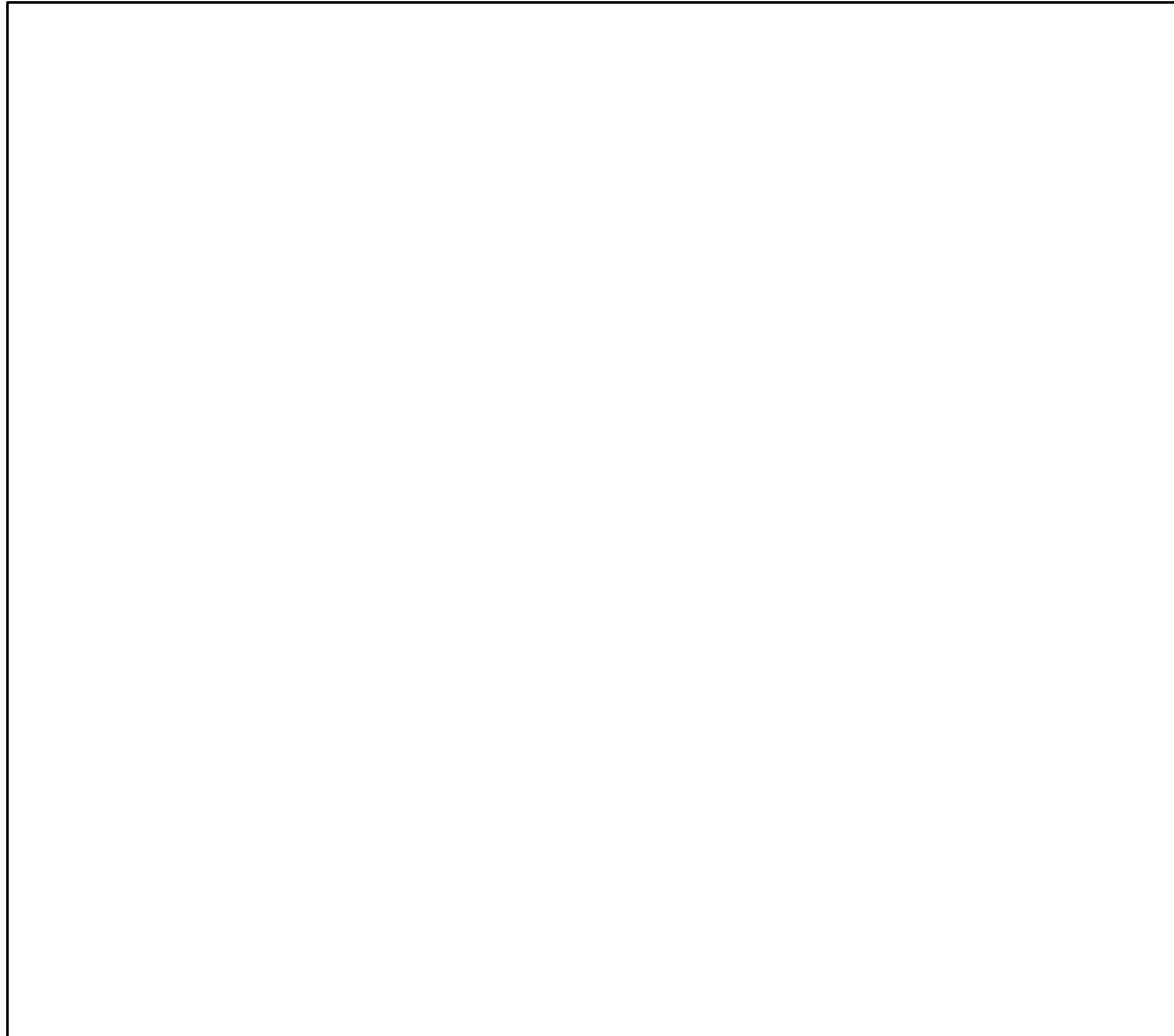
*Provider:* *It's hard I know, but I noticed you walked 10 kilometres here to get treatment your infection. Your determination and concern will help you to be safe.*

**Swanti**

*Swanti: I feel ... as if my whole life has been broken. I can't cope with all this ...what am I going to do?*

*Provider: I understand your feelings Swanti. Your sense of trust has been broken. You care for your husband and family very much, and those feelings will help you to get through the next few days ... but first, let's talk about how we can get you better!*

*Swanti: Yes, yes... you're right of course. I've got to think about this for a while. Are you going to give me some tablets?*



## **EXPLORING CHOICES**

When exploring choices, you can point out different choices or steps that the patient can take towards curing the current STD and preventing another one. You can then help the patient to decide which is the best choice for them. In this way, the patient will have made their own decision to change a behaviour, which is the key to a lasting change.

**Nguyen**

Nguyen: *So it's condoms or one partner or sex without intercourse...*

Provider: *That's right. You can either settle down with one partner or, if you're not ready for that, protect yourself with condoms or non-penetrative sex. Which will be easiest for you right now?*

Nguyen: *Condoms I suppose. I'm not going to settle down yet!*

**Swanti**

Provider: *For today Swanti, I'd like you to make a choice. Would you prefer to avoid sex until you have finished the treatment, or to ask your husband to use condoms?*

Swanti: *That's easy, no sex for a while. That won't be a problem because he knows I'm not feeling well. It'll give me time to think about things a bit.*

Provider: *Yes, it will...that is a good idea.*

## **REHEARSING THE DECISION**

Once a patient has decided by themselves to modify a behaviour or behaviours, it is important to rehearse the decision. This means asking the patient to think through how they will put the decision into practise.

**Nguyen**

Provider: *Very good Nguyen. How are you going to explain this to your girlfriends?*

Nguyen: *Well, I could start by saying there are lots of bad diseases around, and that we must be careful to avoid them.*

Provider: *That sounds great. Go on.*

**Swanti**

Provider: *So, you're planning to avoid sex until you've finished the tablets. Your husband needs to be treated as well*

...

*how will you approach him about it?*

Swanti: *I need to talk to him about a few things. I mean, is it something serious or is he just playing around? Or perhaps I'll just ask him to come and see you ...so you can treat him.*

Rehearsal is also useful when you want to check that the patient has understood your instructions about treatment.

### *Nguyen*

*Provider: Well, Nguyen, I think that's about everything. Just tell me once more what you intend to do with these tablets.*

*Nguyen: I'm going to take all of them just as I've got on this piece of paper – I'll keep the paper in this pocket – and I'm not going with my girlfriends until I've finished them ...but I'll buy some condoms just in case ...*

### *Swanti*

*Provider: You're being very brave, Swanti, and that's important. Go over your plans with me once again.*

*Swanti: Get better, take all the tablets, find time to talk to my husband about a few things. And he needs treatment too...*

*Provider: Yes, well done. And you will come and see me again if you need to?*

*Swanti: Yes. I will.*

## **REINFORCING DECISIONS**

So far you have helped the patient to understand a number of issues. You have also helped prepare them for what they will do after leaving the health centre. Reinforcing decisions is a useful way of summarizing and concluding the interview. Ask the patient to repeat his or her decision to you. Having reinforced their decision to themselves, patients are much more likely to make the planned change in their behaviour.



## **USING CONDOMS TO STAY CURED**

Condoms help people to avoid STD infection by preventing contact with vaginal fluids, semen or blood. Using condoms is especially recommended if a patient currently has sex with several partners, and it is also important when the patient's partner has other sexual partners. But it is not enough to know that condoms are important. Patients also need to use condoms correctly, and consistently.

Many people resist the idea of using condoms. This can be because they are embarrassed about buying or using condoms, or because they are worried about the cost. Some people think that condoms make sex less enjoyable, or that condoms are too big or too small. And there are often myths about them, including rumours that condoms are not effective or that condoms are infected with STDs. People may also associate condoms with commercial sex, rather than for use during sex with a regular partner. It is important to be aware of negative ideas about condoms in your area. These ideas can be barriers to condom use.

## ENCOURAGING CONDOM USE

### Encouraging Condom Use Involves:

- Finding out what the patient knows about condoms and how they feel about using them
- Explaining the benefits of condoms
- Correcting any mistaken beliefs the patient has that might prevent them from using condoms

The communication skills that you have learned to apply to history-taking and educating are important tools for encouraging condom use. You could start easily by asking the patient what they think of condoms. Again, we return to the case-study with Nguyen to illustrate these skills.

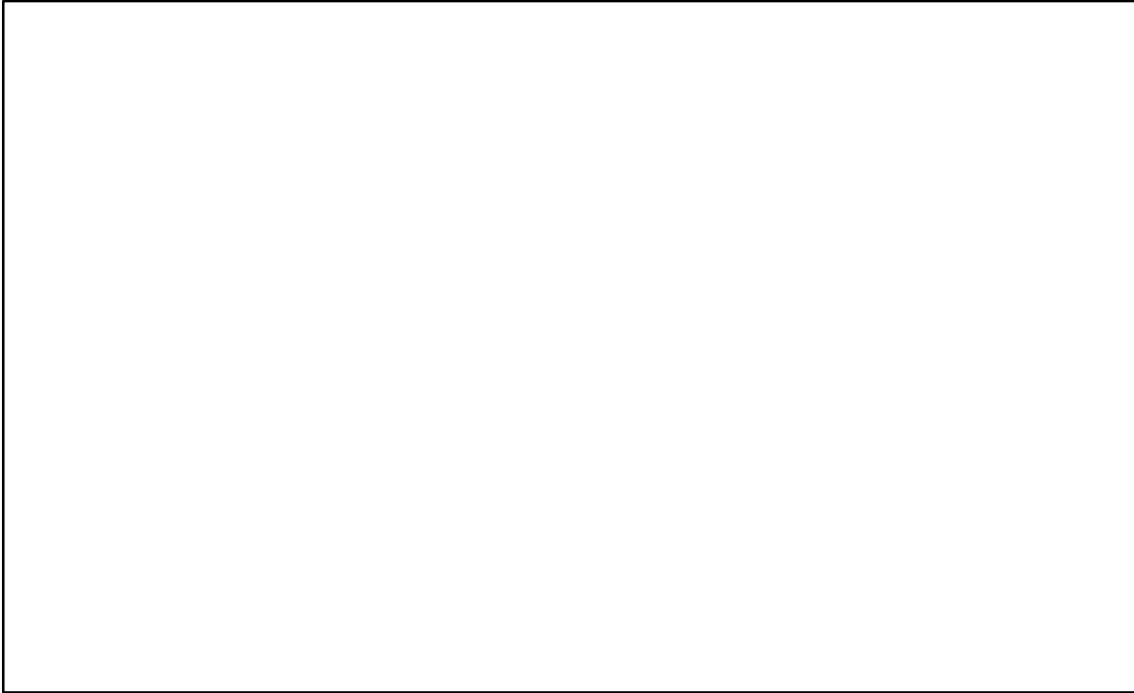
Facilitating questions and discussion points:

*What do you think are the benefits of using condoms? Do you think your patients would also see this as a benefit?*

Condoms can provide a number of possible advantages:

- They prevent transmission of STDs, including HIV.
- they help women to avoid pregnancy.
- Women feel dryer inside.
- The patient will feel safer.
- Many men can prolong intercourse if they wear a condom.

**If the patient continues to be resistant to considering condom use, you can discuss again other forms of safer sex.**



*Preparing to use a condom.*

**Nguyen**

*Nguyen:* You said using condoms is one way of keeping safe, but I wouldn't use them.

*Provider:* Why not?

*Nguyen:* Well, they're a nuisance. I mean they get in the way, if you know what I mean.

*Provider:* So you have tried to use them before?

*Nguyen:* Well, no. But I've been told that.

*Provider:* Well, they needn't get in the way. I can show you how to use them. I know a lot of men who have fun with them because they ask their partners to put the condom on for them.

*Nguyen:* Yes, but what if it comes off?

*Provider:* It will not come off if you use it properly, I promise you. Any other reasons for not liking them?

*Nguyen:* No, that's the main thing.

*Provider:* Some men say that condoms can actually make intercourse last longer. What do you think of that?

*Nguyen:* (Laughs with embarrassment) Sounds OK.

*Provider:* Would you be willing to try using them?

*Nguyen:* OK, I could give them a try.

*Provider:* Good – but remember, if you don't use condoms, you should stick with one partner or practise non-penetrative sex. Let me show you how to use a condom.

Facilitating questions and discussion points:

*Are there any additional mistaken beliefs about condoms among people in your area? Who holds these beliefs?*

Some common mistaken beliefs about condoms:

- Condoms reduce sexual pleasure for men or for women.
- Condoms carry diseases like fungus.
- Condoms are unreliable because they break.
- Condoms can come off the penis and get lost inside the woman.

For each patient, you will need to explain the benefits of using condoms that are most relevant or appealing to that patient.

## DEMONSTRATING CONDOM USE

You should not only discuss condom use with patients, but also demonstrate the correct way to use a condom. Many people believe they know how to use a condom, but in fact are making mistakes which make the condom less effective in preventing STDs. Both men and women need to know how to use a condom correctly.

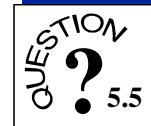
Demonstrating Condom Use
<ul style="list-style-type: none"><li>• Give a complete demonstration to each patient.</li><li>• Ask the patient to repeat the actions themselves, in front of you.</li><li>• Stress the need to carry condoms at all times.</li></ul> <p>Two additional tips:</p> <ul style="list-style-type: none"><li>✍ Water-based lubricants are safe to use with condoms. So are most spermicides. Do not use oil or oil-based lubricants such as petroleum jelly, because they damage the latex.</li><li>✍ Condoms can only be used once.</li></ul>

If a patient says that he or she knows how to use a condom, it is useful to have them demonstrate this. You can then make sure they know how to use the condom correctly and, if necessary you can correct any mistaken ideas.

Please look at the figure below to review the main steps in correct use of a condom. To do your condom demonstration, you will need a supply of condoms and a penis model or a substitute (for example, a banana or a broom handle).

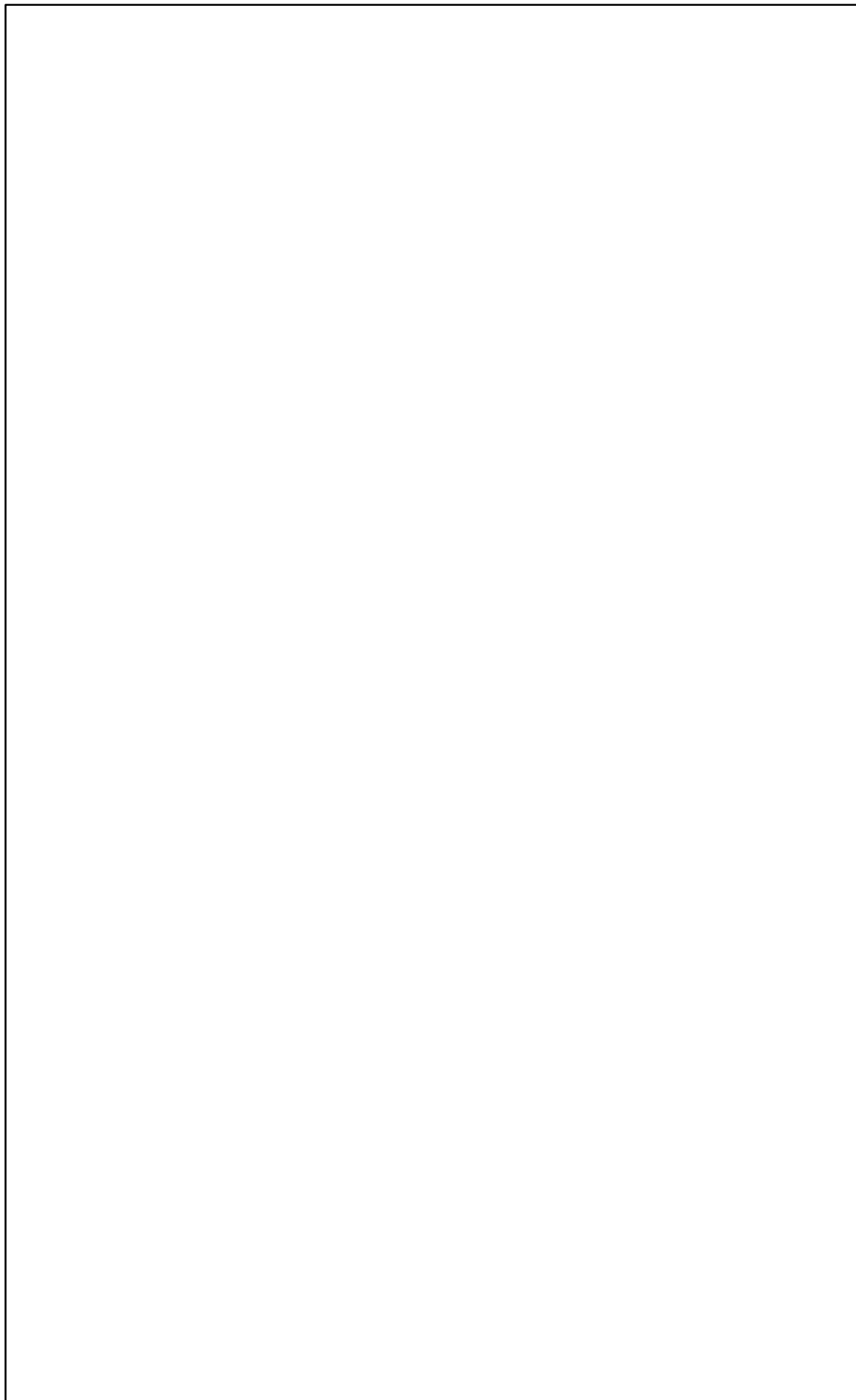
A young man with an STD tells you impatiently: "I already know how to use condoms! What's the point of demonstrating it to me?" What might you say to him?

Many young men might respond as this one does. You might respond by accepting his statement and asking him to demonstrate their use to you: "Fine, why don't you show me (on this model) how you would use one?" This gives you the opportunity to check whether he can use a condom properly and to remind him of the advantages of doing so. If he is too embarrassed to show you, then you could offer to demonstrate it, while asking at each step if this is what he would do.



Facilitating question and discussion point:

## Step-by-step Guide on Correct Condom Use



# REVIEW

## WHY EDUCATE?

Patients with STDs need education to help them make three essential decisions:

- to complete their treatment;
- to change any risky sexual behaviour; and
- to see that their sexual partners are treated.

Education encourages patient behaviour change and is an integral part of syndromic STD case management.

Education is more than just giving information. It is a two-way process that helps patients to make the right decisions for themselves.

## EDUCATING TO PROMOTE BEHAVIOUR CHANGE

Approaches to encouraging behaviour change include:

- ensuring privacy and confidentiality;
- building trust by listening and looking at patients;
- making your messages as non-judgemental as possible;
- using clear and simple language;
- focusing on the information and education needs of each patient;
- limiting and prioritizing your messages;
- helping patients to consider the benefits and costs of a new behaviour;
- focusing on realistic options for behaviour change; and
- making an agreement once the patient chooses to try a new behaviour.

## **TOPICS FOR EDUCATING PATIENTS**

Topics to discuss with STD patients include:

- explaining the STD;
- explaining the treatment;
- assessing behavioural risk;
- assessing barriers to behaviour change;
- encouraging choices to change behaviours;
- confirming decisions; and
- talking about partners.

## **BUILDING EDUCATIONAL SKILLS**

Communication skills combined with educational skills will help the patient to make and maintain behaviour changes.

The educational skills that the STD health care provider uses are:

- explaining and instructing;
- modelling;
- reinforcing strengths;
- exploring choices;
- rehearsing decisions; and
- reinforcing decisions.

## **USING CONDOMS TO STAY CURED**

Encouraging condom use involves:

- finding out what the patient knows about condoms and how they feel about them;
- explaining the benefits of condoms; and
- correcting any mistaken beliefs that may prevent the patient from using condoms.

How to use condoms should be demonstrated to each patient. Those that say they already know how to use a condom should be asked to demonstrate their knowledge to make sure that they use condoms correctly.

# QUESTIONS AND ACTIVITIES

## 5.1 ACTIVITY

What words are commonly used to describe these syndromes in your region, and what do people believe causes them? You may want to turn to your answers to activity 3.2 to recall the local language term(s) you already identified.

Syndrome	Local Language Term(s)	Cause or description
Vaginal discharge		
Urethral discharge		
Genital ulcers		
Lower abdominal pain		

## 5.2 QUESTIONS

Imagine you have taken the history and assessed the risks for each of the four STD cases that follow. On the basis of the information you have been given, make notes to answer these two questions:

- What risk behaviours should the patient aim to avoid in the future?
- What barriers to change might arise from the patient's circumstances?

### ***Violet***

*Violet is a 19-year-old sex worker who lives in a slum area of town. She has one small child who is often sick. Violet is also using her earnings to help support her family who live in a remote village. Her family members disapprove of her job but eagerly accept the money that she sends home. She is afraid of AIDS but finds that many of her clients refuse to use condoms. You have diagnosed a genital ulcer.*

Risk behaviours:

Barriers:

### ***Akira***

*Akira is a 24-year-old single man with a good job and his own home. He doesn't want to settle down for a long time, describing himself as 'a good time guy'. He has three sexual partners and sometimes has casual sex too. However, he says he chooses women who are 'clean' or 'married', so he can't understand why he now has a urethral discharge. During the interview he admits that he often gets drunk or injects drugs with one of his partners before sex.*

Risk behaviours:

Barriers:

### ***Amina***

*Amina is 35, married with three teenage children. She relies on her husband's income from factory work to support the family. During the interview, she said that she has sex only with her husband. She responded to your questions by saying that her husband often worked late at the factory, and that he went for a drink with friends occasionally. She can sometimes smell the alcohol on his breath. However she describes feeling quite secure in his faithfulness to her. She came to the centre with no idea of the cause of her abdominal pain — you have diagnosed pelvic inflammatory disease.*

Risk behaviours:

Barriers:

### **Tapu**

*Tapu is a 47-year-old married man, living in a rural area. His eldest brother died recently and everyone in the family suspects that he died of AIDS. Tradition dictates that Tapu will inherit his brother's 36-year-old wife, taking her as his second wife. He has heard a lot about AIDS on the radio, and so is fearful that he and his first wife might be exposed to AIDS or STD. Presenting initially with bad head pains, Tapu has really come to ask your help in resolving this problem.*

Risk behaviours:

Barriers:

## **5.3 ACTIVITY**

### **ROLE-PLAY FOR ASSESSING RISK BEHAVIOUR**

The aim of this role-play is to practise skills for educating patients up to the point where the patient has understood the need to change sexual behaviour, including what constitutes risky and safe sexual behaviour. This corresponds to the first three topics listed on page 10. At the end of this exercise, you will be able to:

- apply effective communication skills when educating patients about STDs; and
- clarify areas on which you want to work further in order to refine your skills.

#### **General instructions**

1. Please read the four case-studies that follow this page. They will give you a general description of each patient. Imagine you have already taken the patient's history and diagnosed the STD as indicated in each case-study.
2. Decide who will play the role of the patient, the provider and the observer.
3. The patient should select one of the case-studies. Pick the case-study that is similar to cases you commonly see in your clinical setting or that presents issues you want to learn to deal with more effectively. Tell the provider and the observer which case-study you have selected.
4. Individuals playing the part of patient, service provider and observer need to read the instructions for each role that follow the case-study descriptions.
5. When the role-play is completed and each of you is satisfied that you have given or received sufficient feedback, exchange roles and repeat steps 2. through 4. above, so that each participant has the opportunity to practise education skills at least once.

**Violet**

*Violet is a 19-year-old sex worker who lives in a slum area of town. She has one small child who is often sick. Violet has no boyfriend, steady partner or spouse. She is also using her earnings to help support her family who live in a remote village. Her family disapprove of her job but eagerly accept the money that she sends home. She is afraid of AIDS but finds that many of her clients refuse to use condoms; she also has a limited knowledge about STDs. You have just diagnosed a genital ulcer and Violet is afraid it might be an STD.*

**Akira**

*Akira is a 24-year-old single man with a good job and his own home. He does not want to settle down for a long time, describing himself as 'a good time guy'. He has three sexual partners and sometimes has casual sex too. However, he says he chooses women who are 'clean' or 'married', so he can't understand why he now has a urethral discharge. During the interview he admits that he often gets drunk or injects drugs with one of his partners before sex. You have just confirmed the urethral discharge.*

**Amina**

*Amina is 35, married with three teenage children. She relies on her husband's income from factory work to support the family. During the interview, she said that she has sex only with her husband. She has already explained that her husband often works late at the factory, and that he goes for a drink with friends occasionally. She can sometimes smell the alcohol on his breath. However she describes feeling quite secure in his faithfulness to her. She came to the centre with no idea of the cause of her abdominal pain. You have just diagnosed pelvic inflammatory disease.*

**Tapu**

*Tapu is 35, married with four children and living in a rural area. He attended an urban clinic with a swelling in his groin which the service provider diagnosed as an inguinal bubo. In answering the service provider's questions, he admitted reluctantly that he has sex with a number of other partners, many of them casual, in the course of his search for work. He regularly travels to the city, working away from home for three months at a time. He says that his wife is currently six months pregnant. He has not been home for two months though he regularly sends home money. He is currently living with a casual partner in the city.*

## **THE PATIENT'S ROLE**

Please read your selected case-study very carefully, because your aim is to respond as realistically and honestly as you can to whatever the provider says and does. Do not try to make it either easy or difficult for him or her.

1. Based on the limited information you have about the patient, decide in advance what factual information you may need to answer the provider's questions. Common questions might be about how many partners you have, whether you use condoms regularly and what you know about the transmission of STDs.
2. Note your feelings as this patient. For example, how do you feel while waiting for your diagnosis? What questions, if any, do you have for the provider? What is worrying you?
3. During the role-play, identify as much as you can with how this patient would behave. Use empathy to experience what the patient might feel in this situation.
4. After the role-play, explain how you felt about the interview experience. It is important to provide feedback, both on what worked well and what didn't. For example, you might tell the provider you felt reassured by the way they spoke to you softly so that others would not hear, and that you felt a little rushed and only wish they had given you more time to talk about your feelings about having the STD.

Very specific feedback is also helpful for the provider, such as "I didn't understand when it was time to put on the condom... right away or just before the man wants to have intercourse, or what?"

5. As the provider and observer review the exercise, feel free to add any useful insights you have into the provider's behaviour. Make sure that your suggestions are positive ones that will help the provider to develop his or her skills.

## **THE PROVIDER'S ROLE**

The goal of this exercise is for you to get clear feedback on your present skills and areas that you might usefully rehearse or refine.

During the role-play, you will try to obtain the patient's compliance on treatment, and their understanding of safer sex to prevent future infections. In other words, you don't need to specify barriers to behaviour change, advise on risk reduction or conduct the condom demonstration. This is because another role-play later in this module will cover these topics.

Remember to use your skills in education and motivation to help the patient make choices and confirm any decisions.

1. Carefully read the observer's check-list following the description of the observer's role to review the skills and themes that the observer will be looking for in your interview.
2. Re-read the case-study that your 'patient' has selected to familiarize yourself with the information you have already learned while taking their history. If you wish, make notes on questions you want to ask the patient.
3. Spend about five minutes conducting the interview, starting with a conversation about your STD diagnosis, and stopping when you feel sure that the patient understands high-risk and safe sexual behaviour — or after the agreed time if that comes first.
4. After the role-play, allow the patient to give you feedback on how he/she felt during the interview. Next, give your own views and feelings about how the education process went. Finally, the observer will provide feedback based on the check-list on the next page. Feel free to ask either the patient or observer to clarify what they have said. It will be most helpful to you if you are able to get clear suggestions and, hopefully, confirmation of the skills you have mastered.

## **THE OBSERVER'S ROLE**

After the role-play, your task is to give the provider clear and objective feedback on how they conducted the interview. You are looking for the provider's success in terms of patient education.

1. Read through the check-list below to familiarize yourself with the skills and issues that the service provider should use.
2. Time the interview and stop it after an agreed time, such as five minutes.
3. As you observe, make quick notes on the skills you see the provider use, and how effectively you think he/she uses them. If possible, note examples of what was said or done during the interview so that your feedback will be as practical and concrete as possible.
4. Ask the patient and then the provider to review the interview. After they have finished, start your feedback by responding briefly to the provider's self-criticism, and then give your own feedback, skill by skill or however else you think appropriate. Be willing to give negative criticism if necessary, but offer it in a constructive way: "When the patient said ... you said ... Perhaps it would have helped if ..." and so on. Always stress the provider's achievements and be as practical as you can. For example, suggest alternative ways the provider could have introduced specific issues, or ask him/her to identify when one skill might have been more appropriate than the one used.
5. Finally, lead a discussion about what the three of you have learned from the role-play. There might be a number of valid issues that this module has not included.

## OBSERVATION CHECK-LIST FOR ACTIVITY 5.3

Does the Provider:	Use this side for your notes
<p><i>Cover these education issues?</i></p> <ul style="list-style-type: none"> <li>• The STD, its implications and treatment, and the importance of complying with treatment</li> <li>• The patient's risk level</li> <li>• The need to change sexual behaviour and what constitutes safer sex</li> </ul>	
<p><i>Use these education skills</i></p> <ul style="list-style-type: none"> <li>• Explaining and instructing</li> <li>• Modelling</li> <li>• Reinforcing strengths</li> <li>• Exploring choices</li> <li>• Rehearsing decisions</li> <li>• Reinforcing decisions</li> </ul>	
<p><i>Apply these communication skills ?</i></p> <ul style="list-style-type: none"> <li>• Open questions</li> <li>• Facilitation</li> <li>• Summarizing and checking</li> <li>• Reassurance</li> <li>• Direction</li> <li>• Empathy</li> <li>• Partnership</li> </ul>	

## 5.4 ACTIVITY

### ROLE-PLAY FOR SUPPORTING BEHAVIOUR CHANGE

For this role-play, you will have the opportunity to practise educating patients on all the remaining issues, including the use of condoms. The only issue to leave out is the last point on the list of topics, treating the patient's sexual partners, as this will be covered in Module 6.

For this role-play, we will use the same case-studies as for the previous activity (see page 35) and just continue on from where the role-plays finished last time. This should be at the point where the patient has understood what is meant by safer sexual behaviour. The provider's remaining tasks are:

- to identify barriers the patient may have to changing current behaviour; and
- to help the patient identify appropriate behaviour changes and decide which one(s) they will try. The behaviour change information should include using condoms. The service provider should educate the patient on relevant personal benefits of condoms as well as giving a step-by-step demonstration.

Please arrange your role-plays exactly as you did previously, except this time the 'provider' can concentrate on developing particular skills identified during his or her previous role-play and feedback. The observer should look for the same educational and communication skills, and concentrate on the issues above.

<b>Observation Check-list for Activity 5.4</b>	
<b>Does the Provider:</b>	<b>Use this side for your notes</b>
<p><i>Cover these education issues?</i></p> <ul style="list-style-type: none"> <li>• The STD, its implications and treatment, and the importance of complying with treatment</li> <li>• The patient's risk level</li> <li>• The need to change sexual behaviour and what constitutes safer sex</li> </ul>	
<p><i>Use these education skills</i></p> <ul style="list-style-type: none"> <li>• Explaining and instructing</li> <li>• Modelling</li> <li>• Reinforcing strengths</li> <li>• Exploring choices</li> <li>• Rehearsing decisions</li> <li>• Reinforcing decisions</li> </ul>	
<p><i>Apply these communication skills ?</i></p> <ul style="list-style-type: none"> <li>• Open questions</li> <li>• Facilitation</li> <li>• Summarizing and checking</li> <li>• Reassurance</li> <li>• Direction</li> <li>• Empathy</li> <li>• Partnership</li> </ul>	

## 5.5 QUESTIONS

Here is a condom quiz. There are many myths about condom use. Tick the proper column to indicate whether each statement is true or false.

### CONDOM QUIZ

<i>Statement</i>	<i>True</i>	<i>False</i>
Condoms can get lost inside the woman.	•	•
Condoms don't protect against STDs including HIV.	•	•
Condoms can be kept in a pocket or wallet indefinitely.	•	•
It is OK to use glycerin or water-based lubricants with condoms.	•	•
Pull the condom tight over the head of the penis to ensure a snug fit.	•	•
Squeeze the air out of the tip of the condom as you put it on.	•	•
Condoms should be stored in a cool, dark, dry place.	•	•

Ideally, health centres could provide patients with free condoms. If this is not possible, please answer the following questions, so that you can advise your patients accordingly:

- Where can the patient buy condoms?
- How much do they cost?
- Are they of good quality?
- Are different sizes available?

## 5.6 ACTIVITY

### ASSIGNMENT

The health centre offers many opportunities to supplement patient education. These opportunities could be provided by people in different areas of the centre as well as by a range of other communication tools like posters, flipcharts, brochures or others.

#### IDEAS FOR PATIENT EDUCATION IN THE CLINIC SETTING

**Who?** *All staff who meet patients can assist with patient education. For example, staff at reception might contribute by demonstrating respect, empathy and reassurance. This helps maintain patients' dignity and reduces any fear or shame they might feel.*

**Where?** *Patient education can take place at each step that patients go through during a visit to the health centre, from the registration desk to the waiting room, the examination or interview room and the dispensary.*

**How?** *A health centre can draw on a wide range of media for its education process, limited only by the resources available. To name a few:*

- *posters*
- *brochures or leaflets*
- *audio tapes playing*
- *video tapes playing*
- *small group discussions or more formal health talks*
- *condom demonstrations*
- *drama presentations*

You might already have noticed other opportunities for patient education in your own health centre.

For this assignment, you must first walk round your health centre as if you were a patient coming in for treatment. Then answer the following questions:

1. What opportunities for patient education does the centre use?

2. What opportunities could the centre adopt for patient education?
  
3. What practical suggestions would you make to improve patient education at the centre?
  
4. Who could be responsible for developing your suggestion(s)?
  
5. What resources would be needed?

If you can, please discuss your suggestions with your clinic manager to see if they can be implemented.

## **ANSWERS**

### **5.2 QUESTION**

Don't worry if you found this exercise difficult or if your answers differ slightly from ours. You may well have considered issues that are equally important to your area.

#### ***Violet***

The risk behaviour of which we are aware is Violet's occupation, which involves having sexual intercourse with a number of partners.

Violet has two major barriers to change: her reliance on sex work as a source of income to support her child and family; and her inability to persuade clients to use condoms. Presumably she feels that she cannot afford to lose clients by insisting on this.

#### ***Akira***

Akira's risk behaviour includes alcohol and drug use as well as unprotected sex with a number of partners, including casual partners about whose sexual practices he knows nothing. He also has an incorrect idea about safer sexual behaviour which gives him a false sense of security.

Barriers to change will include the effect that any changes would make on his self image as a young 'street-wise' male, together with his belief about what constitutes acceptable behaviour. What approaches do you think could be used to encourage such a person to change his lifestyle?

#### ***Amina***

The risks for Amina are different because they are beyond her immediate control. It is her husband who has engaged in risky sex, not her. We know no more about his risks in detail than does Amina.

Her barriers to change? Clearly, she is financially dependent on her husband. In addition, before deciding on long-term behaviour, she must overcome two major barriers: her shock at discovery of his likely behaviour, and how this is going to affect her marriage.

#### ***Tapu***

Tapu has not yet been practising risky behaviour, but he has attended the health centre because he is afraid of doing so. Clearly, a cultural or religious practice is the unfortunate cause of his dilemma: the barrier is that he does not want to offend against this practice.

## 5.5 QUESTIONS

### Condom Quiz

Check your responses against ours below.

***Condoms can get lost inside the woman.***

**FALSE**

There is always the slight possibility that, if the man does not use the condom properly, it could slip off before withdrawal, but it could not get lost inside.

***Condoms don't protect against STDs including HIV.***

**FALSE**

If used properly, condoms prevent the transmission of STDs including HIV.

***Condoms can be kept in a pocket or wallet indefinitely.***

**FALSE**

A wallet or pocket is too warm to store a condom for a long period. Advise patients never to use condoms which are dry, dirty, brittle, yellowed, sticky, melted or damaged.

***It is OK to use glycerin or water-based lubricants with condoms.***

**TRUE**

However, remember to advise the patient that it is risky to use grease, oils, lotions or petroleum jelly to make condoms slippery — the oils cause the condoms to break.

***Pull the condom tight over the head of the penis to ensure a snug fit.***

**FALSE**

If someone does this, the condom may burst. Always leave space for semen at the tip of the condom.

***Squeeze the air out of the tip of the condom as you put it on.***

**TRUE**

This will leave space for the semen to collect.

***Condoms should be stored in a cool, dark, dry place.***

**TRUE**

Sunlight, moisture and heat all make condoms deteriorate, which is why they should not be kept in pockets or wallets too long.

**STD Case Management—**  
*The Syndromic Approach*  
*for Primary Health Care Settings*

**MODULE 6**  
**PARTNER REFERRAL AND CARE**  
**FACILITATOR'S VERSION**

**TIME FRAME:** 1 hour

**SUPPLIES AND  
EQUIPMENT**

- Flip-chart and flip-chart paper
- Markers (ideally in two or three colours)
- Tape (for posting pieces of flip-chart paper on wall)
- Overhead projector and overhead set, or Flip-chart version of overheads
- Extra pens or pencils and paper for participants

<b>KNOWLEDGE GAIN</b>	<b>SKILLS ACQUIRED</b>
<ul style="list-style-type: none"> <li>• Discuss the importance of partner management.</li> <li>• Explain its possible impact on individuals.</li> <li>• List the differences between patient referral and provider referral.</li> <li>• List the four issues to discuss with the patient.</li> <li>• Name the skills to use when educating STD patients on the need to treat partners.</li> <li>• Describe the value of referral cards at the health centre.</li> <li>• Describe how to manage a referred partner based on the patient's diagnosis.</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrate the ability to manage a patient's partners, while maintaining each person's confidentiality.</li> <li>• Demonstrate the ability to identify proper treatment action for a referred partner based on the patient's diagnosis.</li> </ul>

**STD Case Management—  
The Syndromic Approach  
for Primary Health Care Settings**

**MODULE 6  
PARTNER REFERRAL AND CARE**

**A**fter completing Module 5, you know that partner referral is the final step in educating STD patients. Indeed, it is one of the essential components of effective STD case management. This module discusses partner referral and caring for partners that have been referred.

**CONTENTS**

Principles of Partner Management	1
Contacting Partners	2
Effective Patient Referral	3
Treating Partners	11
Review	12
Questions and Activities	14
Answers	21

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**IMPORTANT:**

*We have already covered basic communication skills for patient education in both Module 3 and Module 5. If you have not already done so, please study these modules first.*

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# **PRINCIPLES OF PARTNER MANAGEMENT**

Partner management is aimed at treating and educating all sexual partners of the patient you first see.

Partner management and care is important because it can break the cycle of STD transmission. Often patients receive effective treatment and yet after they leave the clinic, they have unprotected sexual intercourse with the same person who gave them the first infection, leading to reinfection of the patient.

Identifying the individual who is the infection source can be very difficult or impossible. In terms of STD case management, it is not important. All sexual partners of the patient in the previous two months should be treated if possible, even if they have no symptoms.

When you are caring for a patient, you should be aware of the impact an STD infection can have on their life. Will it affect their home life, their income, their safety? Similarly, when a patient tells a partner that they might have an STD infection, the reaction of the partner can cause problems. Providers need to minimize these kinds of problems by ensuring confidentiality, and by making sure that patients agree to help with partner referral voluntarily. In practise, you should aim to treat as many partners as possible considering the circumstances for each case.

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*Partner referral can break the cycle of STD transmission.  
Maintaining patient confidentiality and requesting voluntary cooperation from patients are keys to partner referral.*

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### Partner Referral and Care Involves:

- Delivering treatment to all sexual partners of the patient
- Treating the partner(s) for the same STD as the patient

Facilitating question and discussion points:

» *There are only two occasions when it is easy to identify the source of a patient's infection. What do you think they might be?*

Only in these two cases is it possible to identify the source of an STD infection:

- When the patient has had unprotected sexual intercourse with only one other person in the last 2 months — that person is the source of their infection.
- When the patient is a baby with neonatal conjunctivitis — the mother is the source of the infection.

## CONTACTING PARTNERS

The purpose of partner referral is to treat as many of the patient's sexual partners as possible. There are two approaches to contacting sexual partners: patient referral and provider referral.

Patient referral means that the patient is responsible for contacting their sexual partners and asking them to come for treatment. It may be helpful to offer the patient suggestions on how to approach partners. Some of the options you can discuss with the patient are summarized in the box below. We will explore the practical issues associated with these approaches in the next section.

For many reasons, the patient might feel unwilling or unable to discuss the STD with their partners. Provider referral means that a member of the health team contacts the partners of the patient instead.

## Two Approaches to Contacting Sexual Partners

- Patient referral — the patient informs partners
- Provider referral — a provider informs partners

» A patient says he'd prefer not to talk to anyone else about his STD infection. He asks "Why do you need to treat my wife and girlfriends?". What would you say to him?

Which is the better approach? Both approaches to partner management have certain advantages but patient referral is more practical. This is because provider referral is costly when you have to pay staff to do it, and also because problems with patient confidentiality may develop. Voluntary patient referral is the approach recommended by the World Health Organization.



## EFFECTIVE PATIENT REFERRAL

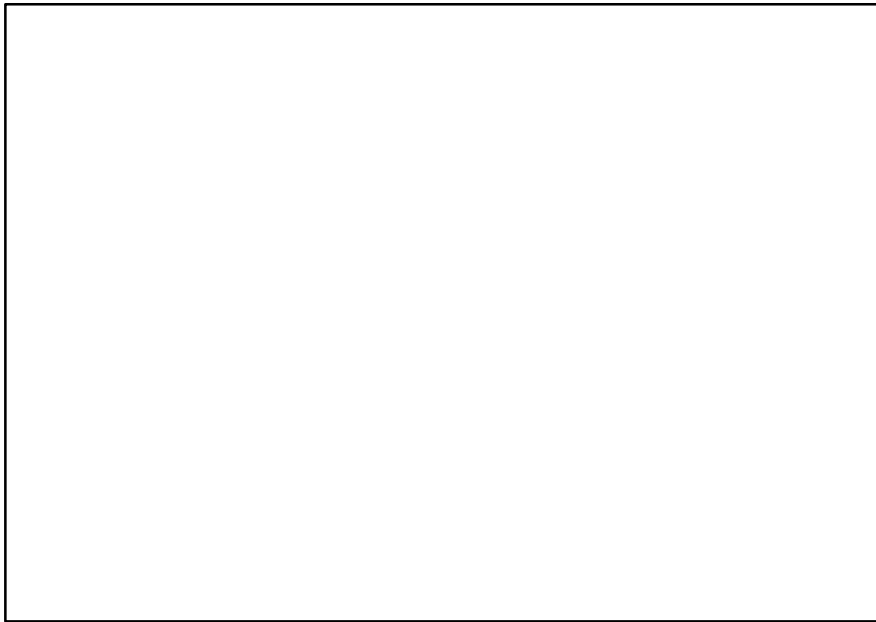
### *Options for Patient Referral*

- *The patient may be able to explain the STD infection and the need for treatment directly to his or her partners.*
- *The patient may be able to go to the health centre with the partner, or ask the partner to attend without saying why.*
- *The patient may be able to give each partner a card that asks him or her to go to the health centre.*

The success of patient referral depends on your communication skills: what you say to the patient, how you say it and, equally important, how you listen and respond to the patient. In this section, we ask you to apply the skills you learned in earlier modules to the goal of treating the patient's partners.

Facilitating question and discussion points:

*Patient referral of a sexual partner.*



## WHAT TO DISCUSS WITH THE PATIENT

### Topics to Discuss with the Patient

- Why it is important for all sexual partners to be treated
- How to avoid re-infection
- How the patient can communicate most comfortably with their partners
- The names of the patient's partner(s), if they are willing to give them

When a patient starts to think about what they might say to their partners about their STD, they may feel very uncomfortable, not unlike how they felt when they first learned about the infection. You can use the communication skills you have learned to help patients manage the emotional burden as well as identify a way to inform their partners.

We can return to a case-study from Module 5 to illustrate how this encounter might end. As you read through the case, note our comments in the right margin. You will notice that the provider uses some but not all of the skills that have been covered in this training.

Facilitating question and discussion points:

» *What must a patient do in order to avoid being reinfected with the same STD?*

To avoid re-infection, a patient should:

- Avoid having sex until they and their sexual partners have completed their course of treatment.
- When they resume sexual activity. They should use a condom, or practice non-penetrative sex or have sex with only one partner who has also been treated for the same STD.

» *We have already said that patients should not be forced to divulge the identity of their partners. When might it be useful to obtain details about their partners?*

It might be useful to know the identity of a patient's partners if:

- you need to use provider referral because the patient refuses to make contact with them. Remember — a patient should not be forced to divulge names, indeed, he or she may not know the name or whereabouts of a casual partner; and
- it is useful for any internal records kept at the health centre. For example, if a patient has asked partners to 'drop by' the health centre without specifying why, records might be the only way to identify what syndrome to treat the partner for — especially if the partner is asymptomatic.

*Nguyen*

<i>Provider</i>	<i>: Nguyen, I said earlier that we'd need to treat your girlfriends also ... How do you feel about talking to them about this?</i>	<i>The provider starts with an open question in order to find out how Nguyen feels and to identify any objections to patient referral.</i>
<i>Nguyen:</i>	<i>Talk to them about it ...um...</i>	
<i>Provider:</i>	<i>You would find it difficult to talk to them?</i>	<i>The provider is using empathy to encourage Nguyen to express his feelings.</i>
<i>Nguyen:</i>	<i>Well ... yes ... it's one thing to discuss being safe, but it's something else to ... well to talk about this discharge.</i>	
<i>Provider:</i>	<i>What makes that difficult?</i>	<i>Open question to probe Nguyen's objections further.</i>
<i>Nguyen:</i>	<i>They'd say I've been with someone dirty.</i>	
<i>Provider:</i>	<i>I can understand that that would be difficult for you. But you understood how you really got the discharge ... I'm sure you could explain that to your girlfriends.</i>	<i>The provider is reassuring the patient and reinforcing strengths to help Nguyen feel more positive about what he has to do.</i>
<i>Nguyen:</i>	<i>What? Explain that anyone can get a sex disease if they sleep with someone without a condom? That it's not about being dirty or anything?</i>	
<i>Provider:</i>	<i>You're right, it's not. It's just about having unprotected sex with more than one person.</i>	<i>The provider confirms Nguyen's words by repeating his idea and offers further explanation to clarify what he has said.</i>
<i>Nguyen:</i>	<i>But they haven't got a discharge or anything.</i>	
<i>Provider:</i>	<i>Women often don't have any symptoms, Nguyen, but STDs can be much more serious for women than for men. I need your help to make sure they get proper treatment.</i>	<i>An explanation is followed by modelling the behaviour that the provider wants Nguyen to adopt.</i>
<i>Nguyen:</i>	<i>Yes. So I have to say that ...</i>	



## PARTNER REFERRAL CARDS

### *The Problem:*

*A young man tells you that his girlfriend asked him to come to the clinic for treatment for an STD. He does not know the name of the syndrome and has no symptoms or signs of any infection. The girlfriend's name that he gives you is not in your health centre's records. You have no way to identify what syndrome to treat him for.*

The situation described above is an example of failed patient referral and care. Frequently, sexual partners arrive at the health centre with no STD symptoms. Without any symptoms or signs of an STD, and with no knowledge of the index patient's syndrome, we cannot treat this partner.

A partner referral card can be very helpful in this situation. Here are two examples of ways to arrange the information on a partner referral card. Before you look at the examples, you might want to think about the kind of information you think should be included on the card.

### Model for Referral Card #1

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Card No. _____ Date of Issue: _____ Diagnostic Code: _____ Partner's names and details: _____ _____ Clinic: <i>Townville, New Town</i>	Card No. _____ Date of Issue: _____ Issuing Clinic: <i>Townville, New Town</i> Name: _____ <p style="text-align: center;"><b><i>Our address, telephone number and office hours are listed on the reverse side.</i></b></p> Diagnostic code: _____
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The example above includes a part to the left that is kept for the health centre records, and a part to the right that is cut off and given to the patient. The patient then gives this part to their sexual partner. If the patient has more than one sexual partner, they could be given several cards that have been cut. If the patient is not able to refer the patient and authorizes the provider to do it, the card already includes information for the provider referral approach.

The advantage of this type of card is that the health centre can keep a record of the partners and monitor whether or not they came for treatment. This information will be useful later to determine whether partner referral is working or not.

**Model for Referral Card #2**

**TOWNVILLE CLINIC**  
*Center Street at corner of Crossing Alley*  
*Townville, Newtown*  
*Tel. No.: 123 - 456*

**OFFICE HOURS:**

Monday	9.00 am to 3.00 pm
Tuesday	9.00 am to 9.00 pm
Wednesday	9.00 am to 3.00 pm
Thursday	9.00 am to 9.00 pm
Friday	9.00 am to 3.00 pm

4/3/97 UD

The second card is simpler, yet it contains the essential information needed to treat the partner. The provider has written down the date and a code, "UD" which stands for urethral discharge, the STD diagnosis for the index patient. Providers can develop their own codes for the different diagnoses. This card has an advantage because it can be used for other purposes besides referring partners of STD patients, and thus there is no stigma associated with carrying it. There are no disadvantages of this card unless it is important for the card to be part of the health centre records in some way.

For any referral card system, it is important to consider both the chances for violations of patient confidentiality and the chances patients will experience social stigma.

## **WHEN PATIENT REFERRAL DOESN'T WORK**

Despite your best efforts, sometimes a patient will refuse to refer a partner for treatment. They may have excellent reasons for refusing. In some health centres, provider referral may be the only option.

## Options for Situations When Patient Referral Doesn't Work

### When the patient feels they cannot refer partners:

- Obtain the patient's permission to proceed with provider referral  
or
- Give the patient a duplicate course of treatment for them to give to their partner

### If partner does not come for treatment:

- Check to see if the partner has gone to a different health centre offering STD services  
and
- Use outreach service providers to try to reach partners

Another option is to give patients a duplicate course of treatment to give to their partner. Duplicate treatment should only be given when the barriers for patient referral are substantial, and when the provider is familiar with the patient.

In order for your centre to follow up partners who do not come for treatment, the centre would need to have considerable resources in terms of staff and time. The box below summarizes the kinds of resources needed to be able to conduct this type of follow-up.

### *Resources for provider referral*

- *The names and details for partners, and the index patient's permission to conduct provider referral.*
- *Trained outreach staff.*
- *A record-keeping system that ensures confidentiality of patient records and allows partners that have not come to the centre after a short period, for instance two weeks, to be identified.*
- *Good communication with other STD service providers in other health centres where partners may go to get treatment (men and women frequently go to different types of centres).*

In some countries, this is not possible because of laws controlling drug dispensing. In other settings, providers consider this to be an unacceptable option because they believe extra drugs will be sold on the illegal market, or that more patients would demand treatment without prior diagnosis. Others consider this to be a good "last resort", based on how urgent they feel it is to treat partners.

» *When might news of STD infection have a serious affect on the relationship between patient and partner?*

News of STD infection can be especially damaging when a patient or partner hears of their partner's infidelity for the first time. Equally, someone with mistaken ideas about the causes of STDs may respond in ways that are inappropriate or extreme. Patients are sometimes blamed for being the source of infection when, as we have seen, it is rarely possible to identify the source of infection. Such events might lead to marital break-down, divorce, loss of home or livelihood, or even ostracism from the social or clan group.



Facilitating questions and discussion points:

» *What do you think of the idea of giving duplicate treatments to index patients? Do you think it is a realistic approach and, if so, under what conditions?*

*Provider referral of a sexual partner.*

# TREATING PARTNERS

The aim of partner management is to treat any partner for the same STD as the patient. Examining the partner is not essential, though either you or the partner might prefer to check for other signs.

Otherwise, we care for the partners of patients in exactly the same way as for the patient, taking their history, treating and educating them. Don't forget that you need to ask these new patients about their sexual partners as well, and you may need to pursue partner referral again.

» *Why do you think partner management is so important in STD case management?*

Partner management is important because it helps to break the cycle of STD transmission by treating and educating both the patient and his or her sexual partners. Partners are treated for the same STD as the patient whether or not they have signs of STD — ensuring that even those people who are asymptomatic are treated.

Diagnosis and Treatment for Partners Based on the First Patient	
Syndrome of Patient	Treatment of Partner
Urethral discharge	Treat partner for gonorrhoea and chlamydia
Genital ulcer	Treat partner for syphilis and chancroid
Vaginal discharge:	
Patient treated for vaginitis and cervicitis	Treat partner for gonorrhoea and chlamydia
Patient treated for vaginitis only	Not necessary for the partner to be treated unless the discharge recurs
Pelvic inflammatory disease	Treat partner for gonorrhoea and chlamydia




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**IMPORTANT:**  
*If a female patient with vaginal discharge is diagnosed with vaginitis only, her partner does not need to be treated unless the vaginitis is recurrent.*

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Facilitating question and discussion points:

## REVIEW

## **PRINCIPLES OF PARTNER MANAGEMENT**

Partner management is important because it can break the cycle of STD transmission.

Identifying the source of infection can be impossible, but for STD case management it is not important—all sexual partners of the previous two months need to be treated.

Partner management must take into account the effect the STD may have on the patient's life, and how easy it is for the patient to talk to their partner(s) about STDs.

Partner management involves:

- delivering treatment to all sexual partners of the patient; and
- providing treatment for the same STD as the patient.

## **CONTACTING PARTNERS**

Partners can be contacted through:

- patient referral, when the patient informs partners that they need to seek STD treatment; or
- through provider referral, when the health care provider contacts the partners that have been named by the patient.

Voluntary partner referral by the patient is the preferred method of contacting partners.

Topics to discuss with the index patient include:

- why it is important for all sexual partners to be treated;
- how to avoid re-infection;
- how the patient can communicate most comfortably with their partners; and
- the names of the patient's partner(s), if the patient is willing to give them.

Communication skills are very important when discussing partners and referral.

Cards may be used to make patient referral easier, especially if the patient feels unable to talk to their partners about the need for STD treatment.

Options for when patient referral doesn't work include;

- obtaining the patient's permission to proceed with provider referral; or
- giving the patient a duplicate course of treatment for them to give to their partner.

Options for when partner doesn't come for treatment are to:

- check to see if the partner has gone to a different health centre; and
- use outreach service providers to try to reach partners.

## **TREATING PARTNERS**

It is not essential to examine referred partners. Apart from the examination, you should follow the same steps for referred partners as for patients: history-taking, education and partner referral.

The diagnosis that guides treatment selection for referred partners is the same as for the patient, except for those partners where the patient was treated for vaginitis; in these cases, the partner does not need to be treated unless the vaginitis is recurrent.

# QUESTIONS AND ACTIVITIES

## 6.1 QUESTION

- a) What two principles should guide providers when discussing partner management so that their STD patients are protected?
- b) Which is the better approach — patient referral or provider referral? On the surface, both approaches to partner management seem to have advantages. Bearing in mind the importance of voluntary consent to inform partners, note down in the box below any possible advantages or disadvantages of each approach that occur to you.

	<b>Advantages</b>	<b>Disadvantages</b>
<b>Patient referral</b>		
<b>Provider referral</b>		

## 6.2 QUESTION

Try identifying the skills the provider uses in another case-study below. Underline anything the provider says that you think illustrates an interpersonal skill, and note what skill you think it is. The first one is completed for you. You may want to think about how this case-study is different from the one you just read with Nguyen in Module 6.

### *Amina*

**Background:** *Amina was so shocked by the news of her husband's possible infidelity that she needed time to think about it. Several days later, she has returned; she tells the provider that she has not had sex and that she is taking the course of tablets correctly but has not yet said anything to her husband. Also Amina's sister-in-law reported hearing that her husband was seen once or twice leaving the bar with a commercial sex worker.*

*Amina: I can't say anything to him. He'll blame me — I know he will ... I have to think about my family ... he'll blame me even if this disease isn't my fault ...*

*Provider: You're very scared about telling him what you think he's done.*

Provider checks that he or she understands

*Amina: Well ... yes I am.*

Amina's feelings.

*Provider: I can see you're still very upset about all this, and I sympathize with your position. You've been very wise to come back again to see me and it seems that you really want to resolve this so that your husband gets treated.*

*Amina: But I can't SAY that to him ...*

*Provider: Well, there are two things you could do. You could ask him to come to the clinic because he might have the same infection as you, or you could ask someone else to talk to him for you. Which would you prefer?*

*Amina: I could just say that he should come here for a check?*

*Provider: Yes, that's all. I would do the rest. If I gave you this card, could you ask him to bring it with him?*

*Amina: And you would treat him and tell him why he needs it?*

*Provider: I would indeed. What are you going to say to him?*

*Amina: Um. That he might have the same sickness as me, and if he takes that card to the clinic...*



### **Akira**

*Akira is a 24-year-old single man with a good job and his own home. He doesn't want to settle down for a long time, describing himself as 'a good time guy'. He has three sexual partners and sometimes has casual sex too. However, he says he chooses women who are 'clean' or 'married', so he can't understand why he now has a urethral discharge. During the interview he admits that he often gets drunk or injects drugs with one of his partners before sex. You have just confirmed a diagnosis of urethral discharge syndrome.*

### **Amina**

*Amina is 35, married with three teenage children. She relies on her husband's income from factory work to support the family. During the interview, she said that she has sex only with her husband. She has already explained that her husband often works late at the factory, and that he goes for a drink with friends occasionally. She can sometimes smell the alcohol on his breath. However she says she feels quite secure in his faithfulness to her. She came to the centre with no idea of the cause of her abdominal pain — you have told her she has pelvic inflammatory disease.*

### **Tapu**

*Tapu is 35, married with four children and living in a rural area. He attended an urban clinic with a swelling in his groin which the service provider diagnosed as an inguinal bubo. In answering the service provider's questions, he admitted reluctantly that he has sex with a number of other partners, many of them casual, in the course of his search for work. He regularly travels to the city, working away from home for three months at a time. He says that his wife is currently six months pregnant. He has not been home for two months though he regularly sends home money. He is currently living with a casual partner in the city.*

### **Bing**

*Bing is a 22-year-old single male who lives in the poor area of a large city. He finished secondary school but has been unable to find a steady job in the past three years. He works at whatever casual jobs he can find, trying to save money to start a small business. Most of his friends are in the same situation. They spend their evenings together at one of the local bars. He usually has a few beers and sometimes goes home with one of the young women at the bar. He has had several STDs but because they were readily treated at the health clinic, he isn't worried about this urethral discharge.*

**Swanti**

*Swanti is a 38-year-old married woman with four children. She and her family live in a middle class area of the city. Both she and her husband work to put their children through school. Two months ago, Swanti started a sexual relationship with a young male colleague at work. When she noticed her genital ulcer, she felt sure it was punishment for her infidelity and stopped the relationship. She has come to the health centre feeling very guilty and anxious.*

**Wei**

*Wei is a 15-year-old girl, working for her uncle as a housekeeper. Soon after she moved into his house, Wei was raped by her uncle and since then he has been demanding sex on a regular basis. She tried to run away back to her family but he caught her and beat her. Her uncle brought her in because she was complaining of lower abdominal pain.*

**Francis**

*At the age of 26, Francis has finally decided to settle down. He is engaged to a 24-year old teacher, and very much in love. She has asked him to visit the clinic because she thinks he might have an infection. He has handed in a referral card; the code on it indicates that his fiancée has a vaginal discharge, caused by both vaginitis and cervicitis.*

**THE PATIENT'S ROLE**

Please refresh your memory of the role you played in the last role-play exercise, or select a new one from the ones on the previous pages. Inform the provider and the observer of which case-study you have chosen. As before, your aim is to respond as realistically and honestly as you can to whatever the provider says and does. Don't try and make it either easy or difficult for him or her.

After the role-play, you should be the first one to give feedback to the provider. Start by telling him or her how you feel now, at the end of the interview, and review key points during the exercise when the provider's comments either helped or hindered you in any way.

While the provider and observer review the exercise, feel free to add any useful insights you have into the provider's behaviour. At this point, make sure that your suggestions are positive ones that will help the provider to develop their skills.

## **THE PROVIDER'S ROLE**

As with Module 5, your aim is to get feedback on your present skills and areas where you might make improvements.

During the role-play, use the same skills as before to encourage the patient to refer his or her partner(s) for treatment. You might like to review the observer's check-list that follows to remember what the observer will be looking for.

After the role-play, allow the patient to give you feedback on how he/she felt during the interview. Next, give your own views and feelings about how the education process went. Finally, the observer will provide feedback based on the check-lists he or she is using. Feel free to ask either the patient or observer to clarify what they have said. You want to finish the role-play with helpful objectives and, hopefully, confirmation of your perceived strengths.

## **THE OBSERVER'S ROLE**

Your aim is to observe this final part of the interview very carefully so that you can give the 'provider' clear, objective feedback on what they have achieved.

Read through the check-list on the next page to familiarize yourself with the skills and issues that the provider should use.

Time the interview, stopping it after three minutes to complete the discussion on partner referral.

As you observe, make quick notes on the skills you see the provider use, and how effectively you think he or she uses them.

Ask the patient to review the interview first, and then the provider. Start your feedback by responding briefly to the provider's self-criticism, and then give your feedback, one skill at a time, or however else you think appropriate. Be willing to give negative criticism if necessary, but offer it in a constructive way. Always stress the provider's positive achievements and be as practical as you can.

Finally, lead a discussion about what you have all learned from the role-play. Some valid issues that were not addressed in this module might come up.

## OBSERVATION CHECK-LIST FOR ACTIVITY 6.5

Does the Provider:	Use this side for your notes
<p><i>Cover these education issues?</i></p> <ul style="list-style-type: none"> <li>• The STD, its implications and treatment, and the importance of complying with treatment</li> <li>• The patient's risk level</li> <li>• The need to change sexual behaviour and what constitutes safer sex</li> </ul>	
<p><i>Use these education skills</i></p> <ul style="list-style-type: none"> <li>• Explaining and instructing</li> <li>• Modelling</li> <li>• Reinforcing strengths</li> <li>• Exploring choices</li> <li>• Rehearsing the decision</li> <li>• Reinforcing decisions</li> </ul>	
<p><i>Apply these communication skills ?</i></p> <ul style="list-style-type: none"> <li>• Open questions</li> <li>• Facilitation</li> <li>• Summarizing and checking</li> <li>• Reassurance</li> <li>• Direction</li> <li>• Empathy</li> <li>• Partnership</li> </ul>	

# ANSWERS

## 6.1 QUESTIONS

- a) The two principles we were thinking of are that partner management must be confidential and voluntary. The privacy of both patients and partner must be maintained and no-one should be forced to say or do anything they are unwilling to do. These two principles are crucial to any approach to partner management.
- b) Your answers to this question may be different from ours, especially if your health centre already uses one or both approaches. If so, please use our notes below as a basis for discussion.

	Advantages	Disadvantages
<p><b>Patient referral</b></p> <ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• The patient has control over referral — so both confidential and voluntary.</li> <li>• No cost to the health centre. If successful, able to contact and treat more partners — is more efficient.</li> </ul>	<ul style="list-style-type: none"> <li>• In some cases, partners may not be referred quickly.</li> </ul>
<p><b>Provider referral</b></p> <ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Does not depend on patient's ability to refer partners.</li> <li>• Patient offered immediate support from service provider</li> <li>•</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Depends on willingness of patient to give names to providers.</li> <li>• Cost, time and practical problems of tracing partners</li> <li>• Need for extra, highly trained outreach staff</li> <li>• May be viewed by patients as a threat to confidentiality</li> </ul>

Perhaps you agree that the most difficult part of this question was to find positive advantages for provider referral. At a price, provider referral can contact and treat more partners — but at the possible expense of confidentiality. Finding partners can be difficult, even when their names are known. Also, providers trying to find someone may

quickly become known in any tight-knit community. Then there is the matter of paperwork: great care must be taken to ensure that such paperwork protects the patient's identity. For all these reasons, we hope you agree that patient referral is the better approach for partner management.

## 6.2 QUESTION

We hope that you found this review helpful. Our notes below explain the skills we think that the provider is using. Please discuss your analysis with colleagues or your trainer if there is anything you are not sure about.

<b>Case-study — Amina</b>	
<i>Amina: I can't say anything to him. He'll blame me — I know he will ... I have to think about my family ... he'll blame me even if this disease isn't my fault ...</i>	
<i>Provider: <u>You're very scared</u> about telling him what you think he's done.</i>	Provider checks that he or she understands Amina's feelings.
<i>Amina: Well ... yes I am.</i>	
<i>Provider: I can see you're still very upset about all this, and <u>I sympathize</u> with your position. <u>You've been very wise to come back again to see me and you really want to resolve this and have your husband treated.</u></i>	The provider offers empathy. The provider is reinforcing Amina's strengths — by praising her wisdom and understanding of STDs, the provider helps her feel more positive about dealing with it.
<i>Amina: But I can't SAY that to him ...</i>	
<i>Provider: Well, there are <u>two things you could do</u>. You could simply <u>ask him to come to the clinic</u> because he might have your infection, or you could <u>ask someone else to talk to him for you</u>. Which would you prefer?</i>	Exploring choices to help Amina select the most appropriate solution
<i>Amina: I could just say that he should come here for a check?</i>	
<i>Provider: <u>Yes, that's all. I would do the rest. If I gave you this card, could you ask him to bring it with him?</u></i>	The provider offers partnership in order to resolve the problem.
<i>Amina: And you would treat him and tell him why he needs it?</i>	
<i>Provider: I would indeed. <u>What are you going to say to him?</u></i>	The provider helps Amina to rehearse what she will say. In this way, she anticipates the real moment when she will speak with her partner.
<i>Amina: Um. That he might have the same sickness as me, and if he takes that card to the clinic...</i>	

Notice that the solutions to the case-study on page 5 are quite different from this one. In Nguyen's case, he was encouraged to speak to his partners himself, something he was willing to do once the provider had helped him resolve the obstacle of embarrassment. Many patients will be willing to do the same thing if you educate and support them properly, so patient referral will often be effective.

However, some patients will, like Amina, feel unable to discuss the STD or safe sex with their partners. In this situation, the alternatives of leaving education to the provider, or of asking a mutual friend or family member to talk to a partner, might be successful.

## 6.4 QUESTIONS

***For what should you treat the young woman?***

As with any partner, the young woman should be treated for the same STD as her boyfriend, the original patient. In this case, he had a genital ulcer, so she must also be treated for genital ulcer.

***Should this young women be examined?***

Examination is not necessary because you intend to treat her in any case. However, you might consider it important to check for signs of other STD. Also, the patient may prefer to be examined.

**COURSE  
EVALUATION  
TOOLS**

## TRAINING PARTICIPANT LEARNING ASSESSMENT

Name: \_\_\_\_\_

Position/Title: \_\_\_\_\_

Province/Town: \_\_\_\_\_

*How many health care workers work in the clinic where you are based?*

Doctors \_\_\_\_\_ Midwife/health officer \_\_\_\_\_

Nurses \_\_\_\_\_ Community health workers \_\_\_\_\_

*Approximately what proportion of the patients in your clinic are suspected to be STD cases?*

- less than 1 in 100 patients
- 1 to 10 in 100 patients
- more than 10 in 100 patients

*What kinds of health problems are most common among the patients in your clinic?*

*How do you expect to benefit from this training programme?*

*Note down your skills and experience that you think are useful for you in managing or helping to manage STD patients.*

## PRE-TEST /POST-TEST

1. In \_\_\_\_\_ (year), the total number of STD cases reported to the government of \_\_\_\_\_ was:

- a)
- b)
- c)

2. True or False — **all** STD can be transmitted:

- a) from mother to child after birth
- b) by sharing soiled clothes
- c) by using a soiled toilet
- d) by sexual intercourse

Indicate which STD infections are curable or incurable:

	Curable	Incurable
3. HIV/AIDS		●
4. Syphilis		●
5. Chlamydia		●
6. Gonorrhoea		●
7. Herpes		●
8. Trichomoniasis		●
9. Candidiasis		●
10. Chancroid		●

11. Approximately what percentage of females experience asymptomatic STD?

- a) 10-30%
- b) 40-60%
- c) 60-80%
- d) more than 80%

12. STD control is a valuable strategy for the prevention of HIV/AIDS because:

- a) You can tell people who are already having risky sex that they are doing something wrong and will suffer for it.
- b) Being infected with an STD makes it easier to pass HIV infection from one person to another.
- c) Treating people with STD will make it more likely they will use condoms.
- d) You will immediately have fewer STD patients and have more staff to handle HIV/AIDS cases.

13. The STD most likely to facilitate HIV transmission is:

- a) genital ulcer syndrome (GUS)
- b) any STD that causes genital inflammation
- c) an STD that causes urethral discharge or cervicitis
- d) an STD that causes vaginitis

14. Which of the following is the most high risk behaviour for STD infection?

- a) A man having unprotected oral sex with another man
- b) A man and a sex worker/prostitute having vaginal sex without a condom
- c) Receiving manual stimulation (hand job) from a prostitute
- d) Having casual sex with a foreigner

15. When a married monogamous woman comes for a check up at a community health centre complaining of pelvic pain and malodorous vaginal discharge, which of the following actions should the clinician **NOT** take?

- a) Don't spend any time talking to her and refer her to go to an OB-gyne specialist for surgery.
- b) Palpate her abdomen to check for guarding or rebound tenderness.
- c) Ask about recent pregnancy and delivery history.
- d) If she is not pregnant, give her an analgesic for the discomfort and send her home to rest.

16. Which of the following questions is **NOT** appropriate for history-taking?

- a) You say you have a problem urinating. Do you have any pain when you urinate?
- b) Have you ever had an ulcer like this before?
- c) Well, well you tell me you have a "drip". Can you tell me which girl you were with so I can tell the brothel owner to keep her from working?
- d) Have you had sex with a new person recently, say in the last three months?

17. A 21-year old man complaining of frequent urination comes to your health centre. After taking a history and examining him, you now know that he has some discharge from his penis. You also learn that he is recently married to a very young woman and has in his words "been living it up" meaning he has had unprotected intercourse with three different prostitutes since his wedding day. The **BEST RESPONSE** of the health worker is:

- a) We will be able to treat you today but it is also very important to treat your new wife as soon as possible. Let's talk about how to do that.
- b) We will treat you today and if your wife shows any symptoms similar to yours, she can go to her doctor right away.
- c) Let's hope your wife doesn't find out that you were here. She would probably be furious at you.
- d) It is critical for you wife to be treated immediately. If she is pregnant, this could cause big problems for her or the baby. I know who your wife is and I will tell her what you did and make sure she has good medical care.

18. Which of the following drugs can be given in pregnancy?

- a) tetracycline
- b) metranidorole
- c) ciprofloxacin
- d) augmentin

19. Which of the following topics does **NOT** need to be discussed with STD patients?

- a) Asking about sexual risk behaviour.
- b) Checking to see if the patient knows the differences between gonorrhoea, chlamydia, syphilis and chancroid.
- c) Checking to see if the patient knows how to use a condom properly.
- d) Asking the patient how he or she wants to inform their sexual partners that they may be infected and should go to a health centre.

20. Which of the following is **NOT** true about health education for STD patients?

- a) Health education is too time-consuming for doctors or busy health care workers to do.
- b) You need to do more than just informing the patient about their illness and how to treat it, and giving them free condoms.
- c) Making the patient feel comfortable while he or she is in your clinic is an important part of delivering good STD care and education.
- d) It is difficult for many health care workers and patients to have a productive two-way discussion.

21. Which of the following is **NOT** involved in assessing behavioural risk?

- a) Asking patients to recall how they think they got infected with an STD.
- b) Asking a man who says he “went out” with a prostitute to tell you whether he had vaginal or anal intercourse with her.
- c) Asking a sex worker if she knows whether her steady boyfriend has sex with other women.
- d) Asking a recently married young woman who says she only has had sex with her husband if she has been able to use condoms.

22. A woman has lower abdominal pain with tenderness on palpation but no guarding. Which of the following is **correct**?

- a) Treatment is amoxicillin 3 gm., augmenting tab, probenecid 2 tabs and tetracycline 500 mg. qid for 7 days.
- b) She should be referred to a surgeon immediately.
- c) *Trichomonas vaginalis* would be a common causative organism.
- d) She is unlikely to have complications unless she is pregnant.
- e) All of the above.

23. A 30-year old male has a three-day history of a thick, greenish discharge from his penis. He takes amoxicillin 3.0 grams po, probenecid 2 tab and Augmentin 1 tab at the health centre while being observed. He returns in one week still complaining of a discharge. Which of the following is **NOT LIKELY** to be an explanation of the persistent discharge?

- a) He had gonorrhoea, but has been re-infected.
- b) The cause of his discharge was chlamydia infection.
- c) He had gonorrhoea which was resistant to the treatment given.
- d) He did not comply with the initial treatment.
- e) He was infected initially with both gonorrhoea and chlamydia.

24. Which of the following is **NOT** appropriate in developing a community-based programme for the control of STD?

- a) Identifying and working with women's and youth groups.
- b) Obtaining cooperation from community leaders before developing the programme.
- c) Finding out the terms people use to discuss sex and STD.
- d) Attempting to identify the clients of prostitutes, and work with them towards developing safer sexual practices.
- e) Holding public meetings and advising prostitutes that they are at high risk of AIDS unless they find other work.

25. Which of the following is **TRUE** for chlamydial infection?

- a) It is a common but not very serious sexually transmitted disease.
- b) It can cause premature birth, and PID and vaginal discharge in women.
- c) It is a viral disease that is not treatable.
- d) It causes symptoms in women and children but not in men.

26. The practice of treating for two different types of genital ulcer disease (chancroid and syphilis) at the same time is:

- a) Bad because an individual is rarely infected with two different pathogens.
- b) Wasteful because a good clinical examination will almost always lead to a specific diagnosis.
- c) Necessary because it is difficult to predict clinically the cause of many genital ulcers.
- d) Dangerous because of drug interactions.

27. The protection against HIV infection provided by using condoms properly for each act of sexual intercourse is best expressed as:

- a) 25%
- b) 65%
- c) 95%

28. A young female sex worker comes to a health centre with a vaginal discharge. She has had several previous visits for STD. She wants to talk to you about these problems. Which of the following is most appropriate?

- a) She should be told to find other work.
- b) You should find out how she feels about coming for regular health check-ups and about using condoms.
- c) You should make sure she knows about each of the STD infections she could be exposed to in her work.
- d) You should warn her that she might have AIDS.

29. A woman comes to the health clinic with lower abdominal pain. Which of the following statements is **FALSE**:

- a) PID should be suspected.
- b) She is likely to have a trichomonas infection.
- c) Ectopic pregnancy should be suspected, especially if her period is late.
- d) She is likely to have a chlamydial infection.

30. A 25-year old pregnant woman presents to a health centre complaining of a heavy, green discharge. What is the recommended treatment?

- a) Nystatin pessaries 1 bd for 5 days.
- b) Fasigyn pessaries 1 bd for 5 days.
- c) Nystatin pessaries 1 bd for 5 days + metronidazole 200 mg. tds for 5 days.
- d) Amoxycillin 3 grams stat + probenecid 2 tablets stat +Augmentin 1 tablet stat.
- e) Amoxycillin 3 grams stat + probenecid 2 tablets stat +Augmentin 1 tablet stat + erythromycin 500 mg. qid for 7 days.

31. A pregnant woman has just had a positive RPR test. Which of the following is **NOT** correct?

- a) She should have one injection of benzathine penicillin 2.4 million units IM.
- b) She should have the baby treated for congenital syphilis if she delivers a few days after being treated.
- c) There is no need to have the diagnosis of syphilis in pregnancy confirmed by another laboratory test such as TPHA.
- d) She should be treated with at least two injections of benzathine penicillin 2.4 million units IM, at weekly intervals.

32. The way to get the best protection from a condom is to remove it:

- a) when the penis is soft.
- b) before ejaculation while the penis is still hard.
- c) after ejaculation but before the penis is soft.
- d) after ejaculation.

## ANSWERS TO PRE-TEST/POST-TEST

### Additional Comments

- |              |  |
|--------------|--|
| 1.           |  |
| 2. d         |  |
| 3. incurable |  |
| 4. curable   |  |
| 5. curable   |  |
| 6. curable   |  |
| 7. incurable |  |
| 8. curable   |  |
| 9. curable   |  |
| 10. curable  |  |
| 11. c        | For chlamydia, approximately 70% of infected women are asymptomatic and for gonorrhoea, approximately 80% of infected women are asymptomatic.  |
| 12. b        |  |
| 13. a        | Genital ulcers have been shown to be most likely to facilitate HIV transmission but inflammatory STDs, like gonorrhoea or chlamydia do as well and are more common than GUD in some settings.  |
| 14. b        | The most risky sexual behaviours for STDs are penetrative vaginal or anal intercourse between either men and women or between men.   |
| 15. a and d  | Using the syndromic approach, you may be able to manage her case right away.   |
| 16. c        | This is an unwelcoming way to begin a clinic encounter.  |
| 17. a        | Partner referral options should be discussed in an open fashion so that the patient can say how he or she prefers to do it.  |
| 18. d        |  |
| 19. b        | When using the syndromic approach, patients do not need to focus on disease agents or etiologies, it is more helpful if they are aware of STD symptoms and can tell you about risk behaviours. |

20. a Even busy health care workers can incorporate some health education aspects into their encounters with patients.
21. b It is not helpful to distinguish vaginal from anal intercourse because the difference between them in terms of risk is minimal - both are high risk sexual behaviours when a condom is not used.
22. a
23. d He took the treatments while still at the clinic therefore we can assume he completed the treatment recommendation.
24. e
25. b
26. c
27. c Using condoms consistently and correctly for all acts of sexual intercourse is approximately 95% effective for preventing HIV or STD infection. Only abstinence from sexual intercourse is 100% effective.
28. b
29. b
30. b
31. a
32. c

SUMMARY REPORT FOR  
SYNDROMIC APPROACH TRAINING COURSE

Date: \_\_\_\_\_

Facilitator: \_\_\_\_\_

Location of training: \_\_\_\_\_

	<b>Name of participant</b>	<b>Institutional affiliation and contact information</b>	<b>Facilitator's assessment for follow-up</b>
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
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15			

Facilitator's general recommendations for follow-up:

**STD Case Management —**  
*The Syndromic Approach*  
*for Primary Health Care Settings*

**ANNEXES**

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I. STD GLOSSARY

II. COURSE EVALUATION TOOLS



## STD GLOSSARY

AIDS	Acquired immunodeficiency syndrome.
Amniotic sac	Membranes that enclose amniotic fluid and the fetus in the womb.
Anaerobic bacteria	One of the causes of PID; bacteria (usually of the genus <i>Bacteroides</i> ) that do not require oxygen to live.
Antenatal	Before birth.
Asymptomatic	Showing or causing no symptoms.
<i>Candida albicans</i>	Scientific name for the yeast-like fungus (also known as 'thrush') that is one of the causes of vaginitis.
Candidiasis	A form of vaginitis caused by the yeast-like fungus <i>Candida albicans</i> (also known as 'thrush').
Cervicitis	Inflammation of the cervix, usually caused by gonorrhoea or chlamydia.
Cervix	Lower part of the uterus that protrudes into the vagina, often called the neck of the uterus or womb.
Chancroid	One of the causes of genital ulcer syndrome; STD caused by the bacterium <i>Haemophilus ducreyi</i> .
Chlamydia	A common term for infection with <i>chlamydia trachomatis</i> (see definition for <i>Chlamydia trachomatis</i> ).
<i>Chlamydia trachomatis</i>	Scientific name for the bacteria that causes chlamydia. One of the causes of vaginal discharge, urethral discharge, and eye discharge in the newborn.
Chlamydial	Caused by chlamydia, as in chlamydial urethritis.
Clinical diagnosis	Using clinical experience to identify an STD.
Clinical box	A type of box on a flow-chart that states the typical symptom(s) of a particular syndrome.
Closed questions	Questions that only encourage one- or two-word answers, for example "Are you married?" (compare with open questions).
Complications	A secondary disease or condition that can arise if a disease is not treated.

Comprehensive care	Treatment of STD that also includes education, for behaviour change and partner referral and care.
Congenital syphilis	Syphilis passed from the mother to the child during pregnancy.
Conjunctivitis	Inflammation of the mucous membrane of the eyes and eyelids.
Culture techniques	Growing microorganisms in sterile culture medium so that they can be identified.
Direction	One of the six verbal communication skills, asking the patient to focus on one idea at a time.
Dysuria	Painful or difficult urination.
Ectopic pregnancy	Pregnancy outside the uterus (usually in the fallopian tubes); a life-threatening condition, which can cause extensive internal bleeding.
Efficacy	The measure of how effective a treatment is.
Efficacy of transmission	Likelihood that the contact with an infective agent results in infection.
Empathy	One of the six verbal communication skills, expressing your understanding of the patient's situation as a way to encourage him or her to express concerns.
Endometritis	Inflammation of the endometrium (lining of the uterus).
Epidemiology	The study of the incidence, distribution and causes of a disease or infection in a population.
Epididymis	A duct behind the testicle that links the testicle with the spermatic cord.
Epididymitis	Inflammation of the epididymis, usually due to gonorrhoea or chlamydia infection.
Etiologic/etiological	Using laboratory tests or microscopy to identify a causative agent.
Etiologies	Causative agents.
Facilitation	One of the six verbal communication skills, using words, phrases or sounds to encourage the patient to continue talking.
Fallopian tubes	The tubes which carry ova from the ovaries to the uterus.
Fibrous scarring	Scarring that looks like, or consists of, fibres.
Fistula	Abnormal passage between a hollow organ and the skin surface.
Flow-chart	A chart which shows the steps that need to be taken to perform a task.

<i>Gardnerella vaginalis</i>	The scientific name for the bacteria that cause vaginitis. This bacterial infection causes a condition referred to as bacterial vaginosis or vaginal bacteriosis.
Genital lesions	Skin scars or injuries in the genital region.
Genital ulcer disease/syndrome (GUD/GUS)	The name for the syndrome where ulcers or sores are found in the genital region, usually caused by syphilis and chancroid.
Glans penis	The rounded part forming the end of the penis.
Glycerin	Colourless, water-based lubricant that is safe to use with condoms.
Gonococcal	Caused by gonorrhoea, as in gonococcal urethritis.
Gonorrhoea/ gonorrhoeae	A common term for infection with <i>Neisseria gonorrhoeae</i> .
Gram stain	Laboratory technique used to identify bacteria.
Guarding	When examining women for lower abdominal pain, guarding is the condition you find when the abdominal muscles become rigid and do not allow you to apply pressure. It is usually a sign of peritonitis or an intra-abdominal abscess. Both are potentially serious conditions.
GUS	An abbreviation for genital ulcer syndrome. Also sometimes called GUD or genital ulcer disease.
Gynaecological	Concerning the physiological functions and diseases of the female reproductive system.
Herpes	A common cause of genital blisters and sores (also referred to in the flow-chart for genital ulcers as vesicular lesions). An STD caused by the <i>Herpes simplex</i> virus (HSV).
HIV	Abbreviation for human immunodeficiency virus, the virus that causes AIDS.
i.m.	Abbreviation for intra-muscularly; in the case of treatment guidelines, refers to instructions to deliver an injection into or within a muscle.
Inguinal bubo(es)	Name of a syndrome where a patient complains of painful swelling in the groin, usually caused by lymphogranuloma venereum or chancroid.
Inguinal hernia	A ruptured muscle wall in the groin through which internal organs may be partly displaced.
Inguinal lymph nodes	Lymph nodes in the groin.
Inguinal region	Groin area.
Intra-abdominal abscess	A potentially serious abscess inside the abdominal cavity.

Intravaginally	Into or within the vagina.
K-Y Jelly	A water-based jelly-like lubricant that is safe to use with condoms.
Lactation	Another term for breast-feeding.
Lympho-granuloma venereum (LGV)	An STD caused by the bacterium <i>Chlamydia trachomatis</i> ; one of the causes of genital ulcers and inguinal buboes.
Lower abdominal pain	The name for the syndrome where women complain of pain in the lower abdomen, which is usually, but not always, caused by pelvic inflammatory disease (PID).
Lymph nodes	Small areas of tissue that are part of the lymphatic system.
Mass	Lump of tissue (often malignant).
Menses	Menstruation or the blood and other materials discharged from the uterus at the time of menstruation.
Mucous membrane	Mucous-secreting tissue lining many body cavities and tubular organs.
<i>Neisseria</i>	Scientific name for the bacterium which causes gonorrhoea. One of the causes of vaginal discharge, urethral discharge, or lower abdominal pain in women, scrotal swelling and neonatal conjunctivitis.
Neonatal conjunctivitis	Inflammation of the mucous membranes of the eyes or eyelids in the newborn caused by gonorrhoea or chlamydia spreading to the baby's eyes as it passes through the cervix and vagina during birth. Purulent (or pus-filled) discharge is evident in the baby's eyes.
Oedema	Swelling.
Oil-based lubricants	Lubricants which are <u>not</u> recommended for use with condoms.
Open questions	Questions that invite detailed answers, usually beginning 'How?', 'What?', 'Where?', or 'Why?' (see also closed questions).
Ophthalmia neonatorum	Conjunctivitis occurring in a baby less than one month old, usually due to gonorrhoea or chlamydia infection.
Ophthalmic	Concerning the physiological functions and diseases of the eyes.
Oral dose	Drugs taken by mouth.
Ovum/ova	Egg or eggs (ova is plural).

Paediatric	Concerning the physiological functions and diseases of children.
Palpate/palpation	To examine by touch.
Partner referral and care	Contacting, treating and educating all the sexual partners of an index patient treated for STD.
Partnership	One of the six verbal communication skills, offering the patient a commitment, with you or the health team.
Patient referral	The WHO-recommended method of contacting sexual partners, which relies on the patient informing his or her partner(s).
Patient referral card	A card the patient can give to his or her sexual partner(s) to encourage them to go to a health centre for treatment. The card might also be part of a health centre's administrative records.
Pelvic inflammatory disease (PID)	A general term covering infections of the female genital tract that often prompt a patient to present with the syndrome of lower abdominal pain; usually caused by gonorrhoea, chlamydia or anaerobic bacteria.
Pelvic masses	Tumorous growths in the pelvic region.
Perinatal	Of, or relating to, the time before, during or immediately after childbirth.
Perineum	The area between the anus and scrotum or vulva.
Period of	The period of time between the patient becoming infectiousness infected with an STD and when he or she receives treatment. For the purposes of partner referral and care, this can be assumed to be two months.
Peritoneum	Lining of the abdominal cavity.
Peritonitis	Inflammation of the peritoneum.
Petroleum jelly	Jelly-like lubricant which is <u>not</u> recommended for use with condoms.
PID	An abbreviation for pelvic inflammatory disease (see definition above), one of the causes of lower abdominal pain.
Plasma	Colourless fluid that is part of blood, lymph or milk.
Prenatal	Of, or relating to, the time before childbirth.
Provider referral	Method where specially trained health care workers contact sexual partners of the index patient.
Purulent	Discharging pus.

Reassurance	One of the six verbal communication skills, persuading the patient that you accept his or her feelings and that the problem will pass in time.
Rebound tenderness	This is one of the signs of peritonitis or an intra-abdominal abscess that you look for during an examination for the syndrome of lower abdominal pain. The patient will feel severe pain when you press down slowly and gently on a tender area and then suddenly release the pressure. Along with guarding, it is usually a sign of a potentially serious condition.
RPR	An abbreviation for 'rapid plasma reagin' one of the laboratory tests used to identify syphilis (see also VDRL).
Salpingitis	Inflammation of the fallopian tubes.
Scrotal swelling	The name for the syndrome where men present with swollen, hot and painful testis/testes; usually, but not always, caused by gonorrhoea or chlamydia.
Serum	The amber-coloured liquid that separates from blood after coagulation.
Sexually transmitted diseases (STDs)	Diseases passed from one person to another through sexual intercourse.
Sign	A clinical problem you can see by examination.
Sinus	A cavity as channel; a tube or passage to an abscess.
Spermatozoa	Mature motile sperm cells.
Spermicidal foam	Foam that kills sperm, often used with condoms as extra protection.
STDs	An abbreviation for sexually transmitted diseases (see definition above).
Summarizing and checking	One of the six verbal communication skills, summarizing what the patient has said to check that you have understood correctly.
Susceptibility to infection	How much resistance the body has to infection; for example, little resistance would mean that the patient was highly susceptible.
Symptom	A clinical problem that the patient complains of.
Symptomatic	When characteristic symptoms are easily noticed.
Syndrome	A collection of symptoms and signs.
Syndromic case	Management of a patient based on his or her STD management syndrome rather than on the detection of a disease's specific causes. Treatment is given for all causative agents.

Syphilis	A common term for infection with <i>Treponema pallidum</i> .
Testis	The medical name for a testicle (plural is testes).
Trauma	Any physical wound or injury, sometimes also used to describe the shock following a wound or injury.
<i>Treponema pallidum</i>	The scientific name for the bacterium that causes syphilis. One of the causes of genital ulcers.
<i>Trichomonas vaginalis</i>	The scientific name for the bacterium that causes trichomoniasis. One of the causes of vaginal discharge.
Trichomoniasis	A common term for infection with <i>Trichomonas vaginalis</i> .
Tubal pregnancy	A potentially fatal pregnancy that occurs in the fallopian tubes.
Tubo-ovarian abscess	A potentially serious abscess in the fallopian tubes or ovaries.
Ulcer	An open sore.
Ulcerative STD	Any STD that produces ulcers.
<i>Ureaplasma urealyticum</i>	The scientific name for one of the bacteria that cause vaginal discharge syndrome.
Urethra	The duct by which urine is discharged from the bladder (see also urethritis).
Urethral discharge	The name of the syndrome where the patient (male) presents with a discharge from the penis, usually caused by gonorrhoea or chlamydia.
Urethral meatus	Opening or passage of the urethra.
Urethral stricture	Narrowing of the urethra, caused by infection.
Urethritis	Inflammation of the urethra, usually caused by gonorrhoea or chlamydia.
Urological	Of the urinary system.
Uterine cavity	Body cavity containing the uterus.
Vaginal bacteriosis	Another common term for bacterial vaginosis, a form of vaginitis caused by the organism <i>Gardnerella vaginalis</i> .
Vaginal discharge	The name of the syndrome where the patient (female) presents with a discharge from the vagina, usually caused by gonorrhoea or chlamydia.
Vaginitis	Inflammation of the vagina caused by bacterial vaginosis or vaginal bacteriosis, trichomoniasis or candidiasis.

Vas deferens	Duct that carries sperm from the testicle to the urethra (also called the spermatic cord).
VDRL	An abbreviation for 'Venereal Disease Research Laboratory', the name of a test used to identify syphilis (see also RPR).
Vertical transmission	Infection passing down from the mother to the fetus or child.
Vesicular lesions	Rash of tiny blisters before they burst and form a sore, often caused by the <i>Herpes simplex</i> virus (HSV). Small blister-like sores that are a characteristic sign of herpes.
Vulva	External female genitals.
Water-based lubricants	Lubricants that are safe to use with condoms.

**COURSE  
EVALUATION  
TOOLS**

## TRAINING PARTICIPANT LEARNING ASSESSMENT

Name: \_\_\_\_\_

Position/Title: \_\_\_\_\_

Province/Town: \_\_\_\_\_

*How many health care workers work in the clinic where you are based?*

Doctors \_\_\_\_\_ Midwife/health officer \_\_\_\_\_

Nurses \_\_\_\_\_ Community health workers \_\_\_\_\_

*Approximately what proportion of the patients in your clinic are suspected to be STD cases?*

- less than 1 in 100 patients
- 1 to 10 in 100 patients
- more than 10 in 100 patients

*What kinds of health problems are most common among the patients in your clinic?*

*How do you expect to benefit from this training programme?*

*Note down your skills and experience that you think are useful for you in managing or helping to manage STD patients.*

## PRE-TEST /POST-TEST

1. In \_\_\_\_\_ (year), the total number of STD cases reported to the government of \_\_\_\_\_ was:

- a)
- b)
- c)

2. True or False — **all** STD can be transmitted:

- a) from mother to child after birth
- b) by sharing soiled clothes
- c) by using a soiled toilet
- d) by sexual intercourse

Indicate which STD infections are curable or incurable:

	Curable	Incurable
3. HIV/AIDS		●
4. Syphilis		●
5. Chlamydia		●
6. Gonorrhoea		●
7. Herpes		●
8. Trichomoniasis		●
9. Candidiasis		●
10. Chancroid		●

11. Approximately what percentage of females experience asymptomatic STD?

- a) 10-30%
- b) 40-60%
- c) 60-80%
- d) more than 80%

12. STD control is a valuable strategy for the prevention of HIV/AIDS because:

- a) You can tell people who are already having risky sex that they are doing something wrong and will suffer for it.
- b) Being infected with an STD makes it easier to pass HIV infection from one person to another.
- c) Treating people with STD will make it more likely they will use condoms.
- d) You will immediately have fewer STD patients and have more staff to handle HIV/AIDS cases.

13. The STD most likely to facilitate HIV transmission is:

- a) genital ulcer syndrome (GUS)
- b) any STD that causes genital inflammation
- c) an STD that causes urethral discharge or cervicitis
- d) an STD that causes vaginitis

14. Which of the following is the most high risk behaviour for STD infection?

- a) A man having unprotected oral sex with another man
- b) A man and a sex worker/prostitute having vaginal sex without a condom
- c) Receiving manual stimulation (hand job) from a prostitute
- d) Having casual sex with a foreigner

15. When a married monogamous woman comes for a check up at a community health centre complaining of pelvic pain and malodorous vaginal discharge, which of the following actions should the clinician **NOT** take?

- a) Don't spend any time talking to her and refer her to go to an OB-gyne specialist for surgery.
- b) Palpate her abdomen to check for guarding or rebound tenderness.
- c) Ask about recent pregnancy and delivery history.
- d) If she is not pregnant, give her an analgesic for the discomfort and send her home to rest.

16. Which of the following questions is **NOT** appropriate for history-taking?

- a) You say you have a problem urinating. Do you have any pain when you urinate?
- b) Have you ever had an ulcer like this before?
- c) Well, well you tell me you have a "drip". Can you tell me which girl you were with so I can tell the brothel owner to keep her from working?
- d) Have you had sex with a new person recently, say in the last three months?

17. A 21-year old man complaining of frequent urination comes to your health centre. After taking a history and examining him, you now know that he has some discharge from his penis. You also learn that he is recently married to a very young woman and has in his words "been living it up" meaning he has had unprotected intercourse with three different prostitutes since his wedding day. The **BEST RESPONSE** of the health worker is:

- a) We will be able to treat you today but it is also very important to treat your new wife as soon as possible. Let's talk about how to do that.
- b) We will treat you today and if your wife shows any symptoms similar to yours, she can go to her doctor right away.
- c) Let's hope your wife doesn't find out that you were here. She would probably be furious at you.
- d) It is critical for you wife to be treated immediately. If she is pregnant, this could cause big problems for her or the baby. I know who your wife is and I will tell her what you did and make sure she has good medical care.

18. Which of the following drugs can be given in pregnancy?

- a) tetracycline
- b) metranidorole
- c) ciprofloxacin
- d) augmentin

19. Which of the following topics does **NOT** need to be discussed with STD patients?

- a) Asking about sexual risk behaviour.
- b) Checking to see if the patient knows the differences between gonorrhoea, chlamydia, syphilis and chancroid.
- c) Checking to see if the patient knows how to use a condom properly.
- d) Asking the patient how he or she wants to inform their sexual partners that they may be infected and should go to a health centre.

20. Which of the following is **NOT** true about health education for STD patients?

- a) Health education is too time-consuming for doctors or busy health care workers to do.
- b) You need to do more than just informing the patient about their illness and how to treat it, and giving them free condoms.
- c) Making the patient feel comfortable while he or she is in your clinic is an important part of delivering good STD care and education.
- d) It is difficult for many health care workers and patients to have a productive two-way discussion.

21. Which of the following is **NOT** involved in assessing behavioural risk?

- a) Asking patients to recall how they think they got infected with an STD.
- b) Asking a man who says he “went out” with a prostitute to tell you whether he had vaginal or anal intercourse with her.
- c) Asking a sex worker if she knows whether her steady boyfriend has sex with other women.
- d) Asking a recently married young woman who says she only has had sex with her husband if she has been able to use condoms.

22. A woman has lower abdominal pain with tenderness on palpation but no guarding. Which of the following is **correct**?

- a) Treatment is amoxicillin 3 gm., augmenting tab, probenecid 2 tabs and tetracycline 500 mg. qid for 7 days.
- b) She should be referred to a surgeon immediately.
- c) Trichomonas vaginalis would be a common causative organism.
- d) She is unlikely to have complications unless she is pregnant.
- e) All of the above.

23. A 30-year old male has a three-day history of a thick, greenish discharge from his penis. He takes amoxicillin 3.0 grams po, probenecid 2 tab and Augmentin 1 tab at the health centre while being observed. He returns in one week still complaining of a discharge. Which of the following is **NOT LIKELY** to be an explanation of the persistent discharge?

- a) He had gonorrhoea, but has been re-infected.
- b) The cause of his discharge was chlamydia infection.
- c) He had gonorrhoea which was resistant to the treatment given.
- d) He did not comply with the initial treatment.
- e) He was infected initially with both gonorrhoea and chlamydia.

24. Which of the following is **NOT** appropriate in developing a community-based programme for the control of STD?

- a) Identifying and working with women's and youth groups.
- b) Obtaining cooperation from community leaders before developing the programme.
- c) Finding out the terms people use to discuss sex and STD.
- d) Attempting to identify the clients of prostitutes, and work with them towards developing safer sexual practices.
- e) Holding public meetings and advising prostitutes that they are at high risk of AIDS unless they find other work.

25. Which of the following is **TRUE** for chlamydial infection?

- a) It is a common but not very serious sexually transmitted disease.
- b) It can cause premature birth, and PID and vaginal discharge in women.
- c) It is a viral disease that is not treatable.
- d) It causes symptoms in women and children but not in men.

26. The practice of treating for two different types of genital ulcer disease (chancroid and syphilis) at the same time is:

- a) Bad because an individual is rarely infected with two different pathogens.
- b) Wasteful because a good clinical examination will almost always lead to a specific diagnosis.
- c) Necessary because it is difficult to predict clinically the cause of many genital ulcers.
- d) Dangerous because of drug interactions.

27. The protection against HIV infection provided by using condoms properly for each act of sexual intercourse is best expressed as:

- a) 25%
- b) 65%
- c) 95%

28. A young female sex worker comes to a health centre with a vaginal discharge. She has had several previous visits for STD. She wants to talk to you about these problems. Which of the following is most appropriate?

- a) She should be told to find other work.
- b) You should find out how she feels about coming for regular health check-ups and about using condoms.
- c) You should make sure she knows about each of the STD infections she could be exposed to in her work.
- d) You should warn her that she might have AIDS.

29. A woman comes to the health clinic with lower abdominal pain. Which of the following statements is **FALSE**:

- a) PID should be suspected.
- b) She is likely to have a trichomonas infection.
- c) Ectopic pregnancy should be suspected, especially if her period is late.
- d) She is likely to have a chlamydial infection.

30. A 25-year old pregnant woman presents to a health centre complaining of a heavy, green discharge. What is the recommended treatment?

- a) Nystatin pessaries 1 bd for 5 days.
- b) Fasigyn pessaries 1 bd for 5 days.
- c) Nystatin pessaries 1 bd for 5 days + metronidazole 200 mg. tds for 5 days.
- d) Amoxycillin 3 grams stat + probenecid 2 tablets stat +Augmentin 1 tablet stat.
- e) Amoxycillin 3 grams stat + probenecid 2 tablets stat +Augmentin 1 tablet stat + erythromycin 500 mg. qid for 7 days.

31. A pregnant woman has just had a positive RPR test. Which of the following is **NOT** correct?

- a) She should have one injection of benzathine penicillin 2.4 million units IM.
- b) She should have the baby treated for congenital syphilis if she delivers a few days after being treated.
- c) There is no need to have the diagnosis of syphilis in pregnancy confirmed by another laboratory test such as TPHA.
- d) She should be treated with at least two injections of benzathine penicillin 2.4 million units IM, at weekly intervals.

32. The way to get the best protection from a condom is to remove it:

- a) when the penis is soft.
- b) before ejaculation while the penis is still hard.
- c) after ejaculation but before the penis is soft.
- d) after ejaculation.

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Sources: *Manual for Training in Care and Prevention of Sexually Transmitted Diseases*, National STD Prevention Program, Republic of the Philippines, and *Health Worker Training in Sexually Transmitted Diseases*, Facilitator Notes, Strengthening STD/AIDS Control in Kenya Project.

## ANSWERS TO PRE-TEST/POST-TEST

### Additional Comments

- |              |  |
|--------------|--|
| 1.           |  |
| 2. d         |  |
| 3. incurable |  |
| 4. curable   |  |
| 5. curable   |  |
| 6. curable   |  |
| 7. incurable |  |
| 8. curable   |  |
| 9. curable   |  |
| 10. curable  |  |
| 11. c        | For chlamydia, approximately 70% of infected women are asymptomatic and for gonorrhoea, approximately 80% of infected women are asymptomatic.  |
| 12. b        |  |
| 13. a        | Genital ulcers have been shown to be most likely to facilitate HIV transmission but inflammatory STDs, like gonorrhoea or chlamydia do as well and are more common than GUD in some settings.  |
| 14. b        | The most risky sexual behaviours for STDs are penetrative vaginal or anal intercourse between either men and women or between men.   |
| 15. a and d  | Using the syndromic approach, you may be able to manage her case right away.   |
| 16. c        | This is an unwelcoming way to begin a clinic encounter.  |
| 17. a        | Partner referral options should be discussed in an open fashion so that the patient can say how he or she prefers to do it.  |
| 18. d        |  |
| 19. b        | When using the syndromic approach, patients do not need to focus on disease agents or etiologies, it is more helpful if they are aware of STD symptoms and can tell you about risk behaviours. |

20. a Even busy health care workers can incorporate some health education aspects into their encounters with patients.
21. b It is not helpful to distinguish vaginal from anal intercourse because the difference between them in terms of risk is minimal - both are high risk sexual behaviours when a condom is not used.
22. a
23. d He took the treatments while still at the clinic therefore we can assume he completed the treatment recommendation.
24. e
25. b
26. c
27. c Using condoms consistently and correctly for all acts of sexual intercourse is approximately 95% effective for preventing HIV or STD infection. Only abstinence from sexual intercourse is 100% effective.
28. b
29. b
30. b
31. a
32. c

SUMMARY REPORT FOR  
SYNDROMIC APPROACH TRAINING COURSE

Date: \_\_\_\_\_

Facilitator: \_\_\_\_\_

Location of training: \_\_\_\_\_

	<b>Name of participant</b>	<b>Institutional affiliation and contact information</b>	<b>Facilitator's assessment for follow-up</b>
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Facilitator's general recommendations for follow-up: