Avahan is the India HIV/AIDS initiative of the Bill & Melinda Gates Foundation. This document was funded by the Bill & Melinda Gates Foundation; contents of this document do not necessarily reflect the Foundation’s views.

The World Health Organization [WHO] provided technical support in the development of these guidelines.
# Contents

| Abbreviations, units of measurement, symbols | v   |
| Preface                                      | vii |
| Foreword                                     | ix  |
| 1 Introduction                               | 1   |
| 2 Clinic Operations                         | 5   |
| 2.1 Community Approach                       | 7   |
| 2.2 Coordination with Outreach Services      | 7   |
| 2.3 Clinic Structure                         | 7   |
| 2.4 Staffing and Operations                  | 8   |
| 2.5 Staff Training and Skills                | 9   |
| 2.6 Clinic Equipment                         | 9   |
| 3 Clinical Management of Sexually Transmitted Infections | 11  |
| 3.1 Female Sex Workers                       | 13  |
| 3.2 Male and Transgender Sex Workers         | 15  |
| 3.3 Other (Non–Sex Worker) Symptomatic Patients | 16  |
| 3.4 Standard Treatments                      | 16  |
| 3.5 Documentation                            | 16  |
| 3.6 Medications and Commodities              | 16  |
| 3.7 Allergic Reactions and Anaphylaxis       | 17  |
| 3.8 Referral of Patients                     | 18  |
| 4 Laboratory Services                        | 21  |
| 4.1 Laboratory Tests                         | 23  |
| 4.1.1 Simple Laboratory Tests                | 23  |
| 4.1.2 Higher-level Laboratory Tests          | 24  |
| 4.2 Laboratory Standard Operating Procedures | 24  |
| 4.3 Referral Laboratory Services             | 24  |
| 5 Infection Control                          | 25  |
| 5.1 Universal Precautions                    | 27  |
| 5.2 Cleaning, Disinfecting and Sterilizing Equipment | 27  |
| 5.3 Disposal of Hazardous Waste              | 27  |
| 5.4 Post-Exposure Prophylaxis                | 28  |
| 6 Education and Counseling for Patients      | 29  |
| 6.1 Components of Health Education and Counseling | 31  |
| 6.2 Lubricant and Condom Distribution and Information | 32  |
| 6.3 Information, Education and Communication Materials | 32  |
| 6.4 HIV Counseling and Referral for Testing  | 32  |
| 7 Ethical Standards, Confidentiality and Right of Refusal | 33  |
| 7.1 Ethical Standards                        | 35  |
| 7.2 Confidentiality                         | 35  |
| 7.3 Right of Refusal                         | 36  |
8 Monitoring, Evaluation and Reporting 37
8.1 Monitoring 39
8.2 Evaluation 40
8.3 Reporting 40
9 Technical Support and Supervision 41

Annexes
A Improving Operations and Outcomes of STI Management Services by Using Community-Led Approaches 45
B Operational Flow Chart – Illustrative 55
C Suggested Minimum Avahan Clinic Equipment List 59
D Guidelines for Managing STIs in Female Sex Workers—Screening, Diagnosis and Treatment 65
E Guidelines for Managing STIs in Male and Transgender Sex Workers—Screening, Diagnosis and Treatment 79
F National AIDS Control Organization (NACO) Guidelines 97
G NACO Flowcharts on Syndromic Management of STIs 127
H Standard Operating Procedures and Forms for STI Drug and Consumables Stock Management 149
I Management of Anaphylaxis in Adults 157
J Guidelines for Universal Precautions 161
K Guidelines for Cleaning, Disinfecting and Sterilizing 175
L Guidelines for Disposal of Hazardous Waste 183
M Guidelines for HIV Post-Exposure Prophylaxis 191
N Key Messages for Health Education and Counseling 199
O Condom Education Guidelines 209
P Confidentiality Policy and Agreement 217
Q Forms for Monitoring and Reporting 221
R Referral and Network Development 241
**Abbreviations**

- AIDS – Acquired Immune Deficiency Syndrome
- ARD – Ano-rectal Discharge
- AFB – Acid fast bacilli
- ARV – Anti-retroviral
- AZT – Zidovudine
- BID – Twice Daily
- CMIS – Computerized Management Information System
- COGS – Clinic Operational Guidelines and Standards
- DICs – Drop-in-Centers
- EIA – Enzyme-linked Immunoassay
- FEFO – First expires, first out
- FTA-Abs – Fluorescent Treponemal Antibody Absorbed test
- GUD – Genital Ulcer Disease
- HBsAg – Hepatitis B surface Antigen
- HBV – Hepatitis B Virus
- HCV – Hepatitis C Virus
- HCW – Health Care Worker
- HIV – Human Immuno-deficiency Virus
- HLD – High Level Disinfection
- Hpf – High Power Field
- HPV – Human Papillomavirus
- HSV – Herpes Simplex Virus
- ID – Identity
- IDU – Injecting Drug User
- IEC – Information, Education, Communication
- IM – Intramuscular
- IP – Implementing Partner
- IU – International Unit
- LAP – Lower Abdominal Pain
- MSM – Men who have Sex with Men
- NGO – Non-Government Organization
- OM – Operational Manual
- ORS – Oral Rehydration solution
- PE – Peer Educator
- PEP – Post Exposure Prophylaxis
- PID – Pelvic Inflammatory Disease
PTB – Pulmonary Tuberculosis
QID – Four times a day
RPR – Rapid Plasma Reagin
RNTCP – Revised National Tuberculosis Control Programme
RTI – Reproductive Tract Infection
SOP – Standard Operating Procedure
STI – Sexually Transmitted Infection
TID – Thrice in a Day
TPHA – Treponema pallidum Hemagglutination Assay
UD – Urethral Discharge
VDRL – Venereal Disease Research Laboratory
VD – Vaginal Discharge
VCD – Vaginal Cervical Discharge
VCT – Voluntary Counseling and Testing
WBC – White blood cells
3TC – Lamivudine

Units of Measurement

\[\text{cm} \quad \text{centimeters} \]
\[\mu\text{L} \quad \text{microliter} \]
\[\circ\text{C} \quad \text{degree Celsius} \]
\[\circ\text{F} \quad \text{degree Fahrenheit} \]
\[\text{g} \quad \text{gram} \]
\[\text{mg} \quad \text{milligram} \]
\[\text{mL} \quad \text{milliliter} \]
\[\text{mm} \quad \text{millimeter} \]
\[\text{Lbs} \quad \text{pounds} \]
\[\text{Kpa} \quad \text{kilopascals} \]
\[\text{pH} \quad \text{negative logarithm of hydrogen ion concentration} \]

Symbols

\[\circ \quad \text{Degrees} \]
\[< \quad \text{Smaller than} \]
\[> \quad \text{Greater than} \]
\[% \quad \text{Percentage} \]
\[\text{i.e.} \quad \text{that is} \]
Migration, population mobility, and sex work continue to drive sexually transmitted epidemics in India and the surrounding region. Yet interventions targeting high-risk networks are rarely implemented at sufficient scale to have impact. For the Southeast Asia region, only 19% of sex workers, 5% of injecting drug users and 1% of men who have sex with men are estimated to have access to even basic prevention services.

The India AIDS Initiative (Avahan) of the Bill & Melinda Gates Foundation, aims to bring effective HIV prevention services to an estimated 250,000 persons in high-risk networks in India’s 6 highest HIV prevalence states. Additional interventions target clients of sex workers including high-risk men along the national highways. Avahan interventions address key gaps in the current prevention response including limited coverage, partial interventions, inadequate data and lack of community involvement.

Avahan works through state and local level NGOs and CBOs and PVOs to organize outreach, community mobilization, and dedicated clinics for sex workers, men who have sex with men, injecting drug users, and truckers. As of early 2006, more than 340 clinics linked to outreach and increasing community ownership are operational with project support.

Family Health International and the World Health Organization are working together to build the capacity of these partners to provide effective STI services. This document, *Clinic Operational Guidelines and Standards* (COGS) defines the minimum standards for STI services for Avahan-supported clinics and related community outreach. COGS were developed based on an initial participatory assessment, Avahan-wide field experiences, existing Indian national guidelines and inputs from technical experts. It forms the basis for training and supervision, and serves as a benchmark against which the performance of individual clinics can be monitored.

I hope this manual will be useful in guiding STI programme managers, technical teams, and clinic and outreach teams involved in STI service provision for sex workers and other key populations.

Dr. Gina Dallabetta
Technical Manager
Avahan India AIDS Initiative of the
Bill & Melinda Gates Foundation
Foreword

Effective STI control among vulnerable key populations is an important strategy to reduce HIV transmission under the Avahan India AIDS Initiative. Family Health International (FHI) is pleased to be supporting Avahan with STI capacity raising of state lead partners through a grant from the Bill & Melinda Gates Foundation (BMGF) to ensure the provision of effective and quality STI services which are acceptable and accessible to key populations.

In partnership with the World Health Organization (WHO), FHI developed the *Clinic Operational Guidelines and Standards* (COGS) to provide common approaches for STI prevention and management strategies, and operating guidelines and standards for Avahan-supported STI clinics. This document is the result of several months of careful deliberation and consultation with international and national STI and public health specialists and implementers to ensure that the recommendations are based on available evidence in India, international best practice, and importantly be feasible and practical in field settings. The COGS complements the existing national guidelines for STI management by the National AIDS Control Organization (NACO) and benefited from review by the STI Consultative Group chaired by NACO.

We encourage all staff of Avahan-supported clinics - STI program, technical and clinic managers - to implement the minimum guidelines and standards, in order to scale-up the provision of quality STI services to meet the needs of the key populations who are affected and those at risk. FHI appreciates the support of NACO through the development process, the technical partnership with WHO, and the inputs and funding of the Bill & Melinda Gates Foundation - Avahan India AIDS Initiative for this publication. The COGS is presented in a folder which will be updated as needed to provide new information and refine approaches based on evidence and experience.

Kathleen Kay
Country Director
Family Health International, India
Chapter 1

Introduction
Introduction

The clinic operational guidelines and standards (COGS) have been developed to improve the overall quality of Avahan clinics’ diagnosis and management of sexually transmitted infections (STIs) and clinical service delivery. To achieve this, each Avahan clinic should provide the following:

- Establish strong linkages with outreach activities targeted at sex workers and their clients;
- Prevention activities, such as promoting correct and consistent use of male condoms (and female condoms where available) and water-based lubricants and other safer sexual practices;
- Effective services, including immediate diagnosis and clinical management, for patients with STI symptoms;
- Screening programs, immediate diagnosis and clinical management of asymptomatic STIs among targeted high-risk populations;
- Partner management programs (i.e. contact referral);
- On-going monitoring and surveillance; and
- Referral links to HIV counseling, testing, care and other relevant services (e.g., family planning and other reproductive health services).

Treatment recommendations provided by Avahan clinics should be consistent with national STI clinical management guidelines and should be adapted over time, based on the local epidemiological information (e.g. etiology of common STI syndromes, STI prevalence within different populations, and local patterns of antimicrobial susceptibility).
Clinic Operations

2.1 Community Approaches 7
2.2 Coordination with Outreach Services 7
2.3 Clinic Structure 7
2.4 Staffing and Operations 8
2.5 Staff Training and Skills 9
2.6 Clinic Equipment 9
Clinic Operations

2.1 Community Approaches

Avahan clinics should promote meaningful participation of sex workers in the clinic operations and management. The clinics should actively develop strong communication links between the staff and the community for increasing community involvement in the clinics. Clinics should formalize community participation in programs by specifying how community members can participate in developing, managing and monitoring the program. Annex A presents guidelines for community participation and associated capacity-building strategies for gradually engaging community members in the clinic activities and for increasing the participation of key populations in day-to-day management decisions.

2.2 Coordination with Outreach Services

Clinic staff, project outreach teams and peer educators should be selected from within the sex worker community. The team should collaborate closely to ensure that the community has a sound understanding of the project. The staff should explore community perceptions about the clinic activities, assess effectiveness of outreach activities and community satisfaction with clinic operations. If these issues are not addressed in a timely manner, the clinic attendance will be low and the project will have little impact.

Clinic staff should spend time in the community with project outreach staff and peer educators, and should have regular meetings with them to discuss and coordinate clinic activities. Examples of topics for discussion at such meetings include:

- Community satisfaction with clinic services (e.g., clinic hours, privacy, cleanliness);
- Patient compliance with medications and treatment;
- Patient follow-up;
- Acceptability and effectiveness of counseling messages; and
- Questions raised by the community about, for example, health issues.

2.3 Clinic Structure

The internal structure of the clinic should, at a minimum, include the following to ensure physical and auditory privacy; and confidentiality of patient interviews and information:

- Waiting and Registration Area;
- Consultation and Examination Room;
- Laboratory Area (if feasible); and
- Counseling Room.
The Consultation and Examination room; and the Counseling room should have sufficiently thick doors and walls to ensure both auditory and visual privacy. Also patients should be requested to wait in the Waiting and Registration area, and not inside or directly outside the Consultation and Examination room. The examination table should be positioned such as to provide adequate space at the end of the table to properly view the genitalia during speculum examination.

In areas where counseling is performed off-site (e.g., during outreach visits or at a separate drop-in center), it may not be possible to have a separate Counseling Room. In such cases, health education information must be provided in the Consultation and Examination room.

The Laboratory should be in a separate room and should have a sink and sufficient countertop area. To facilitate immediate diagnosis and management of patients, the laboratory should be near the Consultation and Examination room. Clinic buildings and rooms should be properly maintained to ensure a comfortable, safe and hygienic environment. All equipment should be maintained in good working condition.

### 2.4 Staffing and Operations

Clinic should have trained and skilled staff to perform the following functions:

- Clinic administration, patient registration, record-keeping and reporting;
- Sexual and reproductive health history-taking, clinical examination and patient management, including counseling and education;
- Laboratory-based diagnostic testing (where applicable);
- Maintenance of clinical standards for STI management; and
- Procurement and maintenance of clinic supplies.

The functions and tasks of clinic staff with detailed job description for each position should be clearly described in the clinic operational manual (OM), which should include detailed job description for each position. Each clinic should have an adequate number of qualified staff to ensure a smooth flow of patients through the clinic and to allow staff to give each patient enough time and attention without creating excessive waiting time for other patients.

The recommended time allotment for clinic activities are as follows:

- STI clinic service providers should have sufficient time to take history, perform physical examination (including speculum examination for women and possibly proctoscopic examination for men where relevant), diagnose, prescribe treatment, and explain the treatment to the patient. Clinicians should spend a minimum of 15 minutes for a routine sex worker visit at a static clinic site and 10 minutes for a visit at a mobile clinic site.
- Counselors should spend a minimum of 20 minutes for a first visit and 10 minutes for follow-up visits.
- On-site laboratory results should be available within one hour after obtaining a specimen.
To improve access and attendance of the target populations, clinics should remain open during the time when the target population can conveniently access services. The clinic OM should contain an operational flowchart that depicts patient flow and staff responsibility. *Annex B contains an example of a clinic operational flowchart, which can be adapted to local clinic situations.*

### 2.5 Staff Training and Skills

All staff should have appropriate qualification and training to perform their assigned tasks. The staff should be well qualified and competent to carry out medical, nursing and laboratory procedures. Clinicians should be able to perform all the basic clinical procedures (e.g., speculum, bimanual and proctoscopic examinations) that are necessary to diagnose and manage STI patients. In addition, staff should have a non-judgmental attitude towards the target populations served by the clinic.

Rules and norms regarding clinic functioning should be clearly defined and understood by all staff. Each Avahan clinic should make efforts to hire staff from within the sex worker community. In addition, the project staff should develop the capacity of hired staff to perform specific functions within the clinic so that they can participate as integral members of the project team and can perform specific jobs independently during subsequent phases of the project.

Each Avahan clinic should identify the training needs of the staff and, if necessary, seek assistance for training. Also, each clinic should implement a plan for on-going technical support and supervision of staff.

### 2.6 Clinic Equipment

The clinic should maintain its equipment and keep it in good working condition. *Annex C includes a suggested minimum clinic equipment list.*
Chapter 3

Clinical Management of Sexually Transmitted Infections

3.1 Female Sex Workers 13
3.2 Male and Transgender Sex Workers 15
3.3 Other (Non–Sex Worker) Symptomatic Patients 16
3.4 Standard Treatments 16
3.5 Documentation 16
3.6 Medications and Commodities 16
3.7 Allergic Reactions and Anaphylaxis 17
3.8 Referral of Patients 18
Clinical Management of Sexually Transmitted Infections

All Avahan-supported clinics should implement clinical management guidelines for STIs, which includes the following key components:

- Sexual health history-taking;
- Adequate and appropriate physical examination, including a speculum and bimanual examination of the genital tract for all female patients and rectal examination (including proctoscopy, if indicated) for patients practicing receptive anal sex;
- The following tests are recommended where on-site laboratory services are available:
  - Basic microscopy (Gram stain for vaginal and cervical specimens and wet-mount slide preparation for vaginal specimens);
  - Vaginal pH testing;
  - Syphilis serology (on-site quantitative RPR or VDRL and referral for TPHA for positive syphilis serology).
  (Note: Where on-site laboratory services are not available, arrangements should be made with a referral laboratory to provide routine syphilis serology).
- Appropriate and immediate treatment and counseling of every patient, including the “four C’s” (Condom demonstration and promotion, ensuring Compliance with treatment, Counseling and Contact treatment/partner management);
- Follow-up care; and
- Referral network for services not available at the clinic like, referral for syphilis testing if it is not available on-site, family planning and for HIV voluntary counseling and testing (VCT), if requested by the patient after counseling.

3.1 Female Sex Workers

High rates of curable STIs have been observed worldwide in commercial sex settings where condom use rates are low and where there is limited access to effective STI treatment services. A prevalence study in Surat, India showed, 17 percent of sex workers infected with gonorrhea, 9 percent with chlamydia, 23 percent with reactive syphilis serology, 14

percent with trichomoniasis, and 15 percent with genital ulcers on physical examination.\textsuperscript{2} Effective prevention and treatment of STIs among female sex workers requires attention to both symptomatic and asymptomatic infections. The prevention and treatment of STIs in female sex workers in Avahan clinics should have the following two components:

- **Treatment of Symptomatic Infections:**
  Using National AIDS Control Organization (NACO) syndromic management flowcharts and laboratory diagnosis where available;

- **Screening and Treatment of Asymptomatic Infections:**
  - Monthly history taking and physical examination and simple laboratory tests (where available);
  - Treatment for asymptomatic gonococcal and chlamydial infections at the first visit and repeated if sex worker has not come for STI screening for six months; and
  - Semi-annual serologic screening for syphilis.

The treatment of symptomatic infections is based on NACO flowcharts, which can be used directly for female sex workers who present to the clinic with symptoms. The flowcharts in Annex D are adapted to guide STI treatment decisions for female sex workers, whether symptomatic or asymptomatic, during routine visits to clinics.

Female sex workers should be encouraged to attend the clinic for monthly routine check-ups. During the visit, the clinic staff should take a detailed history and perform an examination. If there are signs of infection, treatment should be given according to the NACO flowchart. In addition, even if there is no evidence of infection, treatment is recommended:

- If the sex worker is visiting the clinic for the first time;
- If the time lapse is more than six months since the last STI screening visit.

The rationale for treating sex workers who are asymptomatic is that they are frequently exposed to STIs considering that condom usage is inconsistent and STIs are asymptomatic in at least 50% of the infected women. Evidence has shown that sex workers are less likely to use condoms with their regular partners and they are often subjected to unprotected sex due to partner violence or due to economic reasons. Therefore, it is recommended to provide asymptomatic STI treatment at the first clinic visit and repeated if the time lapse is more than six months since the last STI screening. (Note: This recommendation will be reviewed and revised as data on the epidemiology of STIs among sex workers become available).

Monthly visits for routine examination and counseling should be promoted. Sex workers should be counseled at every opportunity (in the clinic and in the community) on the importance of using condoms. Peer educators, outreach workers and clinic staff should reinforce the following message to sex workers visiting the clinic:

- The only reliable way to protect oneself from HIV and STIs is to use condoms consistently and correctly; and
- Antibiotics dispensed at the clinic are effective only for the few curable STIs.

Outreach staff should also remind sex workers about their clinic appointments and help them keep their appointments. *Annex D contains detailed guidelines for managing STIs in female sex workers.*

### 3.2 Male and Transgender Sex Workers

To effectively manage STIs among male and transgender sex workers, one must address both symptomatic and asymptomatic infections. In the absence of data on STI prevalence among the male and transgender sex worker population in India, the following clinical strategy for detecting and treating STIs among male and transgender sex workers are recommended:

- **Treatment of Symptomatic Infections:**
  
  Using NACO syndromic management flowcharts, with additional flowcharts for anorectal and pharyngeal infections;

- **Screening and treatment for Asymptomatic Infections:**
  
  - Monthly history and physical examination (including proctoscopic examinations when acceptable) and simple laboratory tests, where available;
  - Treatment for asymptomatic gonococcal and chlamydial infections at the first visit and repeated if sex worker has not come for STI screening for six months; and
  - Semi-annual serologic screening for syphilis.

Male and transgender sex workers should be encouraged to visit the clinic for screening on monthly basis. During the visit, staff should take a careful history and perform an examination. A proctoscopic examination should be performed if there are anal symptoms and should be offered as a routine screening procedure to the patient. (Note: Clinic staff must ensure they offer proctoscopic examination as a routine screening procedure in a way that the local community finds acceptable). Close communication with the target community, either directly or through outreach workers and peer educators, is the best way to determine the acceptability of proctoscopic examinations and how best to approach the subject with patients. *For male and transgender sex workers, if there are signs of infection, treatment should be given according to the flowcharts presented in Annex E.* Even if there is no evidence of infection, treatment is recommended at the sex worker’s first visit and repeated again if six months have passed since the last STI screening.
Monthly visits for routine examination and counseling should be promoted. Outreach staff should also remind sex workers about their clinic appointments and help them keep their appointments. *Annex E contains detailed guidelines for managing STIs in male and transgender sex workers.*

### 3.3 Other (Non – Sex Worker) Symptomatic Patients

All Avahan clinics should provide syndromic management according to national guidelines for each and every patient with symptomatic STIs. Where laboratory services are available, all patients presenting with non-ulcerative conditions should be screened for syphilis serology and treated appropriately.

### 3.4 Standard Treatments

As stated above, treatment recommendations should comply with NACO STI clinical management guidelines; and should be standardized and adapted based on the local epidemiological and antimicrobial sensitivity information. Flowcharts that describe the standardized approach to be used in the clinic should be displayed in each room where treatments are prescribed to patients. NACO guidelines are given in the following two documents (see Annexes F and G):

- *Sexually Transmitted Infections – Treatment Guidelines*, 2004;

### 3.5 Documentation

Clinical history, examination findings, laboratory findings and prescribed clinical management for each patient should be recorded on the standardized forms for Avahan monitoring and evaluation purposes. *Annex Q contains an example of a clinic encounter form.*

Each clinic must develop an OM that clearly describes the policies and procedures to be followed by the clinic staff. The OM should include Avahan standards, examples of clinical management flowcharts, roles and functions of clinic staff, referral mechanisms, and clinic documentation that is required to support project monitoring and evaluation.

### 3.6 Medications and Commodities

All clinics should maintain adequate stock of the drugs required to treat STIs (as per standard treatments) at all times. Stocks of these medications should be maintained in the clinic at such a level so as to ensure a continuous and adequate supply without stock-out situations. All medications and clinic consumables should be stored in a secure location and should be used before their expiration date. The inventory of essential STI drugs and indications is shown in the following table. *Standard operating procedures (SOPs) and forms required for managing drug and consumable stocks are presented in Annex H.*
<table>
<thead>
<tr>
<th>Essential STI Drugs</th>
<th>Primary Indication</th>
<th>Alternative STI Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acyclovir 200 mg tablets</td>
<td>Genital herpes (HSV-2)</td>
<td>Acyclovir 400 mg tablets</td>
</tr>
<tr>
<td>Azithromycin 500 mg, or 1 gram tablets</td>
<td>GUD (chancre)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>UD, cervicitis (chlamydia)</td>
<td></td>
</tr>
<tr>
<td>Benzathine penicillin 2.4 million IU</td>
<td>GUD (syphilis)</td>
<td></td>
</tr>
<tr>
<td>intramuscular injection</td>
<td>Reactive syphilis test</td>
<td></td>
</tr>
<tr>
<td>Benzyl benzoate 25% lotion or Gamma benzene</td>
<td>Scabies, pubic lice</td>
<td>Permethrin 5% cream</td>
</tr>
<tr>
<td>hexachloride 1% lotion or cream</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefixime 400 mg tablets</td>
<td>UD, cervicitis (gonorrhea)</td>
<td>Ceftriaxone 250 mg intramuscular injection</td>
</tr>
<tr>
<td>Clotrimazole 500 mg vaginal pessaries or</td>
<td>Vaginal candidiasis (fluconazole is</td>
<td>Clotrimazole 1% cream or Miconazole 2%</td>
</tr>
<tr>
<td>Fluconazole 150 mg tablets</td>
<td>also recommended treatment for oral and esophageal candidiasis)</td>
<td>cream Miconazole 100 mg vaginal pessaries Nystatin 100,000 IU vaginal supp.</td>
</tr>
<tr>
<td>Doxycycline 100 mg tablets</td>
<td>Alternative treatment for chlamydial infection or syphilis</td>
<td></td>
</tr>
<tr>
<td>Erythromycin 250 mg or 500 mg tablets</td>
<td>Alternative treatment for chlamydial infection or syphilis (pregnant women)</td>
<td></td>
</tr>
<tr>
<td>Metronidazole 400 mg tablets</td>
<td>Bacterial vaginosis, trichomoniasis</td>
<td>Tinidazole 500 mg tablets (optional)</td>
</tr>
<tr>
<td>Podophyllin tincture 20%*</td>
<td>Genital warts (Condylomata acuminata)</td>
<td>Trichloroacetic acid 80 to 90%</td>
</tr>
</tbody>
</table>

### 3.7 Allergic Reactions and Anaphylaxis

The recommended and most effective treatment for syphilis is benzathine penicillin. All patients who present with genital ulcer disease (GUD) and/or positive syphilis serology should be treated with penicillin unless it is clear that the patient is allergic to the drug.

Before treating a patient with penicillin, clinic staff must ask the patient if he or she has a history of allergic reaction to penicillin. If the patient answers “yes,” explore the issue further by asking the following questions:

- What was the patient’s age at the time of the reaction?
- What were the characteristics of the reaction?
- How long after beginning penicillin therapy did the reaction begin?
- How was the penicillin administered?
- What other medications was the patient taking and at what time?
- What happened when the penicillin was discontinued?

*For correct Podophyllin application refer to the NACO STI Treatment guidelines on page number 97.*
Intradermal Sensitivity Testing for Penicillin

- May result in anaphylactic reactions in allergic persons, and staff must be prepared for emergency treatment.
- Must not interfere with penicillin treatment of syphilis. Benzathine penicillin should be used in all cases of GUD and positive syphilis serology unless allergic reaction is identified on intradermal sensitivity testing or unless a strong history of previous anaphylaxis, angioedema/urticaria, pruritic rash or bronchospasm is elicited.

All clinics that administer antibiotic medications, particularly by intramuscular injection, should be adequately equipped and prepared for emergency management of an allergic or anaphylactic reaction. Essential drugs and equipment for managing anaphylaxis include:

- Aqueous adrenaline (epinephrine) 1:1,000 dilution, for injection;
- Antihistamines for injection and oral administration (e.g., diphenhydramine and chlorpheniramine);
- Hydrocortisone for injection;
- Ambu bag for ventilation; and
- Oropharyngeal airway.

A wall chart that outlines emergency management of anaphylaxis should be displayed prominently in the area where injections are given and in the area where patients will be observed following an injection.

Clinics are not expected to manage more than the immediate, emergency life-saving aspects of a patient undergoing an anaphylactic reaction. Patients should be transferred to the nearest hospital or other appropriate facility as soon as it is safe to do so.

See Annex I for guidelines for the emergency management of anaphylaxis and the key points that should be included on a wall chart.

3.8 Referral of Patients

Patients whose health problems cannot be addressed or managed appropriately by the services

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available at an Avahan clinic should be referred to a higher-level service, such as a local hospital or speciality care. Such higher-level referrals include STI specialist care, general medical care, family planning, obstetrics/gynecological care, VCT and legal services. Non-governmental organizations can help with referrals.

Referral networks should be established explicitly depending on anticipated needs as a part of establishing a clinic. Clinics should compile a list of recommended providers for referrals that includes names, addresses, telephone numbers and operating hours. Whenever necessary (e.g., due to perceived barriers to accessing services), a referral may be facilitated by a patient advocate. *Guidelines for establishing a referral network are presented in Annex R.*
Laboratory Services

4.1 Laboratory Tests 23
4.1.1 Simple Laboratory Tests 23
4.1.2 Higher-level Laboratory Tests 24
4.2 Laboratory Standard Operating Procedures 24
4.3 Referral Laboratory Services 24
Laboratory Services

Ideally, on-site clinical laboratory services should be available at all clinics; but this is not feasible at all sites and depends on factors such as staff availability, their capacity, physical facilities, and the epidemiology of STIs in the community being served. The decision about whether or not to provide laboratory services and how to phase-in should be made on a site-by-site basis in consultation with Avahan managers. If on-site laboratory services are not available at the clinic, referral links with other laboratory to provide tests for syphilis (RPR/VDRL) and other higher-level tests, which are listed in Section 4.1 should be established.

4.1 Laboratory Tests
Where laboratory services are provided on-site, simple laboratory tests should be performed by a qualified laboratory technician. Higher-level tests should be made available by arrangement with a referral laboratory.

4.1.1 Simple Laboratory Tests
The following simple laboratory diagnostic tests can be performed on-site at a clinic. Test results should be made available immediately (ideally, within one hour) to make diagnosis and provide treatment to the patient in one single visit.

1) **Wet-mount slide preparations for microscopy:**
   - (a) **Normal saline** slide preparation for detection of motile trichomonads. **KOH** [Potassium Hydroxide] slide preparation for detection of candidal spores and pseudohyphae, and “Whiff test” for detection of amines indicative of bacterial vaginosis. (Whiff test to be performed by examining clinician).
   - (b) **Determination of pH** level of vaginal secretions (to be performed by examining clinician).

2) **Gram stain** of cervical specimen for white blood cell (WBC) and gram negative intracellular diplococci.

3) **Gram stain** of slides prepared from vaginal smears to diagnose bacterial vaginosis using Nugent’s or Amsel’s criteria.

4) **Syphilis serology** should ideally be performed on-site using quantitative RPR or VDRL. If such tests cannot be performed at the clinic laboratory, the blood sample should be collected on-site and sent to a referral laboratory for RPR/VDRL.
4.1.2 Higher level Laboratory Tests

The following higher-level laboratory diagnostic tests often cannot be performed at a clinic laboratory, and the specimens must be sent to a referral laboratory.

(1) Reactive syphilis serology confirmation testing: All samples positive for RPR or VDRL should be sent to a referral laboratory for confirmatory tests. This is most commonly done by TPHA, but can also be done by TPPA, FTA-Abs or rapid tests.

(2) HIV testing: HIV testing should be provided through referral of patient to a nearest government-sponsored VCT center which follows national VCT guidelines.

(3) HBsAg EIA testing: Hepatitis B testing should be provided through a referral laboratory.

4.2 Laboratory Standard Operating Procedures [SOPs]

Laboratory SOPs should be in place in all clinic laboratories. Establishing and using SOPs reduces the chances of process variability. There should be written instructions and protocols for all aspects of laboratory practices. SOPs for simple and higher-level laboratory tests and quality control are described in separate laboratory guidelines. Each clinic laboratory should maintain all laboratory equipment in good working condition. An annual maintenance contract for laboratory equipment should be in place. The minimum essential laboratory equipment is listed in Annex C.

4.3 Referral Laboratory Services

In the absence of an on-site laboratory facility, the clinic should establish a formal linkage with a referral laboratory for higher-level tests and for RPR/VDRL. The patient’s blood should be drawn on-site when the patient comes in, and then transported to the referral laboratory by the clinic staff. There should be SOPs for specimen collection, storage, transportation to the referral laboratory, and timely collection and recording of laboratory test results.

The referral laboratory should have the following procedures in place:

- All diagnostic tests performed by a qualified laboratory technician;
- Written SOPs in place for diagnostic testing and infection control;
- Daily maintenance of records;
- Routine internal quality control mechanism;
- External quality assessment schemes or willingness to cooperate with external assessment through Avahan; and
- Results of tests available on a timely basis.
Infection Control

5.1 Universal Precautions 27
5.2 Cleaning, Disinfecting and Sterilizing Equipment 27
5.3 Disposal of Hazardous Waste 27
5.4 Post-Exposure Prophylaxis 28
Infection Control

5.1 Universal Precautions
Universal precautions and infection control measures should be implemented and used at all times to prevent the transmission of blood-borne and other infections. These precautions and control measures should be used with all patients, regardless of their occupation, socio-economic status or HIV serostatus. All staff—including clinical, housekeeping and any other staff who could possibly come in direct physical contact with bodily fluids, waste, linens or spills—should be trained on universal precautions. Health care providers and their patients should be helped to understand that non-sterile care procedures can present a risk for HIV transmission. The sterile medical practices used in the clinic and the methods used to ensure safe injections should be explained clearly and thoroughly to patients so that they have confidence that the clinic services are safe. Patients should also be made aware of the measures that the clinic takes to ensure adherence to the universal precautions. See Annex J for recommended guidelines for universal precautions.

5.2 Cleaning, Disinfecting and Sterilizing Equipment
Guidelines and procedures for cleaning, disinfecting and sterilizing clinic and laboratory equipment, according to national and international standards, are presented in Annex K.

5.3 Disposal of Hazardous Waste
Hazardous waste must be disposed safely, in a manner that eliminates any possibility of infecting clinic staff or community members. Potentially infectious or toxic waste includes the following:

- Dressings and swabs contaminated with bodily fluids, blood or pus;
- Laboratory waste, including samples and used equipment;
- Patient care equipment, including gloves, needles, syringes and items used in direct contact with the patient;
- Chemical waste, such as laboratory reagents; and
- Pharmaceutical waste, such as expired drugs.

Proper waste management begins in the clinic with safe handling of waste and continues until its safe final disposal. Avahan clinics should dispose of hazardous waste through arrangements with a recognized medical waste disposal service or through arrangements with a nearby hospital. Avahan clinic waste management should comply with NACO
guidelines, as described in the *Manual for Control of Hospital Associated Infections: Standard Operating Procedures*. Avahan waste disposal guidelines are attached in Annex L.

### 5.4 Post-Exposure Prophylaxis

All clinic staff who come in contact with patients should receive a three-dose vaccination series for hepatitis B. Any unvaccinated, susceptible person who comes into contact with blood or bodily fluids should immediately receive the hepatitis B vaccination. Any staff member exposed to patient’s blood or bodily fluids, should receive prophylactic treatment for HIV according to national guidelines. In addition, an incident report must be filled out in accordance with clinic procedures. *SOPs for post-exposure prophylaxis (PEP) following HIV exposure are presented in Annex M.*

**Inventory requirements for essential PEP drugs include:**
- Zidovudine (AZT) 300 mg;
- Lamivudine (3TC) 150 mg;
- Indinavir 400 mg or, Efavirenz 200 mg or 600 mg or, Nelfinavir 250 mg or 625 mg.

Zidovudine 300 mg and Lamivudine 150 mg may also be provided as a combination tablet. At all times, the clinic should keep adequate stock for a 28-day treatment course for one person.
Education and Counseling for Patients

6.1 Components of Health Education and Counseling 31
6.2 Lubricant and Condom Distribution and Information 32
6.3 Information, Education and Communication Materials 32
6.4 HIV Counseling and Referral for Testing 32
Education and Counseling for Patients

6.1 Components of Health Education and Counseling

Health education and counseling should be offered to all patients who receive treatment for STIs, including patients treated for asymptomatic STIs, following the “four C’s” (Condom demonstration and promotion, ensuring Compliance with treatment, Counseling and Contact treatment/partner management).

When and where the “four C’s” are conducted will vary with different clinic sites. At minimum, health education should be carried out when the patient is at the clinic. The health education should include providing information on the nature of the infection, its consequences, the importance of complying with treatment regimens, how to reduce risk through condom use (including demonstrating the correct way to use a condom and promoting condom use), and contact treatment/partner management. In case of sex workers, partner referral and treatment refers to regular partners and boyfriends.

STI patients can be counseled either in the clinic or through outreach services. Counseling should be conducted by a person who is a member of the community (or a peer educator), who has been trained in counseling techniques, and who speaks and understands the dialect of the local community. A community member who undergoes a thorough and sustained orientation could gradually become a skilled and acceptable counselor. A counseling session should include more than just health education information; it should also help the patient cope with anxiety and stress caused by the diagnosis. The counseling process should evaluate the patient’s risk of STI transmission, address complex issues (e.g., prevention of HIV infection, unintended pregnancy, partner referral and treatment), and promote adoption and maintenance of preventive behavior in the future.

In addition to providing health education and counseling on STI and HIV, clinic staff should ensure patients are aware of safe healthcare practices and procedures of universal precautions performed at the clinic to prevent HIV or other blood borne infections transmission. For example, when a benzathine penicillin injection is administered, clinic staff should point out to the patient that a new needle and syringe should be used for injection, a different needle should be used to draw the medicine from the vials, and the needles are to
be disposed of in a puncture-proof container. It is also important to inform patients that unnecessary injections should be avoided and that non-sterile practices present a risk of acquiring HIV and other blood-borne infections. Key messages for health education and counseling are presented in Annex N.

6.2 Lubricant and Condom Distribution and Information

Lubricants and condoms should be given directly to each STI patient at the time of counseling. In addition, clinic staff should explain and demonstrate the correct use of lubricants and condoms with help of a penis model. The basic information that should be included in education about lubricants and condoms is presented in Annex O.

6.3 Information, Education and Communication Materials

Information, education and communication (IEC) materials should always be available in the clinic, particularly, at the time of counseling and outreach activities. Whenever possible, IEC materials will be provided by Avahan, NACO, State AIDS Control Societies or other organizations. IEC materials should be translated into local languages, if required.

6.4 HIV Counseling and Referral for Testing

All patients being treated for STIs should be counseled to help them reduce their HIV risks. As part of STI and HIV risk-reduction counseling, each individual should be given information that allows him or her to decide voluntarily for HIV testing (i.e., informed consent). In addition, each patient should be counseled for both the potential benefits and the adverse psychological impacts of knowing their HIV status. Patients should be informed that the clinic can facilitate access to confidential HIV testing and counseling. Each Avahan-supported STI clinic should develop formal referral linkages with a local VCT center that is accessible to patients. A potential referral link would be a government-sponsored VCT center that follows national VCT guidelines. Each Avahan clinic should have a trained counselor who can provide post-test counseling if a patient prefers to have on-going supportive counseling at the STI clinic or drop-in center. The patient’s decision to inform Avahan clinic staff of HIV status is an individual decision, and such information should not be requested by the clinic staff and should not be recorded in any way that leads to patient identification. Important components of pre and post-test counseling are presented in Annex N.
## Ethical Standards, Confidentiality and Right of Refusal

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 Ethical Standards</td>
<td>35</td>
</tr>
<tr>
<td>7.2 Confidentiality</td>
<td>35</td>
</tr>
<tr>
<td>7.3 Right of Refusal</td>
<td>36</td>
</tr>
</tbody>
</table>
Ethical Standards, Confidentiality and Right of Refusal

7.1 Ethical Standards
All treatments, procedures, testing and counseling for the patients should be performed to the highest professional and ethical standards, within the limitations of the service. The staff should ensure, above all, that they do not harm the patient. In all aspects, the basic human rights of each patient must be respected and given the utmost importance.

7.2 Confidentiality
Confidentiality is a cornerstone of high-quality sexual health clinical care. Clinics should have a clear confidentiality policy that is publicized and vigorously emphasized through staff orientation and regular trainings. In addition, all staff must sign a confidentiality agreement.

In all circumstances, the information contained in the patient medical records is confidential (i.e. cannot be communicated to third parties outside the clinic service) and should never be in public view (e.g., to patients in the waiting area). In addition, only the patient’s first name or registration number should be used while discussing cases or when calling a patient from the waiting area.

Patients should be informed regarding the handling of the sexual behavior data provided by them and the circumstances under which such information may be disclosed. It should be clearly stated that such information may be disclosed as an aggregate or individual information; personal identifiers may be disclosed; and how and by whom such information may be used. Clinics can inform patients about these issues by posting a notice on the wall near the reception and waiting area. The clinic staff should also explain verbally about the confidentiality policy to all new patients and disseminate the information through outreach workers and peer educators.

Some patients may not want to provide true details during registration, despite assurances of confidentiality. In such cases, clinic staff should record minimum three identifying information (e.g., first name, pseudonym, birth date and sex: “Mohamed, 10/12/1970, male”). If the information appears to be false, the staff member should request the patient to remember the same information for all subsequent visits (even if it is false) to help retrieve medical records and their registration number.

Clinics should also ensure that a grievance committee is established to investigate complaints by patients. The grievance committee should include members of the community and implementing partner STI supervisory staff. At the time of initial registration, all patients should be informed of the procedures for lodging a complaint.

**Elements that should be in place in the clinic:**

- Written confidentiality policies;
- Comprehensive training for staff on confidentiality issues of data collection and reporting;
- Posted notice to patients, explaining when their information about sexual behavior, diagnoses, sex worker status and other such sensitive information may or must be disclosed to others;
- Confidentiality agreement, to be signed by all staff; and
- Procedures that patients should use to lodge complaints for breach of confidentiality.

*An example of a confidentiality policy and confidentiality agreement are presented in Annex P.*

### 7.3 Right of Refusal

All examinations, procedures and treatments should be clearly explained to and understood by the patient, prior to testing or treatment. The patient must have the option to refuse any or all the services of the clinic. It is unacceptable for patients to be coerced to attend a clinic or to receive treatment. Patients who are intoxicated are, by definition, incompetent to give consent.
Chapter 8

Monitoring, Evaluation and Reporting

8.1 Monitoring .......................... 39
8.2 Evaluation ......................... 40
8.3 Reporting ......................... 40
Monitoring, Evaluation and Reporting

To be effective, an STI intervention and the clinic should address the needs of the community in a community-friendly way. To ensure that the project addresses the community’s needs appropriately, members of the community must be included and share responsibility for monitoring and evaluating the STI clinics and their activities. Monitoring should be the joint responsibility of clinic staff, both sex workers and non–sex workers, and their peers. Members of the community should also participate as much as possible as providers and controllers of services. They should be at the helm of monitoring and evaluating STI services too.

8.1 Monitoring

Monitoring is the regular, methodical process of collecting data to determine the progress and achievements of a program. Specific data are required for Avahan monitoring indicators (see text box below). Data for the Avahan monitoring indicators should be collected at the clinic level and should be entered into the record by Avahan implementing partners. In turn, the Avahan implementing partners should ensure that feedback and reports are provided to clinic managers and staff. The minimum data reporting requirements for Avahan are included in the reporting forms presented in Annex Q.

To support clinic-based monitoring, individual clinics or Avahan implementing partners may collect data on additional variables (i.e., variables not specified in the reporting forms in Annex Q) to ensure effective service delivery and sufficient coverage at the community level. As a basic principle, however, one should collect only the data required to obtain the information necessary for on-going monitoring of project services; collecting additional data “just in case it might be needed” is time-consuming and can place an excessive burden on clinic staff, and often leads to incomplete or inaccurate recording.

<table>
<thead>
<tr>
<th>Avahan Monitoring Indicators</th>
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<tr>
<td>✷ Total number of individuals receiving STI consultations;</td>
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<tr>
<td>✷ Estimated coverage of STI services (percent of target population examined per month based on local estimates of size of population);</td>
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<tr>
<td>✷ Estimated uptake (number of new attendees/estimated size of population);</td>
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<tr>
<td>✷ Average yearly number of visits per individual;</td>
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<tr>
<td>✷ Number and distribution of STI syndromes (VD, GUD, LAP, UD, anal infections, other);</td>
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<tr>
<td>✷ Proportion of sex workers receiving treatment for gonorrhea and chlamydia per year;</td>
</tr>
<tr>
<td>✷ Number of STI treatments distributed (by type); and</td>
</tr>
<tr>
<td>✷ Number of condoms distributed.</td>
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</table>
8.2 Evaluation
Evaluation involves analyzing and assessing a project (or program), or part of a project, to determine its quality and progress toward achieving project goals. Evaluation helps project participants self-evaluate and subsequently improve their own practices and the overall project. Quality assessment indicators will be developed to evaluate the coverage and quality of STI clinical services in the Avahan areas. Avahan STI interventions will be evaluated by externally appointed staff under the “Impact Monitoring and Evaluation grant”. These staff should include a representative from the sex worker community.

8.3 Reporting
Good reporting practices help Avahan clinics monitor their programs and permit meaningful evaluation of the programs. Reporting forms should be developed to monitor clinic services and to ensure that data are collected for the standardized reporting variables required by Avahan.

Typical reporting records that should be maintained by each Avahan clinic include:

- Clinic Encounter Form;
- Patient Register;
- Laboratory Register; and

Examples of reporting forms that include Avahan-required data requirements are included in Annex Q.

Clinic staff who are also members of the community should be trained, guided and monitored on a long-term basis to build their capacity to handle the reporting records listed above. In addition, with training, sex workers or literate family members could also be responsible for the following recording forms:

- Medicine Distribution Register for Individual Patients;
- Daily Stock Register;
- Monthly Monitoring Sheet; and
- Monthly Report Register of Peer & Outreach Workers.
Technical Support and Supervision
Technical Support and Supervision

All Avahan-supported clinics should be visited by a qualified clinical supervisor on monthly basis. The frequency of the visits can vary. Initially, the visits can be on monthly basis, but as the staff develop their capacity and improve their skills, visits can be less frequent. The clinical supervisor, appointed by the project should assess all major elements of clinic function. At minimum, the clinic should be assessed for compliance with the minimum standards as specified in this document, including:

- Accessibility, coordination with outreach services, and relationship with target community;
- Adequacy of staffing and staff knowledge, skills and performance;
- Adequacy and cleanliness of clinic structure and equipment;
- Safe and effective clinical examination, diagnosis and management;
- Laboratory quality assurance;
- Storage of drugs and consumables;
- Infection control and waste disposal; and
- Documentation, record-keeping and confidentiality.

Supervision and technical support should be carried out using checklists based on the “Guidelines and Tool for Monitoring and Supervision in Avahan Clinics,” prepared jointly by Family Health International [FHI] and the World Health Organization [WHO].
Improving Operations and Outcome of STI Management Services by Using Community-led Approaches
ANNEX - A

Improving Operations and Outcome of STI Management Services by Using Community-led Approaches

Introduction

The process of community mobilization entails community members, groups, and organizations planning, carrying out, monitoring, and evaluating a program and/or service on a participatory and sustained basis. The initial steps of this process involve a community becoming aware of a problem, identifying the issue as a priority, deciding what action should be taken, and involving other stakeholders in a wide range of support activities. In community mobilization efforts, the community remains at center stage of the program, thus ensuring community members participation and empowerment, allowing the community members to take direct control over their lives and environment, and ensuring a feeling of ownership of the program by the community.

In the Avahan context, the term community refers to the key target populations of the Avahan program. These target populations include sex workers (e.g., female, male, and transgender), truckers, drivers, cleaners, injecting drug users (IDUs), and others who are socially marginalized and vulnerable to STIs and HIV/AIDS.

The vulnerability of individuals and social groups is linked primarily to their social position and status. Marginalization and discrimination translate into low self-esteem and feelings of powerlessness in interactions with mainstream society. Their access to information and services is often further limited by the negative attitudes and practices of service providers and policymakers. Addressing this underlying vulnerability is an important component of successful HIV prevention interventions.

A sex worker does not engage in sex work out of a behavioral impulse; rather it is the result of his/her livelihood option. A sex worker can become infected with STI/HIV because of his/her occupation and the hazardous work environment where he/she negotiates the work. Even if condoms are available to sex workers, the sex worker cannot guarantee that his/her clients will use them. The issue is, therefore, not only behavioral, but also linked to various structures that obstruct sex workers’ efforts to choose safer sex practices.

With these issues in mind, Avahan adopted a three part strategy to build community ownership, community mobilization and an enabling environment. “Community Mobilization” approach can help reduce the transmission of HIV by influencing the sociopolitical context that shapes behavior and practices; addressing structural factors that make individuals and communities...
vulnerable to HIV; helping remove barriers to access of relevant information and services; enabling individuals/communities to act based on their decisions; and creating an environment to sustain change and to enhance engagement of community members in improving the status and quality of their lives.

The process of moving from an externally led programme to one where the community is mobilised requires building community “ownership” (within and outside the program). The community is also given support to become increasingly mobilized and empowered by changing the existing power relations at all possible levels.

**The three-tiered community mobilization strategy involves:**

1. Mobilizing communities through active engagement; and collective actions by the community to establish their rights and privileges as citizens;
2. Ensuring control over access and use of services by the community; and
3. Building an enabling environment to maintain control, sustain change, and improve the quality of services.

The community leads the program, whether the intervention is for STI management, health education related activities, or for creating an enabling environment. The process creates an environment in which programs are owned and managed by the community, making them more sustainable over time.
Control Over Access and Use of STI Services

STI management is an important component of ongoing interventions. Implementing non-governmental organizations (NGOs) must develop implementation plans to ensure that community members can and do participate in roles as gatekeepers and/or controllers of services, including a role in monitoring the STI service components of programs.

An implementing NGO must remember the following important facts:

- In developing and designing STI services, the community should be involved in identifying the core issues and in providing recommendations.
- In implementing recommendations, the community should be actively involved in implementing feasible solutions.
- In ensuring the quality of STI services, the community should play an important role in monitoring the delivery and management of quality STI services.
- In ensuring governance in STI delivery mechanisms, the community should have control and participate fully in developing and providing STI services.

Community-led processes seek to increase community participation incrementally. Taking a “life-cycle” approach to designing and implementing services, community engagement should be encouraged initially and can be expected to develop and mature over time. As this happens, the use of STI services will likewise increase over the life of a program.

It is thus important to carefully examine every action undertaken to develop STI services in light of fostering increasing community ownership:

- How is the STI component of the program designed?
- Who is playing what role in developing and managing STI services?
- Will the process undertaken empower the community?
- Will the process facilitate “ownership” by the community?

Community-led Approaches to STI Management Services

The importance and significance of involving the community in developing and distributing STI services cannot be overemphasized. To improve both the quality and coverage of STI management services, it is necessary to move beyond the traditional approaches to STI management, and to address issues that might restrict STI service within the clinic (e.g., doctor, medicine, and prescription). In this effort, social approaches to STI management have opened new avenues for engaging and involving service recipients as “providers” and “controllers” of STI services. Experience from across the globe confirms the belief that social approaches to STI programs can lead to more relevant and effective STI management; and can increase the overall impact of the program. Principles of community-led STI management
activities can be articulated under the four “D’s” (De stigmatization, Demystification, Decentralization, and Democratization).

**Destigmatization of STI Cases**

One of the primary reasons that STI services are underused or improperly used is the shame and stigma attached to sex, sex work, and STIs. Sex workers and their clients should be encouraged to approach STIs without guilt or stigma and to take appropriate steps to prevent and treat infection.

Peer outreach is the preferred method for removing or minimizing the stigma attached to STIs. One aim of project activities (e.g., interpersonal communication) should be to help people think of STIs as similar to other illnesses. They should accept STIs as occupational diseases and address issues and challenges from that viewpoint. In addition, basic human anatomy and physiology should be introduced in educational activities. Sex workers should be encouraged to examine their genitals, learn how to maintain cleanliness, and develop a healthy and non-judgmental attitude toward sex and sexuality. They should also develop the habit of visiting a clinic if they have reproductive tract symptoms.

**Demystification of Technical Aspects of STI Services**

A trend observed in several disciplines is the mystification of the knowledge base and related skill sets, so as to keep them beyond the reach of the common person. This enables professionals of that discipline to keep their “monopoly” unchallenged.

For example, there have been conscious efforts to mystify the entire domain of health and health care, specifically regarding curative medicine, so that a common person can neither understand nor question the procedures, practices, or even the diagnosis and treatment provided to him/her. This mystification protects the authority of physicians over the entire range of medical treatment and care, preventing others, especially service recipients, from questioning decisions and making medical practitioners more accountable to consumers. In India, for example, the culture of medical practice helped protect medical service providers from the scrutiny of consumers until the 1990s. Although things are changing, not much has changed when the service recipients belong to the lowest rungs of society.

Recently, the Sonagachi Project and other similar projects have succeeded in changing the relationship between service providers and service recipients because program implementers made a conscious effort to demystify STI management services. Community members were allowed to develop their knowledge, skills, and aptitude to deal with STI management services. Community members came to realize that medical doctors are not the only ones who can treat STIs; lay persons (including sex workers), if they are trained appropriately, can understand and assist in managing simple STIs. From the beginning, the Sonagachi Project involved community representatives on the medical team. Later, the Project provided nursing
training to community members and built the capacity of community members to deal with simple laboratory techniques and procedures. All of these efforts empowered community members to move beyond their role as recipients of services; they also played roles as service providers and “gate-keepers” of service provision.

**Decentralization of Medical Service**

Avahan’s goal to reach all community members, specifically among the marginalized community (e.g., sex workers), with quality STI services has already made Avahan’s STI strategy decentralized. It is the peer educators who motivate and counsel community members to seek and access STI services. They also play a role in following up STI cases and encouraging peers to complete the full course of treatment. One of the most difficult components of STI management is notification and treatment of partners, which can be improved greatly by delegating responsibility (with consent of the patient) to peer outreach workers. The counselor also can encourage and help the “index patient” by convincing his or her partner to take a recommended STI treatment. Experience from the Sonagachi and Tangail projects in Bangladesh demonstrates that peers from the same community can play a useful role in improving partner notification and treatment.

Thus, to improve the effectiveness of STI services, the various STI-related services should be carried out by different personnel, ranging from professional counselors and medical doctors to community members and peers. Not all of these personnel are located in the clinic, nor do they perform their respective roles in one place. This realization has opened up an avenue to develop and deliver STI management services as a joint effort between the clinic staff and the outreach teams. With good communication and coordination (i.e., frequent meetings between clinic and outreach teams), this joint approach increases the overall efficacy of a project.

**Democratization of STI Management Services (Issues of Governance)**

As discussed above, both the clinic and the outreach component of a program must be developed in combination to ensure effective STI services. Each component helps accomplish the objectives of STI management, and their respective roles and importance cannot be underestimated.

It is thus important to develop management systems to ensure team members clearly understand their roles and to establish routine procedures to share and reflect on clinic results with members of the outreach team. This should be reflected in monitoring and evaluation plans for STI services so that outreach teams and clinic teams have a common platform for discussing their contributions, constraints and responsibilities. As a clinical audit process is introduced as part of the monitoring mechanism, the audit team must include not only medical and healthcare professionals, but also counselors, peer counselors, and members of the target
population. Also, the outreach teams and clinic teams should hold regular joint meetings to improve the quality of services. Open and transparent communication between the two teams is critical to maintaining the effectiveness of the process.

**STI Interventions Translated Through the Lens of Community Mobilization**

**Clinic Structure and Location**

If an STI clinic is to have adequate utilization rates, it must be located within the locality where the target community is based and/or works. The target community should be involved in selecting sites and advising on the set-up of clinics and related spaces, such as drop-in centers (DICs). DICs usually have such facilities as a toilet, bath/wash/change room with mirror and shelves, mats/benches/chairs, pillows, and so on. The decisions about where DICs should be located should be made in consultation with the target community and sex workers. The DICs should have empowering posters on the walls depicting positive images of sex workers and their roles in program development (e.g., sex workers are part of the solution to HIV epidemic, sex workers’ rights are human rights), in addition to the usual messages on safer sex practices, sex education, nutrition, and health and personal hygiene.

DICs serve as accessible entry points for sex workers to STI clinic services and they can cater to other needs of both the sex workers and the program, including:

- Building trust and confidence;
- Addressing issues of low self-esteem;
- Collectivization of sex workers;
- Creating “space” within the management of the program;
- Inculcating community empowering processes;
- Addressing perceived needs of the community; and
- Addressing the issue of stigma attached to sex and sex work.

The implementing NGO and community members should jointly decide on the timing and scope of a DIC, and initially they should jointly administer the DIC. Gradually, however, the day-to-day operation and management of the DIC could be handed over completely to the community.

Peer educators will receive community members in the DIC, and then guide them to the STI clinic and facilitate their consultation with the clinic doctor and paramedical staff of the clinic. Peer educators should also maintain the registers and books, and monitor progress and follow-ups with dropouts and defaulters.

Guidelines that articulate the rights and responsibilities of the service users (clinic and DIC users) should be prominently displayed at the DIC.
Staffing and Operations

Each clinic should have a clinic manager selected from and by the community to oversee day-to-day management of the clinic. A Clinic Management Committee or Health Management Team could be constituted from among the peers and community members to manage all clinic-related activities. Such a committee should be empowered to make decisions about clinic management through their roles and responsibilities in the terms of reference of the committee.

Community members can be trained to perform different types of work within the clinic. When positions open up that can be filled by community members, every effort should be made to facilitate this.

The community mobilization approach suggests community members should be involved:

- In clinic administration, patient registration, and record-keeping;
- In maintenance of clinic equipment and logistics;
- As peer counselors/peer educators/social change agents;
- As participants in monitoring, evaluation, and reporting;
- In social marketing and distribution of condoms; and
- In building networks and linkages with other services/community outreach.

A Code of Conduct should be established for management of the STI clinic. Also, guidelines articulating the rights and responsibilities of the STI clinic attendees should be prominently displayed in the clinic.

Staff Training and Skills Development

Community members will be working in specific areas of the clinic, and they will receive structured training and have regular interactions with the doctor, counselor, and other community members. Structured training should cover:

- Human anatomy and physiology; and the transmission of STIs;
- Screening and treatment of asymptomatic STI cases;
- STI case management and case follow-up;
- Condom use demonstration and promotion;
- Reporting mechanisms and interpretation of results;
- Use of data in assessing quality of services;
- Counseling of STI cases;
- Developing materials for communication to address stigma attached to sex and STIs; and
- Coordination and leadership skill-building.
Education and Counseling of Patients

Peer educators (from within the community) play the key role in communicating with clinic-registered patients for health education and counseling. The role of the peer educator is similar to that of the appointed counselor. While the lead counselor is responsible for maintaining the quality of counseling, the community member, as peer counselor (selected from the community), will be responsible for establishing links between the community and providers of counseling services.

Distribution of Condoms and Lubricants

Peer educators and social change agents can be the depot holders and distributors of socially marketed lubricants and condoms. The easy accessibility of the community members to the peer educators will help facilitate condom uptake and use. In addition, peer educators can select depot holders from within the community to increase access to condoms for other community members. The peer educators will decide who the depot holders will be and also be responsible for motivating them.
Operational Flowchart – Illustrative
ANNEX - B
Operational Flowchart – Illustrative

The following operational flowchart is from the Operational Guidelines for FHI-Supported Clinics Providing RTI / STI Services in Nepal. It is provided for illustrative purposes and can be adapted to local conditions and included in the Operational Manual.

OPERATIONAL FLOWCHART FOR SEX WORKER VISIT

<table>
<thead>
<tr>
<th>PATIENT FLOW</th>
<th>ACTIVITIES</th>
<th>RESPONSIBLE STAFF</th>
</tr>
</thead>
</table>
| Waiting and Registration Area | • Patient details in confidential register  
                                • Clinic registration number allocated  
                                • Clinical forms prepared | Receptionist |
| Consultation & Examination Room | • Clinical form completed  
                                • Examination by clinician  
                                • Laboratory specimens taken  
                                • Whiff test | History / exam by clinician  
                                Specimens / whiff test by clinician |
| Laboratory Area | • Specimens to laboratory technician | Nurse |
| Waiting Area | • Blood taken  
                                • Wet film examined  
                                • Gram stain, RPR  
                                • Results sent to clinician | Laboratory Technician |
| Consultation & Examination Room | • Results & treatment given  
                                • Health education | Clinician & Nurse |
| Counseling Room | • Counseling and education given with 4 “C’s”  
                                • Leaflets provided  
                                • Next appointment made | Counselor |
Suggested Minimum Avahan Clinic Equipment List
ANNEX - C

Suggested Minimum Avahan Clinic Equipment List

General
1. Access to a male and female toilet;
2. Fans, as needed;
3. Private, soundproof rooms;
4. Sink with running water for washing hands, cleaning equipment etc.;
5. Electricity supply (or batteries for lights);
6. Waste basket in all rooms; and
7. Mops, brooms, and other equipment to clean the clinic.

Waiting and Registration Area
1. Clinic record system – including data summary sheets for attendance and surveillance purposes;
2. Filing cabinet – Lockable;
3. Desks;
4. Chairs;
5. Telephone; and
6. Chairs for waiting room.

Optional (funds and staff permitting):
- Computer;
- Printer;
- Modem;
- Fax; and
- Potted plants for waiting room.

Consultation and Examination Room
For examination:
1. Screens for privacy;
2. Examination couch – Ideally with steps and “cut-away” recess for speculum examination;
3. Examining chair (preferably with wheels);
Clinic Operational Guidelines and Standards (COGS)

4. Sheets for examination couch;
5. Pillow for examination couch;
6. Good examination light – Preferably wall-mounted;
7. Torch with fresh batteries and backup supply of batteries;
8. Gooseneck lamp – Halogen bulb preferred;
9. Kelly pad or other waterproof sheeting; and

**General medical:**
11. Sphygmomanometer;
12. Stethoscope;
13. Thermometer;
14. Adult weighing scales; and
15. Medicine cabinet.

**Instruments and sterilization:**
16. Sterilizer or access to sterilization facilities;
17. Scissors;
18. Instrument tray with cover;
19. Movable instrument holder
20. Cottonball holder;
21. Cottontip holder;
22. Vaginal specula of various sizes;
23. Speculum holder;
24. Proctoscopes /anoscopes;
25. Ovum forceps; and

**Medical Supplies—Consumables**
27. Needles and syringes—disposable;
28. Cotton wool;
29. Gauze pads (2x2 and 4x4);
30. Examination gloves, latex;
31. Sterile cotton-tipped applicators:
a] Small (sterile individually wrapped and non-sterile)
b] large (for cleaning the cervix)

32. Microscope slides and cover slips;
33. Water-soluble lubricant for clinical examination;
34. Disposable tissues;
35. Tongue depressors, disposable;
36. pH paper (4–7 range);
37. 10% potassium hydroxide solution;
38. Physiological saline solution;
39. Disinfectant (sodium hypochlorite);
40. 70% isopropyl alcohol;
41. Distilled water;
42. Male latex condoms;
43. Male polyurethane condoms (if available, for patients allergic to latex);
44. Female condoms (if available);
45. Water-based lubricant for distribution;
46. Demonstrators for male condom use (e.g., wooden dildos); and
47. Sharps disposal containers.

**Pharmaceuticals for Management of STIs, PEP, and Anaphylactic Reaction**

48. Supply of drugs as listed under Sections 3.6, 3.7, and 5.4;
49. Secure system for storing drugs appropriately;
50. Stock management system; and
51. Record system.

**Laboratory (if available)**

**General:**
1. Binocular microscope;
2. Spare bulbs for microscope;
3. Spare fuses for microscope;
4. Waste basket suitable for laboratory; and
5. Refrigerator.

**Equipment, Reagents and Consumables for Specific Tests:**
1. Alcohol lamp;
2. Staining rack;
3. Glass slides, frosted end;
4. Cover slip (22x22mm);
5. Cotton tipped swabs (sterile and non-sterile);
6. Gram stain kit;
7. Potassium hydroxide 10% solution;
8. Sterile distilled water;
9. Normal saline solution;
10. Syphilis RPR:
    a] Rotator
    b] Centrifuge
    c] RPR kit and controls
    d] RPR cards
11. Micropipette (200 µL, 1000 µL, adjustable volume);
12. Yellow pipette tips; and
13. Test tubes (12x75mm).

**Counseling Room**

1. Comfortable chairs for patient and counselor;

   *Optional:*

2. Flipchart with stand;
3. Television and video cassette recorder;
4. Overhead projector with tripod; and
5. Whiteboard.
Guidelines for Managing STIs in Female Sex Workers - Screening, Diagnosis and Treatment
ANNEX - D

Guidelines for Managing STIs in Female Sex Workers-Screening, Diagnosis and Treatment

History and Physical Examination

All female sex workers attending the clinic for STI care or for a routine medical examination should have their history taken and should undergo a physical examination. Patients attending clinics should be assured that the information obtained will remain confidential. Patients should be interviewed and examined in a private, well-lit room. Case record forms should be filled in as accurately and completely as possible, and all specimens taken should be clearly labeled.

History Taking

A sexual history must be taken from patients before examining them and managing their sexual health problems. There are several barriers to open and frank discussions of sexual health issues between patient and clinician. For example, many clinicians are embarrassed to take a sexual history from sex workers. On the other hand, sex workers are reluctant to raise sexual health issues with their doctor or clinician because they feel embarrassed or ashamed. Additional barriers to open discussion between patient and doctor include differences in age, gender, race, sexuality, and culture. In some settings, however, cultural differences between doctor and patient make honest discussions easier because it eliminates the patient’s fear of moral censure.

The medical language used to describe genital anatomy and sexual behavior is complicated and is not commonly used in the general community. The best approach is for the clinician or doctor to adapt to the patient’s level of understanding and language. This means that the clinician must not only understand the local terms used for parts of the body and sexual behavior but also be comfortable using those terms.

The impression to convey to patients is that it is safe for them to talk about sexual behavior and sexuality because it is a normal part of any professional consultation and it is important for their care. In communities where cultural rules about discussing sexual matters are particularly strict, it may be necessary to delegate the task of sexual history taking to someone of the same sex or ethnic background as the patient. Whatever method is used to obtain a sexual history, the patient must be assured that details that he/she gives to healthcare providers are held in strict confidence.

Every clinician will develop his or her own individual style for putting patients at ease, although the most important factor is to use a non-judgmental verbal and non-verbal approach.

**Demographic Details**

Demographic details should be obtained and entered into a standardized case report form. Some of these details will be obtained during the registration process; other pertinent details, such as number of children, will be gathered by the clinician as needed.

**Symptomatology**

It is necessary to find out if the patient has any symptoms, and if so the clinician must list them chronologically along with the duration and progression of the symptoms. If the subject has not been discussed previously, the clinician must ask specifically if the patient has symptoms related to the genitourinary system. Symptoms that should be asked about include the following:

- Dysuria or frequency
- Swelling and/or pain in the groin
- Lower abdominal pain
- Skin rashes or warts
- Vaginal discharge
- Sores around the genitals and anus
- Dyspareunia
- Swellings or lumps

The clinician should obtain details about the patient’s obstetric history (pregnancies, terminations), history of contraception, menstrual cycle, paying particular attention to irregularities in menstruation, dysmenorrhoea, menorrhagia, and/or delay in menses.

The patient should also be asked if she has had any major illnesses or STIs in the past. Also note whether the patient is currently taking any kind of medication and whether or not she is allergic to any medications.

**Sexual History**

When taking a sexual history, reassure the patient that the information is being obtained only to help with treatment, that the information will not be divulged to anyone else, and that all information will be kept absolutely confidential. It is often helpful to start off the questions about sexual behavior by saying, “I would now like to ask you some very personal questions. Please try to answer the questions as best you can. The answers to the questions will help me plan your treatment.”

Obtain details of the patient’s sexual history and ask if she uses condoms with commercial partners. It is also important to obtain details about her sexual practices, including her sites of exposure (i.e., vaginal, oral, anal). If possible, ask her how many partners she has had sex with in the last two weeks. Also ask if she has regular partners or clients and if she uses condoms with them.
# Guide for History Taking from Female Sex Workers

<table>
<thead>
<tr>
<th>General Details</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of children</td>
</tr>
</tbody>
</table>

## Present Illness

**If a vaginal discharge**
- Presenting complaints and duration
- Itching?
- Odor?
- Color and consistency of discharge?

**If lower abdominal pain**
- Vaginal bleeding or discharge?
- Painful or difficult pregnancy or childbirth?
- Painful or difficult or irregular menstruation?
- Missed or overdue period?
- History of recent delivery or abortion?
- Painful vaginal intercourse?
- Fever?

**If a genital or peri-anal ulcer**
- Site?
- Is it painful?
- Recurrent?
- Appearance?
- Spontaneous onset?
- Pain and swelling in the inguinal region?

**If urinary symptoms**
- Pain while passing urine?
- Frequency?

## Other symptoms
- Warts?
- Lumps or swellings?
- Skin rashes?

## Medical History

**Regular STI check-up?**
- When was the last STI check-up?
- Any medications provided?

**Any past STI?**
- Type?
- Dates?
- Any treatment and response?
- Result of any prior tests?

**Obstetric history**
- Pregnancies and outcomes?
- Date of last menstrual period?
- Contraception?

**Other illness?**
- Type?
- Dates?
- Any treatment and response?
- Result of tests?

**Medications?**
- Current medications?

**Drug allergies?**
- History of allergies?
- Name of drugs?
- Type of drug reactions?

**Drug and alcohol use?**
- Patterns and frequency of use?
- Injecting drug use?
- Harm minimization strategies?

## Sexual History

**Duration of sex work?**
**Number of partners in past two weeks?**
**Sites of sexual exposure (i.e., vaginal, oral, anal)?**
**Regular partner?**
**Symptomatic partner?**
**Condom use with regular and commercial partners?**
**Partner violence?**
Physical Examination

Before beginning the physical examination, the clinician or doctor should explain to the patient what she/he is about to do and what the patient can expect from the examination. Reassure her that you will not hurt her and that if she relaxes the procedure will be painless. The examination should be carried out in a private and well-lit room. Make sure to cover the patient with a sheet and expose only those parts of the body that you will be examining. Allow the patient to ask questions about and to take a close look at the equipment (e.g., speculums or swabs) before you use it, and explain how you will use it so that she understands what is happening during the examination. Using a hand mirror can be a useful way to help educate women about their genital anatomy.

Some patients may refuse to let you examine some or all of their anogenital area, even after you have clearly explained the benefits of such an examination. If the patient does refuse, explore the reasons for her refusal. Ask her, for example, “Would you prefer a same-sex clinician or a chaperone or friend in the room?” Explore for other cultural barriers. If the patient still refuses, the clinician must respect the patient’s choice. It is possible that the patient will allow examination on a subsequent visit after more trust is established.

General Examination

To minimize embarrassment to the patient, cover with a sheet the parts of the body that you are not examining. Look in the mouth with the aid of a wooden tongue depressor and examination light and inspect for sores, pharyngeal inflammation, and candida. Palpate the neck, the axillae, supraclavicular, submandibular and epitrochlear areas for enlarged lymph nodes. Look for rashes, swellings, and sores on the chest, back, and abdomen. Inspect the patient’s hands, forearms, and inside the elbow, and note any rashes, nail changes, or “needle track” marks.

Special Note: If the patient is generally unwell, take their pulse, blood pressure, auscultate for lung and heart sounds. If client has had a cough of more than 1 week duration, a history of pulmonary tuberculosis (PTB) or a cough of more than 3 weeks duration with or without a history of PTB, perform sputum examinations three times for the presence of acid fast bacilli (AFB) or refer to nearest Revised National Tuberculosis Control Program (RNTCP) unit at the sub-district level.

Abdominal Examination

Palpate the abdomen, feeling for areas of tenderness and for swelling. Check particularly for tenderness deep in the pelvis. Examine the pubic area and palpate for inguinal lymph nodes or rashes.

*Abdominal palpation and bimanual examination should be carried out on all women complaining of lower abdominal pain.*
External Anogenital Examination
Wear gloves for the anogenital examination. With the patient lying on her back, ask her to bend her knees and separate her legs. Inspect her pubic hair for signs of ectoparasite infestations. Inspect the labia and then retract them to inspect the urethral meatus, clitoris, introitus, and the perineum. Also inspect the perianal area. Note any discharge, ulcers, warts, or growths.

Speculum Examination
Wear gloves to carry out a speculum and bimanual examination. For a speculum examination, the patient should lie on her back with her legs bent at the knees and her feet and knees separated. A bright light source is necessary to inspect inside the vagina.

Separate the labia and insert a warm well-lubricated bivalve speculum and inspect the vagina. Look carefully for abnormal discharge, ulcers, and warts. If vaginal discharge is present, note the type (homogenous, thin, thick/curd-like, frothy), color (white, gray, green/yellow), and amount (scant, moderate, profuse). Wipe the cervix with a cotton swab and note any cervical discharge, ulcers, or warts. If there is a cervical discharge, note the type, color and amount as above. Remember that if a patient has extensive, painful genital ulcers, it may not be possible to perform a speculum examination. Do not hurt your patient.

If laboratory facilities are available, take specimens while the speculum is inside the vagina and while inspecting the vagina and cervix directly. Procedures for taking specimens are outlined below.

A correctly performed speculum examination should not be painful. Do not hurt the patient.

Bimanual Examination
When you have finished inspecting the vagina and cervix, remove the speculum, insert the index and middle fingers of your hand into the vagina, and carry out a digital bimanual examination. The bimanual examination is carried out with the two fingers inside the vagina and with the other hand placed on the lower abdomen. With your fingers inside the vagina and the other hand on the abdomen, examine the pelvis for swellings and tenderness. Check for cervical motion tenderness by gently moving the cervix laterally.

Specimen Collection
If it is necessary to take specimens, follow the laboratory protocol that was developed for the clinic. Specimens should be collected while the speculum is inside the vagina. The procedure is as follows:

1. Take one swab from the vaginal secretions or discharge. Make a smear of the discharge on two microscope slides, one for KOH prep and the other for saline prep.
2. Wipe the cervix with a cotton wool swab and discard the swab.

3. Insert a swab into the cervix, roll it around inside the cervix for 30 seconds, and then remove it and make a smear on a glass slide for Gram stain.

4. After the examination is finished, take 10 ml of venous blood from the arm, place it in a clotted blood tube, and send it to the laboratory for syphilis tests.

**Treatment**

Flowcharts for managing common symptomatic and asymptomatic infections are shown in Figures D-1 through D-3. Figure D-1 is a flowchart for clinical management in settings with laboratory support. Figure D-2 is a modified flowchart for settings without laboratory support. Figure D-3 shows a flowchart for managing positive RPR results.

All clients should be counseled (including referral for regular partners) and receive lubricants and condoms, as discussed in chapter 6, Annex N and Annex O of the Avahan Clinic Operational Guidelines and Standards for STI Services.
Figure D-1
Flowchart for Female Sex Worker Visit

- **Clinic visit by sex worker**

  - **Take history**
  - **First visit to clinic or >6 months since last STI screening?**
    - Yes → **STI treatment 1**
    - No → **Examine patient (external genital, speculum, and bimanual examination)**

  - **Unprotected sex with partner with STI?**
    - Yes → **Treatment according to partner’s symptoms**
    - No → **Vaginal discharge symptoms?**

  - **Vaginal discharge symptoms?**
    - Yes → **STI treatment 1 + 2**
    - No → **Look for signs of STI on exam**

  - **Look for signs of STI on exam**
    - **Genital ulcer?**
      - Yes → **STI treatment 3 and or 4, if herpetic**
      - No → **Bimanual lower abdominal pain and cervical motion tenderness?**
    - **Mucopurulent discharge or red cervix?**
      - Yes → **STI treatment 1**
      - No → **Positive lab results?**

  - **RPR/VDRL**
    - Cervical and vaginal gram stain
    - Vaginal wet-mount microscopy (saline and KOH prep)

  - **Positive lab results?**
    - Yes → **See Laboratory results chart (Table D-2)**

---

a. Without condom or condom failure.
b. All currently active sex workers have positive risk assessment (see NACO guidelines).
c. Bimanual examination for cervical motion tenderness should be done for all sex workers complaining of LAP.
d. Every six months

* STI treatments are shown in Table D-1.
Figure D-2
Flowchart for Female Sex Worker Visit in Clinics without Laboratory Services

Clinic visit by sex worker

First visit to clinic or ≥6 months since last STI screening?

Yes → STI treatment 1

No → Examine patient (external genital, speculum, and bimanual examination)

Take history

Unprotected sex with partner with STI?

Yes → Treatment according to partner’s symptoms

No → Vaginal discharge symptoms?

Yes → STI treatment 1 + 2

No → Draw blood and send to referral laboratory for syphilis test

Look for signs of STI on exam

Genital ulcer?

Yes → STI treatment 3 and or 4, if herpetic

No → Bimanual lower abdominal pain and cervical motion tenderness?

Yes → STI treatment 5

No → Mucopurulent discharge or red cervix?

Yes → STI treatment 1

No → Visible vaginal discharge?

Yes → STI treatment 1 + 2

No → Unprotected sex with partner with STI?

Yes → Treatment according to partner’s symptoms

No → First visit to clinic or ≥6 months since last STI screening?

Yes → STI treatment 1

No → Examine patient (external genital, speculum, and bimanual examination)

Take history

Vaginal discharge symptoms?

Yes → STI treatment 1 + 2

No → Draw blood and send to referral laboratory for syphilis test

a. Without condom or condom failure.
b. All currently active sex workers have positive risk assessment (see NACO guidelines).
c. Bimanual examination for cervical motion tenderness should be done for all sex workers complaining of LAP
d. Every six months

*STI treatments are shown in Table D-1.
Table D-1  STI Treatments Indicated in Flowcharts

<table>
<thead>
<tr>
<th>No.</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| 1   | Cefixime 400 mg orally single dose  
     AND  
     Azithromycin 1 gram orally single dose |
| 2   | Metronidazole 2 grams orally single dose  
     AND  
     Fluconazole 150 mg orally single dose* |
| 3   | Benzathine penicillin 2.4 million units IM  
     AND  
     Azithromycin 1 gram orally single dose |
| 4   | Acyclovir 400 mg orally TID for 7 days |
| 5   | Cefixime 400 mg orally single dose  
     AND  
     Doxycycline 100 mg BID orally for 14 days  
     AND  
     Metronidazole 400 mg BID orally for 14 days |
| 6   | Metronidazole 2 grams orally single dose |

* May substitute Clotrimazole pessary 500 mg intravaginally single dose

Table D-2  Treatment of Positive Laboratory Results*

<table>
<thead>
<tr>
<th>Test Result</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| Gram-negative diplococci  
  OR  
  >20 WBC/hpf on cervical Gram stain | Cefixime 400 mg orally single dose  
  AND  
  Azithromycin 1 gram orally single dose |
| Motile trichomonads on vaginal wet mount | Metronidazole 2 grams orally single dose |
| Budding yeast/hyphae on vaginal KOH preparation | Fluconazole 150 mg, orally single dose  
  OR  
  Clotrimazole pessary 500 dose mg intravaginally single |
| Nugent score > 6 on vaginal Gram stain  
  OR  
  positive Amsel test** | Metronidazole 2 grams orally single dose |
| Positive RPR/VDRL | See flowchart for Management of RPR Results |

* Laboratory procedures and interpretation of positive results are outlined in separate laboratory guidelines.

** Positive Amsel test: presence of three of the four criteria a) homogeneous vaginal discharge b) vaginal pH > 4.5 c) positive whiff test d) presence of clue cells.
### Table D-3 Partner Treatment

<table>
<thead>
<tr>
<th>Kit No.</th>
<th>Primary Infection of STI Patient</th>
<th>Partner Treatment</th>
<th>Medicines to be given</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ano-rectal discharge (ARD)</td>
<td>Treat partner for gonorrhea and chlamydia</td>
<td>Cefixime 400 mg orally single dose &lt;br&gt; <strong>AND</strong> &lt;br&gt; Azithromycin 1 gram orally single dose</td>
</tr>
<tr>
<td></td>
<td>Vaginal Discharge (Cervicitis)</td>
<td>Treat partner for gonorrhea and chlamydia</td>
<td><strong>AND</strong></td>
</tr>
<tr>
<td></td>
<td>Asymptomatic treatment</td>
<td>No treatment for partner</td>
<td><strong>AND</strong></td>
</tr>
<tr>
<td>2</td>
<td>Vaginal Discharge (Vaginitis)</td>
<td>Physician to make clinical judgment&lt;br&gt;If trichomoniasis, treat partner with Metronidazole</td>
<td>Metronidazole 2gm single dose <strong>OR</strong> Metronidazole 400 mg orally BID for 7 days</td>
</tr>
<tr>
<td>3</td>
<td>Genital Ulcer Syndrome (Non herpetic)</td>
<td>Treat partner for syphilis and chancroid</td>
<td>Benzathine penicillin 2.4 million units IM &lt;br&gt; <strong>AND</strong> &lt;br&gt; Azithromycin 1 gram orally single dose</td>
</tr>
<tr>
<td>4</td>
<td>Genital Ulcer Syndrome (Herpes)</td>
<td>Partner requires full sexual health history and examination&lt;br&gt;If herpes lesion present, then treat for herpes</td>
<td>Ayclovir 400 mg orally TID for 7 days</td>
</tr>
<tr>
<td>5</td>
<td>Lower Abdominal Pain (PID)</td>
<td>Treat partner for gonorrhea and chlamydia</td>
<td>Cefixime 400 mg orally single dose &lt;br&gt; <strong>AND</strong> &lt;br&gt; Azithromycin 1 gram orally single dose</td>
</tr>
<tr>
<td>Nil</td>
<td>Inguinal Swelling Syndrome</td>
<td>Treat for LGV</td>
<td>Doxycycline 100 mg BID orally for 21 days.</td>
</tr>
<tr>
<td>Nil</td>
<td>Genital Warts</td>
<td>Partner requires full sexual health history and examination&lt;br&gt;If genital warts present, then treat for genital warts</td>
<td>Apply podophyllin*</td>
</tr>
</tbody>
</table>

*For correct Podophyllin application refer to the NACO STI treatment guidelines on page number 97.*
**Figure D-3**

Management of RPR and VDRL Tests

Blood tested for RPR/VDRL

- **Reactive RPR/VDRL with positive confirmatory test**?
  - **Yes**: Ulcer present?
    - **Yes**: Manage according to genital ulcer flowchart
    - **No**: Observe & follow titer every 3 months
  - **No**: Patient clearly recalls recent treatment for syphilis?
    - **Yes**: Titer remains the same or lower?
      - **Yes**: Re-treat as new infection and follow as per flowchart
      - **No**: Observe & follow titer every 3 months
    - **No**: Evaluate for neurosyphilis or reinfection

- **Repeat after 6 months**

**Note:**
All reactive RPR/VDRL should be sent for confirmatory test. Negative confirmatory test indicates biologic false-positive RPR/VDRL.

*a* Low VDRL/RPR titer (< 1:8) may be due to a biological false positive or a serofast low titer. Nevertheless, Avahan recommendations are to treat in the case of low titer reactive syphilis.
serology identified on the first syphilis screening in sex worker populations because of the high probability of exposure to syphilis, the high likelihood of complications in untreated syphilis, and the increased HIV transmission associated with syphilis infection at the population level.

b Determination of need for treatment must be made on an individual basis and will depend on time since last treatment and on recent exposure history.

c If documentation of previous negative serology is not available and the duration of infection is unknown, the patient should be treated for late latent syphilis, benzathine penicillin (2.4 million units) IM once per week for three weeks.

d Expect at least two dilution lower titer at 6-month visit. However, if initial titer was low ($\leq1:8$), it may be serofast and not decrease over time.
Guidelines for Management of STIs in Male and Transgender Sex Workers - Screening, Diagnosis and Treatment
History and Physical Examination

All male and transgender sex workers attending the clinic for STI care or for a routine medical examination should have their history taken and should undergo a physical examination. Patients attending clinics should be assured that information obtained will remain confidential. Patients should be interviewed and examined in a private, well-lit room. Case record forms should be filled in as accurately and completely as possible, and all specimen taken should be clearly labeled.

History Taking

A sexual history should be taken from patients before examining them and managing their sexual health problems. There are several barriers to open and frank discussions of sexual health issues between patient and clinician. For example, many clinicians are embarrassed to take a sexual history from male and transgender sex workers, especially if they have been taught that male-to-male sex is a perversion. Also, religious sensitivities may require that the doctor, as a high-status person, uphold the moral principles of the religion. Patients can also be reluctant to raise sexual health issues with a doctor because they feel embarrassed or ashamed. Additional barriers to open discussion between patient and doctor include differences in age, gender, race, sexuality, and culture. In some settings, however, cultural differences between doctor and patient can make open discussions easier because it eliminates the patient’s fear of moral censure.

The medical language used to describe genital anatomy and sexual behavior is complicated and is not commonly used in the general community. The best approach is for the clinician or doctor to adapt to the patient’s level of understanding and language. This means that the clinician must not only understand the local terms used for parts of the body and sexual behavior but also be comfortable using those terms.

The impression to convey to patients is that it is safe for them to talk about sexual behavior and sexuality because it is a normal part of any professional consultation and it is important for their care. In communities where cultural rules about discussing sexual matters are particularly strict, it may be necessary to delegate the task of sexual history taking to someone of the same sex or ethnic background as the patient. Whatever method is used to obtain the

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sexual history, the patient must be assured that details that he/she gives to healthcare providers are held in strict confidence.

Every clinician will develop his or her own individual style for putting patients at ease, although the most important factor is to use a non-judgmental verbal and non-verbal approach.

**Demographic Details**

Demographic details should be obtained and entered into a standardized case report form. Some of these details will be obtained during the registration process; other pertinent details, such as number of children, will be gathered by the clinician as needed.

**Symptomatology**

The obvious genital symptoms due to which the patient came to the clinic, may not be the only problem. The clinician should explore for additional symptoms to ensure that nothing is overlooked. The clinician should ask the patient directly about the following symptoms:

- Urethral or rectal discharge, and its amount and character
- Rectal bleeding
- Genital rashes, lumps, and sores
- Itching and/or discomfort in the perineum, perianal, and pubic areas
- Difficulties with urination or defecation

The patient should also be asked if he has had any major illnesses or STIs in the past. Also note whether the patient is currently taking any kind of medication and whether or not he is allergic to any medications. Since many men who have sex with men (MSM) also have female partners, explore relevant issues such as their female partner’s contraceptive needs, when appropriate.

**Sexual History**

When taking a sexual history, reassure the patient that the information is being obtained only to help with treatment and that the information will not be divulged to anyone else, and kept absolutely confidential. It is often helpful to start off the questions about sexual behavior by saying, “I would now like to ask you some very personal questions. Please try to answer the questions as best you can. The answers to the questions will help me plan your treatment.”

Obtain details of his sexual history and ask if he uses condoms with commercial partners. It is also important to obtain details about his sexual practices, including sites of exposure (i.e., penile, oral, anal) and whether he performs the receptive or penetrative role or both. Ask if he has sex with men, women, or both. If possible, ask him how many partners he has had sex with in the last two weeks. Also ask if he has a regular partner and if he uses condoms with that partner.
### Guide for History Taking for Male and Transgender Sex Workers

<table>
<thead>
<tr>
<th><strong>General Details</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Others as needed</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Present Illness</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If a urethral discharge</strong></td>
<td><strong>Presenting complaints and duration</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Color and consistency of discharge?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Difficulty or pain with urination?</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>If rectal pain or discomfort?</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Rectal bleeding or discharge?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Diarrhea?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Abdominal pain or cramping?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Fever?</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Difficulty or pain with defecation?</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>If a genital or peri-anal ulcer</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Site?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Is it painful?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Recurrent?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Appearance?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Spontaneous onset?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Pain and swelling in the inguinal region?</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Any other symptoms</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Warts?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Lumps or swellings?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Skin rashes?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sore throat or oral ulcers?</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Medical History</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regular STI check-up?</strong></td>
<td>When was the last STI check-up?</td>
</tr>
<tr>
<td></td>
<td>Any medications provided?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Any past STI?</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Dates?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Any treatment and response?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Result of any prior tests?</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Other illness?</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Dates?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Any treatment and response?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Result of tests?</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Drug and alcohol use?</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patterns and frequency of use?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Injecting drug use?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Harm minimization strategies?</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Medications?</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current medications?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Feminization practices (where relevant)?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>History of allergies?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Names of drugs?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Type of reactions?</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Drug allergies?</strong></th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Sexual History</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration of sex work?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of partners in past two weeks?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Type of sexual behavior practiced (oral, anal, receptive or penetrative role)?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Gender of sexual partners?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Contraceptive use by female partners?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Regular partner?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Symptomatic partner?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Condom use with regular and commercial partners?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Partner violence?</strong></td>
<td></td>
</tr>
</tbody>
</table>
Physical Examination

Before beginning the physical examination, the clinician or doctor should explain to the patient what he/she is about to do and what the patient can expect from the examination. Reassure him that you will not hurt him and that if he relaxes the procedure will be painless. The examination should be carried out in a private, well-lit room. Make sure to cover the patient with a sheet and expose only those parts of the body that you will be examining. Allow the patient to ask questions and take a close look at the equipment (e.g., proctoscopes and swabs) before you use it. Also, explain how you will use it so that he understands what is happening during the examination.

Some patients may refuse to let you examine some or all of their anogenital area, even after you have clearly explained the benefits of such an examination. If the patient does refuse, explore the reasons for his refusal. Ask him, for example, “Would you prefer a same-sex clinician or a chaperone or friend in the room?” Explore for other cultural barriers? If the patient still refuses, the clinician must respect the patient’s choice. It is possible that the patient will allow examination on a subsequent visit after more trust is established.

General Examination

To minimize embarrassment to the patient, cover with a sheet the parts of the body that you are not examining. Look in the mouth with the aid of a wooden tongue depressor and examination light and inspect for sores, pharyngeal inflammation, and candida. Palpate the neck, the axillae, supraclavicular, submandibular and epitrochlear areas for enlarged lymph nodes. Look for rashes, swellings, and sores on the chest, back, and abdomen. Inspect the patient’s hands, forearms, and inside the elbow, and note any rashes, nail changes, or “needle track” marks.

Special Note: If the patient is generally unwell, take their pulse, blood pressure and auscultate for lung and heart sounds. If a client has been suffering from cough for more than 1 week and has a history of pulmonary tuberculosis (PTB), perform sputum examinations three times for the presence of acid fast bacilli (AFB) or refer to nearest Revised National Tuberculosis Control Program (RNTCP) unit at the sub-district level. Repeat the same process if cough is for more than 3 weeks with or without history of PTB.

Abdominal Examination

Palpate the abdomen, feeling for areas of tenderness and swelling. Examine the pubic area and palpate for inguinal lymph nodes or rashes.

External Anogenital Examination

Wear gloves for the anogenital examination. Inspect the exposed skin from umbilicus to knees for altered pigmentation, rashes, scars, and lumps. Inspect pubic hair for signs of ectoparasite infestations. Inspect the inguinal folds for rashes or lumps.
Palpate the contents of the scrotum for lumps and tenderness. This is performed by gently cradling each testicle in one hand while feeling for the epididymis with the fingers of the same hand. With the other hand, gently roll the vas deferens to detect any lumps. Repeat the scrotal examination with the patient standing, as this is often easier and also allows for better detection of conditions such as hernia and varicocele.

Inspect the skin along the length of the penis from base to tip. Note any lumps, rashes, or ulcers. Retract the foreskin and inspect for lumps, rashes, ulcers and discharge. Inspect the urethral meatus by parting the tip bilaterally, and note any discharge, ulcers or lumps.

Ask the patient to lie down and turn onto the left side (left lateral position), then to bend both knees and flex the hips to 45°. Ask the patient to place his right hand on his right buttock and draw it upward. This position provides full exposure of the perianal area and allows the clinician to have both hands free for inspection and examination. (You may want to kneel down or sit on a chair to keep from bending your back.) Inspect the buttocks, perineum, and perianal area, noting any lumps, ulcers, rashes, scars or discharge.

Proctoscope /Anoscope Examination

A proctoscopic/anoscopic examination is recommended whenever there are anorectal signs or symptoms. During routine checkups without symptoms, it is also recommended for visual inspection and laboratory tests to identify asymptomatic infection. While all patients practicing receptive anal sex should ideally be examined with a proctoscope at each visit, the feasibility of this approach depends on the acceptability of the procedure within the community. Community perceptions of clinic procedures should be monitored through outreach workers, and clinic procedures (e.g., indications for proctoscopic examination) should be adjusted as needed.

A correctly performed proctoscope examination should not be painful. Do not hurt the patient.

Wear gloves to carry out a proctoscope examination. Before beginning the examination, warm the proctoscope with water and apply lubricating jelly to the entire length of the proctoscope and to the perianal area of the patient. Explain to the patient what you are about to do. The patient should be in the left lateral position, as described in the previous section for the external anogenital examination.

Begin the process with a digital examination, using a lubricated and gloved right index finger. Palpate the prostate and lower rectum. The finger is smaller than the proctoscope, so the digital examination is less uncomfortable for the patient and helps to relax and lubricate the
rectum for proctoscopy. In addition, digital examination may uncover different findings than proctoscope examination. Note the presence of masses or lumps beneath the rectal mucosa, the location of painful areas, and the size and contour of the prostate gland.

The examiner should change gloves between the digital rectal examination and the proctoscopic examination. Some clinicians double-glove their right hand and merely discard the outer glove after the digital examination and before the proctoscopic examination.

Rest the proctoscope at the anal verge until the sphincter relaxes, then slowly insert it by applying gentle constant pressure. Rather than pushing the proctoscope in, allow it to follow the line of least resistance, aiming generally toward the navel. Elevating and relaxing the buttocks aids insertion, as does asking the patient to “bear down” as if opening the bowels. Remove the introducer once the proctoscope has reached its limit.

Observe the following with the aid of the patient examination light:

- Color and texture of rectal mucosa;
- Presence and characteristics of discharge;
- Presence of ulceration;
- Bleeding; and
- Lesions.

If it is necessary to take specimens, follow the laboratory protocol that was developed for the clinic. Specimens should be collected while the proctoscope is inside the rectum. Take a swab of the rectal mucosa and make a smear on a glass slide for Gram stain.

After you are finished with the examination, slowly remove the proctoscope, checking for hemorrhoids and/or other lesions as it is withdrawn.

**Treatment**

Many of the infections experienced by male and transgender sex workers can be managed syndromically, using NACO flowcharts *(see Annex G)* for the following symptoms:

1. Urethral discharge;
2. Genital ulcer disease;
3. Inguinal bubo; and
4. Scrotal swelling.

Additional infections common in male and transgender sex workers that are not covered in the NACO flowcharts include pharyngeal and anorectal STIs. Guidelines for managing these infections are presented below.

To maximize compliance with treatment, single-dose treatments are preferable whenever possible.
Pharyngeal Infections

The prevalence of pharyngeal gonococcal and chlamydial infections among men who have sex with men (MSM) and transgenders in Asia is not known. In the absence of etiological tests for gonorrhea and chlamydia, it is difficult to diagnose these infections reliably. Additionally, clinicians should be aware that pharyngeal gonorrhea can be more difficult to cure than urethral infections. Other oropharyngeal STIs (e.g., herpes and warts) can often be detected by inspection and managed according to national guidelines. *Annex F contains the NACO treatment guidelines.*

It is recommended that whenever a patient is suffering from significant pharyngitis and a history of unprotected oral sex makes pharyngeal gonococcal or chlamydial infection a likely diagnosis, patients should be treated syndromically as shown in the following text box.

<table>
<thead>
<tr>
<th><strong>Treatment for Sexually Transmitted Pharyngitis</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cefixime 400 mg orally as a single dose</td>
</tr>
<tr>
<td><strong>PLUS</strong></td>
</tr>
<tr>
<td>Azithromycin 1 gram orally as a single dose</td>
</tr>
</tbody>
</table>

Anorectal Infections

STIs may be spread through anal sex when blood, semen, or other bodily fluids are shared. STIs that affect the anorectal area include:

- Gonorrhea;
- Chlamydia;
- Warts (human papillomavirus infection, HPV);
- Syphilis;
- Herpes (herpes simplex virus infection, HSV); and
- Giardiasis, shigellosis, and infections with other enteric pathogens such as amoeba.

It is possible to acquire an STI without anal penetration. Oral-to-anal contact, whether from kissing or from oral contact with fingers that have been touching the anus or genitals, can spread bacteria and cause infection. Using condoms is an excellent way to prevent STI transmission, although they might be less effective against some STIs (e.g., those transmitted more by skin-to-skin contact, such as HPV) than others.
**Proctitis**

Proctitis is an inflammation of the rectal wall and is the most common reaction to an anorectal STI (due to gonorrhea, syphilis, chlamydia, or herpes). Anyone whose immune system is impaired is at increased risk of developing proctitis, particularly from infections caused by the herpes simplex virus or cytomegalovirus or from reactivation of an earlier infection. Proctitis may be caused by *Salmonella spp.*, *Shigella spp.*, or *Entamoeba histolytica* as a part of gastroenteritis, which may manifest as diarrhea with fever, anorexia, and abdominal cramps. Antibiotics that destroy normal intestinal bacteria and allow other bacteria to grow in their place may also cause proctitis. Herpetic proctitis may be mistaken for the rectal manifestation of ulcerative colitis or Crohn’s disease.

**Symptoms and Diagnosis of Proctitis**

Proctitis typically causes painless bleeding or the passage of mucus (sometimes mistaken for diarrhea) from the rectum. There may also be ineffectual straining to defecate (“tenesmus”), sometimes mistakenly described as “constipation” by patients. The anus and rectum may be intensely painful, with external and internal ulceration, when the cause is gonorrhea, herpes or cytomegalovirus infection.

A proctoscopic examination will reveal rectal pus, bleeding, or ulceration. Samples of pus and ulcer scrapings can be sent to a laboratory for diagnostic tests of bacteria, virus, and fungi.

**Treatment of Proctitis**

All cases of proctitis in male and transgender sex workers should be treated for gonorrhea and chlamydia infections. Symptoms of diarrhea, bloody stools, abdominal cramping, nausea, and/or bloating may indicate *Giardia* infection or amoebic dysentery. Most bacterial diarrheal diseases resolve spontaneously with oral rehydration and anti-diarrheal medication such as loperamide. The treatment of ulcerative colitis, Crohn’s disease, and radiation colitis is beyond the scope of these guidelines.

**Treatment for Sexually Transmitted Proctitis**

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cefixime</strong></td>
<td>400 mg orally as a single dose</td>
</tr>
<tr>
<td><strong>PLUS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Azithromycin</strong></td>
<td>1 gram orally as a single dose</td>
</tr>
</tbody>
</table>

If symptoms of diarrhea, bloody stools, abdominal cramping, nausea, and/or bloating are present: Add treatment for diarrhea according to local epidemiology, including ORS.
Asymptomatic STIs

An effective strategy for preventing and treating STIs among MSM and transgenders involves addressing both asymptomatic and symptomatic infections. Although many of the infections experienced by MSM and transgenders will be symptomatic, many infections will remain asymptomatic. The prevalence of pharyngeal and anorectal gonococcal and chlamydial infections among MSM and transgenders in Asia is not known. Most syphilis in the community is latent (i.e., asymptomatic) and remains undetected unless serological tests are performed.

When simple laboratory services are available, RPR/VDRL screening will detect cases of latent syphilis, and Gram stain of the rectal mucosa will detect some cases of asymptomatic proctitis. However, not all cases of gonococcal and chlamydial proctitis will be detected by Gram stain. Therefore, treatment for both infections will be given at the first clinic visit and repeated if six months have passed since the last STI screening visit. Family Health International will provide updated guidelines to implementing partners for later phases of the project.

Flowcharts for routine male and transgender sex worker visits in settings with and without simple laboratory tests onsite are shown in Figures 1 and 2 respectively.

Counseling

All clients should be counseled (including referral for regular partners) and receive lubricants and condoms, as discussed in Chapter 6 and Annex N and Annex O of the Avahan Clinic Operational Guidelines and Standards for STI Services.
Figure E-1
Flowchart for Male and Transgender Sex Worker Visit

Clinic visit by sex worker

First visit to clinic or ≥6 months since last STI screening? Yes

STI treatment 1

Unprotected sex a with partner with STI? Yes

Treatment according to partner’s symptoms

Pharyngitis with history of unprotected oral sex? Yes

STI treatment 1

Anal discharge or tenesmus? Yes

STI treatment 1

Diarrhea, blood in stools, abdominal cramping, nausea, bloating? Yes

STI treatment 1 + anti-diarrheal meds as needed

Examine patient (oral, external anogenital, digital rectal & proctoscope) b

Look for signs of STI on exam

Genital or anorectal ulcers? Yes

STI treatment 3 and or 4, if herpetic

Rectal pus? Yes

STI treatment 1

Urethral discharge? Yes

STI treatment 1

RPR/VDRL c

Gram stain of rectal swab

Positive lab results? Yes

See Laboratory results chart (Table E-2)

---
a. Without condom or condom failure.
b. If asymptomatic, digital rectal and proctoscope exam only if acceptable.
c. Every six months.

* STI treatments are shown in Table E-1.
Figure E-2
Flowchart for Male and Transgender Sex Worker Visit in Clinics Without Laboratory Services

Clinic visit by sex worker

Take history

First visit to clinic or ≥6 months since last STI screening? Yes

Unprotected sex with partner with STI? Yes

Pharyngitis with history of unprotected oral sex? Yes

Anal discharge or tenesmus? Yes

Diarrhea, blood in stools, abdominal cramping, nausea, bloating? Yes

Examine patient (oral, external anogenital, digital rectal, proctoscope) &

Draw blood and send to referral laboratory for syphilis test

Look for signs of STI on exam

Genital or anorectal ulcers? Yes

Rectal pus? Yes

Urethral discharge? Yes

STI treatment 3 and or 4, if herpetic

STI treatment 1

STI treatment 1

STI treatment 1 + anti-diarrheal meds as needed

STI treatment 1

* STI treatments are shown in Table E-1.

a. Without condom or condom failure.
b. If asymptomatic, digital rectal and proctoscope exam only if acceptable.
c. Every six months.
Table E-1 STI Treatments as Indicated in Flowcharts

<table>
<thead>
<tr>
<th>No.</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cefixime 400 mg orally single dose AND Azithromycin 1 gram orally single dose</td>
</tr>
<tr>
<td>2</td>
<td><strong>NOT APPLICABLE FOR MALES</strong> Metronidazole 2 grams orally single dose AND Fluconazole 150 mg orally single dose *</td>
</tr>
<tr>
<td>3</td>
<td>Benzathine penicillin 2.4 million units IM AND Azithromycin 1 gram orally single dose</td>
</tr>
<tr>
<td>4</td>
<td>Acyclovir 400 mg orally TID for 7 days</td>
</tr>
<tr>
<td>5</td>
<td><strong>NOT APPLICABLE FOR MALES</strong> Cefixime 400 mg orally single dose AND Doxycycline 100 mg BID orally for 14 days AND Metronidazole 400 mg BID orally for 14 days</td>
</tr>
<tr>
<td>6</td>
<td>Metronidazole 2 grams orally single dose</td>
</tr>
</tbody>
</table>

* May substitute Clotrimazole pessary 500 mg intravaginally single dose

Table E-2 Treatment of Positive Laboratory Results *

<table>
<thead>
<tr>
<th>Test Result</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gram-negative diplococci OR &gt;1WBC/hpf on rectal Gram stain</td>
<td>Cefixime 400 mg orally single dose AND Azithromycin 1 gram orally single dose</td>
</tr>
<tr>
<td>Positive RPR/VDRL</td>
<td>See flowchart for Management of RPR Results</td>
</tr>
</tbody>
</table>

* Laboratory procedures and interpretation of positive results are outlined in separate laboratory guidelines.
### Table E-3 Partner Treatment

<table>
<thead>
<tr>
<th>Kit No.</th>
<th>Primary Infection of STI Patient</th>
<th>Partner Treatment</th>
<th>Medicines to be given</th>
</tr>
</thead>
</table>
| 1       | Urethral Discharge (UD)          | Treat partner for gonorrhea and chlamydia | Cefixime 400 mg orally single dose  
AND  
Azithromycin 1 gram orally single dose |
|         | Ano-rectal discharge (ARD)       | Treat partner for gonorrhea and chlamydia |  |
|         | Scrotal Swelling Syndrome        | Treat partner for gonorrhea and chlamydia |  |
|         | Asymptomatic treatment           | No treatment for partner |  |
| 2       | Not applicable for males         |                   |  |
| 3       | Genital Ulcer Syndrome (Non-herpetic) | Treat partner for syphilis and chancroid | Benzathine penicillin 2.4 million units IM  
AND  
Azithromycin 1 gram orally single dose |
|         | Genital Ulcer Syndrome (Herpes)  | Partner requires full sexual health history and examination  
If herpes lesion present, then treat for herpes | Acyclovir 400 mg orally TID for 7 days |
| 5       | Not applicable for males         |                   |  |
| 6       | Urethral Discharge (recurrent)   | Treat partner for trichomoniasis | Metronidazole 2 grams single dose |
| Nil     | Inguinal Swelling Syndrome       | Treat for LGV     | Doxycycline 100 mg BID orally for 21 days. |
| Nil     | Genital Warts                    | Partner requires full sexual health history and examination  
If genital warts present, then treat for genital warts | Apply podophyllin* |

* For correct Podophyllin application refer to the NACO STI treatment guidelines on page number 97.
**Figure E-3**

Management of RPR and VDRL Tests

---

**Blood tested for RPR/VDRL**

- **Reactive RPR/VDRL with positive confirmatory test?**
  - Yes: **Ulcet present?**
    - Yes: Manage according to genital ulcer flowchart
    - No: **Observe & repeat after 3 months**
  - No: **Observe & follow titer every 3 months**

- **Patient clearly recalls recent treatment for syphilis?**
  - Yes: **Titer remains the same or lower?**
    - Yes: No further treatment but observe over time in case of reinfection
    - No: Re-treat as new infection and follow as per flowchart
  - No: **Evaluate for neurosyphilis or reinfection**

- **Falling titer or low titer maintained?**
  - Yes: No further treatment but observe over time in case of reinfection
  - No: Evaluate for neurosyphilis or reinfection

---

**Note:**
All reactive RPR/VDRL should be sent for confirmatory test. Negative confirmatory test indicates biologic false-positive RPR/VDRL.

---

*Low VDRL/RPR titer (< 1:8) may be due to a biological false positive or a serofast low titer. Nevertheless, Avahan recommendations are to treat in the case of low titer reactive syphilis serology identified on the first syphilis screening in sex worker.*
populations because of the high probability of exposure to syphilis, the high likelihood of complications in untreated syphilis, and the increased HIV transmission associated with syphilis infection at the population level.

b Determination of need for treatment must be made on an individual basis and will depend on time since last treatment and on recent exposure history.

c If documentation of previous negative serology is not available and the duration of infection is unknown, the patient should be treated for late latent syphilis, benzathine penicillin (2.4 million units) IM once per week for three weeks.

d Expect at least two dilution lower titer at 6-month visit. However, if initial titer was low (<1:8), it may be serofast and not decrease over time.
NACO STI Treatment Guideline
STI TREATMENT RECOMMENDATIONS

Introduction

STI Treatment Guidelines have been updated on account of the introduction of newer modalities on management of STIs and development of resistance by microorganisms to antibiotics used earlier. The process of finalizing the document in its present form involved consultation with technical experts over a series of meetings and incorporating their critical comments. The treatment regimens recommended in this publication are all deemed to be effective in the Indian context. Careful monitoring of treatment efficacy should be done wherever possible. It is, in general, recommended that a choice be made for the most simple and shortest treatment. For instance, a single dose of oral treatment is preferable over multi-day treatment with multiple drugs. The order in which the treatment regimens are placed indicates an order of preference: in most instances the first listed treatment should be the treatment of choice. All STI patients should be asked to refer their sexual partner(s) for investigation and/or treatment. This can be facilitated by handing out a contact slip to the patient.

1. GONORRHOEA

1.1 Uncomplicated gonococcal infection

This includes anterior urethritis and proctitis in males; cervicitis, urethritis and proctitis in females and pharyngitis in both.

   Recommended regimens

   i. Azithromycin, 2g orally as a single dose *
      or
   ii. Cefixime, 400 mg orally as a single dose
      or
   iii. Ceftriaxone, 250 mg intramuscular (IM) as a single injection

* Will treat both gonococcal and chlamydial infections.
1.2 Rectal and pharyngeal gonococcal infection
   i. Ceftriaxone, 500 mg/1g IM as a single dose

1.3 Complicated and disseminated gonococcal infection
   This includes posterior urethritis, prostatitis, epididymo-orchitis, tysonitis, cowperitis and bartholinitis. The patient should, if necessary, be admitted to a hospital.

   Recommended regimen
   i. *Ceftriaxone, 1g IM or IV once daily for 7 days
      (An alternative third generation cephalosporin may be required if ceftriaxone is not available, but more frequent daily dosage will be needed)
   ii. Cefixime, 400 mg twice daily orally for 7 days
      *For gonococcal meningitis and endocarditis the same dosages apply, but the duration of intravenous therapy will be increased to two weeks for meningitis and four weeks for endocarditis.

   N B. Appropriate supportive treatment like scrotal support, analgesics and sedatives are to be added, if required.

1.4 Gonococcal conjunctivitis

1.4.1 Adults
   Recommended regimen
   i. Ceftriaxone, 500 mg IM as a single dose
      or
   ii. Kanamycin, 2g IM as a single dose
      Local cleaning of eyes by irrigation with saline or tap water is essential. Proper hand washing with soap and water of the patient’s attendant is essential.

1.4.2 Neonates with gonococcal ophthalmia neonatrum and those born to mothers with gonococcal infection
   Neonates with gonococcal conjunctivitis should be treated with the most effective antibiotic available. Persons caring for infected infants should always wash their hands carefully.
   i. Ceftriaxone, 50 mg/kg IM as a single dose to a maximum of 125 mg/kg
      or
   ii. Kanamycin, 25 mg/kg IM as a single dose to a maximum of 75 mg/kg
   In case of discharge from the eyes, these can be gently cleaned with distilled water.

1.4.3 Gonococcal infection in pregnancy
   i. Ceftriaxone, 250 mg intramuscular (IM) as a single injection
      or
ii. Cefixime, 400 mg orally as a single dose  

or  

iii. *Azithromycin, 2g orally as a single dose  

*Azithromycin has not been adequately evaluated during pregnancy; Will treat both gonococcal and chlamydial infections.

1.5 Follow-up of patients with gonococcal infection

Patients should be reviewed on day 3rd and 14th after the onset of the treatment for clinical cure and wherever possible or indicated, smear examination for N. gonorrhoeae. Serological tests for syphilis can be repeated after one month.

1.6 All cases of conjunctivitis in neonates should be treated for both N. gonorrhoeae and C. trachomatis.

2. NON-GONOCCOCAL URETHRITIS (NGU) OR CERVICITIS

2.1 Uncomplicated non-gonococcal infections

Most common causative agents of NGU are chlamydia trachomatis and ureaplasma urealyticum. NGU includes urethral, endocervical and rectal infections.

The patient can be asked to hold the urine for 5 hours before reporting to the clinic. A finding of 5 or more pus cells or clumps in the urethral discharge or urinary sediment, under an oil immersion without intra - cellular diplococci (ICDC) is indicative of NGU.

Recommended regimen (effective against both chlamydia trachomatis and ureaplasma urealyticum)

i. Azithromycin, 2g orally in a single dose*

or  

ii. Doxycycline, 100 mg orally twice daily for 7 days  

or  

iii. Erythromycin base/ erythromycin stearate, 500mg orally for 7 days

* Will treat both gonococcal and chlamydial infections.

NB. Doxycycline is contra-indicated during pregnancy. Alternative regimens are used in pregnancy.

Regimens in pregnancy

i. Erythromycin base/ stearate, 500 mg orally 4 times a day for 7 days; erythromycin should not be taken on empty stomach

or  

ii. Amoxycillin, 500 mg orally three times a day for 7 days on empty stomach  

or  

iii. *Azithromycin, 2 g orally as a single dose on empty stomach

*Azithromycin has not been adequately evaluated during pregnancy.
2.2 Neonatal non-gonococcal conjunctivitis

**Recommended regimen**

i. Erthromycin syrup, 50 mg/kg per day orally in four divided doses for 2 weeks

In case of non-availability of erythromycin syrup, trimethoprim, 40 mg with sulfamethoxazole 200 mg orally twice daily for 14 days

Care of the eyes: In case of discharge from the eyes, it should be gently cleaned with distilled water or saline.

* All cases of conjunctivitis in neonates should preferably be treated for both gonococcal and non-gonococcal infection.

2.3 Infantile pneumonia

**Recommended regimen**

i. Erthromycin base / stearate syrup, 50 mg/kg per day orally in 4 divided doses for 3 weeks.

In case of non-availability of erythromycin syrup, co-trimoxazole (trimethoprim, 40 mg plus sulphamethoxazole, 200 mg) to be given orally, twice daily for 3 weeks

2.4 Follow-up of patients with non-gonococcal infection

This is similar to gonococcal infection

3. TRICHOMONIASIS

**Recommended regimens**

i. Metronidazole, 2g orally in a single dose/ metronidazole, 400mg orally twice daily for 7 days

or

ii. Tinidazole, 2g orally in a single dose

Patients taking metronidazole or tinidazole should be cautioned to avoid taking alcohol while on these drugs and upto 24-48 hours after the last dose

Patients should be asked to come for follow up if symptoms persist.

Patients not cured with initial single dose of metronidazole or tinidazole, ‘often respond very well to 7 days repeat treatment with metronidazole

3.1 Management of sexual partners

Sexual partners of women of trichomoniasis should be treated with single oral dose of 2 g, metronidazole or tinidazole. Patient should be advised against sexual intercourse until both partners are adequately treated.
3.2 Pregnancy

There is increasing evidence of association between infection with T. vaginalis and premature rupture of the choroid-amniotic membrane and low birth weight.

Metronidazole and tinidazole are contra-indicated in the first trimester of pregnancy, but may be used during the second and third trimesters. The minimum effective dose should be used (metronidazole, 400mg orally twice daily for 7 days). However, in symptomatic women, in the first trimester and those intolerant to metronidazole/tinidazole, imidazole pessaries/cream may be given for 7 days.

Lactating women should be treated with a single oral dose of 2g of metronidazole or tinidazole.

3.3 Neonatal Infections

Infants with symptomatic trichomoniasis or with urogenital colonization persisting after the fourth month of life should be treated with metronidazole.

Metronidazole/tinidazole, 5 mg/kg orally 3 times a day for 7 days.

4. BACTERIAL VAGINOSIS (BV)

BV is a clinical syndrome in which normal flora of vagina, Lactobacillus sp. is replaced with high concentration of anaerobic bacteria, such as G. vaginalis and mycoplasma hominis etc. BV is an endogenous reproductive tract infection. Antiseptic or vaginal douching, if being employed, should be stopped. Sexual transmission of the disease is not proven.

4.1 Treatment

Recommended regimens

i. Metronidazole, 400 mg orally twice daily for 7 days metronidazole, 2 g orally as a single dose

or

ii. Tinidazole, 2 gm orally as a single dose

However, in symptomatic women, in the first trimester and those intolerant to metronidazole tinidazole, imidazole pessaries/cream may be given for 7 days.

4.2 Pregnancy

Metronidazole is contra-indicated during the first trimester of pregnancy, but may be used, if necessary, during the second and third trimesters. There is some evidence that bacterial vaginosis may increase the incidence of premature rupture of the membranes. It should, therefore be treated when diagnosed in third trimester.
4.3 Sexual partners

Sexual transmission of BV is not proven. Treatment of sexual partners has not been demonstrated to be beneficial.

5. CANDIDIASIS

5.1 Vulvo-vaginal candidiasis

Therapy generally involves topical use of a wide variety of imidazole antifungal agents (eg. clotrimazole, miconazole, econazole) or polyene anti-fungal agents (nystatin). Generally, imidazoles act more quickly and appear to be more effective than polyenes.

**Recommended regimens**

i. Miconazole or clotrimazole, 100 mg intravaginally daily for 6 days

or

ii. Clotrimazole, 500 mg intravaginally as a single dose

or

iii. Fluconazole, 150 mg orally as a single dose

5.2 Recurrent Infection

Reduction or elimination of predisposing factors such as antibiotic or oral contraceptive use, immunosuppressive drugs including corticosteroids or review of diabetic status and examination of sexual partner, are helpful in dealing with frequent recurrences.

5.3 Candidal balanoposthitis

Clotrimazole (1%) cream or miconazole (2%) cream may be applied locally till complete healing.

5.4 Vulvovaginal candidiasis in pregnancy

Only topical imidazole miconazole, clotrimazole etc. should be used. The safety of oral treatment with azoles is not yet established.

5.5 Candidiasis and HIV

Candidiasis affecting multiple sites, including vulva and vagina often occurs in HIV disease. Relapses of candidiasis are frequent. Prolonged treatment and suppressive therapy with imidazoles is often required.

6. SYPHILIS

6.1 Acquired syphilis

6.1.1 Early syphilis

(This includes primary, secondary and early latent infection upto 2 years duration).
**Recommended regimens**

i. Benzathine benzylpenicillin, 2.4 million IU deep IM in a single session (two equally divided doses in each buttock) after doing intradermal sensitivity test for penicillin or

ii. Procaine benzylpenicillin, 1.2 million IU (3 vials, each having combination of 1 lakh units of benzyl penicillin G sodium + 3 lakh units of procaine benzylpenicillin), IM once daily for 10 days

NB. Jarisch-Herxheimer reaction (mild fever, body aches and exacerbation of symptoms within hours of injection) should be treated with paracetamol tablet, 500 mg thrice daily on 1st day. Patient should be preferably forewarned of the possibility of the reaction.

**Alternative regimens for penicillin hyper-sensitive, non pregnant patients**

i. Doxycycline, 100 mg orally twice a day for 15 days or

ii. Minocycline, 100 mg orally twice a day for 15 days or

iii. Erythromycin base / stearate, 500 mg orally 4 times a day for 15 days or

iv. Tetracycline HCl, 500 mg orally 4 times a day for 15 days

**6.1.2 Late latent (asymptomatic) and late benign syphilis of more than 2 years duration or of indeterminate duration**

**Recommended regimens**

i. Benzathine benzylpenicillin, 2.4 million IU deep (vide supra) IM weekly for 3 consecutive weeks or

ii. Procaine benzylpenicillin, 1.2 million IU (vide supra) IM once daily for 20 consecutive days

**Alternative regimen for penicillin – allergic, non-pregnant patients**

i. Doxycycline, 100 mg orally twice daily for 30 days.

ii. Tetracycline HCL, 500 mg orally 4 times daily for 30 days.

iii. Erythromycin base / stearate, 500 mg orally 4 times a day for 30 days.

**6.1.3 Cardiovascular syphilis**

**Recommended regimens**

i. Procaine benzylpenicillin, 1.2 million IU (3 vials, each having a combination of 1 lakh units of benzylpenicillin G sodium + 3 lakh units of procaine benzylpenicillin) IM, daily for 20 consecutive days.
Alternative regimen for penicillin – allergic, non pregnant patients

i. Doxycycline, 100 mg orally twice daily for 30 days.

ii. Detracycline HCl, 500 mg orally 4 times daily for 30 days.

iii. Erythromycin base / stearate, 500 mg orally 4 times a day for 30 days

NB. To prevent complications of Jarisch-Herxheimer reaction in cardiovascular syphilis, 3 tablets of prednisolone (5 mg each) in a single oral dose should be given daily in the morning, after food, for two days prior to treatment, and 3 days after. Cardiologists should be associated while treating cardiovascular syphilis.

6.1.4 Neurosyphilis

Recommended regimens

i. Aqueous benzylpenicillin, 12-24 million IU daily intravenously administered as 2-4 million IU 4 hourly for 14 days

or

ii. Procaine benzylpenicillin,1.2 million IU IM once daily for 4 weeks

or

iii. Procaine benzylpenicillin,1.2 million IU IM once daily + probenecid, 500 mg orally 4 times daily for 4 weeks

NB. The latter recommended regimen (ii & iii ) should be used only for patients whose out-patient attendance can be assured.

Benzathine benzylpenicillin has no role in the treatment of neurosyphilis as it does not cross the blood – brain barrier in sufficient quantity.

6.1.5 Alternative regimens for pencillin hyper-sensitive patients

i. Doxycycline, 100 mg orally twice a day for 30 days

or

ii. Tetracycline HCl, 500 mg orally 4 times a day for 30 days

or

iii. Erythromycin base / stearate, 500 mg orally 4 times a day for 30 days

6.1.6 Syphilis in pregnancy

Pregnant women should be regarded as a separate group that requires close surveillance, especially to identify possible re-infection after treatment has been completed. All pregnant women reporting for first antenatal check up should be serologically screened for syphilis. Serological tests should ideally be repeated in 3rd trimester.

Recommended regimens

Pregnant women who are not hypersensitive to penicillin should be treated with benzathine benzylpenicillin in the same dosage as recommended for non-pregnant
patients at the same stage of disease (vide supra).

Penicillin hypersensitive pregnant women should be treated with erythromycin stearate in the dosage and duration as recommended for non-pregnant patients at the same stage of the disease (vide supra).

NB. Erythromycin estolate is contraindicated in pregnancy.

Follow up:

For pregnant women, quantitative VDRL should be repeated in treated patients at 3 monthly intervals, until delivery. After delivery, the follow-up of the mother is as for non-pregnant patients.

6.2 CONGENITAL SYPHILIS

6.2.1 Early congenital syphilis (upto 2 years of age)

Recommended regimens

i. Aqueous benzylpenicillin, 100,000 ~ 150,000 IU/kg/day IV in two divided doses daily for 10 days

or

ii. Procaine benzylpenicillin, 50,000 IU/kg IM in a single daily dose for 10 days

In infants with normal cerebro-spinal fluid, the following can be recommended:

i. Benzathine benzylpenicillin, 500,000 units/kg IM in a single dose

For penicillin hypersensitive patients (after the first month of life)

ii. Erythromycin base / stearate, 7.5-12.5 mg/kg/day orally 4 times a day for 30 days

6.2.2 Late congenital syphilis (more than 2 years duration)

i. Aqueous benzylpenicillin 2 to 3 lakh units/kg/day IV or IM in divided doses for 14 days

or

ii. Erythromycin base / stearate, 7.5-12.5 mg/kg/day orally 4 times a day for 30 days

NB. Dosage should not exceed than that of late acquired syphilis.

6.3 Follow up and treatment

Patients with early syphilis treated adequately should be evaluated clinically and serologically after 3 months. A repeat evaluation should be performed 6 months and 13 months after treatment to reassess the condition of the patient and to detect possible re-infection. Patients with cardiovascular and neurosyphilis, both acquired and congenital should be followed up for many years. This should include clinical, serological and where necessary, radiographic examinations.
For pregnant women quantitative VDRL should be repeated in treated patients at 3 monthly intervals, until delivery. After delivery, the follow-up of the mother is as for the non-pregnant patients.

Repeat treatment may be considered when:
- Clinical signs or symptoms of active syphilis still present or recur;
- There is a sustained four-fold increase in the titre of the VDRL test; or
- If a high titre (1/8 or more) persists for a year.

6.4 Syphilis and HIV infection
Patients with syphilis should be encouraged to be tested for HIV infection because of the frequent association of the two diseases, and the implications for clinical assessment and management. Neurosyphilis should be considered in the differential diagnosis of neurological disease in HIV infected persons. When clinical findings suggest that syphilis is present, but serological tests are negative or inconclusive, alternative tests such as biopsy of the lesion/s, dark field examination and direct fluorescent antibody staining of materials obtained from lesion/s should be used. In cases of congenital syphilis, the mother should be encouraged to be tested for HIV infection, and if her test is positive, the infant should be referred for follow-up.

Therapy for early syphilis in HIV infected patients is the same as for non- HIV patients. However, certain authorities recommend examination of cerebrospinal fluid or late syphilis therapy for early syphilis in HIV co-infected patients. Careful follow-up is necessary to ensure adequacy of treatment.

7. CHANCROID
7.1 Recommended regimen
i. Erythromycin stearate / erythromycin base, 500 mg orally 4 times a day for 7 day
ii. Rythromycin ethyl succinate, 800 mg orally 4 times a day for 7 days
N.B In case of concomitant syphilis, treatment can be given for 15 days.
iii. Ciprofloxacin, 500 mg orally twice a day for 3-5 days or till the clearance of lesions or
iv. Ceftriaxone, 250 mg IM as a single dose or
v. Azithromycin, 1 g orally as a single dose or
vi. Doxycycline, 100 mg orally twice daily for 7 days or
vii. Trimethoprim (80 mg) + sulphamethoxazole (400 mg), 2 tabs orally twice a day for 2 weeks
NB. Treatment should be given for the period indicated, or until such time, the lesions heal.

7.2 Management of lesions
Fluctuant bubo should be aspirated through the surrounding healthy skin. Aspiration should not be done from the dependent side. Incision and drainage or excision of bubo delays healing and is contra-indicated.

7.3 Chancroid and HIV infection
In patients with concomitant HIV infection, these regimens are often found to be inadequate. Increased dose and a more prolonged duration of therapy might be necessary. Patients should be followed up weekly till there is complete clearance of chancroid lesions.

8. LYMPHOGRANULOMA VENEREUM

8.1 No controlled trials on treatment of lymphogranuloma venereum are available. However, the following are the recommended regimens
i. *Doxycycline, 100 mg orally twice a day for 21 days
or
ii. *Tetracycline, 500 mg orally 4 times a day for 21 days
or
iii. Trimethoprim (80 mg) + sulphamethoxazole (400 mg) 2 tabs twice daily for 21 days
or
iv. Erythromycin stearate or base, 500 mg orally 4 times a day for 2 weeks
* In pregnant and lactating females, erythomycin base / stearate, 500 mg orally 4 time a day for 21 days
NB. Some cases may require longer treatment than the 2 weeks recommended. Sequelae of disease, such as rectal, inguinal, urethral strictures/fistulae may require surgery. Tetracyclines are contra-indicated in pregnancy.

8.2 Bubo
Hot fermentation. Buboes should not be incised, but aspirated with a wide bore needle. Aspiration should be done through the surrounding normal skin, from the non-dependent area.

9. GRANULOMA INGUINALE (DONOVANOSIS)

Recommended regimen
i. Doxycycline, 100 mg orally twice a day for 14 days
or
ii. Tertracycline HCL, 500 mg orally 4 times a day for 14 days
or
iii. Erythromycin stearate or base, 500 mg orally 4 times a day for 14 days
or
iv. Trimethoprim (80 mg) + sulphamethoxazole(400 mg), 2 tabs twice a day orally for
14 days or until lesions have completely healed
Lesions should be kept clean.
NB. Some patients might require longer treatment that the 14 days as recommended
above.

10. PELVIC INFLAMMATORY DISEASE (PID) / LOWER ABDOMINAL PAIN
Because of the multi-causality of PID, and the difficulties in establishing an etiology
for individual infection/s, it is recommended that PID is to be treated for concurrent
infections for gonorrhoea, non-gonococcal (C. trachomatis, Mycoplasma hominis)
and anaerobic infections.

10.1 OUT PATIENT THERAPY
Recommended regimen
i. Azithromycin, 2g orally single dose under supervision( to treat both gonococcal and
chlamydial infections)
PLUS
ii. Metronidazole, 400 mg orally twice a day for 2 weeks( to treat anaerobic bacteria)
Alternative regimen
i. Cefixime, 400mg orally single dose under supervision ( to treat gonococcal infection)
PLUS
* Doxycycline, 100mg orally, twice a day for 2 weeks (to treat chlamydial infection)
PLUS
Metronidazole, 400 mg orally twice a day for 2 weeks ( to treat anaerobic bacteria)
ii. Ceftriaxone, 250mg I.M. single dose ( to treat gonococcal infection)
PLUS
* Doxycycline, 100mg orally, twice a day for 2 weeks ( to treat chlamydial infection)
PLUS
Metronidazole, 400 mg orally twice a day for 2 weeks( to treat anaerobic bacteria)
* In individuals allergic/intolerant to doxycycline and in all pregnant women, erythromycin base/stearate,
500 mg orally 4 times day for 14 days is to be used.
These regimens can be used as ambulatory treatment. For some patients admission may be required. Sexual partner(s) should be treated for gonorrhoea and chlamydia.

NB. Since IUD is a risk factor for the development of PID, its removal is recommended after the start of anti microbial therapy. In place of IUD, other contraceptive measures should be advised.

10.2 IN PATIENT THERAPY

Out patients with PID should be followed up for 72 hours and admitted if there is no improvement in their condition.

Recommended Regimens

i. Ceftriaxone, 250 mg IM injection once daily
   PLUS
   Doxycycline, 100 mg orally twice daily or tetracycline HCl, 500 mg orally 4 times daily
   PLUS
   Metronidazole, 400 mg orally or by IV twice daily

ii. Ciprofloxacin, 500 mg orally or by IV twice daily
   or
   Spectinomycin, 2g IM twice daily
   PLUS
   Doxycycline, 100 mg orally twice daily or tetracycline HCl, 500 mg orally 4 times daily
   PLUS
   Metronidazole, 400 mg orally or by IV twice daily

NB. Therapy in both the above mentioned regimens is to be continued until 2 days after the patient has improved, to be followed up by doxycycline, 100 mg orally twice daily for 14 days or tetracycline HCl, 500 mg orally 4 times daily for 14 days. and metronidazole, 400 mg orally twice daily for 14 days. Patients on metronidazole must avoid alcohol consumption while on treatment. Tetracyclines are contra - indicated in pregnancy and should be replaced by erythromycin base / stearate / ethyl succinate.

11. HERPES PROGENITALIS/ GENITAL HERPES

There is no known cure, but the course of symptoms can be modified if oral or systemic therapy with acyclovir is started as soon as possible, preferably within 72 hours following the onset of symptoms. Topical therapy with acyclovir produces only minimal shortening of the duration of symptomatic episodes and is not recommended.
11.1 First Clinical Episode

**Recommended regimen**

i. Acyclovir, 200 mg orally 5 times a day for 7 days
   or
   Acyclovir, 400 mg orally 3 times daily for 7 days

11.2 Recurrent infections

Most patients of genital herpes will have recurrence of genital lesions. Recurrences can be managed by keeping the genital area clean by using saline or soap and water washes. If there is evidence of bacterial infection, a short course of erythromycin stearate / base / ethyl succinate or trimethoprim-sulphamethoxazole may be given. Occasionally severe symptomatic disease can occur. These patients may require treatment with oral acyclovir, if available.

i. Acyclovir, 200 mg orally 5 times daily for 7 days
   or
   Acyclovir, 400 mg orally 3 times daily for 7 days
   or
   Acyclovir, 800 mg orally twice daily for 7 days

Treatment may reduce the formation of new lesions, the duration of pains, time required for healing and viral shedding. It does not influence the natural course of the recurrent disease.

N B. Educate the patient about the natural course of disease, as often the patients are greatly distressed by recurring lesions. Reassurance and proper counseling are often helpful. Where patients experience severe pain especially early, give analgesics and reassure the patient that it is a part of the natural course of the disease.

Sexual contact should be avoided as long as there are active lesions.

Cervical cytology should be routinely done in females with herpes genital infection.

Acyclovir systemic therapy should not be used in pregnant women. Caesarian section is normally indicated if the mother has active lesions at the time of birth, to avoid infection and development of complications in the neonate.

11.3 Suppressive Therapy

Daily suppressive anti-viral therapy may be employed in patients with frequent recurrences of genital herpes (six or more recurrences per year). Since daily antiviral suppressive therapy reduces the recurrence rate of herpes genitalis by more than 75%, option for daily suppressive therapy may be discussed with all such patients.
suffering from recurrent herpes genitalis. Safety and efficacy of daily suppressive therapy with acyclovir (as long as six years) is well established. Suppressive therapy has not been found to be associated with emergence of clinically significant acyclovir resistance. However, it does not eliminate asymptomatic viral shedding.

**Recommended Regimen**

i. Acyclovir, 400 mg orally twice a day continuously for at least one year; recurrence rate should than be re-assessed after the stoppage of acyclovir.

**11.4 SEVERE HERPES GENITALIS INFECTION**

i. Acyclovir, 5-10 mg/ kg IV every 8 hours for 5 to 7 days

**11.5 GENITAL HERPES IN PREGNANCY**

First clinical episode of genital herpes should be treated with oral acyclovir. Neonatal herpes can develop in babies born to mothers, who develop primary herpes genitalis shortly before vaginal delivery. Babies born to women with recurrent disease are at very low risk. Caesarian section is indicated if mother has active lesions at the time of birth.

**11.6 TREATMENT FOR NEONATES**

i. Acyclovir, 10 mg/kg IV 3 times a day for 10 days

**11.7 HERPES AND HIV CO – INFECTION**

Persistent and/or severe muco-cutaneous ulcerations involving large areas of perianal, scrotal or penile skin is indicative of HIV co–infection. Doses and duration of treatment with acyclovir should be increased.

**Recommended Regimen**

i. Acyclovir, 400 mg orally 3–5 times daily until complete clinical healing of lesions

**12. GENITAL WARTS**

Human papilloma virus is a common sexually transmitted pathogen; specific types of which may give rise to invasive carcinoma of the uterine cervix or to benign exophytic genital warts. The virus types causing these two conditions are distinct. Patients with genital warts are no more likely than patients with other STIs to develop cervical carcinoma. However, it is a recommended practice to examine the cervix in all females STI patients and to perform the regular cervical smears in the in the population for Papanicolaou examination.

**Recommended regimen**

(a) Chemical cauterization

i. 20% podophyllin in compound tincture of benzoin applied to the warts, while carefully protecting the surrounding area with vaseline, to be washed off after 1-3 hours. It is
recommended that podophyllin, 0.5 ml or less per session be applied and/or 10 cm² or less of warts per session be cauterized. Treatment to be repeated weekly till lesions resolve completely. Podophyllin application should be done under medical supervision. Patients should be warned against self-medication.

iii. Podofilox (podophyllotoxin) 0.5% solution or gel twice daily for 3 days, followed by 4 days of no treatment; the cycle repeated up to 4 times. Not more than 0.5 ml of podofilox should be applied per day.

iv. Imiquimod 5% cream applied with a finger at bed time, to be washed in the morning with soap and water. It should be applied three times a week up to 12 to 16 weeks.

v. Trichloroacetic acid (TCA) 50 to 75% can be applied carefully to the warts, excess of TCA may be removed by applying ordinary talc or sodium bicarbonate. TCA application should be done at weekly interval.

NB. Podophyllin and podophyllotoxin are contra-indicated in pregnancy and lactation. They should preferably be avoided as a treatment modality for anal warts.

(b) Physical

i. Cryo therapy with liquid nitrogen, solid carbon dioxide or cryoprobe, if available. Repeat application at 1-2 weeks interval. Cryo therapy is preferred by many consultants. It is non-toxic, does not result in scarring if done properly and does not require any anesthesia.

ii. Electrocautery

iii. Surgical excision

NB. No treatment is completely satisfactory. In most clinical situations, podophyllin (or podophyllotoxin) or trichloroacetic acid (TCA) are used to treat external genital lesions.

Vaginal warts

Recommended Regimens

i. Podophyllin, 10-25%, using vaginal speculum

ii. Trichloroacetic acid (TCA), 50-75%, using vaginal speculum

Cervical warts

i. Electrocautery or cryotherapy is the treatment of choice

ii. Podophyllin or podophyllotoxin and TCA applications are contra-indicated

iii. Biopsy of warts to rule out malignant change

iv. Cervical cytology should be done before starting the treatment
13. MOLLUSCUM CONTAGIOSUM

Individual lesions usually regress without treatment in 9-12 months. Each lesion should be thoroughly opened with a fine needle or scalpel. The contents should be expressed and the inner wall touched with 30% trichloro acetic acid or phenol solution.

14. SCABIES

14.1 Recommended regimens

i. Benzyl Benzoate (BB) 25% lotion, to be applied all over the body below the neck, after a bath, for two consecutive nights. Patient should bathe 24 hours after the second application, and have a change of clothing. Bed linen is to be washed properly and dried under sunlight. A second course of drug application may be given after 7-10 days, if required.

or

ii. Gamma benzene hexachloride (GBH) 1% lotion or cream applied as a very thin film all over the body below the neck at night without taking a bath, to be washed off thoroughly next day morning, after 8-10 hours. The application of the drug should be repeated after 7 days, if required. Clothes should be washed properly and dried under sunlight. This drug is contra-indicated in pregnant women, lactating mothers, infants and patients of scabies with secondary infection or with eczematization, as it increases the risk of absorption, leading to systemic toxicity, resulting in seizures and aplastic anemia. It should be applied with caution in the elderly.

or

iii. Permethrin 5% cream to be applied all over the body as a thin film and washed off after 8-10 hours. A second application is sometimes required.

or

Sulphur 6% in petrolatum applied to the entire body from the back down for 3 nights after a bath. Patients may bathe before reapplying the drug and should bathe 24 hours after the final application.

or

Crotamiton 10% cream to be applied to the entire body from neck down at night for 2-5 nights and washed off thoroughly by taking a bath 24 hours after the last application.

14.2 Infants, children less than 10 years old, pregnant or lactating women

Recommended regimen

i. Crotamiton 10% cream to be applied as above

or

ii. Sulphur 6% in petrolatum to be applied as above

or
iii. Permethrin 5% cream to be applied as above

NB. Sexual and close household contacts must be treated simultaneously, even those who are not complaining of any itching or do not have any skin lesions.

Pruritus/itching may persist for few weeks after adequate therapy. Oral antihistamine should be given for the relief of itching.

A second course of local acaricide is needed if there is no clinical improvement.

All clothing, including bed linen, used by the patient and his contacts should be washed properly and well dried in sun light. Woolen clothes worn by the patient or the contacts should preferably be drycleaned.

15. PEDICULOSIS PUBIS (PHTHIRIASIS)

Recommended regimens

i. Gamma benzene hexachloride (GBH), 1% lotion or cream, to be rubbed thoroughly with the fingers into the infested hairy and adjacent areas, near the roots of the hair at night, Followed by bath the next morning or it can be applied at any time during the day and washed off after 8 hours.

or

ii. Benzyl Benzoate (BB) 25% emulsion or lotion to be applied as 15 (i)

or

iii. Permethrin 1% lotion, to be rubbed thoroughly with fingers into the infested and adjacent hairy areas and washed off after 10 - 30 minutes.

Special instructions

Re-treatment is indicated after 7 days if lice are found or eggs observed at the hair-skin junction. Clothing or bed linen that may have been contaminated by the patient within the past two days should be washed and well dried. Woolen clothes to be dry-cleaned.

Sexual partner must also be treated along the same lines.

NB. Gamma benzene hexachloride should be avoided in pregnant women, lactating mothers, children and patients of pediculosis pubis with secondary infection or with eczematization. It should not be applied near the eyes. Pediculosis of the eyelashes should be treated by the application of occlusive ophthalmic ointment to the eyelid margins daily for 10 days to smother lice and nits.

16. STI AND HIV INFECTION

The relationship between STIs and HIV infection is three-fold. Firstly, STIs and HIV infection are associated with the same risk behavior, that is, unprotected sexual
intercourse with multiple partners. Thus, the same measures that prevent STIs also prevent sexual transmission of HIV infection.

Secondly, the presence of STIs has been found to facilitate the acquisition and transmission of HIV infection. A 10 fold increased risk for HIV transmission has been associated with diseases that cause genital ulcers, such as syphilis, chancroid and genital herpes. The risk associated with diseases causing discharge, especially gonorrhoea, chlamydial infection and trichomoniasis is up to 4-fold. Thus, early diagnosis and effective treatment of STIs can contribute significantly towards the reduction in HIV transmission.

There is mounting evidence that some STI pathogens are more virulent in the presence of HIV related immune-deficiency. This might have consequences for treatment recommendations for STIs, although more studies need to be carried out before changes can be proposed.

The following is recommended

i. No HIV testing should be done routinely for all STIs patients. HIV testing may be considered in patients with severe or therapy-resistant forms of STIs and should be done only after obtaining the consent and with proper pre-and post-test counseling. There should be guarantee for confidentiality.

If STI patients are screened for HIV surveillance purposes, then unlinked anonymous testing only should be done, on blood samples drawn for other purposes (VDRL testing).

ii. In some cases of STIs in the presence of HIV infection, larger doses and longer treatment duration of the drugs listed under the different STIs may be required. These patients should be followed up regularly for longer duration.

iii. Excessive use of anti-microbials should be avoided, as it is likely to lead to more rapid development of antibiotic resistance.

iv. Although counselling of individual patients on risk reduction and prevention of transmission to partners should be done with all STI patients, this is of vital importance for those infected with HIV.

PRACTICAL CONSIDERATIONS IN CASE MANAGEMENT

Following are the main components in STI control:

1. Promotion of safe sex behavior;
2. Condom promotion for safe sex including planning and management of its easy availability;
3. Promotion of health care seeking behavior;
4. Integration of STI prevention and its managements in to the primary health care,
reproductive health care centers and private clinics;
5. Education of individuals at risk (females and male sex workers, adolescents, truck drivers, army personnel and prisoners) on modes of disease transmission and means of reducing the risk of transmission;
6. Early detection of infection in asymptomatic subjects and in subjects who are symptomatic but unlikely to seek diagnostic and therapeutic services;
7. Effective management of STI infected individuals;
8. Treatment and education of the sexual partners of STI infected individuals; and
9. Prevention and care of congenital syphilis and neonatal conjunctivitis, more so in population at risk.

The treatment of STIs is based primarily on changing the sexual behaviour that put people at risk and on promoting the use of condoms.

CLINICAL CONSIDERATIONS

Routine STI care should be delivered through general health services. For individuals requesting health services for evaluation of an STI, appropriate care consists of the following components. (The order in which interventions are carried out may vary, depending on the specific case and diagnosis)

History taking

The importance of a proper history cannot be overemphasized. Patients with problems relating to the genitalia tend to be guarded and evasive in giving history in the short time available in a busy outpatient clinic.

- Adopt a polite, friendly and non-judgmental attitude that would encourage the client to develop confidence and trust in you;
- Ask an open-ended question such as “what brought you to the hospital?” to initiate a dialogue, but thereafter ask brief & precise questions which call a brief response mostly to the “yes” and “no” type to save time;
- In order to make an accurate diagnosis, it may be necessary to ask more questions during examination or, even after, giving the patients greater privacy;
- Do not show annoyance if the patient’s history has obvious discrepancies or he keeps changing the history; and
- Phrase your questions in such a way to minimise the opportunity of the patient to mislead you. For example, “when did you have sex with someone” is preferable to “did you have sex with someone”.

Medical and Behavioural Risk Assessment

Managing a patient/client with an STI involves not only proper diagnosis and appropriate treatment but also education, partner management and counseling, if needed. The basis of
these components of patient management is medical and risk assessment. Medically, the presenting condition may not depict the full spectrum of STIs currently affecting the patients. Inquire about common symptoms like discharge from the urethra in a patient with genital ulcers or recurring genital ulcers in a patient presenting with a urethral discharge. If laboratory facilities permit, consider serological tests for syphilis. Inquire about the previous treatment as it may indicate whether patient has already had sub optimal medication. It is also necessary to assess risk of drug hypersensitivity and drug interactions. If the patient is to receive proper education and counseling, it has to be preceded by a behavioral risk assessment. The questions that need to be answered are: is there a partner who may re-infect the client; is he unlikely to act irresponsibly because of an alcohol or drug abuse problem; does he engage in unprotected penetrative sex with multiple partners for economic reasons, etc.?

**Physical examination**

This is an important step that will help you to arrive at a probable diagnosis and prevent you from making an incorrect diagnosis based on the patient’s history alone.

- Approach examination with professionalism and confidence devoid of shyness and embarrassment;
- Provide privacy and confidentiality;
- Ensure adequate exposure to the genital area for making thorough examination. Even if pressed for time, do not rush through the examination. If the patient shows any reluctance take time to explain why an examination is necessary for correct diagnosis and treatment. Examination of genitals in some populations may be a sensitive issue;
- Have a female person in the room while examining a female patient; and
- Ensure that universal precautions are observed in the clinic. All materials used should be sterile or disposable. After use all reusable gloves and other equipment should be sterilized and soft waste such as swabs, gauze and disposable gloves should be incinerated or burnt.

**Laboratory investigations if available and indicated**

Syndromic management of STIs is based on the presumption that laboratory facilities are not available. Do not delay or withhold treatment because laboratory investigations are incomplete or results of tests are not available. If available, clients engaging in high-risk activities should be offered the VDRL test and test for HIV accompanied by pre-test and post-test counseling. Treatment failures should be re-evaluated for possible re-infection and then referred to a facility providing adequate laboratory support.

**Diagnosis**

On the basis of the history you have taken and the physical examination you have carried out, use the flow chart for making a syndromic diagnosis. Be careful when confronted with
lower abdominal pain and scrotal swelling. Make doubly certain that you are not dealing with a surgical emergency.

**Curative or Palliative therapy**

Treat the patient using the flow charts and the national treatment guidelines. While in most instances treatment will be curative, with viral STIs only palliative therapy is possible. Genital herpes is a good example where the therapy is only palliative. This fact must be properly explained to the patient and counseling provided if needed. Another condition where only palliation is possible is candidal vulvo-vaginitis, which can be very refractory to treatment in some instances. Where a patient is treated for syphilis on the basis of positive serological tests, it is important to explain to the patient that the tests may continue to show seropositivity even though the patient has received adequate therapy, hence it is important to do VDRL testing in dilutions.

**Education and Counseling**

The following issues should be addressed in the education and counseling of patients.

i. Present episode of STI;

   Educate the patient on his or her present STI, and how it was acquired. In conditions like recurrent genital herpes and recurrent vulvo-vaginitis, counseling is greatly needed, as the patients are very distressed.

ii. Prevention of STIs and HIV;

   Explain to the patient the association between STIs and HIV and that it is the same risk behavior that is responsible for acquisition of these two conditions. Educate the patient on methods of risk reduction through safer sex including abstinence.

iii. Condom use;

   Discuss and explain to the patient the use of condom for risk reduction. Issue free condoms if feasible. Demonstrate on a dildo or other suitable object the correct way of wearing a condom. Sensitize the patient about condom. If he is a regular risk taker, then he should be advised to be a consistent condom user.

**Official reporting of the case**

Some form of reporting of STI cases is required though this is often neglected. Reporting by name is discouraged. The lack of data about incidence/prevalence of STIs in most countries of the region is due to poor reporting. Health care providers who manage STI cases should participate in STI surveillance including STI pre-sentinel surveillance when called upon to do so by providing the STI control program with the required data in the form provided for the purpose.

**Identification, notification and evaluation of sexual partner(s)**

This is an important public health activity by which the partners of those identified as having an STI are traced, informed of their probable exposure to infection and offered medical and
counseling services; the objective of this exercise being to break the chain of transmission. Partner notification should be considered whenever an STI is diagnosed. In a specialized STI clinic, it may be sensible to limit partner notification to certain priority diseases and syndromes, and to depend on the patient (index patient) to notify his/her partners (patient referral).

**Clinical follow-up when appropriate**

The ideal situation would be to do a clinical follow-up on every case of STI to establish a cure. In some situations this is not feasible, such as where a bread winner has to forego a day’s wages or where extensive travel has to be undertaken to attend the clinic or health facility.

Individuals who are seeking health care services for other reasons such as ante-natal care, but who are at risk of acquisition of STI should undergo the following as part of their routine health care, if resources permit:

1. **STI risk assessment:**
   
   STI risk assessment should be considered whenever sexually active persons such as ante-natal care attenders and family planning clinic attenders complain of symptoms suggestive of STIs or a patient in a surgical clinic complains of burning sensation on passing urine.

2. **Directed physical examination based on elicited symptoms:**
   
   A woman attending a gynaecology clinic for irregular menstrual bleeding may be found to have low grade fever and tenderness in her fornices suggestive of a sub-acute PID. Such patients could be managed using the appropriate flow chart.

3. **Screening for asymptomatic infection:**
   
   This is often not cost-effective unless the exercise is limited to known risk behavior groups. For example, sex workers may be screened with the VDRL/RPR test for syphilis, HIV serology and gonococcal culture, if available.

**HEALTH EDUCATION**

**ESSENTIAL FOR PREVENTION AND CONTROL OF STIs**

**Introduction**

Now more than ever it is important to explore strategies for the prevention of STIs. With the HIV/AIDS epidemic, a patient with an STI may have acquired HIV infection or may get HIV infection in future. Therefore, treatment alone is not sufficient and health education to prevent sexually transmitted infections is of paramount importance. The goal should be to help people change their behavior. This will entail discussions on sex and sexuality from doctor to patient, from parent to child and from teacher to student.
Communicating about STI is extremely difficult as it is necessary to discuss sexual practices; a topic many people in several cultures would rather avoid. In order to prevent STI and spread of HIV infection, it is necessary for individuals to change their behavior. This might entail choosing not to have many partners, or to use condom.

**Social aspects**

STIs have been in existence for centuries. The risk factor for contracting an STI is having many sexual partners, or to have a partner who may be having many sexual partners. Although anyone can get a STI, certain groups of individuals are more prone due to their lifestyle and social or economic circumstances. These might include:

- Migrant workers who live away from their families.
- Men who travel as part of their work, truck drivers, people in hospitality industry.
- Those who resort to sell sex for financial reasons.
- Armed forces personnel who are posted away from their families.

The conditions in which many people live expose them to behavior options, which place them at increased risk of contracting a STI.

Abstinence or a mutually faithful relationship with one lifelong partner is very effective in preventing STI. For health education, the approach must be more practical. Those who habitually have STIs will not easily change their behavior. However, they may be convinced to use a condom and seek proper treatment for their STIs. In the era of HIV/AIDS, practical messages and approaches are essential.

**Sex Education**

Education on sex and sexuality should be imparted to school going children, more so in 11th and 12th class and students in colleges and it should preferably, be included as part of the teaching curriculum. An expert group should be formed to develop and appropriate curriculum, which would include special training for teachers on how to discuss sex and sexuality in an open and frank manner. Education on sex and sexuality should start at prepubertal age and continue through all formal educational settings.

The syllabus should focus on the social and psychological aspects of sex and sexuality to allow students to explore their own feelings, misconceptions, and attitudes. Sexually transmitted infections including HIV/AIDS should be introduced in the light of discussions on sex and sexual behavior. This will include discussions on methods of protections from disease and from undesirable pregnancy. The physiological aspects of sex and changes in the body during puberty should be a part of the syllabus.

**Providing health education**

Health education on STIs should be provided to the general public concentrating on promotion of adequate health care seeking behaviour. General Information, Education and
Communication materials on STIs should be developed for distribution in clinics and other public health facilities.

Every time a physician sees a patient with a STI it is an opportunity for health education. The physician commands respect from the community and from individuals, therefore, the impact of his message is greater.

Targeted materials and approaches should be developed for groups known to practice high-risk behaviors for contacting STIs. These groups might include: migrant workers, men who travel frequently, the defense forces, patients in STI clinics and those practicing commercial sex and their clients. These materials should be developed with the literacy levels, behavior patterns and ethnic consideration in mind.

Basic messages on STIs can be grouped in three areas: how one contracts STIs; how one can protect oneself against STIs; and appropriate health care seeking behavior for treatment. Messages on STI should be objective and provide imagination in straightforward manner. Moral overtones only turn away the very people, the public health officials are trying to reach. In addition, messages should aim at individual responsibility for sexual behavior and protection from diseases.

**How one contracts an STI**

STIs, including HIV infection are contracted through sexual contact. Most STIs are curable, with the exception of HIV infection and some other viral STIs.

The high-risk behavior for contracting an STI is having multiple sexual partners, or having a partner with promiscuous behavior. One is at particular high risk when having sex with someone who has STI/s. Many STIs are asymptomatic; one can have sex with someone who looks clean and still contract STI. HIV infection, the precursor of AIDS does not show symptoms for many years, yet can be contracted during the asymptomatic phase.

**How to protect oneself against STIs**

Use of good quality latex condoms for every sexual encounter is the best-known method for prevention of STIs, including HIV infection.

**Appropriate health care seeking behavior**

Taking prophylactic injections or oral medications and washing the genitalia and urinating after intercourse are all ineffective methods or prophylaxis.

Individual suspecting STI/s should seek treatment from qualified institutions and practitioners and avoid self-medication and reliance on quack and ‘sex doctors’.

The long-term health consequences of chronic STI/s should be emphasized.

Messages should be coordinated with the existence of good quality STI services and condom programming.
All health education programs for HIV/AIDS infection should include information on STIs, emphasizing the link between STIs and HIV. The same risk behavior predisposes for both STIs and HIV infections and the presence of STIs increases the risk of HIV transmission.

**Health education and counseling for STI patients**

Every time a physician sees a patient with STI infection, or with a suspected STI, it is an opportunity for health education and individual counseling. The patient has shown to be at risk for STI, and consequently is also at risk for HIV infection. Health education and counseling in the health care setting should focus on the following messages:

- **Treatment compliance.** For the treatment to be successful, it is important that the whole course of treatment is taken, even if the patient feels improved after a few days. Incomplete treatment might lead to chronic infection with potentially serious long-term consequences. It can also lead to the emergence of resistant strains.

- **Partner notification.** The patient was infected by a sexual partner and/or may have infected another partner. These people are at risk of being infected themselves and if so, will continue to spread the infection or reinfect the patient. Partner(s) of STI patients should, therefore, be medically examined and treated if found to be infected.

- **Prevention of future infection.** Advice should be given to prevent future acquisition of STIs, including HIV infection. This includes recommendations on a reduction of the number of sexual partners and on the consistent use of condoms, and wherever possible one or more good quality condoms should be dispensed to the patient. Clear and simple instruction on condom use should be provided; a demonstration on the use of condom might be required.

- **Health care seeking behavior.** The patient should be advised to return if the symptoms do not disappear and to seek adequate health care for any future episodes of STIs.

It is often necessary to include basic information on the fact that STIs spread through sexual contact that many STIs are asymptomatic (so it is often not possible to know whether a sex partner is infected), and that most STIs are curable, with the exception of HIV infection and some other viral infections. Long term health consequences of chronic STIs should be emphasized.

It will often not be possible for the treating physician to spend adequate time with each patient for health education and counseling. Health education and counseling can also be done by sympathetic male or female multipurpose workers or by nurses. Still, the treating physician usually commands respect from the community and the individual, and their message has often a great impact. So, even if little time is available, the physician should try to reinforce the health education and counseling done by other workers in the facility.
One of the most important aspects of management of patients with STIs, and of health education and counseling of STI patient, is a sympathetic and non-judgmental attitude. Moralistic messages and a condemning attitude of health care workers are counterproductive and will drive patients away. Privacy and confidentiality of the patient’s disease including HIV infection are absolutely essential and an atmosphere of professionalism is required at STI clinics.

**Condom instructions**

1. Carefully open the package so that the condom does not tear. Do not unroll condom before putting it on. The condom should only be put on the erect penis;

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

3. Continue squeezing tip while unrolling the condom till it covers the entire penis;

4. Always put the condom on before sexual penetration;

5. After ejaculation, hold rim of condom and pull the penis out before it gets soft;

6. Slide condom off without spilling liquid (semen) inside; and

7. Throw away or bury the condom.

**Remember**

- Do not use grease, oils, lotions or petroleum jelly (Vaseline) to make condoms slippery. These make the condoms break;

- Use a condom each time you have sex;

- Use a condom once only;

- Store condom in cool, dry place;

- Do not use condom that may be old or damaged; and

- Do not use a condom if the package is broken; the condom is brittle or dried out; the colour is uneven or changed and is unusually sticky.
NACO Flowcharts on Syndromic Management of STIs
ANNEX - G

NACO Flowcharts on Syndromic Management of STIs

Flow Charts on the Syndromic Management of Sexually Transmitted Infections

National AIDS Control Organisation
Ministry of Health & Family Welfare
Government of India
New Delhi
2004

Acknowledgements
Sincere thanks are expressed to WHO Regional Office for South East Asia, New Delhi and specially Dr Jai P Narain, Coordinator HIV, TB and other Communicable Diseases WHO/SEARO for according permission to use photographs and material from the WHO SEARO publication “Flow Charts on the Management of Sexually Transmitted Infections” which has been consulted for preparing this document.

This publication has been designed as per Indian conditions and is intended to be used by health professionals for treatment of STI patients based on the syndromic approach.

PRACTICAL CONSIDERATIONS IN DIAGNOSIS AND TREATMENT OF STIs

Introduction
Routine STI care should be delivered through general health services. Individuals seeking care for STIs should receive the following comprehensive care package which includes:

History Taking
Patients with problems relating to the genital area tend to be guarded and evasive in giving a history. Adopt a polite and non-judgemental attitude. Ask an open end question to initiate a dialogue.

The presenting symptoms, previous treatment, drug allergy and sexual history should be asked.

Behavioral Risk Assessment
Appropriate education and counseling must be preceded by behaviour risk assessment. Make sure that the patient understands that all the information will be kept strictly confidential.

Physical Examination
This is an important step to arrive at a probable diagnosis and will prevent making an incorrect diagnosis based on the patient’s history alone. Privacy and confidentiality should be ensured.
Laboratory investigations, if available and indicated

The syndromic approach for management of STIs is based on the presumption that laboratory facilities are not available, and that treatment should be provided at the patient’s first contact with health services. Therefore do not delay or withhold treatment just because laboratory facilities are not available or laboratory test results are awaited. (Indicate that lab tests should be initiated when patients do not respond to treatment).

**Diagnosis**

On the basis of the history and the physical examination, make a syndromic diagnosis. Use the appropriate Flow-Chart for managing the patient.

**Therapy**

Treat the patient using the Flow-Chart as recommended in this document.

**Counselling and Education**

Educate the patient regarding the present STI, the association between STI and HIV infection and that the same risk behaviour can lead to acquisition of these two conditions. Educate the patient on the methods of risk reduction through safer sex practices. Discuss the use of condoms; provide free condoms if feasible. Demonstrate on a wooden model of penis the correct way to put on the condom.

**Reporting of the Cases**

Reporting of STI cases is required for STI surveillance.

**Partner Notification**

This is an important public health activity by which the partners of those having STI are traced and offered medical and counselling services.

**Clinical follow-up**

Ask the patient to return for clinical examination as indicated in the Flow Charts.

**ESSENTIAL COMPONENTS OF SYNDROMIC MANAGEMENT FOR STI PATIENTS**

**Introduction**

The essential components of syndromic management for STI patients include diagnosis and treatment based on syndromes; education on risk reduction and condom provision; counselling, partner notification and follow up.

**Syndromic Diagnosis and Treatment**

The current methods of laboratory diagnosis of STI are often time consuming, unreliable and expensive, and require sophisticated equipment and training in their use. In addition, for certain tests, patients are required to return one or two days later. This is not feasible in many settings, where patients must travel long distances to receive health care and even if they return, the probability of developing complications is increased and the period of infectivity is prolonged by the delayed treatment. Few health institutions in our country have the laboratory facilities required for accurate etiological diagnosis. Under the simplified and syndrome-based approach
developed and promoted by WHO and currently being used in a large number of countries, diagnosis is based on the identification of a consistent group of symptoms and easily recognizable signs (syndromes) and the provision of effective treatment that will deal with the majority of the organisms responsible for producing each syndrome. When a patient comes with complaints, his/her management can be decided according to the clinical management flow chart.

Education on Risk Reduction and Condom Provision
In every instance, the contact of STI patients with the health facility should be utilized to promote safer sexual behaviour and to educate patients on how to minimize or eliminate the risk of acquiring or transmitting STI/HIV infection to others. They should be taught how to correctly use condoms. Condoms must be made available in all health facilities treating patients with STI, either free of charge or at an affordable price.

Counselling, Partner Notification and follow-up
Each patient should be properly counseled about his/her risk behaviour, chances of acquiring and transmitting STI/HIV infection, and the importance of safer sex behaviour. The counselling services should be provided in a confidential manner. If counselling services cannot be undertaken during the routine outpatient sessions, separate time (appointment) to provide this service should be scheduled. The patient should be encouraged to inform all of his/her partners that, there is a possibility that they may have the infection and that, there is a need for them to seek medical advice and treatment. This should be done in a voluntary and non-coercive manner.

SALIENT POINTS TO REMEMBER FOR PREVENTION AND MANAGEMENT OF STIs

Give all patients
1. Treatment as per the guidelines.
2. Instructions for dosing and follow-up.
3. Education and Counselling.
4. Condoms and instructions on proper use of the condom.

Education and counselling for patients
1. Taking the full course of treatment will cure most STIs.
2. Avoid sex during treatment period to prevent spread of STIs.
3. Help your sexual partner(s) to get treatment.
4. Stay uninfected with use of condoms.
5. Reduce risk of acquiring new infection by having just one sex partner.
6. Protect yourself against HIV/AIDS- Seek counselling to see if you should be tested for HIV.
7. If you or your wife is pregnant, report to the antenatal clinic as soon as possible to protect both the mother and the baby.
**Syndrome 1 - URETHRAL DISCHARGE**

Examine male patients complaining of urethral discharge and/or dysuria for evidence of discharge. If no discharge is seen, massage along the ventral aspect of penis towards the meatus, to look for discharge. The common causes of urethral discharge are *N. gonorrhoae* and/or *C. trachomatis*.

**TREATMENT**

Treat for both gonococcal and chlamydial infections.

**Recommended regimen**

**Azithromycin** 2 g orally single dose, under supervision (to treat both gonococcal and chlamydial infections)

**Alternate regimens**

**Option 1**

**Cefixime** 400 mg orally, single dose, under supervision (to treat gonococcal infection)

**Plus**

**Doxycycline*** 100 mg orally, 2 times daily for 7 days (to treat chlamydial infection)

**Option 2**

**Inj. Ceftriaxone** 250 mg I. M. single dose (to treat gonococcal infection)

**Plus**

**Doxycycline*** 100 mg orally, 2 times daily for 7 days (to treat chlamydial infection)

*In individuals allergic/intolerant to doxycycline,

**Erythromycin base/stearate** 500 mg orally, 4 times daily for 7 days

Treat for Trichomoniasis if discharge persists even after full treatment for gonococcal and chlamydial infections.
SYNDROME 1
URETHRAL DISCHARGE

Patient complains of urethral discharge

Examine; milk urethra if no discharge seen

Discharge present?  No  →  Any other STD present?  No  →  Educate
Counsel
Provide condoms and promote usage
Refer to VCTC

Yes

Use appropriate flow-chart

• Treat for gonorrhoea and chlamydia
• Educate
• Counsel
• Provide condoms and promote usage
• Treat partner*
• Advise to return after 7 days
• Refer to VCTC

7 days

Examine for discharge. If no discharge, milk urethra

Discharge present?  No  →  Cured, but
Educate
Counsel
Provide condoms and promote usage
Refer to VCTC

Yes

Check compliance  No  →  Repeat treatment

Yes

Treat for trichomoniasis

Discharge persists?  No  →  Refer to higher-level facility

Yes

* Treat partner for gonococcal and chlamydial infections
Syndrome 2 - GENITAL ULCER
The most common STIs presenting with genital ulcer(s) are syphilis, chancroid and genital herpes. Treat adequately to cover both syphilis and chancroid or genital herpes depending on history and examination.

TREATMENT
Ask all patients to wash genital area with soap and water.

IF VESICLES ARE SEEN OR/AND HISTORY OF RECURRENCES GIVEN

First episode: Acyclovir 200 mg orally 5 times daily for 7 days
Recurrent episodes: Acyclovir ,400 mg orally, 3 times daily for 5 days
Note: There is no known cure of herpes but the course of the symptoms can be modified by acyclovir.

IF VESICLES ARE NOT SEEN AND NO HISTORY OF RECURRENCES GIVEN
Treat for both syphilis and chancroid.

Recommended regimen

Inj. benzathine penicillin,* 2.4 million units I.M, in 2 equally divided doses. Give injection in each buttock, after testing for sensitivity for penicillin (to treat syphilis)

          Plus

Azithromycin 1 g, single dose, orally under supervision (to treat chancroid)

Alternate regimen

Option 1

Inj. benzathine penicillin,* 2.4 million units I.M, in 2 equally divided doses ; give one injection in each buttock, after testing for sensitivity for penicillin (to treat syphilis)

          Plus

Inj. ceftriaxone, 250 mg, single dose I.M ( to treat chancroid)

Option 2 (Do not use in pregnant women )

Inj. benzathine penicillin,* 2.4 million units, I.M in 2 equally divided doses. Give, one injection in each buttock, after testing for sensitivity for penicillin (to treat syphilis)

          Plus

Ciprofloxacin 500 mg two times a day orally for 3 days (to treat chancroid)

*In individuals allergic/intolerant to penicillin

Doxycycline 100 mg, 2 times daily, for 15 days, but in pregnant women allergic / intolerant to penicillin

Erythromycin base/ stearate 500 mg, 4 times daily for 15 days.
Ask these women to bring the new born baby for treatment within 7 days of birth.
**SYNDROME 2**
**GENITAL ULCER**

Patient complains of genial sore or ulcer

- **Examine**

  Vasicles found or/and history of recurrences?

  - Yes
    - **Examine**
      - Yes
      - **Educate**
      - **Counsel**
      - **Provide condoms and promote usage**
      - **Refer to VCTC**
      - No
      - **Ulcera present?**

  - No
    - **Ulcera present?**

    - Yes
      - **Educate**
      - **Counsel**
      - **Provide condoms and promote usage**
      - **Refer to VCTC**
      - No
      - **Ulcera healed?**

      - Yes
        - **Responding to treatment?**

        - Yes
          - **Refer to higher-level facility**

        - No
          - **Advise to return after 7 days**

      - No
        - **Ulcera persists?**

        - Yes
          - **Refer to higher-level facility**

        - No
          - **Refer to higher-level facility**

* Treat for syphilis, chancroid and counsel on herpes genitalis.
Syndrome 3 - VAGINAL DISCHARGE (WITHOUT SPECULUM)

Vaginal discharge is commonly due to vaginitis and/or cervicitis. Cervicitis is caused by *N. gonorrhoeae* and *C. trachomatis* while *Trichomonas vaginalis, Candida albicans,* and bacterial vaginosis cause vaginitis. However, clinical differentiation between the two conditions is difficult. An assessment of the woman’s risk status may help in making a diagnosis of cervicitis. If risk assessment is negative treat for vaginitis. Where it is not possible to differentiate and/or the risk assessment is positive, treat patients for both cervicitis and vaginitis.

**TREATMENT**

**CERVICITIS:**

**Recommended regimen**
- **Azithromycin**, 2 g orally, single dose, under supervision (to treat both gonococcal and chlamydial infections).

**Alternate regimen**

**Option 1**
- **Cefixime** 400 mg, orally, single dose, under supervision (to treat gonococcal infection)
  - Plus
- **Doxycycline*** 100 mg orally, 2 times daily for 7 days (to treat chlamydial infection).

**Option 2**
- **Inj. Ceftriaxone** 250 mg I.M, single dose (to treat gonococcal infection)
  - Plus
- **Doxycycline*** 100 mg orally, 2 times daily for 7 days (to treat chlamydial infection).

**VAGINITIS:**

**Recommended regimen**
- **Metronidazole****, 2g orally, single dose, under supervision (to treat trichomoniasis and bacterial vaginosis).
  - Plus
- **Fluconazole** 150 mg orally, single dose (to treat candidiasis)

**Alternate regimen**
- **Metronidazole****, 400 mg orally 2 times a day, for 7 days. (to treat trichomoniasis and bacterial vaginosis.
  - Plus
- **Clotrimazole** 500 mg vaginal pessary once only (to treat candidiasis).

*In individuals allergic/intolerant to doxycycline and in all pregnant woman give erythromycin base/stearate, 500 mg orally, 4 times daily, for 7 days instead of doxycycline.*

**Do not give Metronidazole during the first trimester of pregnancy.**
SYNDROME 3.1
VAGINAL DISCHARGE
(WITHOUT SPECULUM Examination)

Patient complains of vaginal discharge

Low abdominal pain

Yes → Use appropriate flow-chart

No

Assess the risk
• Symptomatic partner?
• Recent new partner?
• Multiple Partners?
• Spouse returning after a long stay away from home?

Yes →
• Treat for cervicitis and vaginitis
• Educate
• Counsel
• Provide condoms and promote usage
• Treat Partner*
• Advise to return after 14 days
• Refer to VCTC

No →

Discharge persists?

Yes
• Treat for cervicitis
• Educate
• Counsel
• Provide condoms and promote usage
• Advise to return after 7 days
• Refer to VCTC

No

Vaginal discharge persists?

Yes → Refer to higher-level facility

No

Discharge persists?

Yes

Refer to higher-level facility

No

* Vaginitis may or may not be associated with an STD but the treatment of the partner may be helpful. Treat partner for gonococcal, chlamydial and trichomonal infections.
SYNDROME 3.2 VAGINAL DISCHARGE (WITH SPECULUM EXAMINATION)

Vaginal discharge is due to vaginitis and/or cervicitis. Cervicitis is caused by *N. gonorrhoeae* and *C. trachomatis* while *Trichomonas vaginalis, Candida albicans,* and *Bacterial vaginosis* cause vaginitis. However, clinical differentiation between the two conditions is difficult. An assessment of the woman’s risk status may help in making a diagnosis of cervicitis. If risk assessment is negative treat for vaginitis. Where it is not possible to differentiate and/or the risk assessment is positive, treat the patients for both cervicitis and vaginitis.

**TREATMENT**

**CERVICITIS:**

**Recommended regimen**

Azithromycin, 2 g orally, single dose, under supervision (to treat both gonococcal and chlamydial infections).

**Alternate regimen**

*Option 1*

Cefixime 400 mg, orally, single dose, under supervision (to treat gonococcal infection) 

**Plus**

Doxycycline* 100 mg orally, 2 times daily for 7 days (to treat chlamydial infection).

*Option 2*

Inj. Ceftriaxone 250 mg I.M, single dose (to treat gonococcal infection)

Doxycycline* 100 mg orally, 2 times daily for 7 days (to treat chlamydial infection).

**VAGINITIS:**

**Recommended regimen**

Metronidazole** 2 g orally, single dose, under supervision (to treat trichomoniasis and bacterial vaginosis).

**Plus**

Fluconazole 150 mg orally, single dose (to treat candidiasis)

**Alternate regimen**

Metronidazole** 400 mg orally 2 times a day, for 7 days. (to treat trichomoniasis and bacterial vaginosis)

**Plus**

Clotrimazole pessary, 500mg intravaginally, once only (to treat candidiasis) or 100mg intravaginally, once daily for six days (to treat candidiasis).

*In individuals allergic/intolerant to doxycycline and in all pregnant women, give erythromycin base/stearate, 500 mg orally, 4 times daily, for 7 days instead of doxycycline.

**Do not give Metronidazole during the first trimester of pregnancy.**
SYNDROME 3.2
VAGINAL DISCHARGE
(WITH SPECULUM Examination)

Patient complains of vaginal discharge

Low abdominal pain

Yes

Use appropriate flow-chart

No

Endo-cervical discharge present on speculum examination?

No

Assess the risk
• Symptomatic partner?
• Recent new partner?
• Multiple Partners?
• Spouse returning after a long stay away from home?

No

Yes

• Treat for vaginitis only
  • Educate
  • Counsel
  • Provide condoms and promote usage
  • Refer to VCTC

Yes

Discharge persists?

• Treat for cervicitis and vaginitis
  • Educate
  • Counsel
  • Provide condoms and promote usage
  • Treat Partner*
  • Return after 14 days
  • Refer to VCTC

No

Yes

Vaginal discharge persists?

• Educate
• Counsel
• Provide condoms and promote usage
• Refer to VCTC

No

Yes

Vaginal discharge persists?

Refer to higher-level facility

Discharge persists?

• Educate
• Counsel
• Provide condoms and promote usage
• Return after 7 days
• Refer to VCTC

* Vaginitis may or may not be associated with an STD but the treatment of the partner may be helpful.
Treat partner for gonococcal, chlamydial and trichomonal infections.
**Syndrome 4- SCROTAL SWELLING**

A serious complication of gonococcal and chlamydial urethritis is epididymo-orchitis. The patient often gives a history of urethral discharge. The scrotum becomes swollen, warm and painful. If quick and effective therapy is not given, destruction and scarring of the testicular tissues may occur, causing sub-fertility. Other causes of sub-fertility are mumps virus infection and filariasis.

**TREATMENT**

Treat for both gonococcal and chlamydial infections.

**Recommended regimen**

*Azithromycin* 2g orally, single dose under supervision (to treat both gonococcal and chlamydial infections)

**Alternative regimen**

**Option 1**

*Cefixime* 400 mg orally, single dose under supervision (to treat gonococcal infection)

**Plus**

*Doxycycline* 100 mg orally 2 times daily for 14 days (to treat chlamydial infection)

**Option 2**

*Inj. Ceftriaxone* 250 mg I.M, single dose (to treat gonococcal infection)

**Plus**

*Doxycycline* 100 mg orally, 2 times daily, for 14 days (to treat chlamydial infection)

**Supportive therapy:**

To reduce pain advise bed rest, scrotal elevation with a scrotal support (T-bandage) and analgesics

*In individuals allergic/intolerant to doxycycline,*

*Erythromycin,* 500 mg, 4 times daily orally, for 14 days.
SYNDROME 4
SCROTAL SWELLING

Patient complains of painful scrotal swelling

History of injury to scrotum?
Yes → Refer to higher-level facility
No → Examine scrotum

Swelling of scrotum
Yes → Filaria and/or mumps
No → Testis rotated or retracted?*

Yes → Treat appropriately
No → Tenderness and swelling persists?

Yes → Refer immediately to higher-level facility
No → Cured

* A rotated testis is usually found in adolescents and young adults. Also, patients with rotated testis usually give a history of previous scrotal pain.
**Syndrome 5 - LOWER ABDOMINAL PAIN IN FEMALES**

Lower abdominal pain is often the presenting feature of women with pelvic inflammatory disease (PID). **PID** is defined as an infection of the female genital tract above the cervix and may include endometritis, salpingitis, tubo-ovarian abscess and peritonitis. **PID** occurs as a result of ascending infection from the cervix and is caused by *N. gonorrhoeae, C. trachomatis* and anaerobic bacteria. Occasionally, **PID** may be caused by *Mycoplasma hominis*. Infertility due to tubal occlusion and ectopic pregnancy are serious complications of **PID**.

**TREATMENT**

Treat patient for gonococcal and chlamydial infection as well as for anaerobic bacteria.

**Recommended regimen**

Azithromycin 2 g orally, single dose under supervision (to treat both gonococcal and chlamydial infections).

```
Plus
```

Metronidazole** 400 mg orally, 2 times daily, for 14 days (to treat anaerobic bacteria).

**Alternate regimen**

**Option 1**

Cefixime 400 mg orally single dose under supervision (to treat gonococcal infection)

```
Plus
```

Doxycycline* 100 mg orally, 2 times daily, for 14 days (to treat chlamydial infection)

```
Plus
```

Metronidazole** 400 mg orally, 2 times daily, for 14 days (to treat anaerobic bacteria).

**Option 2**

**Inj. ceftriaxone** 250 mg I.M, single dose (to treat gonococcal infection)

```
Plus
```

Doxycycline* 100 mg orally, 2 times daily, for 14 days (to treat chlamydial infections)

```
Plus
```

Metronidazole** 400 mg orally, 2 times daily, for 14 days (to treat anaerobic bacteria)

*In individuals allergic/intolerant to doxycycline and in all pregnant/lactating women use Erythromycin base/stearate, 500 mg orally, 4 times daily, for 14 days instead of doxycycline.*

**Generally, Metronidazole is not recommended during the first trimester of pregnancy. However, it should not be withheld from a highly acute case of **PID, which always represents an emergency.**

**Caution:** **PID** can be a serious condition. Treating doctor must refer the patient to the hospital if she does not respond to treatment within 3 days and even earlier in case there is worsening of her condition.
SYNDROME 5
LOWER ABDOMINAL PAIN IN FEMALES

Patient complains of lower abdominal pain

Take history and do abdominal and vaginal examination

Missed overdue period, vaginal bleeding?
Recent delivery/abortion?
Rebound tenderness?
Guarding?
Pelvic mass?

Yes

Refer immediately to higher-level facility

No

Pain on moving cervix and temperature 38°C or higher?

Yes

Other illness present?

Yes

Manage appropriately

No

• Treat for PID
• Educate
• Counsel
• Provide condoms & promote usage
• Treat partner
• Refer to VCTC

Advise to return after 3 days or even earlier if pain persists or gets worse.

Improved?

Yes

• Complete treatment
• Advise to return, if pain persists
• Refer to VCTC

No

Refer to higher-level facility

• Reassure
• Advise to return after 3 days, if pain persists

** Treat partner for gonococcal and chlamydial infections.
Syndrome 6 - INGUINAL BUBO

This is a painful swelling of the lymph nodes in the inguinal region. A bubo may occur in chancroid or lymphogranuloma venereum (LGV). It can also result from any kind of acute infection of the skin on the pubic area, genitals, buttocks, anus, thighs, legs, feet, and toes.

TREATMENT

Recommended regimen

Doxycycline 100 mg orally, 2 times a day for 21 days.

Alternative regimen

Option 1

Tetracycline 500 mg orally, 4 times a day for 21 days.

Option 2 (for pregnant and lactating women)

Erythromycin base/stearate 500 mg orally, 4 times a day for 21 days.

If bubo becomes fluctuant, aspirate pus with a wide bore needle and syringe. Make entry into the bubo through adjacent normal healthy skin over a non-dependent area. Never incise and drain.
SYNDROME 6
INGUINAL BUBO

Patient complains of enlarged and/or painful inguinal lymph nodes

Take history and examine

Ulcer(s) present in genital area?

Yes → Use the flow-chart for genital ulcers

No →

• Treat for lymphogranuloma venereum
• Educate
• Counsel
• Provide condoms and promote usage
• Treat partner*
• Advise to return after 14 days
• Refer to VCTC

14 days

Responds to treatment?

No → Refer to higher-level facility

Yes →

• Complete the treatment
• Educate
• Counsel
• Provide condoms and promote usage

*Treat for LGV and counsel for other STIs.
**Syndrome 7 - OPHTHALMIA NEONATORUM**

Ophthalmia neonatorum is the condition, where the baby develops purulent conjunctivitis in one or both eyes within four weeks of birth. It is a medical emergency and unless treatment is initiated within 24 hours there could be permanent damage to the eyes resulting in blindness. The discharge from the eyes may be caused by *N.gonorrhoeae, C.trachomatis* and less frequently by other bacteria.

**TREATMENT**

Clean the eyes with distilled water or saline.

**Recommended regimen**

*Inj. ceftriaxone* 50mg/kg body weight, I M single dose, up to maximum of 125mg (to treat gonococcal infection),

Plus

*Erythromycin syrup* 50mg/kg body weight orally, daily in 4 divided doses for 14 days (to treat chlamydial infection)

**Alternate regimen**

*Inj. Kanamycin* 25mg/kg body weight I.M single dose, up to a maximum of 75mg (to treat gonococcal infection),

Plus

*Erythromycin syrup* 50mg/kg body weight orally, daily in 4 divided doses for 14 days (to treat chlamydial infection)
SYNDROME 7
OPHTHALMIA NEONATORUM
(Neonatal Conjunctivitis)

New-born with discharging eyes

Take history and examine baby

Conjunctivitis present?

Yes

• Treat baby for gonococcal and chlamydial infections
• Treat mother and father for gonococcal and chlamydial infections
• Educate parents
• Advise to return after 2 days

Improved?

No

Refer to higher-level facility

Yes

Manage appropriately

Other illness present?

No

• Reassure mother
• Review, if symptoms persist

Yes
Standard Operating Procedures and Forms for STI Drug and Consumables Stock Management
ANNEX - H

Standard Operating Procedures and Forms for STI Drugs and Consumables Stock Management

The following guidelines are for clinic-level management of STI drugs and consumables (including condoms). Implementing partners will need, in addition, a centralized storage area to store the supplies of these items before they are sent to the individual clinics. For detailed information on recommended procedures for central storage of STI drugs, refer to the following document from the World Health Organization, UNICEF, and John Snow, Inc./USAID: Guidelines for the Storage of essential Medicines and Other Health Commodities, http://www.who.int/medicines/library/qsm/storage_pocketguide.pdf.

Inventory Control and Ordering

Clinics should have a drugs and consumables storage area, such as a lockable cupboard, and keep a working stock (i.e., a single container) in the treatment area.

Stock records for the drugs storage area should include information on:

- Product name/description;
- Stock on hand/beginning stock balance;
- Receipts;
- Issues;
- Losses/adjustments;
- Closing/ending balance;
- Transaction reference (e.g., issue voucher number or name of supplier or recipient);
- Special storage conditions;
- Item codes; and
- Expiration dates.

An example of an Inventory Control Card is attached at the end of this annex.

The daily consumption of medications from the store should correspond to the total medications issued to patients receiving treatment. The Patient Register form (see Annex Q) includes columns for STI treatments dispensed, and the totals of these columns should match the daily usage recorded on inventory control cards. The forms in Annex H cover only pre-packaged treatment packs. For all other medications, the clinic should develop an internal stock control

system for registering drugs dispensed.

**Ordering Stock**

A standard requisition form should be used to order drugs and supplies from the central store. An example of a requisition voucher is attached at the end of this annex. Clinic staff should ensure they place orders early enough to ensure adequate stock of all items at all times. A one-month supply should be on hand at all times.

**Receiving Stock**

The following procedure should be used when receiving stock.

1. Count the number of units for each product received and compare the number with the number on the issue voucher.
2. Record the date and quantity received on a stock card. Check for damaged or expired stock and return to the central store.
3. Ensure that the expiration date is visibly marked on every package or unit.
4. Check for any special conditions for storage. It is important to follow the manufacturer’s recommended storage conditions for all products. The following terms relate to temperature and storage of medical supplies:

   - **Keep cool** means: Store between 8°C & 15°C
   - **Store at room temperature** means: Store between 15°C & 25°C, max of 30°C

   N.B. Adrenaline has a shortened shelf-life when stored above 25°C
5. Arrange products in the storage area so that the first to expire is the first out (FEFO).

   **NOTE:** The order in which products are received is not necessarily the order in which they will expire. It is important to check the expiration dates and make sure the dates are visible when the products are in storage.

Examples of the following forms are attached at the end of this annex:

- Inventory Control Card
- Requisition and Issue Voucher
- Monthly Consumption Report
## INVENTORY CONTROL CARD

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<th>Commodity Number</th>
<th>Description</th>
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<th>Maximum Stock</th>
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<th>Location</th>
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<tr>
<td>Date</td>
<td>Transaction Reference</td>
<td>Quantity Received</td>
<td>Quantity Issued</td>
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**REQUISITION AND ISSUE VOUCHER**

Date: ________________  
Ship to: ________________

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<th>Article</th>
<th>Quantity on Hand</th>
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</table>
### MONTHLY CONSUMPTION REPORT

**Name of Facility:**

**Facility Responsible Officer:**

**Facility Contact Telephone #:**

**Reporting Period:** Start Date:  End Date:

<table>
<thead>
<tr>
<th>Product Code</th>
<th>Product Generic Name</th>
<th>Product Strength</th>
<th>Unit of Measure</th>
<th>Quantity Received During Period</th>
<th>Quantity Issued During Period</th>
<th>Adjustments During Period (e.g., expired)</th>
<th>Days Out of Stock</th>
<th>Opening Balance</th>
<th>Closing Balance</th>
<th>Days of Stock</th>
<th>Con- sumption Expired in Last 6 Months</th>
<th>Comments</th>
</tr>
</thead>
</table>

**Adjusted Consumption:**

**Expired in Last 6 Months:**

**Days Out of Stock:**

**Comments:**

**Signature of Responsible Person:**

**Date:**
Management of Anaphylaxis in Adults
Management of Anaphylaxis in Adults\textsuperscript{8, 9, 10, 11}

The following guidelines are for the treatment of an adult patient who is in the state of anaphylaxis:

1. Place patient in supine position with feet elevated.
2. Give cardiopulmonary resuscitation if appropriate, securing the airway with oropharyngeal airway device.
3. Give \textbf{intramuscular aqueous adrenaline (epinephrine)} \textsuperscript{1:1,000 dilution 0.5 mL (0.5 mg). Usual site of injection is the upper arm. The site may be gently massaged to facilitate absorption. The dose may be repeated two or three times at 5- to 10-minute intervals. If anaphylaxis is caused by an injection, administer aqueous adrenaline, 0.15 mL, into injection site to inhibit further absorption of the injected substance.}
4. Antihistamines sometimes provide dramatic relief of symptoms. Give \textbf{Diphenhydramine 50-100 mg IM or Chlorphenamine (chlorpheniramine) 10-20 mg IM} as a single dose.
5. Give \textbf{Hydrocortisone 250 mg IM single dose. The benefit of steroids is not realized for 6 to 12 hours after administration, so their primary role is to prevent the recurrence of or protracted anaphylaxis.}
6. \textbf{Transfer patient to hospital immediately for continued emergency management.} The doctor should accompany the patient to the hospital to ensure immediate care on arrival. Extra doses of adrenaline should be transported with the patient in case the patient has a relapse before reaching the hospital. Stay with the patient until care is directly transferred in person to another doctor.

Anaphylaxis Wall Chart¹²

Before administering drugs or injections, ask the patient about previous allergies to drugs.

Signs of possible ANAPHYLAXIS:

- Shock;
- Difficulty breathing; and
- Itchy rash or hives.

1. Call for help – preferably a doctor
2. Check
   Airway;
   Breathing – Give mouth-to-mouth respiration; and
   Circulation – Perform CPR if necessary.
3. If Anaphylaxis, give Adrenaline intramuscularly
   - Dosage: Adult 0.5 ml (if elderly 0.3 ml), repeat every 5–10 minutes until adequate response; and
   - Check blood pressure and pulse at 5- to 10-minute intervals.
4. Give Hydrocortisone IM – Dosage: Adult 250 mg
5. Give Chlorpheniramine 10-20 mg or Diphenhydramine 50-100 mg IM
6. Transfer patient to hospital
   - Repeat Adrenaline if necessary. Take extra doses with you;
   - Record all details of treatment. Give copy to the hospital staff with patient; and
   - Stay with the patient until another doctor takes over the care in person.

Guidelines for Universal Precautions
Infection prevention principles have two main aims:

- To reduce the rate of infection and disease transmission to patients; and
- To protect healthcare workers.

Implementing these universal precautions are meant to reduce the risk of transmitting organisms from known or unknown sources of infection (e.g., patients, contaminated objects, used needles and syringes) within healthcare facilities. Universal precautions are the minimum level of infection prevention required to prevent the transmission of viruses such as HIV, hepatitis B, and hepatitis C.

Universal precautions should be in place for all healthcare settings at all levels—in hospitals, clinics, health posts, mobile clinics, and community health centers. Infection prevention principles can be adopted in all healthcare settings, even in settings where water and electricity supply is not constant. Every healthcare setting can adopt a set of practices to minimize the spread of infection between patients and between staff and patients (nosocomial infections).

Universal Precautions are designed for use by all people (patients, health workers, ancillary staff, and laboratory staff), regardless of whether or not they are infected.

Universal precautions should always be applied when handling:

- Blood (including dried blood);
- All other bodily fluids, secretions, and excretions (excluding sweat), regardless of visible blood;
- Non-intact skin; and
- Mucous membranes.

Universal precautions include good hygiene practices such as washing hands before and after patient contact, wearing gloves and other protective devices, following aseptic techniques, safe handling of sharps, cleaning treatment and care areas, and disposing of medical waste.

13 Adapted from Guiding principles for infection control in health care settings in Timor-Leste. Prepared by Lou McCallum for Family Health International.

### Summary of Universal Precautions

<table>
<thead>
<tr>
<th>Component</th>
<th>Guidelines</th>
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</thead>
<tbody>
<tr>
<td><strong>Hand Washing:</strong></td>
<td>- After touching blood, bodily fluids, secretions, excretions, and contaminated items</td>
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<td>- Immediately after removing gloves; and</td>
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<td>- Before contact with next patient.</td>
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<tr>
<td><strong>Gloves:</strong></td>
<td>- For contact with blood, bodily fluids, secretions, and contaminated items; and</td>
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<tr>
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<td>- For contact with mucous membranes and non-intact skin.</td>
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<tr>
<td><strong>Masks, Goggles, Face Masks:</strong></td>
<td>- Protect mucous membranes of eyes, nose, and mouth when contact with blood and</td>
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<td>bodily fluids is anticipated.</td>
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<td><strong>Gowns:</strong></td>
<td>- Protect skin from blood or bodily fluid contact; and</td>
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<td>- Prevent soiling of clothing during procedures that may involve contact with blood</td>
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<tr>
<td></td>
<td>or bodily fluids.</td>
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<tr>
<td><strong>Linen:</strong></td>
<td>- Handle soiled linens so that they do not touch skin/mucous membranes; and</td>
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<td>- Do not pre-rinse soiled linen.</td>
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<tr>
<td><strong>Patient Care Equipment:</strong></td>
<td>- Handle soiled equipment in a manner to prevent contact with skin or mucous</td>
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<td>membranes and to prevent contamination of clothing or the environment; and</td>
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<td>- Clean reusable equipment before reusing it.</td>
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<tr>
<td><strong>Environmental Cleaning:</strong></td>
<td>- Routine care, cleaning, and disinfection of equipment and furnishings in patient care</td>
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<td>areas.</td>
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<tr>
<td><strong>Sharps:</strong></td>
<td>- Avoid recapping used needles;</td>
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<td>- Avoid removing used needles from disposable syringes;</td>
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<td>- Avoid bending, breaking, or manipulating used needles by hand; and</td>
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<td>- Place used sharps in puncture-resistant containers.</td>
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<tr>
<td><strong>Patient Resuscitation:</strong></td>
<td>- Use mouthpieces, resuscitation bags, or other ventilation devices to avoid</td>
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<td>mouth-to-mouth contact during resuscitation.</td>
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<td><strong>Patient Placement:</strong></td>
<td>- Place patients who contaminate the environment or cannot maintain appropriate hygiene in</td>
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<td>private rooms.</td>
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### 1. HAND WASHING

**Purpose**
Hand washing is the single most important procedure in preventing infection. The purpose of hand washing is to mechanically remove soil and debris from the skin and to reduce the number of transient microorganisms on the skin.

<table>
<thead>
<tr>
<th>Types of Hand Washing</th>
<th>Standard hand wash</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Wash hands 10–15 seconds with soap and running water. Air dry or dry with paper or personal towel.</td>
</tr>
</tbody>
</table>

Standard hand wash should be performed:
- Before and after each contact with patients;
- Before and after gloving for any clinical or surgical procedure;
- If performing more than one task, requiring different gloves, for the same patient;
- Upon arriving at work and before leaving;
- After touching anything that may have been contaminated;
- After handling any blood, bodily fluids, or liquid or solid waste; and
- After using the toilet.

**Surgical scrub**
Scrub for 3–5 minutes with a soft brush or orange stick and an antiseptic soap before performing surgical or invasive procedures.

<table>
<thead>
<tr>
<th>The standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every health setting should have facilities in place for staff to clean their hands between patients and between procedures on one patient.</td>
</tr>
</tbody>
</table>

Best practice includes a sink with running water, soap, and paper towels or clean personal towels.

If running water is not available, a plastic container with a tap in the bottom and a bucket under the tap should be used. The water should be replaced daily. A bowl of water for hand washing is not an acceptable standard.

If clean water is not available, staff should have access to a waterless alcohol-based hand-rub as an alternative. The hand rub is made up of 2 ml glycerine, propylene glycol, or sorbitol in 100 ml of 60 – 90% alcohol. This can be used only if there are no visible bodily fluids on the health worker’s hands.
2. PROTECTIVE BARRIERS

Purpose

Protective barriers are used to minimize the risk of transfer of bodily fluids and microorganisms from patient to staff member and from staff member to patient.

Barriers include gloves, face masks, protective gowns, caps, aprons, and eye goggles.

The standard

Gloves should be worn when:

- Examining mucous membranes or non-intact skin (e.g., genital examination);
- Drawing blood (phlebotomy), fingersticks / heelsticks or establishing intravenous access, but not required for giving IM injections;
- Handling soiled instruments, equipment, or linens; and
- Disposing of contaminated medical waste (e.g., cotton, gauze or dressings).

Health staff should change gloves between patients and between procedures on the same patient. Two types of gloves should be available:

- Examination gloves to wear when coming in contact with bodily fluids or mucous membranes.
- Heavy-duty utility gloves to wear when cleaning equipment or handling hospital waste.

Gloves are not required for all patient procedures, only for those procedures where it is likely that the health worker will come in contact with mucous membranes or bodily fluids such as blood, urine, feces, or other fluids. As a precaution, gloves should be worn for all genital examinations. The same pair of gloves should not be worn when moving from one patient to another.

Health staff should wash hands with soap and free-flowing water immediately after removing their gloves (after each patient) and before touching anything else.
3. INJECTION ADMINISTRATION

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Safely administering injections is necessary to prevent transmission of blood-borne infections during health care procedures.</th>
</tr>
</thead>
</table>
| The standard | ✦ Wash hands before administering an injection;  
✦ Clean the area of skin to be injected if it is visibly dirty. An antiseptic (clean, single-use swab) may be used to disinfect the target area of skin before injection;  
✦ Single, disposable needle and syringe should be used for every single injection administered;  
✦ Reconstitute every medication unit;  
✦ Inspect the packaging of the syringe and needle to ensure that it is not torn, punctured, or damaged;  
✦ Use single-dose vials to prepare medication;  
✦ Discard medications that show evidence of cracks or breach of integrity;  
✦ Be aware of and avoid sudden or jerking movements by the patient during and after injection;  
✦ Needles should not be manipulated from the syringe before disposal;  
✦ Do no recap needles after use and before disposal; and  
✦ Immediately dispose of needles and syringes in puncture-proof sharps containers. |
4. SAFE HANDLING OF NEEDLES AND OTHER SHARP INSTRUMENTS

**Purpose**
Healthcare staff can be exposed to viruses such as hepatitis B or HIV through accidental cuts from sharp instruments or through needle-stick injuries. Small amounts of blood and other bodily substances can remain on used instruments or in the hole inside the needle. All healthcare settings should have in place a system for the safe use and disposal of sharp instruments, including needles.

**The standard**
- Sharp instruments should not be passed directly from one staff member to another; that is, a safe zone should be used (e.g., place the sharps in a tray and allow the other staff member to pick them up from the tray);
- Needles should be used once only;
- Best practice is that needles not be re-capped;
- If needles are re-capped, staff should use the single-handed re-capping method by placing the cap on a hard flat surface and pushing the needle into the cap with one hand, without placing their other hand on the cap;
- Puncture-proof containers should be placed in all areas where needles are used. Used needles and syringes should be placed in the containers whether or not a needle destroyer is used;
- If specially manufactured sharps containers are not available, other puncture-proof buckets or containers with lids should be used;
- The sharps container should be sealed and removed when it is three-quarters full; and
- Containers should be disposed of by incineration.
### Purpose
Aseptic techniques are designed to reduce the chances of microorganisms entering the body during surgery, when dressing wounds, when using catheterization, or during any other procedures that involve breaking the skin or mucous membrane.

### The standard
Any health worker performing surgery, carrying out a procedure that breaks the patient’s skin or enters the patient’s body, or dressing a wound should use aseptic techniques.

- Surgical scrub hand washing;
- Using instruments and dressings that have been sterilized or undergone high-level disinfection (HLD);
- Wearing a mask and sterile gloves;
- Setting up and maintaining a sterile field; and
- Properly preparing the patient’s skin or the area involved in the procedure by using antiseptic and sterile gauze to disinfect.
6. PROCESSING INSTRUMENTS AND EQUIPMENT

**Purpose**

All instruments that are involved in invasive procedures (i.e., those that cut or pierce the skin or touch the mucous membrane) have the potential to transmit microorganisms and infections.

A three-step method is used to process instruments and equipment:

1. **Step 1:** they are decontaminated.
2. **Step 2:** they are washed.
3. **Step 3:** they are either sterilized or high-level disinfected to remove any blood or bodily fluids and secretions and to prevent microorganisms from passing from one patient to another.

**The Standard**

All reusable items should be decontaminated, cleaned, and either sterilized or disinfected using high-level disinfection techniques. This applies to re-usable gloves, surgical instruments, and any re-usable equipment that comes in contact with tissue under the patient’s skin or with mucous membranes.

Instruments that come into contact with intact mucous membranes may be either steam-sterilized (if possible), undergo HLD, or be processed under low-temperature automated chemical sterilant systems.

Instruments that puncture sterile tissue, enter the vascular system, or are otherwise contaminated with blood or bodily fluids should undergo steam or chemical sterilization as appropriate.

Place reusable items/instruments in marked containers immediately after use.

Avoid hand-to-hand transfer of sharp, reusable instruments.

Maintain separate bench space for clean equipment and dirty equipment.

Store sterilized instruments in a dry, clean, dust-free and covered space until next use and sterilization.

Guidelines for sterilization and disinfection are presented in Annex K.
7. HOUSEKEEPING AND WASTE DISPOSAL

**Purpose**

Thorough cleaning is an essential part of preventing infection. Maintaining a clean environment reduces the microorganisms that come in contact with patients and staff. Medical waste poses a threat to health workers and communities if it is not properly disposed of.

**The standard**

Surfaces (i.e., floors, walls, patient bedside tables, chairs, doors, and partitions) can be cleaned with soap and water solution or a nonphenol-based commercial floor cleaner, then thoroughly dried. Areas that are likely to contain higher concentrations of microorganisms should be cleaned with a disinfectant solution. Such areas include toilets, bathrooms, examination and treatment tables, and trolleys used during procedures.

Clean examination tables, other patient-care equipment, and other surfaces at risk of contamination using a disinfectant cleaning solution.

Paper or protective liners should be used to keep linen on beds and examining tables clean.

If linen are contaminated with blood or other bodily fluids, wear gloves to remove them and place the linens in an appropriately marked leak-proof biohazard bag for transport. Linen contaminated with blood should be washed separately from other items, using detergent and bleach.

All spills should be cleaned up immediately (see chapter 10). Each unit or clinic should develop a cleaning schedule to ensure that all areas are cleaned routinely.

All health services must have a system in place for safe disposal of materials contaminated with bodily fluids or substances. Guidelines for the disposal of biologic waste are presented in Annex L.
8. SAFE USE OF MULTI-DOSE VIALS

**Purpose**
Using multi-dose vials in an incorrect manner can transfer microorganisms from one patient to another. The fluid inside the vial can become contaminated and this can result in microorganisms being passed from the contaminated fluid to patients. Microorganisms can also be present on the top of the vial and can be pushed into the vial by the needle if the vial top is not disinfected between uses.

**The standard**
The health worker who first opens a multi-dose vial should clearly write the date and time of opening on the label. A new, sterile needle and syringe should always be used to draw up medicine or fluid from a multi-dose container. The top of the container should be wiped with an alcohol wipe or with clean gauze wetted with alcohol. The top should be allowed to dry before inserting the needle.

Open solutions (e.g., 0.9% NaCl, Ringers Lactate) should be disposed of after 24 hours. Multi-dose antibiotics and medicines should be used in accordance with the manufacturer’s instructions. If contamination is suspected, the multi-dose vial or container should be disposed off.

9. HANDLING LABORATORY SPECIMENS

**Purpose**
Clinical specimens should be regarded as potentially infectious. The blood or bodily fluids contained in the specimen (in the blood tube or on a microscope slide) have the potential to transmit infections in the case of breakage or spillage. In addition, the outside of the container may be contaminated.

**The standard**
Wear gloves when handling laboratory specimens. Blood specimens should be transferred to the laboratory in spill-proof tubes, either vacutainers or screw-capped tubes, and placed in leak-proof polythene bags. All specimens should be properly labeled. Specimens and laboratory requisition forms should not be in contact. One way to ensure the forms are not contaminated by the specimen is to double-bag the forms and place them in the outer bag.
## 10. MANAGING SPILLS

**Purpose**
Spills of blood or other potentially infectious material must be properly disposed of before the area can be cleaned.

**The standard**
- Use heavy-duty or utility gloves when addressing spills and cleaning surfaces;
- For small spills (< 10 cm diameter), apply dry, absorbent paper towels or a cloth saturated with a disinfectant solution directly to contain the fluid spill;
- For large spills (> 10 cm diameter) coat the area with a disinfectant solution (e.g., 0.5% chlorine) and wipe the spill with dry, absorbent paper towels, a damp cloth, sponge, or a mop to contain the majority of the spill. Wear disposable cleaning gloves during the procedure;
- Dispose off the paper towels and/or cloth by following the procedures for infectious, non-sharps, clinical waste disposal;
- Immediately clean with detergent and water using dry, absorbent paper towels, a cleaning cloth, sponge, or mop;
- If cleaning is difficult and there is a risk of bare skin coming into contact with the area of spillage, also use a disinfectant such as bleach (0.5% chlorine solution) after cleaning with detergent and water; and
- Wash hands with soap and free-flowing water.
Guidelines for Cleaning, Disinfecting and Sterilizing
ANNEX - K

Guidelines for Decontaminating, Cleaning, Disinfecting and Sterilizing

Preparation of Sodium Hypochlorite for Decontamination and High Level Disinfection

Sodium Hypochlorite (Bleach)

Sodium hypochlorite (bleach) is an excellent decontaminant and disinfectant; however, its disadvantage is that it corrodes metal. The advantages of using bleach for decontamination and disinfection are that:

- Bleach is inexpensive;
- Bleach kills HIV, hepatitis B, and hepatitis C quickly; and
- Bleach can be used to decontaminate large surfaces.

Bleach is usually sold in concentrated form and must be diluted before using. The best concentration for decontamination is 0.5% chlorine. At this dilution, bleach can be used for wiping up blood spills or decontaminating soiled equipment.

The strength of the bleach varies from manufacturer to manufacturer; thus, it is important to know the strength of the bleach that is available in your clinic. The concentration of household bleach in India is usually 4–5% chlorine or 2–3% chlorine. The dilutions required to prepare a 0.5% chlorine solution are shown below.

<table>
<thead>
<tr>
<th>Concentration of Household Bleach</th>
<th>Dilution Required to Reach 0.5% Chlorine Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>1 part bleach to 9 parts water</td>
</tr>
<tr>
<td>4%</td>
<td>1 part bleach to 7 parts water</td>
</tr>
<tr>
<td>3%</td>
<td>1 part bleach to 5 parts water</td>
</tr>
<tr>
<td>2%</td>
<td>1 part bleach to 3 parts water</td>
</tr>
<tr>
<td>1%</td>
<td>1 part bleach to 1 parts water</td>
</tr>
</tbody>
</table>

A 0.5% chlorine solution can also be prepared from a 30% bleaching powder. Mix 3 level teaspoons (15 grams) of bleaching powder with 1 liter of water to prepare a 0.5% concentration.

16Adapted from AIDS Control and Prevention Project (AIDSCAP), Family Health International, Arlington, VA, USA and Infection Prevention: a reference booklet for health care providers, EngenderHealth 2001
Sodium hypochlorite (bleach) rapidly loses strength, especially if exposed to sunlight. Therefore, fresh solutions must be made up each day to ensure that the bleach solution is strong enough to kill HIV.

**Decontaminating and Cleaning Processes**

**Used Rubber Gloves in Preparation for Reuse**

1. Make a 0.5% solution of bleach;
2. Decontaminate used gloves by soaking it in cold bleach solution for 10 minutes. This will kill HIV and the hepatitis B virus, and decontaminate the gloves;
3. Prepare lukewarm, soapy water and wash the gloves in water;
4. Rinse the gloves in cold, clean water to remove all the soap; and
5. Prepare the gloves for sterilization.

**Metal Instruments**

1. Soak used instruments by soaking it for 10 minutes in cold 0.5% bleach solution to decontaminate. This will kill HIV and the hepatitis B virus;
2. Rinse the instruments in cold, clean water;
3. Prepare hot, soapy water;
4. Scrub the instruments with a brush in the hot, soapy water;
5. Give special attention to any teeth or screws on the instrument;
6. Rinse away all soap in cold, clean water; and
7. Prepare instruments for sterilization.

**High Level Disinfection (HLD) using chemicals**

**Ethyl Alcohol or Isopropyl Alcohol**

Both ethyl and isopropyl alcohol are excellent disinfectants. Ethanol (70% ethyl alcohol) kills all viruses, while isopropyl alcohol kills bacteria and most viruses. However, alcohol does not kill bacterial spores. Other advantages of alcohol are:

- Alcohol does not corrode metal; and
- Alcohol is not as expensive as some other disinfectants.

The disinfectant strength of alcohol becomes weaker with use and a fresh solution must be made up weekly. And if it is imported into a country, it is likely to be expensive. Also, if used often enough, alcohol will eventually damage rubber.
Using Sodium Hypochlorite (bleach) as Disinfectant for Instruments and Equipment

1. Clean all instruments and equipment thoroughly as directed in section on cleaning metal instruments above;
2. Dilute the concentrated bleach solution to 0.5% chlorine strength and cover the instruments with the diluted bleach;
3. Let the instruments soak for at least 30 minutes;
4. Remove the instruments or equipment with large forceps that have also been disinfected;
5. Rinse the instruments with filtered, sterile water; and
6. Store the instruments in a dry, covered container that has been previously disinfected.

Using Ethyl Alcohol or Isopropyl Alcohol as a Disinfectant

1. Clean all instruments and equipment thoroughly as directed in section on cleaning metal instruments above;
2. Cover the instruments completely with a 70% solution of alcohol, and leave them in the alcohol for at least 30 minutes;
3. Remove the instruments or equipment from the alcohol with large forceps that have also been disinfected; and
4. Store the instruments in a dry, covered container that has also been disinfected.

<table>
<thead>
<tr>
<th>Method</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sodium hypochlorite (bleach)</td>
<td>• Usually the least expensive disinfectant available</td>
<td>• Corrodes metal</td>
</tr>
<tr>
<td></td>
<td>• Quickly kills HIV</td>
<td>• Must make up fresh solution each day</td>
</tr>
<tr>
<td></td>
<td>• Can be used to disinfect large surfaces</td>
<td>• Corrosive to skin and mucous membranes</td>
</tr>
<tr>
<td>70% ethyl alcohol or isopropyl alcohol</td>
<td>• Usually less expensive than other disinfectants</td>
<td>• Must make up fresh solution at least once per week</td>
</tr>
<tr>
<td></td>
<td>• Kills all bacteria</td>
<td>• Will damage rubber goods with repeated use</td>
</tr>
<tr>
<td></td>
<td>• Kills all viruses</td>
<td>• Expensive if imported</td>
</tr>
</tbody>
</table>
**HLD by Boiling**

1. Clean all instruments carefully, as directed;
2. Open scissors, hemostats, and similar instruments;
3. Cover the instruments completely in the water;
4. Close lid of boiler and heat solution to a rapid boil;
5. Continue boiling for 20 minutes. (Add 5 minutes for every 1,000 feet [300 meters] above sea level);
6. After the instruments have boiled for the required amount of time, remove them with sterile forceps; and
7. Place the instruments in a dry, sterile container.

**Sterilization**

**Steam Sterilization by Pressure Cooker**

1. Clean all instruments carefully, as directed;
2. Open scissors, hemostats, and similar instruments;
3. Wrap instruments in cotton cloth or a paper wrapper;
4. Place instruments on the rack inside the pressure cooker;
5. Bring water to a boil in the pressure cooker, until steam escapes from the pressure valve only;
6. Turn down heat and make sure that steam is still escaping from the pressure valve;
7. Do not allow the pressure cooker to boil dry;
8. Sterilize for 30 minutes at 121°C at 15 pounds per square inch (101 Kpa);
9. After 30 minutes of sterilizing, let the instrument packs dry completely;
10. Remove objects from the cooker with large, sterile forceps;
11. Place the instruments in a dry, sterile container; and
12. Re-sterilize the equipment if it is not used within one week.

**Steam Sterilization by Autoclave**

1. Clean all instruments carefully, as directed;
2. Open scissors, hemostats, and similar instruments;
3. Wrap instruments in cotton cloth or a paper wrapper;
4. Sterilize for 30 minutes at 121°C at 15 pounds per square inch (101 Kpa);
5. After 30 minutes of sterilizing, let the instrument packs dry completely;
6. Remove objects from the autoclave with large, sterile forceps;
7. Place the instruments in a dry, sterile container; and
8. Re-sterilize equipment if it is not used within one week.
### Dry Heat Sterilization by Electric Oven

1. Clean all instruments carefully, as directed;
2. Open scissors, hemostats, and similar instruments;
3. Wrap instruments in cotton cloth;
4. Sterilize for 2 hours at 170ºC in an electric oven;
5. Remove objects from the oven with large, sterile forceps;
6. Place the instruments in a dry, sterile container; and
7. Re-sterilize equipment if it is not used within one week.

---

#### Advantages and Disadvantages of Various Sterilization/HLD Method

<table>
<thead>
<tr>
<th>Method</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autoclave or pressure cooker</td>
<td>• Kills all microorganisms, including HIV&lt;br&gt;• Inactivates all bacterial endospores, including those that cause tetanus and gangrene</td>
<td>• Requires source of heat (electricity, kerosene, or fire)&lt;br&gt;• Needs careful maintenance&lt;br&gt;• Autoclaves are expensive</td>
</tr>
<tr>
<td>Dry heat</td>
<td>• Household oven can be used&lt;br&gt;• Heat kills HIV&lt;br&gt;• Works well in humid climates</td>
<td>• Needs electricity, gas, or other fuel&lt;br&gt;• Cannot be used for plastic or rubber items</td>
</tr>
<tr>
<td>Boiling</td>
<td>• Inactivates all microorganisms, including HIV&lt;br&gt;• Resources are usually available</td>
<td>• Does not kill endospores, unless water is made alkaline by addition of bicarbonate of soda&lt;br&gt;• Alkalinized water can cause irritation of skin or respiratory tract</td>
</tr>
</tbody>
</table>
Guidelines for Disposal of Hazardous Waste
ANNEX - L

Guidelines for Disposal of Hazardous Waste\textsuperscript{17,18,19}

There are various types of hazardous waste generated at the clinic level. These wastes should be segregated and disposed off in a manner that does not cause risk of infection or injury to clinic staff or the general public.

Categories of Healthcare waste generated at clinic Level

The types of hazardous waste generated at the clinic level include sharps, infectious medical waste, pharmaceutical waste and other hazardous waste.

Sharps waste: Single-use disposable needles, needles from auto-disable syringes, scalpel blades, disposable trocars, sharp instruments requiring disposal and sharps waste from laboratory procedures.

Other infectious medical waste: Waste contaminated with blood and other bodily fluids, including gloves, cotton, dressings, linens, disposable intravenous sets, catheters and so on. This also includes infectious laboratory wastes such as waste from laboratory tests and other items that were in contact with the specimens, such as gloves.

Pharmaceutical waste: Expired, damaged or otherwise unusable medicines and items contaminated by or containing medicinal substances.

General waste: Waste that is not infectious, sharp or toxic can be handled like domestic refuse for disposal.

Waste Segregation and Storage

Waste segregation reduces the volume of waste that requires special handling. Segregation is the responsibility of the waste producer and should take place at the first disposal point. Under no circumstances should clinic staff attempt to sort waste or correct waste segregation after it has been placed in disposal containers. If hazardous waste is accidentally thrown into a non-hazardous container, treat the entire container as hazardous waste.


Waste should be segregated and placed in color-coded bags according to Ministry of Forest and Environment guidelines and labeled with the biohazard symbol as shown below.

<table>
<thead>
<tr>
<th>Type of Waste</th>
<th>Color of Bag</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharps waste</td>
<td>Blue/white</td>
<td>Danger, contaminated sharps</td>
</tr>
<tr>
<td>Infectious waste</td>
<td>Red</td>
<td>Infectious biological substances</td>
</tr>
<tr>
<td>Infectious waste</td>
<td>Yellow</td>
<td>Infectious non-biological substances</td>
</tr>
<tr>
<td>Pharmaceutical waste</td>
<td>Black</td>
<td>Toxic substances</td>
</tr>
</tbody>
</table>

Appropriate containers with plastic bag liners should be placed at all locations where particular categories of waste are generated. Containers should be emptied when they are three-quarters full. Waste bags should be tightly sealed, either by tying the neck or by using a self-locking bag; waste bags should not be stapled. Replacement plastic bags should be available at all locations where waste is produced.

A specific separate area or room should be designated for storage of full waste bags. The storage area should be:

- Easy to clean and disinfect; and have a hard, impermeable floor;
- Have readily available cleaning supplies and protective clothing;
- Locked to prevent access by unauthorized persons;
- Inaccessible to animals, insects and birds;
- Protected from the sun; and
- Easily accessible to waste collection vehicles.

It is the responsibility of the clinic to dispose of waste in a safe manner. In most cases, this means contracting with a commercial waste-disposal service or making an arrangement with a nearby hospital facility. In either case, it is the responsibility of the clinic staff to know the disposal procedures of the commercial service or hospital and to use only those services that follow recommended procedures.

**Sharps Waste**

Sharps disposal containers are puncture and water-resistant impermeable containers. When used correctly, they reduce the risk of skin-puncture injuries that potentially can spread disease. Sharps disposal containers can be commercial or can be home-made of strong plastic or metal.

**Guidelines for Use of Sharps Containers**

- Do not recap syringes before disposal;
Place the syringes and needles in the sharps box immediately after use;
Keep the sharps container where the injections are given;
Do not overfill the sharps containers (maximum about ¾ full);
When ¾ of the container is full, then close and seal the container;
Store the container in a safe and secure location until ready for final disposal;
Do not empty and refill sharps boxes. Fill once and discard immediately; and
Place filled and sealed sharps disposal containers in disposal bags that are labeled or color-coded for highly infectious waste.

The used and unopened sharps containers should be sterilized by autoclaving, microwaving or incineration; and then buried encapsulated or disposed of in a secure landfill. An alternative strategy recommended by NACO is to chemically disinfect sharps in hypochlorite solution (see Annex K) before placing them in a puncture-proof container. Instruments should be used when transferring the sharps to the container; under no circumstances should a staff member attempt to transfer sharps by hand. The puncture-proof container should be sealed when it is three-quarters full and then buried, encapsulated, or disposed of in a secure landfill.

If a needle destroyer is used then, the needle remnants and syringes should be disposed of with other infectious waste as described in the following section. If a needle cutter is used then, the cut-off needles should be treated as sharps waste, i.e. that they should be sterilized and disposed off in the same way as uncut sharps.

Other Infectious Medical Waste
Infectious medical waste should be sterilized by autoclaving, microwaving, or incinerating, and then buried or disposed off in a secure landfill.

Pharmaceutical Waste
Improper disposal of pharmaceutical waste can result in contaminated water supplies and the use and resale of expired or inactive medicines, or improperly incinerated products, which can result in releasing toxic pollutants into the air. Small quantities of pharmaceutical waste can be incinerated (if < 1% of total waste), encapsulated, disposed off in a secure landfill, or buried.

Moderate quantities of liquid or semi-liquid pharmaceuticals, such as intravenous solutions, eye drops, cough syrups and vitamins may be diluted in a large flow of water and discharged into municipal sewers. It is not acceptable to dispose of even small quantities of pharmaceutical waste into slow-moving or stagnant water bodies. Antibiotics should never be disposed of in this fashion.
The following should be considered in selecting options for waste treatment and disposal at the clinic:

1. The quantities of waste produced daily in the clinic;
2. Availability of appropriate sites for waste treatment and disposal:
   - Space for pit burials;
   - Distance from water source, residential areas;
3. Presence of available legally recognized central facility for waste treatment within a reasonable distance; and
4. Availability of resources (human, financial and material).

An example of a waste disposal system within the clinic appears below:

* decontamination – soak in 0.5% Sodium hypochlorite (bleach) for at least 10 minutes

^ sanitary landfill – appropriate space, located away from agricultural, residential areas and ground and safer water sources, pit enclosed to prevent leakage

Note: Plastic waste should not be incinerated
Definitions of Waste Disposal Methods

**Burial pits:** The bottom of the pit should be at least 1.5 m above the groundwater level, 3–5 m deep, and lined with a substance of low permeability (e.g., clay). Surround the opening with a mound to keep runoff water from entering the hole, and build a fence around the area. Periodically, cover waste layers with 10–15 cm of soil.

**Encapsulation:** Cement-lined pits or high-density plastic containers or drums are filled to 75% capacity with healthcare waste. The container is then filled with plastic foam, sand, cement, or clay to immobilize the waste. The encapsulated waste is then disposed of in a landfill or left in place if the container is constructed in the ground.

*(Note: Burial pits and encapsulation are suitable only in locations without shallow groundwater and for small volumes of waste.)*

**Incineration:** Medium and high-temperature incineration devices require a capital investment and an operations and maintenance budget. They operate on fuel, wood, or other combustible material and produce solid ashes and gases. Pollutants are emitted to varying degrees. The ash is toxic and must be buried in a protected pit. Combustible waste is reduced to incombustible waste with a decreased volume. The high temperatures kill microorganisms. Medium-temperature incinerators, commonly a double chamber design or pyrolytic incinerator, operate at a medium-temperature combustion process (800°–1,000°C). High-temperature incinerators, recommended by WHO, treat healthcare waste at a temperature > 1,000°C. When operated by staff trained in correct use and maintenance, it completely destroys needles and syringes, kills microorganisms, reduces the volume of waste, and generates less air pollution than low-temperature burning.

*(Note: Incinerate pharmaceuticals only if absolutely necessary. Waste with high mercury or cadmium content, such as broken thermometers, used batteries, and lead-lined wooden panels, should not be incinerated.)*

**Low-temperature burning:** Burning devices that do not exceed 400°C include single-chamber brick hearths, drum burners and burning pits. They burn incompletely and do not fully destroy waste. They may not kill all microorganisms. Given these shortcomings, low-temperature burning should be used only as a short-term solution.

**Burn and bury:** Pit burning is a low-cost, but relatively ineffective, means of waste disposal. A fence should surround the pit to prevent children, animals, and others from coming into contact with the waste. The pit should be located to avoid walking paths (high-traffic areas). The fire, usually started with a petroleum-based fuel and allowed to burn, should be supervised by designated staff and located downwind of the facility and residential areas. The low-temperature fire emits pollutants, and the ash and remaining material should be covered with 10–15 cm of dirt.

**Other methods:** In addition to the common methods, other methods are used in some settings, including needle removal/needle destruction, melting syringes, steam sterilization (autoclaving and hydroclaving), and microwaving (with shredding).
Guidelines for Post-Exposure Prophylaxis
ANNEX - M

Guidelines for Post-Exposure Prophylaxis\textsuperscript{20}

This annex presents the guidelines for post-exposure prophylaxis (PEP).

1. **Objective**

   To describe the PEP process so that healthcare workers know how to manage the situation if there is contact with potentially infectious materials.

2. **PEP Procedure**

   Immediately following exposure:
   
   1. Wash the areas exposed to potentially infectious fluids with soap and water;
   2. Flush exposed mucous membranes with water. If saline is available, flush eyes with saline; and
   3. Do not apply caustic agents, including antiseptics or disinfectants, to the exposed areas.

3. **Inform Medical Officer and supervisor of the exposure as soon as possible.**

4. **Medical Officer to complete Health Facility Occupational Exposure Incident Report form:**

   a. Date and time of exposure;
   b. Exposure site(s);
   c. Where and how the exposure occurred;
   d. If a sharp object was involved, type and brand of device;
   e. Type and amount of fluid;
   f. Severity of exposure (e.g., depth of sharp puncture);
   g. Exposure source:
      
      – Infectious status, if known; and
      – If HIV-infected, stage of disease, viral load, history of antiretroviral therapy.
   h. Counseling and post-exposure management; and
   i. Details on exposed HCW:
      
      – Existing medical status; and
      – Hepatitis B vaccine status.

5. **Medical Officer will evaluate the exposure for potential transmission of HIV based on:**

   a. **Type and amount of body fluid/tissue:**
      
      – Blood;
      – Fluids containing blood;
      – Semen;
      – Vaginal secretions;
      – Cerebrospinal fluid;

\textsuperscript{20}Adapted from Antiretroviral Therapy Program, Impact Project, Family Health International, Arlington, VA, U.S.A.
Clinic Operational Guidelines and Standards (COGS)

- Synovial fluid;
- Pleural fluid;
- Peritoneal fluid;
- Pericardial fluid; and
- Amniotic fluid.

b. Type of exposure:
- Percutaneous injury;
- Mucous membrane exposure;
- Non-intact skin exposure; and
- Bites resulting in blood exposure.

c. Infectious status of source:
- Presence of HIV antibody;
- Presence of HBsAg; and
- Presence of HCV antibody.

d. Susceptibility of exposed person:
- Hepatitis B vaccine and response status; and
- HIV, HBV, and HCV immune status.

6. The exposed healthcare worker will be offered pre-HIV test counseling based on informed consent as well as ongoing counseling as desired.

7. The confidentiality of the exposed healthcare worker will be maintained.

8. If the HIV status of the source person is not known, the source person will be informed of the incident and consent obtained to perform HIV diagnostic testing.

- Testing to determine HIV infection should be performed as soon as possible; a rapid HIV-antibody test is recommended.
- Confidentiality of the source person will be maintained at all times.
- If the source person is HIV-negative, baseline testing or further follow-up of the exposed healthcare worker is not necessary.

9. If the source person refuses to be tested for HIV, treat as for unknown status (see 11 below).

10. The authorization of the Senior Administrator will also be sought in the case of a minor where a parent or guardian is not available.

11. If the source person or the HIV status of the source person is unknown, the exposure will be evaluated on the likelihood of high risk for infection, i.e. where and under what circumstances the exposure occurred. Take local epidemiological data for HIV infection rates into consideration.

12. Perform baseline HIV test on person who was exposed using rapid antibody test. Additional recommendations: full blood count; liver and renal function tests.
13. Determine if the exposure is low risk or high risk for HIV infection.

a. Low Risk:
   - Exposure to small volume of blood or fluid contaminated with blood from asymptomatic HIV-positive patient with low viral load;
   - Percutaneous exposure with a solid needle; and
   - Any superficial injury or muco-cutaneous exposure.

b. High Risk:
   - Exposure to large volume of blood or potentially infectious fluids;
   - Exposure to blood or blood-contaminated fluids from an HIV-infected patient with a high viral load;
   - Injury with a hollow needle;
   - Deep and extensive injuries; and
   - Confirmed ARV drug resistance in the source patient.

<table>
<thead>
<tr>
<th>Regimen for Risk Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Category</strong></td>
</tr>
<tr>
<td>Low</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>2 weeks</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>6 weeks</td>
</tr>
<tr>
<td>3 months</td>
</tr>
<tr>
<td>6 months</td>
</tr>
</tbody>
</table>
14. Start ARV medications within 1-2 hours of exposure if possible. If a delay occurs, initiate PEP regardless of the interval. Currently, there is no defined interval after which PEP is not effective.

15. Administer PEP for 28 days.

16. Perform recommended serology after exposure:

<table>
<thead>
<tr>
<th>2 Weeks</th>
<th>Full blood count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Liver and renal function tests</td>
</tr>
<tr>
<td>6 Weeks</td>
<td>HIV serology</td>
</tr>
<tr>
<td>3 months</td>
<td>HIV serology</td>
</tr>
<tr>
<td>6 months</td>
<td>HIV serology</td>
</tr>
</tbody>
</table>

17. Offer counseling to person who has been exposed to HIV infection:
   - Assure maintenance of confidentiality;
   - For healthcare workers, inform them of the probability of infection from accidental exposure (CDC statistics):
     - 0.3% from percutaneous injury from HIV-infected source; and
     - 0.03% from muco-cutaneous exposure from HIV-infected source.
   - Inform them of the benefits and possible adverse effects of ARV prophylaxis; and
   - Counsel them on prevention or abstinence with sexual partners until HIV infection has been ruled out.

18. Toxicity of ARVs:
   1. Adverse symptoms with ARVs, such as headache, nausea, and diarrhea, are common; and
   2. Management without changing the PEP regimen is recommended (e.g., prescribing analgesic, anti-motility, or anti-emetic agents).

19. Report the exposure to supervisor.
Incident Report
(Clinic name)

1. Name and position of exposed person: ________________________________

2. Date and time of exposure: ________________________________

3. Where and how exposure occurred (describe): (if sharp object was involved, describe type of device)
   ________________________________

4. Type and amount of fluid exposed to: ________________________________

5. Severity of exposure (e.g., depth of sharp puncture):
   ________________________________

6. Risk definition (circle one) 
   Low risk  High risk

7. For exposure source:
   a. HIV status: 
      Negative  Positive
      Unknown (test pending)  Unknown (refuses test)
   Date of test:
   Place of test:
   b. If HIV-infected, describe stage of disease, history of treatment:
   c. Hepatitis B status: 
      Vaccinated  History of or active Hepatitis B infection
      Unknown  Unknown (refuses test)
   Date of HBsAg test:
   Place of test:

8. For exposed healthcare worker:
   a. Current medical status: ________________________________
   b. HIV serostatus: ________________________________
   c. Hepatitis B vaccine status: ________________________________

9. Management and counseling of exposed person:
   a. Laboratory tests performed: ________________________________
   b. Medications: ________________________________
   c. Counseling given:  Yes  No

10. Exposure reported to: ________________________________

Name and position of reporting person: ________________________________
Signature: ________________________________
Date: ________________________________
Key Messages for Health Education and Counseling
Key Messages for Health Education and Counseling

Health education and counseling are closely linked, and it is possible for both activities to take place at the same time. The goal of educating and counseling patients with STIs is to enable them to make informed decisions about changing their sexual behavior. The STI consultation provides an opportunity not only to treat persons with an STI, but also to educate them about ways to prevent infections in the future. This is especially true when counseling sex workers with STIs.

Health Education

Health education is the provision of accurate and truthful information. The aim is to make the patient better informed, so that he/she can make an informed decisions about sexual behaviors and practices.

Health education messages should include information on the following:
- How the infection was acquired through unprotected sexual contact with an infected partner;
- Nature of the infection and possible complications;
- Treatment compliance-How to take the medication and the importance of completing the full course of treatment, even if the symptoms disappear or if the infection was asymptomatic;
- Abstinence from sexual activity or 100% use of condoms until cured;
- How to prevent becoming infected in the future;
- How to use a condom correctly;
- Importance of using condoms consistently with clients as well as with regular partners and boyfriends;
- Discussion with both female and male patients about how to access contraception (where appropriate);
- Partner referral and treatment of regular partners and boyfriends; and
- Importance of visiting the clinic for regular monthly follow-up examinations.

Following is an example of a partner referral card:

<table>
<thead>
<tr>
<th>Clinic Name and Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opening hours:</strong></td>
</tr>
<tr>
<td>Monday – Saturday: 1 pm to 9 pm</td>
</tr>
<tr>
<td>Sunday: closed</td>
</tr>
</tbody>
</table>

Date: __________  Referral code: ________

Adapted from Guidelines for the management of sexually transmitted infections in female sex workers. WHO Regional Office for the Western Pacific. July 2002.
Counseling

Counseling relates to issues of anxiety and coping with the infection or its consequences, biomedical as well as social. Counseling is intended to help the patient cope with anxiety and stress brought about by a positive diagnosis. The counseling process should also evaluate a person’s risk of STI transmission and explore preventive behavior for the future. Counseling should be provided by a trained counselor and the counseling should be kept confidential between the patient and the healthcare provider.

Individual counseling has a greater impact in motivating persons to change their sexual behavior than group counseling. Counseling is an important component in the management of STIs, especially the “incurable” STIs such as genital herpes and HIV infection. Patients with STIs may especially need counseling when dealing with such issues as:

- Informing regular partners and boyfriends;
- Coping with complications of infection;
- Coping with the incurable infections;
- Contraception and STI implications in pregnancy;
- Modifying sexual behavior; and
- Negotiating condom use.

It may not be possible for sex workers to inform their clients about attending STI facilities for care. However, sex workers should be counseled about the importance of their regular partners and boyfriends receiving treatment, even though a sex worker may find it difficult to inform his or her partner(s). A counselor may be able to help with this.

Sex workers with STIs can become fearful and depressed after learning of the potential complications of their illness. This is particularly true for those who have suffered repeatedly from STIs.

Counseling has proved helpful in changing people’s sexual behavior, particularly in encouraging those who are HIV negative to adopt safe sex practices so that they remain negative.

Sex workers and their clients should all be encouraged to use condoms 100 percent of the time. They should be made to realize that their lives depend on condom use. In addition to providing information and education to sex workers, projects should empower them to protect their health by increasing their control over their own lives and teaching them the skills to successfully negotiate condom use.

**Steps for a counselor when counseling a patient with STIs include the following:**

- Reassure your patient of confidentiality;
- Ask your patient if he/she has any signs or symptoms of STIs, about recent sexual activities, and what, if anything, has been done to treat the condition;

\[22\] Adapted from Counseling for STI/HIV prevention in sexual and reproductive health settings. International Planned Parenthood Federation.
Explain the findings and diagnosis and that the infection is passed through sexual intercourse;

Explain the nature and consequences of STIs;

Explain the treatment, name, and dosage of the medications, possible side effects of the drugs, and the importance of completing the full course of treatment; and

Explore with the patient the best way to tell his/her regular partners about the infection. If the patient is reluctant or worried about telling partners, explore alternatives, but do not push the patient into a potentially dangerous situation.

Help the patient develop a plan for reducing risk in the future:

Help the patient explore options for safer sex;

Explain that the patient can make a choice that suits them now and change it as circumstances or preferences change;

Review the sexual activities mentioned by the patients and discuss the levels of risk of these activities;

Explain to the patients how to make their preferred sexual activities safer;

Explore the good and bad points of each choice for safer sex in terms of STI/HIV prevention, enhancing relationships, partners’ preferences, and feasibility. Discuss the possible consequences of their choices; and

Help patients make their own decisions:

Help patients put their choices into practice by providing them with the necessary skills;

Promote and provide condoms;

Ask about the patient’s experience using condoms;

Provide information about condoms and demonstrate how to put on a condom;

If a patient has no experience using a condom, ask what he/she has heard about them, how they feel, and what the barriers are to using a condom; and

When you understand the client’s concerns, explore solutions.

Arrange for the follow-up visit to assess whether the patient has been correctly treated/cured and to provide additional support.

Voluntary Counseling and Testing

Voluntary counseling and testing (VCT) for HIV is cost-effective in facilitating behavior change, and it is an important entry point for HIV care and support. VCT increases patients’ perceptions of their vulnerability to HIV, promotes behavior change, and facilitates early referral for care and support, which benefits those who test positive as well as those who test negative.

The clinic should recognize the special conditions that pertain to promoting VCT to sex workers. Sex workers who take advantage of HIV counseling and testing services may experience negative psychological and social effects, either because they sought the services or because of their positive HIV status. Before referring sex workers for VCT, care and other support services should be available, confidentiality of testing should be ensured; and the stigma and legal status in which they work should be assessed. VCT should be perceived as beneficial to the entire community. The counselor should explain the advantages and disadvantages of HIV testing to the sex worker.

The advantages of taking an HIV test include:

- Knowledge of HIV status facilitates early referral for care and support. An HIV-positive patient can be closely monitored and given prophylaxis for opportunistic infections, when appropriate. If antiretroviral drugs are available, a patient can obtain treatment to enhance and prolong his/her life;
- If a patient or partner is not pregnant, HIV testing offers an opportunity to discuss contraceptive needs and pregnancy plans;
- If a patient or partner is pregnant, knowing her HIV status gives her an opportunity to pursue means to prevent transmission of HIV to the child;
- Knowledge of HIV status enables a patient to take precautions to help prevent transmission to sexual partners. Also, their partners can be tested to see if they need care;
- If more people take the HIV test and are open about their status, it will help normalize HIV and reduce stigma;
- Knowing one’s HIV status will stop people from worrying about their status and enable them to take positive actions, whatever the result; and
- For HIV-negative patients, knowing their HIV status can lead them to take appropriate HIV prevention measures and to reduce their risk behavior.

The disadvantages of taking an HIV test include:

- Testing can increase the risk of violence against sex workers;
- Testing can increase the possibility that sex workers will be stigmatized by community members and healthcare workers; and
- An HIV-positive result can increase levels of anxiety and have psychological implications.

Pre-Test Counseling

Pre-test counseling should be performed by trained staff and should involve the following.

Pre-Test Counseling in Avahan clinic as part of STI/HIV risk reduction counseling:

1. Determine the patient’s level of knowledge;
2. Provide information on HIV/STI and contraception (where relevant);
3. Conduct a personalized risk assessment;
4. Develop a personalized risk-reduction plan;
5. Demonstrate correct use of condom and emphasize consistent use;
6. Explain the STI-HIV test and discuss implications of the test results;
7. Help the client understand why the test is needed and make a decision about the test;
8. Assess the patient’s ability to cope;
9. Provide psychological and emotional support; and referrals as appropriate; and
10. Help the patient think about possible reactions to the test result and whom to inform.

**Post-Test Counseling**

Post-test counseling should be performed by trained staff and should involve the following:

**Ongoing Post-Test Counseling, if client informs counselor of results**

1. Review the patient’s risk of infection;
2. Develop a personalized risk-reduction plan;
3. Demonstrate correct use of condoms and emphasize consistent use;
4. Explain the test and clarify its meaning;
5. Explain the limitation of the HIV test results and caution the patients about potential misuse of results. (Negative results mean that the client is HIV-negative only so long as no new exposure to risk occurs); and
6. Provide psychological and emotional support; and referrals as appropriate.

**Post-Test Counseling**

1. Help patient understand and accept the test results.
2. Help patient make choices based on the results.

<table>
<thead>
<tr>
<th>Interpreting HIV Test:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative:</strong> No antibodies to HIV</td>
</tr>
<tr>
<td>Person is not infected with HIV</td>
</tr>
<tr>
<td>Person may be infected with HIV – window period</td>
</tr>
<tr>
<td><strong>Positive:</strong> Antibodies to HIV and person is infected with HIV</td>
</tr>
<tr>
<td><strong>Indeterminate:</strong></td>
</tr>
<tr>
<td>May be infected and in the process of developing antibodies</td>
</tr>
<tr>
<td>Antibodies in the blood that are similar to HIV antibodies</td>
</tr>
<tr>
<td>Repeat test after three months</td>
</tr>
</tbody>
</table>
Actions for counselors during post-test counseling:

Negative test results
1. Discuss the challenges of remaining negative;
2. Discuss and reinforce safer-sex practices; and
3. Influence to take positive outlook.

Actions for counselors during post-test counseling:
Positive test results
1. Help patient to maintain health by:
   - Encouraging patient to attend referral services for follow-up care and support
   - Emphasize to patient the need to seek immediate medical care when sick, even with minor illnesses;
   - Refer patient to tuberculosis screening if there are symptoms;
   - Refer patient to a peer support group;
   - Empower patient to disclose health condition to trusted family member(s), partner(s), and/or friend(s);
   - Prevent condition that will weaken immune system by promoting healthy lifestyle (e.g., eating nutritious food, maintaining ideal body weight, exercising, reducing stress, and avoiding alcohol and/or cigarette smoking);
   - Help prevent HIV-positive patient from transmitting virus to others;
   - Promote to the patient using safer sex practices with all partners and/or abstaining from sexual intercourse; and
   - If patient or patient’s partner is currently pregnant or considering becoming pregnant, discuss contraception and options to protect unborn child from becoming infected; if necessary refer patient to healthcare provider trained in family planning and preventing mother-to-child transmission.
2. Emphasize to HIV-positive patient that he/she must not donate blood, blood by-products, or organs for transplant.

Actions for counselors during post-test counseling:
Indeterminate test results
1. Explain to patient that an indeterminate result means that he/she may still be capable of transmitting the virus to others if he/she has the infection, or may still get infected if he/she does not use a condom;
Promote safer sex practices with all partners;
Emphasize ways to avoid transmission of HIV through blood by sharing personal items (e.g., toothbrushes, nippers, and razors);
Encourage patient to inform their partner(s) about the indeterminate test result and that he/she is awaiting confirmation after 3 months; and
Discuss contraception, pregnancy or plans for pregnancy with the STI/HIV-trained counselor and/or a healthcare provider.

2. Emphasize to patient not to donate blood, blood by-products, or organs for transplant.

How to handle clients who are unable to cope with a positive test result:
1. During the counseling session, encourage the client to express his/her feelings about the current situation and redirect the client’s attention to talk about his/her options at the moment;
2. Encourage the client to take advantage of existing social support systems; and
3. Refer the client to appropriate community and other government resources.

Record-Keeping
Maintaining the confidentiality of client VCT records is critical. Strategies to maintain confidentiality of client records include the following:

- Store all patient records in locked file;
- Return all client records to locked file immediately following VCT sessions;
- Use codes and unique identifiers rather than client names on blood specimens sent to laboratory for testing; and
- Place HIV test results in a locked cabinet.
Condom Education Guidelines
ANNEX - O
Condom Education Guidelines

Male Condoms and Prevention of STIs, including HIV

The surest way to avoid transmission of sexually transmitted infections (STIs), including HIV, is to abstain from sexual intercourse or to be in a long-term mutually monogamous relationship with a partner who has been tested and is known to be uninfected. For persons whose sexual behaviors place them at risk for STIs, correct and consistent use of the male latex condom can reduce the risk of transmission of STIs, including discharge, genital ulcer diseases, HIV, and the risk of unintended pregnancy.

However, no protective method is 100% effective and condom use cannot guarantee absolute protection against any STI or unintended pregnancy. Furthermore, condoms lubricated with spermicides may increase the risk of HIV transmission. To achieve the maximum protective effect of condoms, they must be used correctly and consistently. Incorrect use can lead to condom slippage or breakage, thus diminishing their protective effect. Inconsistent use (i.e., failure to use condoms with every act of intercourse) can lead to STI transmission or pregnancy because transmission and/or conception can occur with a single act of intercourse.

Studies have shown that latex condoms are highly effective in preventing HIV transmission when used consistently and correctly. These studies looked at uninfected people considered to be at very high risk of infection because they were involved in sexual relationships with HIV-infected people. The studies found that even with repeated sexual contact, 98-100% of the people who used latex condoms correctly and consistently did not become infected.

Detailed instructions on the correct use of male condoms follow. Condom use should be demonstrated to the patient using a penis model or banana.

Adapted from CDC materials by Family Health International, 16 April 2004.
Instructions for Use of Male Condom

1. Remove the condom from the package carefully, to avoid tearing.

2. Squeeze the air out of the tip of the condom.

3. Unroll the condom onto the erect penis.

4. After ejaculation, withdraw the penis from the vagina while the penis is still erect. Hold on to the rim of the condom while withdrawing to prevent it from slipping off and the semen spilling into the vagina.

5. Remove condom from penis, and tie a knot in it to prevent spills or leaks. Dispose of condom safely (where it cannot cause any hazard)

Female Condoms

Safety and Effectiveness

The effectiveness of the female condom for preventing pregnancy is similar to other barrier methods, such as the diaphragm and latex male condom (88% contraceptive effectiveness over six months for the female condom in the United States). If used correctly and consistently every time, the female condom is 95% effective.

The ability of the female condom to prevent the transmission of HIV and other sexual diseases is speculative, but promising. Laboratory studies have found that the female condom is impermeable to various STI organisms, including HIV. Only one study involving human use has been done to evaluate its STI prevention properties. Among 20 women with recurrent vaginal trichomoniasis, none of them experienced re-infections while using the device consistently and correctly.

According to the manufacturer, no allergic reactions have been reported. The female condom is a good option for the small number of people who are allergic to latex, the material used in most male condoms. However, the female condom should not be used by people who are sensitive to polyurethane or silicone.

Using the Female Condom

The female condom is a thin, soft polyurethane sheath with two flexible polyurethane rings. The inner ring is closed and helps with insertion and placement. The outer ring and about one inch of the sheath remains outside the vagina during use. Each condom is pre-lubricated with silicone and a container of water-based lubricant is supplied for those who prefer more lubrication. Because female condoms are made from polyurethane, they are not damaged by oil-based lubricants.

There is only one size of female condom, no fitting is required. The female condom is designed to fit most women.

Any sharp object, including fingernails, rings, or other jewelry, can rip or tear the female condom. The rip and tear rate in one study, however, was less than 1% of the female condoms used. The device can be used by pregnant and menstruating women.

In studies conducted over six years among diverse populations, many women reported that they liked the female condom and would recommend it to others. There were few complaints about insertion, and some women said it took more than one attempt to get used to inserting the condom. The most frequent complaints were that women were not liking the inner ring and the movement of the device during use.

Adapted from The female condom: Frequently asked questions Who can use it, how effective is it, does it prevent STDs? Network September 1995, 16 (no. 1).
How to Use a Female Condom

The female condom is a relatively new method and requires practice and patience. The woman should practice putting it in and removing it several times before using it for the first time during sexual intercourse. It is lubricated and is slippery, making it difficult to insert initially. However, it becomes easier and easier to insert with practice. It will become more comfortable with use for both, the female and her partner.

Step-by-step instructions for using a female condom:

- Open the package carefully; tear at the notch on the top right of the package. Do not use scissors or a knife to open it;
- Place yourself in a position that is comfortable for insertion (e.g., squat, raise one leg, or sit or lie down);
- Look at the condom and make sure it is lubricated. Condoms are pre-lubricated, if additional lubricant is needed then either water or oil-based lubricant may be used;
- While holding the sheath at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow. With the other hand, separate the outer lips of the vagina;
- Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place;
- Place the index finger on the inside of the condom, and push the inner ring up as far as it will go. Be sure the sheath is not twisted. The outer ring should remain on the outside of the vagina;
- The female condom is now in place and ready for use with the partner. When ready, gently guide the partner’s penis into the sheath’s opening with the hand to make sure that it enters properly; be sure that the penis is not entering on the side, between the sheath and the vaginal wall;
- Use enough lubricant so that the condom stays in place during sex. If the condom is pulled out or pushed in, there is not enough lubricant; add more to either the inside of the condom or the outside of the penis;
- To remove the condom, twist the outer ring to prevent leakage and gently pull the condom out. Try to pull it out before standing up. During use of a female condom, the partner does not have to pull out immediately after ejaculation, as he should when using a male condom. He can go soft inside and the female condom can be removed when the female is ready; and
- Wrap the condom in the package or in tissue, and throw it in the garbage. Do not put it into the toilet.

Instructions for Use of Female Condom

The female condom is a soft, loose-fitting sheath with a flexible polyurethane ring at each end. The inner ring at the closed end is inserted into the vagina. The outer ring at the open end remains outside the vagina during intercourse and covers outer genitalia.

1. Remove the female condom from the package, and rub it between two fingers to be sure the lubricant is evenly spread inside the sheath. If you need more lubrication, squeeze two drops of the extra lubricant included in the package into the condom sheath.

2. The closed end of the female condom will go inside your vagina. Squeeze the inner ring (closed end) between your thumb and middle finger. Insert the ring into your vagina.

3. Using your index finger, push the sheath all the way into your vagina as far as it will go. It is in the right place when you cannot feel it. Do not worry, it can’t go too far.

4. The ring at the open end of the female condom should stay outside your vagina and rest against your labia (the outer lip of the vagina). Be sure the condom is not twisted. Once you begin to engage in intercourse, you may have to guide the penis into the female condom. If you do not, be aware that the penis could enter the vagina outside of the condom’s sheath. If this happens, you will not be protected.

5. After intercourse you can safely remove the female condom at any time. If you are lying down, remove the condom before you stand to avoid spillage. Dispose off the female condom safely (where it cannot cause any hazard). Do not reuse it.

---

Information on Female Condoms and Men Who Have Sex with Men\(^{29}\)

Some men who have sex with men have problems or complaints about male condoms, which include ill-fitting condoms, reduction in sensitivity, putting them on interrupts spontaneity and that they split during sex. Female condoms have not yet been tested for use in anal sex, so men using the female condom for male-to-male sex do so at their own risk.

The female condom can be inserted into the rectum before anal sex. The outer ring ensures that the bag does not slide inside the anus, while the inner ring helps with insertion. The outer ring is fixed and the inner ring can be removed.

**How to Use Female Condoms for Anal Sex**

There are two ways to use a female condom for anal sex, one with the inner ring and one without the inner ring.

1. With the inner ring:
   - It takes practice to insert the female condom smoothly, and extra lubricant is required, even though it comes pre-lubricated. Put water-based or oil-based lubricant on the inside and outside of the condom;
   - Before inserting, pinch the inner ring in half from the outside to flatten it, then slide the ring into the anus;
   - When the ring is inside, slide the index finger inside to push the ring in farther;
   - Apply more lubricant to your partner’s penis just before he inserts it; and
   - Guide the penis to be sure that it goes inside the bag and not between the bag and the rectal wall.

2. Without the inner ring:
   - The female condom can be used as a baggy condom without the inner ring;
   - Remove the inner ring;
   - Place extra water-based or oil-based lubricant inside the condom. Extra lubricant helps the penis slide in and out and prevents the bag from clinging to the penis; and
   - Slide the condom over your partner’s penis just before intercourse.

To remove a female condom, twist the outer ring to keep the semen from leaking and then gently pull. During use of a female condom, the partner does not have to pull out immediately after ejaculation, as he should when using a male condom. He can go soft inside and the bag can be removed when the male partner is ready.

\(^{29}\)Adapted from: Bourne, C. *Clinical Guidelines for Sexual Health Care of Men Who Have Sex with Men in Asia*. IUSTI Asia Pacific, Bangkok, 2006.
Confidentiality Policy and Agreement
Confidentiality Policy

Every project clinic should have a written confidentiality policy. The confidentiality policy should be posted in a prominent place in the registration area. The policy should be read aloud to all new patients, and they should be given an opportunity to ask questions. The entire clinic staff should be familiar with all components of the policy.

Minimum components of a confidentiality policy are as follows:

1. Statement of confidentiality of information

   Sample statements:
   - All patient information will be kept confidential;
   - No patient information will be disclosed to staff or other persons who are not directly involved in the medical care and counseling of the patient; and
   - All patient records will be kept in a secure place and only clinic staff with direct patient responsibilities will have access to the records.

2. Use of data for monitoring and evaluation

   Sample statement:
   - Patient statistics, including medical and social information, will be collected for monitoring and evaluation purposes by the Avahan project. However, all personal identifying information will be removed except for the ID number. Persons outside the clinic who receive this information will not be able to associate the information with a particular individual.

3. Procedures for lodging complaints by patients for breach of confidentiality

   Sample statement:
   - If a patient feels that his/her confidentiality has been violated, complaints may be made to ________________________ (provide name of responsible individual). Complaints will be considered by a grievance committee composed of members of the community and the umbrella NGO.
Oath of Confidentiality

All project clinic staff members will be required to read and sign an oath of confidentiality. Signed oaths are to be kept in staff members’ personnel files. An example of an oath of confidentiality is presented below.

Oath of Confidentiality

I understand that, in the course of my duties in this service, I will come in contact with sensitive, personal information about patients attending this health facility. I understand that this information is highly confidential and pledge to protect the confidentiality of all patients attending the service. I will protect the confidentiality of patients by not discussing or disclosing any information about them to an unauthorized person, including the fact that they attended these services. Unauthorized persons may include, but are not limited to, my family, friends, co-workers and community leaders. I understand the potential social harm that may come to patients whose personal and medical information is disclosed to unauthorized persons. I understand that wilful disclosure of any information about any patient in this service could result in termination of my employment or result in legal action against me.

Signature of staff member: ____________________________

Witness: __________________________________________

Date: ____________________________
Forms for Monitoring and Reporting
ANNEX - Q

Forms for Monitoring and Reporting

Annex Q contains examples of the following forms:

1. Clinic Encounter Form;
2. Patient Register;
3. RPR/VDRL Register; and
### Clinic Encounter Form (to adapt)

<table>
<thead>
<tr>
<th>ID: __________</th>
<th>Date: ______ / ______ / _______</th>
<th>Sex:</th>
<th>Female</th>
<th>Male</th>
<th>Transgender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(dd/ mm/ yyyy)</td>
<td>Age:</td>
<td>_______ years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st STI visit?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referred by</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Peer educator/outreach worker (PE/ORW)</td>
<td></td>
</tr>
<tr>
<td>☐ Self</td>
<td></td>
</tr>
<tr>
<td>☐ Partner</td>
<td></td>
</tr>
<tr>
<td>☐ Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of clinic visit</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ STI Symptoms visit</td>
<td></td>
</tr>
<tr>
<td>☐ STI check-up visit</td>
<td></td>
</tr>
<tr>
<td>☐ STI follow-up visit</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptoms (as described by patient)</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration of symptoms (duration of the longest running symptom)</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________ days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examination findings</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Vaginal discharge</td>
<td></td>
</tr>
<tr>
<td>☐ Cervical discharge or very red cervix</td>
<td></td>
</tr>
<tr>
<td>☐ Genital ulcer</td>
<td></td>
</tr>
<tr>
<td>☐ Lower abdominal pain (female)</td>
<td></td>
</tr>
<tr>
<td>☐ Cervical motion tenderness</td>
<td></td>
</tr>
<tr>
<td>☐ Urethral discharge (male)</td>
<td></td>
</tr>
<tr>
<td>☐ Anorectal discharge</td>
<td></td>
</tr>
<tr>
<td>☐ None</td>
<td></td>
</tr>
<tr>
<td>☐ Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Syndrome diagnosis</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ VCD</td>
<td></td>
</tr>
<tr>
<td>☐ LAP</td>
<td></td>
</tr>
<tr>
<td>☐ ARD</td>
<td></td>
</tr>
<tr>
<td>☐ Asymptomatic only</td>
<td></td>
</tr>
<tr>
<td>☐ None</td>
<td></td>
</tr>
</tbody>
</table>
### Syndrome treatment
(Add color of packs)
- Rx1 (asympt., cervicitis, UD, ARD)
- Rx2 (vaginitis)
- Rx3 (GUD)
- Rx4 (herpes)
- Rx5 (PID)
- Rx6 (UD 2nd line)
- Other
- None

### Referrals
Tick all that apply
- Syphilis screening
- VCT
- Medical
- Other

### Laboratory tests
By lab in the clinic
Tick all that apply
- RPR/VDRL
- VCT
- Microscopy
  - Gram staining
  - Wet mounts
- Other

### Education/Counseling
- HIV/STI counseling
- Condoms demonstrated
- Condoms provided
- Partner treatment discussed
- IDU Harm Reduction discussed
- Abscess Management given

### Plan and Comments
Date for next visit

---

**Note:** Items in **bold underlined** should be ticked on register form
**Guideline for filling Client Encounter Form**

**General Instructions:**

This form is a sample form that can be used in project clinics, provider referral clinics or mobile clinics to document patients’ visits to the clinic. Partners can also continue using their current clinic forms, but please ensure that all the underlined information in the client encounter form is captured on the existing clinic formats. The name of the IP, NGO, Project and clinic name/ID number should be written at the top of every sheet. Partners should adapt the syndrome and treatment options to what is listed in their clinics.

<table>
<thead>
<tr>
<th>ID number</th>
<th>ID number of patient that is given during outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Date of visit to the clinic in the format dd/mm/yyyy</td>
</tr>
<tr>
<td>Sex</td>
<td>Circle the sex of the patient: Male, Female, or Transgender</td>
</tr>
<tr>
<td>Age</td>
<td>Write the age of the patient in years. If the individual’s age is not known, write the best estimate.</td>
</tr>
<tr>
<td>Referred by</td>
<td>Patients should be asked how they were referred to the clinic. Select one option on how the patient was referred to the clinic:</td>
</tr>
<tr>
<td></td>
<td>a. “Self”- if the individual came on their own</td>
</tr>
<tr>
<td></td>
<td>b. “PE/ORW”- if the individual was referred by an outreach worker or peer educator</td>
</tr>
<tr>
<td></td>
<td>c. “Partner” - patient knows or thinks partner has an STI and has come for treatment</td>
</tr>
<tr>
<td></td>
<td>d. “Other”- if the individual came to the clinic through a different means (e.g. referral from another clinic, referral by a friend, etc.)</td>
</tr>
<tr>
<td>First STI visit</td>
<td>Circle “Yes” if this is the individuals’ first visit to the clinic ever. [If the individual previously visited the clinic for general health services (non-STI), but this is the first time he/she is availing STI services (has STI symptoms, gets STI checkup without symptoms and/or receives asymptomatic treatment), this is still considered to be a first STI clinic visit.]</td>
</tr>
<tr>
<td>Type of clinic visit (tick only one box)</td>
<td>Determine the category of services provided during the visit:</td>
</tr>
<tr>
<td></td>
<td>a. “STI symptoms visit”– the individual complained of symptoms of STI and was treated accordingly.</td>
</tr>
</tbody>
</table>
b. “STI check-up” – the individual does not complain of STI symptoms but receives genital examination which may include speculum or proctoscope examination and/or STI treatment (based on symptoms and signs). If the individual came to the clinic for general health complaints and received genital examination which may include speculum or proctoscope examination and/or STI treatment, check this box.

c. “STI follow-up” – the individual returned to the clinic within two weeks of last treatment for a review by the doctor for their previous STI. This may happen for many reasons (e.g. symptoms not cleared, allergic to medicines, would like a review by the doctor, etc.). If the individual accesses the clinic more than two weeks after the last visit to the clinic, it should not be marked as a follow-up visit.

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Write the STI symptoms that the patient has, as described by the patient.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of symptoms</td>
<td>Record how long the patient has been having the current STI symptoms. If the individual has multiple symptoms, record the length, in days, of the longest running symptom.</td>
</tr>
<tr>
<td>Examination findings</td>
<td>Select all options that were found upon examination. Write notes if necessary. Note: If a speculum examination is done, the type of visit is an STI visit (symptoms, checkup, or follow-up).</td>
</tr>
<tr>
<td>Syndromic diagnosis</td>
<td>Select the STI diagnosis of the individual. If an individual has multiple STI, select all that apply. ONLY APPLIES TO STI SERVICES (STI symptom visit, STI checkup visit, and STI follow-up visit.)</td>
</tr>
<tr>
<td>a. “VCD”</td>
<td>Vaginal/cervical discharge: check if 1) woman with symptomatic vaginal discharge, 2) asymptomatic patient with vaginal discharge seen on examination or 3) cervical discharge seen on speculum examination.</td>
</tr>
<tr>
<td>b. “GUD”</td>
<td>Genital ulcer disease: check if female or male with genital or anorectal ulceration with or without blisters</td>
</tr>
<tr>
<td>c. “LAP”</td>
<td>Lower abdominal pain: check if patient has lower abdominal pain or tenderness or cervical motion tenderness</td>
</tr>
<tr>
<td>d. “UD”</td>
<td>Urethral discharge: check if male with urethral discharge with or without dysuria or other symptoms</td>
</tr>
<tr>
<td>e. “ARD”</td>
<td>Anorectal discharge: check if male with symptoms of tenesmus or if anorectal discharge seen on examination.</td>
</tr>
</tbody>
</table>
f. “Other” - Check for any other STI-related condition

g. “Asymptomatic only” - Check if asymptomatic treatment is being given without any other indication for it.

h. “None” - Check if no STI-related conditions and asymptomatic treatment has not been given

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Select all treatments that were given. ONLY APPLIES TO STI SERVICES (STI symptom visit, STI checkup visit, and STI follow-up visit.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. “Rx1”</td>
<td>Check if standard treatment given for cervicitis, urethritis, anorectal discharge, or asymptomatic treatment: treatment for gonococcal infection (cefixime 400 mg or ceftriaxone 250 mg, single dose) plus chlamydial infection (azithromycin 1 gram, single dose)</td>
</tr>
<tr>
<td>b. “Rx2”</td>
<td>Check if standard treatment given for vaginitis: treatment for trichomoniasis and/or bacterial vaginosis (metronidazole 2 grams or tinidazole 2 grams, single dose) plus treatment for candidiasis ( clotrimazole 500 mg, single dose or fluconazole 150 mg, single dose)</td>
</tr>
<tr>
<td>c. “Rx3”</td>
<td>Check if standard treatment given for genital ulcer disease: treatment for syphilis (benzathine penicillin 2.4 mg units, single dose) or doxycycline 100 mg, 2 x a day for 15 to 30 days) plus treatment for chancroid (azithromycin 1 gram, single dose or ciprofloxacin 500 mg, 2 x a day for 5 days)</td>
</tr>
<tr>
<td>d. “Rx4”</td>
<td>Check if standard treatment given for herpetic ulcers (acyclovir 400 mg, 3 x a day or 200 mg, 5 x a day for 7 days)</td>
</tr>
<tr>
<td>e. “Rx5”</td>
<td>Check if standard treatment given for PID (cefixime 400 mg, single dose or ceftriaxone 250 mg, single dose plus doxycycline 100 mg, 2 x a day for 14 days plus metronidazole 400 mg, 2 x a day for 14 days)</td>
</tr>
<tr>
<td>f. “Rx6”</td>
<td>Check if standard second-line treatment given for males with urethritis (metronidazole 2 grams, single dose)</td>
</tr>
</tbody>
</table>

| Referrals | If the patient was referred for lab tests or medical care, select all applicable referrals that were given. This applies to all types |
of patient visits (STI and general health).

- **“Syphilis screening”** - if the individual was referred for a syphilis test
- **“VCT”** - if the individual was referred to a voluntary counseling and testing facility
- **“Medical”** - if the individual was referred to another doctor, clinic or hospital for any other medical services (e.g. STI complication; and HIV care and support)
- **“Other”** - if the individual was referred to any other services (e.g. social services, legal services)

### Laboratory Tests

If tests are performed in a lab within the clinic, select all applicable tests that were given

- **“RPR/VDRL”** - if blood was drawn for a syphilis test. This applies to all types of patient visits (STI and general health)
- **“VCT”** - if voluntary counseling and testing for HIV/AIDS was done
- **“Other”** - if any other tests were done in the clinic laboratory

### Prevention Screening

Select, from the options below, other services that the patient was given. This applies to all types of patient visits (STI and general health)

- **“HIV/STI counseling”** - if the patient was given counseling related to HIV/AIDS or STI
- **“Condoms demonstrated”** - if a condom demonstration was done with the patient
- **“Condom provided”** - if the patient was given condoms by clinic staff
- **“Partner treatment discussed”** - if STI treatment for sex partners was discussed with the patient
- **“IDU harm reduction”** - for IDU’s, if the individual was given information on harm reduction related to drug use
- **“Abscess management given”** - for IDU’s if the individual was given treatment for abscesses during the clinic visit
<table>
<thead>
<tr>
<th>Clinic Operational Guidelines and Standards (COGS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention screening</strong></td>
</tr>
<tr>
<td>Management</td>
</tr>
<tr>
<td>Adolescence</td>
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<tr>
<td>IDU Harm Reduction</td>
</tr>
<tr>
<td>Parent Treatment</td>
</tr>
<tr>
<td>Condoms</td>
</tr>
<tr>
<td>HIV/STI Counselling</td>
</tr>
<tr>
<td><strong>Tests in the clinic</strong></td>
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<tr>
<td>Other</td>
</tr>
<tr>
<td>VCT</td>
</tr>
<tr>
<td>APR/VDRL</td>
</tr>
<tr>
<td><strong>Referrals</strong></td>
</tr>
<tr>
<td>Medical</td>
</tr>
<tr>
<td>VCT</td>
</tr>
<tr>
<td>Syphilis Screening</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Other</td>
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<tr>
<td>Rx5</td>
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<td>Rx4</td>
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<td>Rx3</td>
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<tr>
<td>Rx2</td>
</tr>
<tr>
<td>Rx1</td>
</tr>
<tr>
<td><strong>Primary Target Group Register for Visits to Clinic</strong></td>
</tr>
<tr>
<td>Syndromes</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Asymptomatic only</td>
</tr>
<tr>
<td>Other</td>
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<td>ABD</td>
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<td>ud</td>
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<tr>
<td>LAP</td>
</tr>
<tr>
<td>GUD</td>
</tr>
<tr>
<td>VCD</td>
</tr>
<tr>
<td><strong>Duration of symptoms</strong></td>
</tr>
<tr>
<td>&lt;2 weeks</td>
</tr>
<tr>
<td>8-14 days</td>
</tr>
<tr>
<td>3-7 days</td>
</tr>
<tr>
<td>≥2 days</td>
</tr>
<tr>
<td><strong>Type of visit</strong></td>
</tr>
<tr>
<td>STI Follow-up</td>
</tr>
<tr>
<td>STI Check-Up</td>
</tr>
<tr>
<td>STI Symptomatic</td>
</tr>
<tr>
<td>1st STI Visit</td>
</tr>
<tr>
<td><strong>Referred by</strong></td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Partner</td>
</tr>
<tr>
<td>Self</td>
</tr>
<tr>
<td>Peer/OW</td>
</tr>
<tr>
<td><strong>Demographics</strong> (complete all)</td>
</tr>
<tr>
<td>Date (dd/mm/yyyy)</td>
</tr>
<tr>
<td>ID No.</td>
</tr>
<tr>
<td>S.No.</td>
</tr>
</tbody>
</table>
Guidelines for filling Primary Target Group Register for Visits to Clinics

General Instructions:

This register is to assist in collection and reporting of data in the Avahan CMIS. Data from the individual patient forms that have been developed by Implementing Partners (IP) should be transferred to this register and then passed on to the person responsible for data entry. If partners operate multiple clinics or use referral clinics, separate registers should be maintained for each type of clinic. This register should only have information on sex workers (male, female, or transgender) that access the project clinics. Data from partner visits and IDU’s that are not sex workers should not be reported here. The Avahan core indicators are listed on this register; other information that NGOs collect will not be entered in the CMIS.

**ONLY RECORD CLINIC VISITS FOR SEX WORKERS RECEIVING STI SERVICES**

STI services include visits where:
- patients present with STI symptoms, and/or;
- speculum or proctoscope exam is carried out, and/or;
- asymptomatic treatment is given.

If the patient comes to the clinic for a general health complaint and undergoes an STI examination and/or STI treatment, it is considered to be an STI visit and this form should be filled out.

The name of the IP, NGO, Project and clinic name/ID number should be written at the top of every sheet. Depending on the frequency of filling the register (weekly, bi-monthly), data may run into several pages, therefore, the following numbering system should be used: “Current Page number”/ “Total page numbers this month” For example if this is the first page in a months’ register and there are a total of ten pages please fill in “Page 1/10”. Partners should adapt the syndrome and treatment options to what is listed in their clinics.

Before entering the information from this register into the CMIS, partners should always update the “Registration of Individuals” within the software; otherwise the software will not accept entries of new individuals. Age and sex of individuals is captured in the Registration of Individuals format.
<table>
<thead>
<tr>
<th>S.No</th>
<th>A running number that starts over at the beginning of each month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Enter the date of visit according to dd/mm/yyyy</td>
</tr>
<tr>
<td>ID number</td>
<td>Enter the ID number of the individual. The ID numbers are given in outreach.</td>
</tr>
<tr>
<td>Referred by</td>
<td>Who referred the patient to the clinic?</td>
</tr>
<tr>
<td></td>
<td>a. “PE/ORW” - the patient was referred by a peer educator or an outreach worker</td>
</tr>
<tr>
<td></td>
<td>b. “Self” - the patient came to the clinic on their own</td>
</tr>
<tr>
<td></td>
<td>c. “Partner” - patient knows or thinks partner has an STI and has come for treatment</td>
</tr>
<tr>
<td></td>
<td>d. “Other” - the patient came through other means, for example, referred by another clinic, referred by a friend, etc.</td>
</tr>
<tr>
<td>First STI visit</td>
<td>Circle “Yes” if this is the individuals’ first visit to the clinic ever. [If the individual previously visited the clinic for general health services (non-STI), but this is the first time he/she is availing STI services (has STI symptoms, gets STI checkup without symptoms and/or receives asymptomatic treatment), this is still considered to be a first STI clinic visit.]</td>
</tr>
<tr>
<td>Type of clinic visit (tick only one box)</td>
<td>Determine the category of services provided during the visit:</td>
</tr>
<tr>
<td></td>
<td>a. “STI symptoms visit” - the individual complained of symptoms of STI and was treated accordingly.</td>
</tr>
<tr>
<td></td>
<td>b. “STI check-up” - the individual does not complain of STI symptoms but receives genital examination which may include speculum or proctoscope examination and/or STI treatment (based on symptoms and signs). If the individual came to the clinic for general health complaints and received genital examination which may include speculum or proctoscope examination and/or STI treatment, check this box.</td>
</tr>
<tr>
<td></td>
<td>c. “STI follow-up” - the individual returned to the clinic within two weeks of last treatment for a review by the doctor for their previous STI. This may happen for many reasons (e.g. symptoms not cleared, allergic to medicines, would like a review by the doctor, etc.). If the individual accesses the</td>
</tr>
</tbody>
</table>
Clinic more than two weeks after the last visit to the clinic, it should not be marked as a follow-up visit.

| **Duration of symptoms** | Record how long the patient has been having the current STI symptoms. If the individual has multiple symptoms, record the length of the longest running symptoms according to the following breakdown:

| a. “<2 days” | the patient has had STI symptoms present for 0 - 2 days before accessing the clinic |
| b. “3 - 7 days” | the patient has had STI symptoms present for 3 - 7 days before accessing the clinic |
| c. “8 - 14 days” | the patient has had STI symptoms present for 8 – 14 days before accessing the clinic |
| d. “>2 weeks” | the patient has had STI symptoms for greater than 2 weeks |

| **Syndrome diagnosis** | Select the STI diagnosis of the individual. If an individual has multiple STI, select all that apply. ONLY APPLIES TO STI SERVICES (STI symptom visit, STI checkup visit, and STI follow-up visit).

| a. “VCD” | Vaginal/cervical discharge: check if 1) woman with symptomatic vaginal discharge, 2) asymptomatic patient with vaginal discharge seen on examination, 3) cervical discharge seen on speculum examination |
| b. “GUD” | Genital ulcer disease: check if female or male with genital or ano-rectal ulceration with or without blisters |
| c. “LAP” | Lower abdominal pain: check if patient has lower abdominal pain or tenderness, or cervical motion tenderness |
| d. “UD” | Urethral discharge: check if male with urethral discharge with or without dysuria or other symptoms |
| e. “ARD” | Ano-rectal discharge: check if male with symptoms of tenesmus or if ano-rectal discharge seen on exam |
| f. “Other” | Check if any other STI-related condition |
| g. “Asymptomatic only” | Check if asymptomatic treatment is being given without any sign or symptoms |
Clinic Operational Guidelines and Standards (COGS)

h. “None” - Check if no STI-related conditions and asymptomatic treatment is not being given.

<table>
<thead>
<tr>
<th>Syndromic Treatment</th>
<th>Select all treatments that were given. ONLY APPLIES TO STI SERVICES (STI symptom visit, STI checkup visit, and STI follow-up visit).</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. “Rx1”</td>
<td>- Check if standard treatment given for cervicitis, urethritis, anorectal discharge, or asymptomatic treatment: treatment for gonococcal infection (cefixime 400 mg or ceftriaxone 250 mg single dose) plus chlamydial infection (azithromycin 1 gram single dose)</td>
</tr>
<tr>
<td>b. “Rx2”</td>
<td>- Check if standard treatment given for vaginitis: treatment for trichomoniasis and/or bacterial vaginosis (metronidazole 2 grams or tinidazole 2 grams single dose) plus treatment for candidiasis ( clotrimazole 500 mg. single dose or fluconazole 150 mg. single dose)</td>
</tr>
<tr>
<td>c. “Rx3”</td>
<td>- Check if standard treatment given for genital ulcer disease: treatment for syphilis (benzathine penicillin 2.4 M units single dose or doxycycline 100 mg. 2 x a day for 15 to 30 days) plus treatment for chancroid (azithromycin 1 gram single dose or ciprofloxacin 500 mg. 2 x day for 5 days)</td>
</tr>
<tr>
<td>d. “Rx4”</td>
<td>- Check if standard treatment given for herpetic ulcers (acyclovir 400 mg. 3x a day or 200 mg 5 x a day for 7 days)</td>
</tr>
<tr>
<td>e. “Rx5”</td>
<td>- Check if standard treatment given for PID (cefixime 400 mg. single dose or ceftriaxone 250 mg. single dose plus doxycycline 100 mg. 2 x a day for 14 days plus metronidazole 400 mg. 2 x a day for 14 days)</td>
</tr>
<tr>
<td>f. “Rx6”</td>
<td>- Check if standard second-line treatment given for males with urethritis (metronidazole 2 grams single dose)</td>
</tr>
<tr>
<td>g. “Other”</td>
<td>- Treatment for STI was given but it did not follow the standard treatment options</td>
</tr>
<tr>
<td>h. “None”</td>
<td>- No treatment for STI was given</td>
</tr>
</tbody>
</table>

<p>| Referrals | If the patient was referred for lab tests or medical care outside of the clinic, select all applicable referrals that were given: This applies to all types of patient visits (STI and general health). |</p>
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Syphilis screening</strong></td>
<td>If the individual was referred for a syphilis test to another facility.</td>
</tr>
<tr>
<td><strong>VCT</strong></td>
<td>If the individual was referred to a voluntary counseling and testing facility.</td>
</tr>
<tr>
<td><strong>Medical</strong></td>
<td>If the individual was referred to another doctor, clinic, or hospital for any other medical services (e.g. STI complication, HIV care and support).</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>If the individual was referred to any other services (e.g. social services, legal services).</td>
</tr>
</tbody>
</table>

### Laboratory Tests

If tests are performed in a lab within the clinic, select all applicable tests that were given. This applies to all types of patient visits (STI and general health).

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RPR/VDRL</strong></td>
<td>Blood was drawn for a syphilis test.</td>
</tr>
<tr>
<td><strong>VCT</strong></td>
<td>Voluntary counseling and testing for HIV/AIDS was done.</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>Any other laboratory tests were done in the clinic laboratory.</td>
</tr>
</tbody>
</table>

### Prevention Screening

Select, from the options below, other services that the patient was given. This applies to all types of patient visits (STI and general health).

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV/STI counseling</strong></td>
<td>If the patient was given counseling related to HIV/AIDS or STI.</td>
</tr>
<tr>
<td><strong>Condoms</strong></td>
<td>The patient was given a condom demonstration and distribution by clinic staff.</td>
</tr>
<tr>
<td><strong>Partner treatment discussed</strong></td>
<td>If STI treatment for sex partners was discussed with the patient.</td>
</tr>
<tr>
<td><strong>IDU harm reduction</strong></td>
<td>For IDU’s, if the individual was given information on harm reduction related to drug use.</td>
</tr>
<tr>
<td><strong>Abscess management</strong></td>
<td>For IDU’s, if the individual was given treatment for abscesses during the clinic visit.</td>
</tr>
</tbody>
</table>
### RPR/VDRL Register (revise as necessary)

<table>
<thead>
<tr>
<th>Name of clinic</th>
<th>Name of organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>ID number</td>
</tr>
<tr>
<td>1</td>
<td></td>
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<tr>
<td>2</td>
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<td>3</td>
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<td>46</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td></td>
</tr>
</tbody>
</table>
### Monthly Summary Report (revise as necessary)

<table>
<thead>
<tr>
<th>Name of clinic</th>
<th>Name of organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Year</td>
</tr>
</tbody>
</table>

#### Total number of clinic visits:

<table>
<thead>
<tr>
<th>Sex workers</th>
<th>First clinic visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Others</td>
<td>Checkup</td>
</tr>
<tr>
<td></td>
<td>Symptoms</td>
</tr>
<tr>
<td></td>
<td>Partner referral</td>
</tr>
</tbody>
</table>

#### Syndromes diagnosed:

<table>
<thead>
<tr>
<th>VD</th>
<th>UD</th>
<th>Asymptomatic tx.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GUD</td>
<td>ARD</td>
<td></td>
</tr>
<tr>
<td>LAP</td>
<td>Other</td>
<td>None</td>
</tr>
</tbody>
</table>

#### Treatments given:

<table>
<thead>
<tr>
<th>Rx1</th>
<th>Rx4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rx2</td>
<td>Rx5</td>
</tr>
<tr>
<td>Rx3</td>
<td>Rx6</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

#### Number of laboratory tests performed:

<table>
<thead>
<tr>
<th>RPR/VDRL</th>
<th>Microscopy (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td># positive RPR/VDRL</td>
<td>Others (Specify)</td>
</tr>
<tr>
<td># confirmed positive (TPHA)</td>
<td></td>
</tr>
</tbody>
</table>

#### Number of condoms distributed:

A. Starting stock balance
B. Incoming stock during the month
C. Ending stock balance
D. Number of condoms distributed

\( A + B - C = D \)
### Clinic Referrals:

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis screening</td>
<td></td>
</tr>
<tr>
<td>TPHA</td>
<td></td>
</tr>
<tr>
<td>VCT</td>
<td></td>
</tr>
<tr>
<td>HIV care and support</td>
<td></td>
</tr>
<tr>
<td>Medical services</td>
<td></td>
</tr>
<tr>
<td>Other services</td>
<td></td>
</tr>
</tbody>
</table>

### Clinic Emergencies:

<table>
<thead>
<tr>
<th>Event</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaphylactic reactions</td>
<td></td>
</tr>
<tr>
<td>Work-related HIV exposures reported</td>
<td></td>
</tr>
<tr>
<td>PEP</td>
<td></td>
</tr>
</tbody>
</table>

### Changes in clinic staffing (new staff, staff leaving, promotions):


### Outreach coordination:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meetings held with outreach team and/or community</td>
<td></td>
</tr>
<tr>
<td>Complaints lodged against clinic</td>
<td></td>
</tr>
</tbody>
</table>

### Comments:


### Person completing form:

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Data collection</td>
<td>Clinic Services Level</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Clinic maintains register and sends copies of data sheets to NGO within 7 days after end of reporting month. Also sends outreach worker (ORW) contact sheets. Maintains original copies of records.</td>
<td></td>
</tr>
<tr>
<td>Report consolidation</td>
<td>NGO responsible for monitoring tracks reports and forwards to IP by day 14 of next month</td>
</tr>
<tr>
<td>Data entry</td>
<td>IP data management person enters data as it comes in and tracks reporting completeness. Informs NGO of late or missing data. Files reports and sends data file to FHI M&amp;E by day 21.</td>
</tr>
<tr>
<td>Data analysis and feedback</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- Job descriptions should specify data roles and responsibilities.
- Feedback on results (both reporting performance and STI trends) should always take place.
Referral and Network Development
ANNEX - R

Referral and Network Development

Patients of STI clinics often have other needs and may benefit from accessing additional and/or different services. It may not be possible for the clinic to address all the needs of the patient, but the clinic should have a resource referral system in place. Referrals are important to ensure a continuum of care by helping patients access all the relevant services available to address their medical, psychological, social, and legal needs.

Additional services for which a patient might need to be referred elsewhere include:

- Serologic syphilis screening, if a clinic does not have onsite laboratory facilities;
- Laboratory confirmatory testing for reactive serologic syphilis screening;
- Tertiary care, such as treatment for complicated STIs and treatment failures;
- Voluntary counseling and testing;
- HIV care and support;
- Special counseling services;
- Harm reduction services for sex workers who are injecting drug users; and
- Other social services, including legal services.

Clinic staff should be aware that there are limits to the services they can provide. These limitations should be explained clearly to the patients so that they do not feel rejected when the clinic cannot address a certain need. Clinic staff should refer patients to services that can address the clinic client’s highest priority needs and are appropriate, acceptable, and accessible to patients’ culture, language, gender, sexual orientation, and developmental level. As in the clinic, referral services should not be discriminatory and judgmental and should respect confidentiality and basic human rights. Also, the referral should be timely; clinic staff should know where to refer a patient for the least cost to the patient, the least amount of waiting time, and the minimum of delays. If possible someone should accompany a patient who is referred to a referral service.

Clinic staff should be aware of the health and social care services available in the area.

A referral directory should be developed and regularly updated to include the following:

- Name of organization
- Address
- Telephone number
- Name of key contact people
- Services offered by organization
- Hours of operations/timings
The referral directory should be compiled as a reference guide and be available to all staff in the clinic.

Referrals should be formalized by creating a referral agreement that should include:

- Defining the conditions to be referred, including ensuring confidentiality;
- Access mechanism;
- Communication mechanism; and
- Quality assurance.

Referral forms should be developed to document information about the service to which the client is being referred and the date and purpose of the referrals. All information should be provided and confidentiality maintained.

A system to track a referral from point of initiation to point of delivery and, as a feedback loop, from point of service delivery back to point of initiation should be established. A system of written feedback using the referral request form, documenting the status of service delivery and other pertinent information, should be developed. Maintaining confidentiality and returning the form back to the clinic should be considered important.

Examples of a referral agreement and referral forms are attached at the end of this annex.

A monthly report on referrals made and actions taken should be maintained.

An audit should be conducted to determine whether the changes have actually improved the system. These may include the following:

- Time it takes to make a referral;
- Clinic staff compliance with the referral agreement; and
- Patient feedback.
SAMPLE REFERRAL AGREEMENT

STI Clinic and Hospital XX

The following is a collaborative service agreement between the STI Clinic and Hospital XX

Core Service Agreements:

<table>
<thead>
<tr>
<th>STI Clinic will provide the following core services:</th>
<th>Hospital XX will provide the following core services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>◆ Syndromic case management of all symptomatic cases</td>
<td>◆ Management of complication of STI cases</td>
</tr>
<tr>
<td>◆ Monthly clinical screening of STI and asymptomatic treatment</td>
<td>◆ Management of treatment failures</td>
</tr>
<tr>
<td>◆ Health education and counseling</td>
<td>◆ Confirmatory testing of reactive RPR test</td>
</tr>
<tr>
<td></td>
<td>◆ VCT services, including pre- and post-test counseling and HIV testing. VCT services will provide a continuum of care services for HIV-positive cases to address the psychological, medical, social, and other needs of patients.</td>
</tr>
</tbody>
</table>

Access Agreements:

<table>
<thead>
<tr>
<th>STI Clinic will provide the following access:</th>
<th>Hospital XX will provide the following access:</th>
</tr>
</thead>
<tbody>
<tr>
<td>◆ Same-day access for any patient referred from Hospital XX</td>
<td>◆ Same-day access for any emergency referral from the STI Clinic</td>
</tr>
<tr>
<td>◆ Accompanied referral to Hospital XX</td>
<td>◆ TPHA test results released 1 day after submission of specimens</td>
</tr>
<tr>
<td></td>
<td>◆ HIV test result released on same day of specimen collection</td>
</tr>
<tr>
<td></td>
<td>◆ Physician will be available during clinic hours for emergency questions and, consultation and evaluation</td>
</tr>
</tbody>
</table>
Communication Agreements:
Clinic staff in the STI Clinic and Hospital XX will use the Referral Form (see attached) to communicate requests for services between clinics. Staff agree to respond as requested on the Referral Form.

Quality Assurance Agreements:
STI Clinic and Hospital XX will establish standard of care for the provision of on-demand health care for sex workers. Training and education processes will be developed based on these standards of care. Quality assurance measures will be maintained and monitored on these standards of care. Staff further agree to respect confidentiality and basic human rights of patients. Staff further agree to be non-judgmental and non-discriminatory.

Signature of Program Coordinator (STI Clinic)  
Signature of Hospital XX Director
Referral Form

Date: _______________________  Patient ID #: _______________________

To: _________________________  Address: ___________________________

____________________________________  Time: ___________

This is to refer the bearer of this letter for further management: ________________

____________________________________

Findings: ___________________________

____________________________________

Impression / Diagnosis: ___________________________

Referred by:

Name and Signature ___________________________

Organization and Contact Details ___________________________

______________________________

Referring Person’s Copy: To be returned to STI Clinic

Date: _______________________  Participant ID #: _______________________

Findings: ___________________________

____________________________________

Impression / Diagnosis: ___________________________

Action taken ___________________________

____________________________________

Name and Signature of the Physician

______________________________