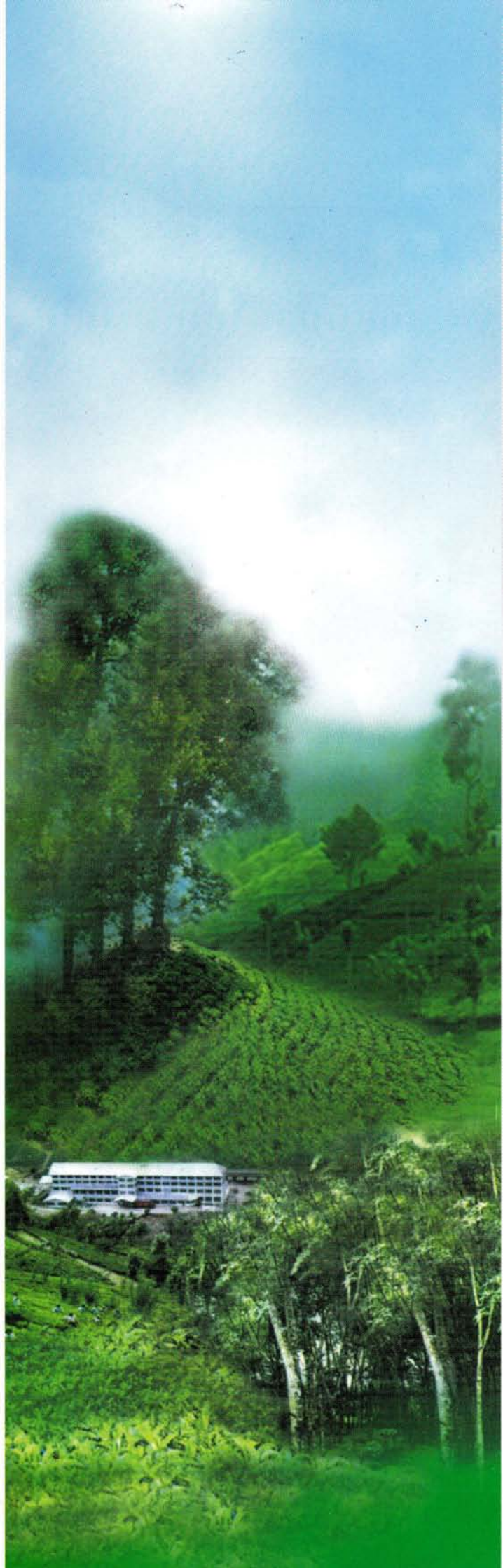
STM unit

MANAGEMENT OF SEXUALLY TRANSMITTED DISEASES IN THE PLANTATION SECTOR

A GUIDE TO IDENTIFY, TREAT AND REFER PATIENTS



National STD/AIDS Control Programme
Sri Lanka.

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

MANAGEMENT OF SEXUALLY TRANSMITTED DISEASES IN THE PLANTATION SECTOR

A Guide to identify, treat and refer patients

2nd Edition

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Message from the Director National STD/AIDS Control Programme

Nearly two decades after Sri Lanka reported its first case of HIV infection, it remains one of the few countries in the South-East Asia region with a low level HIV epidemic. The data collected in the first Behavioral Surveillance Survey (BSS) of October 2006 through March 2007, indicate relatively high levels of risk behavior amongst sex workers, men who have sex with men, drug users and prisoners. Hence the main focus of the national programme is on prevention of HIV among these most-at-risk populations (MARPs). However, certain conditions of high vulnerability are observed in the country. They include conflict situation, high mobility of the military, internally displaced persons (IDPs), separation of spouses due to overseas employment and plantation sector workforce with low access to health services.

Sri Lanka's plantation sector is comprised of about 300,000 workers and their families who live mainly in the central hilly areas and in remote areas of the country. Many of them are socially marginalized and have inadequate access to education, health and social services. Although the Sri Lankan government has placed a high priority on the development of the plantation industry and an export economy in order to revitalize the Sri Lankan economy, services for plantation residents and overall improvements to basic living conditions on plantations have lagged behind the government's support for the plantation industry.

The Demographic and Health Survey 2006/2007 observes that health and demographic indicators in the plantation sector are not in par with the national figures. This survey has shown that the knowledge about HIV/AIDS, its transmission and prevention is low in the plantation sector. To improve the status of plantation communities, the Sri Lankan government has implemented various projects in cooperation with many donors. In this backdrop the proposal submitted to the Global Fund for prevention of AIDS/Malaria/Tuberculosis (GFATM) by the National STD/AIDS Control Programme identified plantation workers as a target population. Behavior change communication, management of sexually transmitted infections (STI), voluntary counseling and testing for HIV infection were among the several interventions identified.

This guide will help medical staff of the plantation sector to identity STI, treat and refer patients as prevention and control of STI is one important strategy in preventing new HIV infections.

Director NSACP

About the Module.

The original World Health Organization (WHO) modules on syndromic management of STDs were modified by the National STD/AIDS control Programme to suit the plantation sector of Sri Lanka. The following resource persons held several consultative workshops to prepare the module. It was pre tested among the Estate Medical officers and Estate Medical Assistants and finalized.

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The first edition was published in 2004. Few modifications were made to the current edition.

Dr. S. Samarakoon
Consultant Venereologist / NSACP and Co-ordinator

Contents

MANAGEMENT OF SEXUALLY TRANSMITTED DISEASES IN THE PLANTATION SECTOR

A Guide to identify, treat and refer patients

Sexually transmitted diseases (STD) are a group of infections which are mainly transmitted through unprotected sexual intercourse with an infected person.

Other methods by which Sexually transmitted infections (STI) can be transmitted are :

- Transfusions or other contact with contaminated blood or blood-products (syphilis, human immunodeficiency virus infection -HIV, hepatitis B virus infection)
- From an infected untreated mother-to-child. This can take place
  - While in utero across the placenta (HIV and syphilis),
  - At delivery (gonorrhoea, chlamydia, herpes simplex virus infection -HSV, hepatitis B virus infection and HIV)
  - After birth particularly through breast milk (HIV)

Today the spectrum of infections has widened from the commonly known syphilis, gonorrhoea and genital herpes infections to include more than 20 bacterial, viral, fungal and protozoan infections. Most bacterial, fungal and protozoan infections can be cured with anti microbial agents whereas most viral infections cannot be cured.

Failure to diagnose and treat STD adequately and correctly at an early stage results in serious complications in men, women & children. Disproportionately these complications affect the health and social well being of women and their offspring. Some of them include infertility in women (failure to conceive due to blockage of fallopian tubes), infertility in men (blockage of spermatic cord) , acute and chronic pelvic pain, foetal wastage, intra uterine growth retardation, congenital abnormality, neonatal infection and cancer.

The incidence of acute STD is increasing in the South Asian countries. The epidemic of the Human Immunodeficiency Virus (HIV) which causes Acquired Immuno Deficiency Syndrome (AIDS), has now brought the control of STD into sharper focus, particularly because it is established that sexually transmitted infections especially those causing genital ulceration greatly increase the risk of HIV transmission. Thus the correct management of sexually transmitted diseases is a major strategy for HIV/AIDS prevention.

In Sri Lanka the traditional approach to the management of STD has been on a basis of identifying causal organisms, where the clinical findings are supported with laboratory tests. However, these facilities may not be easily available in many institutions. In addition, delays inherent in the reporting of test results hinder the timely treatment of patients. Moreover, delays in treatment may result in loss of follow up of a significant proportion of clients who continue to be infectious. Most plantation workers use the health care services provided by the plantation authorities for various illnesses. Therefore, if patients present with sexually transmitted infections, this would be an opportunity to identify such patients, provide treatment for certain selected STDs as instructed in this book and refer others to the appropriate level.

The numerous different ST infections produce a small number of presentations. They can be grouped into 7 categories.

1. Genital ulceration : due to syphilis, herpes, chancroid, lymphogranuloma venereum, granuloma inguinale,
2. Urethral discharge: due to gonorrhoea, chlamydia infection
3. Vaginal discharge : due to gonorrhoea, chlamydia, trichomonas, candida and bacterial vaginosis
4. Lower abdominal pain: due to gonorrhoea, chlamydia infection
5. Scrotal swelling: due to gonorrhoea, chlamydia infection
6. Swelling of the groin: due to chancroid, lymphogranuloma venereum,
7. Conjunctivitis with purulent discharge in newborns of mothers infected with certain STIs (gonorrhoea and chlamydia)

This book helps you to identify the common patterns of signs and symptoms of STIs on clinical grounds after a history is taken and a basic clinical examination is carried out.

If you have identified that a STD is present, it is best that this patient is referred to the nearest STD clinic. In the STD clinic, laboratory tests are available to confirm the clinical diagnosis. In addition, investigating for the presence of other STIs, counselling, blood tests for syphilis and voluntary testing for HIV are other services available in these specialized clinics. All STD patients should be encouraged to have a HIV test. This is done after pre test counselling and this service is available in STD clinics.

Yet, even the patients who are referred may not seek treatment at STD clinics due to the stigma attached to such illnesses. Very often they prefer to attend private clinics other than specialized STD clinics. Therefore, if the patient is unable to attend a STD clinic or if you feel that the patient will evade attending a STD clinic despite your advice, this book will also provide knowledge and skills for you to provide education on risk reduction, condom provision, counselling and contact tracing.

What you need to do is to:

- Identify into which category the patient's presenting signs and symptoms fall and use the appropriate flow chart. It will guide you how to manage the STI. (Remember all information provided by patients should be kept confidential).

<u>This book will enable you to :</u>

1. Understand the factors that influence transmission, STD burden
2. Develop skills in history taking and examination
3. Arrive at a diagnosis and provide treatment when necessary using flow charts, when to refer to a STD clinic, how patients should be followed up
4. Gather knowledge and skills on education on safer sex, including condom promotion and provision
5. Understand the importance and approaches of partner management, and data gathering

TRANSMISSION OF STI

HOW ARE STIs TRANSMITTED

The main mode of transmission of STI is through

- Unprotected penetrative sexual intercourse (vaginal, anal or oral) with an infected partner. Other modes of transmission include:
- Mother-to-child: during pregnancy (HIV and syphilis), at delivery (gonorrhoea, chlamydia, herpes simplex virus (HSV), hepatitis B virus and HIV) or after birth (HIV, hepatitis B)
- Transfusions or other contact with blood or blood-products (syphilis, HIV, hepatitis B)

THE FACTORS THAT INFLUENCE TRANSMISSION

- **Social factors**
  Perhaps the most important ones include:

  - Lack of knowledge of safer sex
  - Lack of access to affordable cndoms
  - Dislike of condoms
  - Cultural and religious reasons
  - The fact that sexual practices are deeply rooted in the everyday life of people and their communities
  - Inability to negotiate for safer sex

- **Biological factors**
  Certain biological factors also increase transmission of STI.

  Age
  The nature of the vaginal mucosa and cervical tissue in young women makes them very susceptible to infection. Young women are especially at risk in cultures where they marry or become sexually active during their early teenage years.

  Gender
  STD are primarily transmitted to women through vaginal intercourse. It is easier for a woman to be infected by a man than for a man to be infected by a woman in this way. This is because women have a larger surface exposed (i.e. the vagina) during penetrative sex.

  Circumcision (surgical removal of the foreskin of penis)
  Circumcised men are less likely to get an STI than uncircumcised men.

- **Behavioural factors:**
  - A recent change of partner;

- Having more than one sexual partner;
- Having a partner who has other partners;
- Having sex with casual partners, commercial sex workers or their clients, men who have sex with men , partners whose other contacts are not known and whose status in terms of STD is not known;
- Continuing to have sex when symptoms are present;
- Persons with STD, not informing sexual partners that they need treatment;
- Substance abuse (alcohol, heroin etc.);
- Treatment seeking pattern.

- **Delay in getting treatment for STDs**

To name just a few reasons why people may fail to get early treatment:

- Persons with STD often have no symptoms (asymptomatic)

> - 70% of women and 50% of men infected with chlamydia may not have symptoms:
> - Up to 80% of women and 10% of men infected with gonorrhoea may also not have symptoms

- Appropriate health facilities may not be available or affordable;
- Health facilities do not have the necessary drugs;
- Initially people may prefer to try alternative health sources such as indigenous treatment;
- The stigma so often attached to STD may lead people to hide what they feel is shameful, and so avoid seeking treatment unless the level of pain overrides their resistance;
- Self medication

- Not taking the full, prescribed course of treatment for STD

Effective treatment is only possible if patients take the full, prescribed course of treatment. Patients may fail to do this for a variety of reasons including the cost of treatment, lack of health education, conviction that the treatment taken so far will work, or low opinion of the health clinic's service

- Failure to bring in sexual partners for treatment

Stigma may also affect a patient's readiness to inform his or her partner and the partner's readiness to accept treatment

Who is affected?

STDs including HIV infection are widespread throughout the world. They affect sexually active people so STD occurs in both males and females. However, statistics rarely show an equal distribution between men and women, nor do they show an equal distribution between different age groups.

Distribution of STD by age and sex

Most children below 14 years of age are free from STD infection, other than for congenital syphilis, ophthalmia neonatorum and HIV infection.

Between the ages of 14 and 19 years, cases occur more commonly among females. This is due to several factors: -

- The start of sexual activity is usually earlier for girls than for boys;
- Girls have sex with older partners, who are more experienced and also more likely to carry infections (this situation is commonly seen in African countries);
- Biological vulnerability of young girls - due to characteristics of the genital tract of young girls they are especially vulnerable to infection with STD.

Global figures show that for both males and females, rates of STD tend to be highest in the 15-29 age group, decreasing in later ages.

Most large studies show that, after the age of 19, cases occur more or less equally in both sexes. However, there is usually a slight male preponderance. Why? There are several possible reasons, some perhaps more obvious than others:

- Sexually transmissible infections often produce no symptoms or only mild symptoms in women. Therefore fewer women come forward for treatment - and they fail to appear in statistics;
- Services in general may be more accessible to men than women. For example, where men migrate to urban areas for employment, they have access to the urban services – and therefore are more likely to appear in statistics;
- As we have discussed before, cultural and economic constraints might also prevent a proportion of women from attending for treatment;
- A large number of men might be infected after practicing unsafe sex with a small number of sex workers;
- Older men may be more sexually active than women of the same age;
- Men are more likely to change partners than women.

In many developing countries, the best available indicators of STD levels in women are surveys carried out at antenatal, family planning, or gynaecological clinics. They show a high prevalence of STD among the women attending these clinics.

Vulnerable Groups

In most communities there are certain people who may be particularly vulnerable to STD. These people vary from community to community but may include:

- Teenagers who are sexually active;
- Women who have several partners 'in order to make ends meet';
- Commercial sex workers and their clients;
- Men and women whose jobs force them to be away from their families or regular sexual partners for long periods of time (within and out of the country)

- Children without parental supervision
- Men who have sex with men

For various reasons these people may seldom come to health facilities for treatment when they have a STD, and special efforts often need to be made to reach them.

SERIOUS COMPLICATIONS THAT CAN ARISE FROM UNTREATED STD

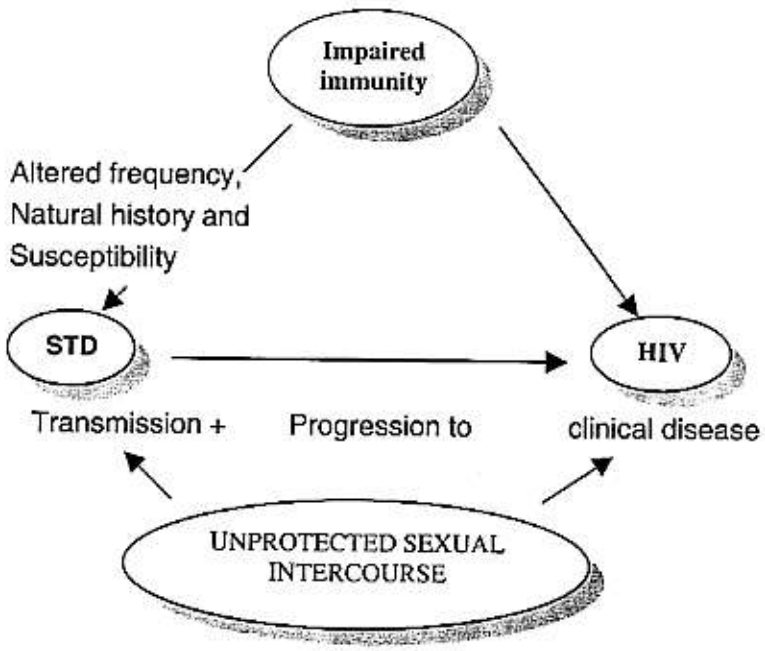
STD can be devastating. In women they can be fatal. Complications include:

- Chronic abdominal pain
- Infertility in women & men
- Potentially blinding eye infections or pneumonia in infants
- Death due to sepsis, ectopic pregnancy and cervical cancer
- Spontaneous abortion
- Urethral stricture in men (narrowed part of the urinary passage)
- Transmission of HIV infection
- There may be social consequences as well. For example, when a husband learns that his wife has STD, the result can sometimes include battering or divorce. Husbands may abandon infertile wives.

THE LINK BETWEEN STD & HIV

Other sexually transmitted diseases make it easier for HIV to pass from one person to another. **Chancroid, syphilis, herpes, chlamydia, gonorrhoea, and trichomoniasis** may increase the risk of HIV transmission **2 to 9 times.** The link between HIV-infection and other STD may partly explain why HIV has spread so rapidly in Africa compared to Europe and the US; where STD are more often treated and cured.

So we can develop the diagram above to show this two-way link between HIV and STD:



HISTORY TAKING AND EXAMINATION

Welcome and Registration:
At the initial visit the patient should be registered. Open a file for each patient. The files should be kept in a locked cupboard.

To increase service coverage health education material should be distributed among estate workers informing the availability of these services. The services of the area Public Health Nurses and Public Health Inspectors and of the estate health staff (midwife, plantation family welfare officers) should also be utilized. Since there is stigma attached to STIs health workers should be courteous and caring. Such positive attitudes greatly influence the acceptability and utilization of services provided.

History taking
Patient should be assured that all information provided would be **confidential.** History taking should be done in a place where there is **privacy.** When taking the history of a STD patient, we need to gather information about four areas:

1. General details about the patient - Socio-demographic data (age, sex, marital status, occupation category)
2. The patient's present illness
3. His or her medical history
4. His or her sexual history - Behavioral data

By taking a proper history we learn the patient's symptoms and identify any signs by examining them. Signs and symptoms enable us to decide which flow chart to use and treat the patient appropriately.

It is important to understand from the start that, even if you have a good deal of experience in interviewing patients, interviewing someone with symptoms of a STD is unique. It is unique because these symptoms occur in the genital area causing the patient some degree of embarrassment. Adopt a polite, friendly and non-judgmental attitude that would encourage the client to develop confidence or trust in you. In order to make an accurate diagnosis it may be necessary to ask several questions. Gather information to help you make a correct diagnosis.

Establishing a good rapport with the patient

Develop good communication skills. They are

- Non-verbal skills: how we behave towards the patient
- Verbal skills: the way we talk to the patient and ask questions

Non-verbal skills in history taking

The key to effective non-verbal behaviour is to treat the patient with respect, and give him or her your full attention.

1. ***Provide the patient with privacy.*** Clearly, privacy and confidentiality are essential, so the interview must take place somewhere quiet where you won't be disturbed;

2. ***Establish eye contact with the patient.*** Look directly at him or her. In this way, you can watch for key feelings that will help you to respond appropriately. The only time to avoid eye contact is when a patient seems very angry, since a direct gaze could be interpreted as aggressive;

3. ***Listen carefully to what the patient says.*** Show that you are listening by leaning forward slightly towards the patient. Nod your head or comment occasionally to encourage them. Don't fidget or write while the patient is talking, and don't interrupt him or her;

4. ***Sit if the patient is sitting*** and stand when the patient stands. Stay as close to the patient as is culturally acceptable. It is much better to be beside a table or desk than be behind one!

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

Verbal Skills in History-taking

Use 'open' and 'closed' questions effectively during the interview.

'Open' and 'closed' questions

When talking to anyone, there are broadly two sorts of questions we can ask:
- 'Closed' questions
- 'Open' questions

Closed questions are ones that ask a patient to answer in one word or a short phrase, often with "yes" or "no": -

"Is the swelling painful?"
"Is your period late?"
"Do you have a regular partner?"
"What is your age?"
"Where do you live?":

Open questions enable the patient to give a longer reply: -

"What is troubling you?'
"What kind of medicines are you taking at the moment?"

Open-ended questions allow the patient to explain what is wrong or how they feel in their own words, and to tell you everything they think is important. Closed questions, on the other hand, ask the patient to answer a precise question in the service provider's words.

How can we best use the two types of questions? Patients often have trouble revealing information about their own sexuality, so open questions will help them to be more comfortable when you begin the questions. Generally, you will also gather much more information from one open question than you can from a closed one.

History-taking information	
1. GENERAL DETAILS ▪ Name ▪ Marital status ▪ Address ▪ Employed / unemployed	Age sex Type of Employment
2. PRESENT ILLNESS ▪ Presenting complaints and duration	
MEN: ▪ If a urethral discharge – ▪ If scrotal swelling –	 *Pain while passing urine? Frequency ?* *History of trauma? Is there painful swelling?*
WOMEN: ▪ If a vaginal discharge - ▪ Lower abdominal pain – ▪ Menstrual history ▪ Obstetric history and contraceptive history	*Pain while passing urine? Frequency?* *Vaginal bleeding or discharge? Painful or difficult pregnancy or childbirth?* *Painful or difficult or irregular menstruation?* *Missed or overdue period?*
MEN AND WOMEN: ▪ If a genital ulcer – ▪ If an inguinal swelling ▪ Other symptoms, such as itching or discomfort	*Is it painful? Recurrent? Appearance? Spontaneous onset?* *Is it painful? Associated with genital ulcer? Swelling elsewhere in the body?*
3. MEDICAL HISTORY ▪ Any past STD – ▪ Other illness – ▪ Medications ▪ Drug allergies	*Type? Date? Any treatment and response? Results of tests?* *Type? Dates? Any treatment and response? Results of tests?*
4. SEXUAL HISTORY ▪ Currently sexually active ▪ New partner in the last 3 months ▪ Partner symptomatic ▪ Patient having sex with more than one partner ▪ Spouse returning after a long stay away	

Examination

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 the examination with professionalism and confidence, devoid of shyness and embarrassment

- Provide privacy and confidentiality
- General physical examination.
- Genital examination - Ensure that there is adequate exposure of the genital area for making a thorough examination. Even if pressed for time, do not rush the examination. If the patient shows any reluctance, take time to explain why an examination is necessary
- Have a female assistant when examining a female patient
- Ensure that universal precautions are observed in the clinic. Ensure adequate stocks of gloves, swabs, gauze, bed sheets, disinfectants and other material are available. All material used should be sterile or disposable. After use, all reusable gloves and other equipment should be sterilized and the soft waste, such as swabs, gauze and disposable gloves should be suitably disposed of
- Explain to the patient in detail what you are going to do.

Examining male patients for STD

General physical examination – examine the mouth for the presence of ulcers, lumps, observe for any generalized skin rashes, palpate for enlarged generalized lymph nodes

1. Genital examination - Ask the patient to remove his clothing from the waist down and then lie on the examination couch.
2. Examine penis, noting any rashes or sores. Then ask the patient to retract the foreskin if present, and look at the:
   * glans penis *urethral opening
3. Palpate the inguinal region in order to detect the presence or absence of enlarged lymph nodes and swellings
4. Palpate the scrotum, feeling for individual parts of the anatomy:
   * Testes * Spermatic cord * epididymis
5. Examine perineum and anus
6. Record the presence or absence of:
   * Ulcers * Urethral discharge (noting the colour and amount)
   * Warts * Swellings in the genital area / groin

Examining female patients for STD

1. General physical examination – examine the mouth for the presence of ulcers, lumps, observe for any generalized skin rashes, palpate for enlarge generalized lymph nodes.
2. Genital examination - Ask the patient to remove her clothing from the waist down and then lie on the examination couch. In order to save her embarrassment, use a sheet to cover the parts of the body that you are not examining.
3. Ask the patient to bend her knees and separate her legs, then examine the vulva, anus and perineum. Always examine in the presence of a female attendant with the patient's consent.
4. Palpate the inguinal region in order to detect the presence or absence of enlarged lymph nodes and buboes
5. Palpate the abdomen for pelvic masses and tenderness, taking great care not to hurt the patient
6. Record the presence or absence of:

   - Ulcers / blisters - warts - swelling
   - Vaginal discharge (noting the type, colour, amount and odour)

Common Presentations of STDs

	Presentation	Symptoms	Signs	Most common disease
1)	Vaginal discharge	Vaginal discharge Vaginal itching Dysuria (pain on urination) Pain during sexual intercourse	Vaginal discharge	VAGINITIS: - Trichomoniasis - Candidiasis - Bacterial vaginosis CERVICITIS: - Gonorrhoea - Chlamydia
2)	Urethral discharge	Urethral discharge Dysuria Frequent urination	Urethral discharge (if necessary ask patient to milk urethra)	Gonorrhoea Chlamydia
3)	Genital ulcer	Genital sore	Genital ulcer Enlarged inguinal lymph nodes	Syphilis Chancroid Genital herpes
4)	Lower abdominal pain	Lower abdominal pain and pain during sexual intercourse	Vaginal discharge Lower abdominal tenderness on palpation Temperature 38°C or >	Gonorrhoea Chlamydia Mixed anaerobes
5)	Scrotal swelling	Scrotal pain and swelling	Scrotal swelling	Gonorrhoea Chlamydia
6)	Inguinal bubo	Painful enlarged inguinal lymph nodes	Swollen lymph nodes Fluctuation Abscesses or fistulae	Lymphogranuloma Venereum (LGV) / Chancroid
7)	Ophthalmia neonatorum	Swollen eyelids Eye discharge Baby cannot open eyes	Oedema of the eyelids Purulent discharge	Gonorrhoea Chlamydia

URETHRAL DISCHARGE

The patient complains of having noticed a discharge from the penis. He may/may not complain of dysuria. He should be examined for evidence of urethral discharge. If none is seen the urethra should be gently massaged along the ventral aspect of the penis towards the urethral opening, this will help to express the pus from the urethra. These signs and symptoms together will help you to make a diagnosis of urethral discharge.

Urethral discharge is caused, most of the time, by

Gonorrhoea and
Chlamydia infection so treatment should be for ***both*** these causes.

Treating a patient presenting with an urethral discharge correctly is important as :

- Both gonorrhea and chlamydia infection are common
- Dual infection can occur (both these infections could be present at the same time)
- Both these infections can cause complications
- Both can facilitate the transmission and getting infection of HIV.

Therefore it is essential that we treat the patient for both of these conditions.

There are other causes of urethral discharge such as infection with *Trichomonas vaginalis.* Should the patient be treated for these causes as well? Treatment is not urgent because it does not lead to devastating complications.

Urethral Discharge
Recommended Therapy

Treatment for Gonococcal urethritis

- **Cefuroxime Axetil** 1g + **Probenecid** 1 g in a single oral dose

Treatment for Chlamydia Urethritis

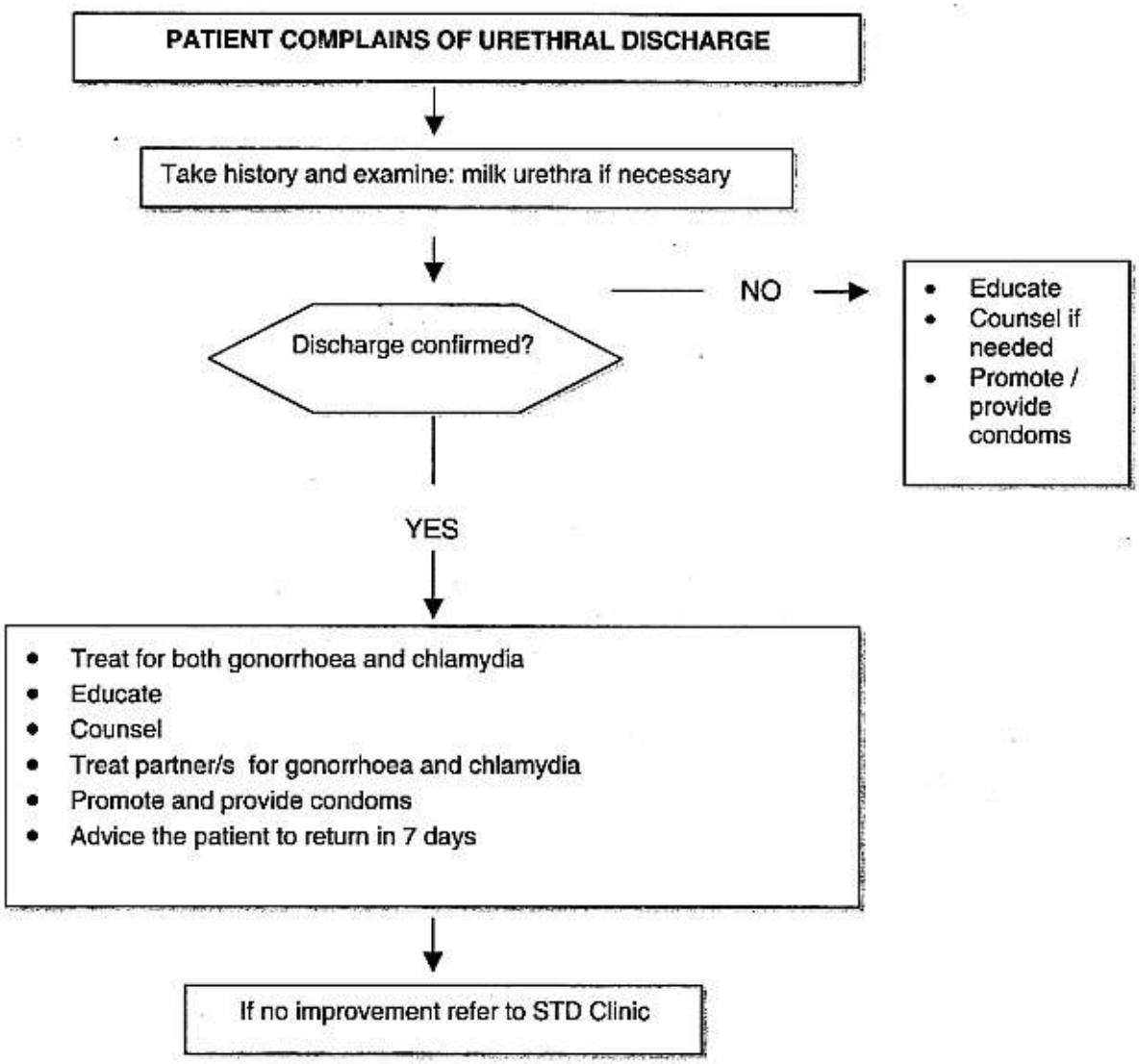
- **Doxycycline** 100 mg orally twice daily for seven days, **OR**
- **Tetracycline** 500 mg orally four times daily for seven days

Alternate Therapy

- **Erythromycin** 500 mg orally four times daily for seven days.

Remember to treat the partner for gonorrhoea and chlamydia infection.
When treating the partner take a detailed history and if she is pregnant do not use Doxycycline. Use Erythromycin.

URETHRAL DISCHARGE FLOW-CHART



URETHRAL DISCHARGE

Fig - 1
Urethral discharge due to Gonorrhoea

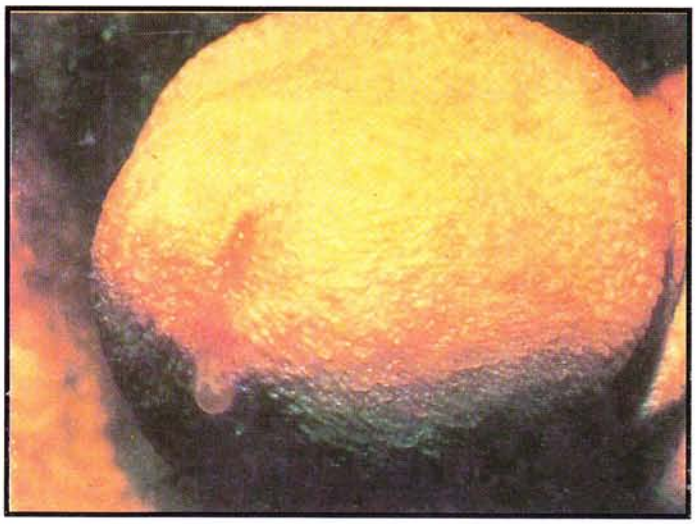
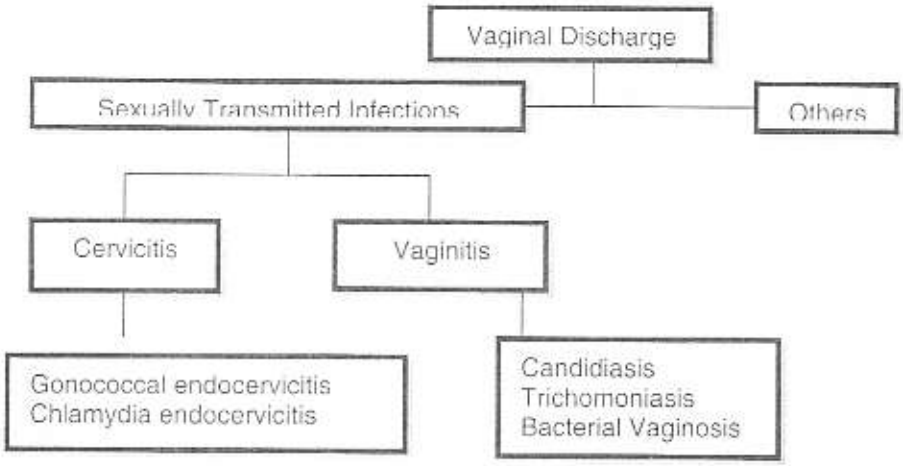


Fig - 2
Urethral discharge due to Chlamydia

VAGINAL DISCHARGE

It is normal for women to have some vaginal discharge. This is known as a physiological discharge. It may be more pronounced during certain phases of the menstrual cycle, during and after sexual activity, during pregnancy and lactation. Sometimes women may complain of vaginal discharge when they perceive it as being unusual if it causes itchiness or discomfort, when it is usually due to a pathological cause. There are several pathological causes that lead to vaginal discharge. One such cause is the presence of sexually transmitted infections.



What we are concentrating here are on STI which could cause a vaginal discharge. Vaginal discharge could be due to cervicitis (infection of the cervix) or vaginitis (infection of the vagina) or both.

Cervicitis	Vaginitis
Caused by gonorrhoea and chlamydia	Caused by trichomoniasis, candidiasis and bacterial vaginosis
Less common cause of vaginal discharge	Most common cause of vaginal discharge
Difficult to diagnose	Easy to diagnose
Major complications	Less complications
Need to treat partner for both gonorrhoea and chlamydia	Treat partner for trichomoniasis

As shown above the sexually transmitted infections that cause cervicitis are gonorrhoea and chlamydia. Cervicitis is difficult to diagnose without inspecting the cervix using a speculum. Therefore experts have suggested an alternative. That is when taking the history if the patient answers 'yes' to any one of these questions relating to risk factors then treat for cervicitis and vaginitis both.

- Patient has had sex with more than one partner in the preceding three months
- Patient has had sex with a new partner in the preceding three months
- Partner having symptoms suggestive of sexually transmitted infections
- Spouse returning after long stay away

It is important to treat for cervicitis, because if the condition is not correctly and adequately treated it leads to serious complications. The patient's sexual partner(s) must also be treated.

If the patient responds negatively to all questions, she can be treated for vaginitis only. Remember to ask the patient whether she has lower abdominal pain in addition to vaginal discharge. If so she has to be managed according to the lower abdominal pain flow chart.

Recommended therapy

Treatment for Vaginitis

(Includes treatment for **Trichomoniasis, Candidiasis and Bacterial vaginosis**)

Treatment for trichomoniasis and bacterial vaginosis

Metronidazole 2g as a single oral dose to be taken at the clinic under supervision, **OR**
Metronidazole 400 mg given orally twice daily for 7 is also effective.

NOTE: Do not prescribe Metronidazole in the first trimester of pregnancy.

Treat the patient's partner for trichomoniasis with
Metronidazole 2g as a single oral dose OR Metronidazole 400 mg twice daily for 7 days
(Advise the patient to take the complete course of tablets. Warn the patient against drinking alcohol while taking Metronidazole)

Treatment for vaginal candidiasis

Nystatin 100 000 units (one pessary), inserted intravaginally once a day at night for 14 days, **OR**
Miconazole or **Clotrimazole** 200 mg, inserted into the vagina once a day at night for 3 days

Treatment for cervicitis

Gonococcal cervicitis

Cefuroxime Axetil 1g + Probenecid 1g in a single oral dose

Chlamydia cervicitis

Doxycycline 100 mg orally twice daily for 7 days **OR Tetracycline** 500 mg orally four times daily for 7 days.

NOTE: Doxycycline and tetracycline should not be used during pregnancy or lactation.

Alternative therapy
Erythromycin 500 mg four times a day for 7 days

VAGINAL DISCHARGE

Fig - 9
Normal vaginal secretion.

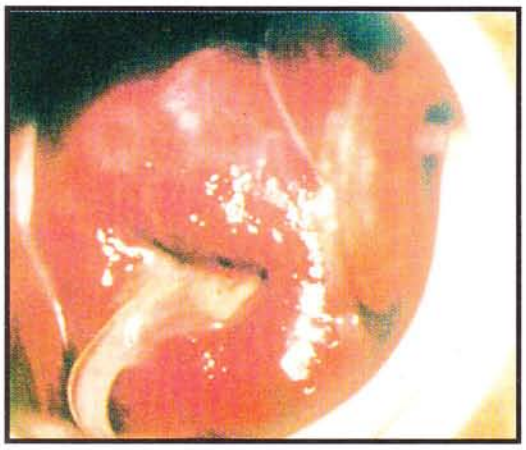


Fig - 10
Gonococcal cervicitis

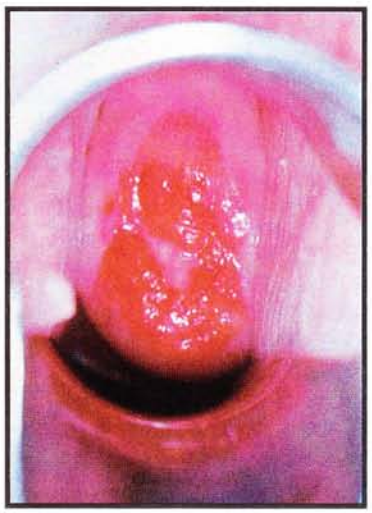


Fig - 11
Chlamydial cervicitis

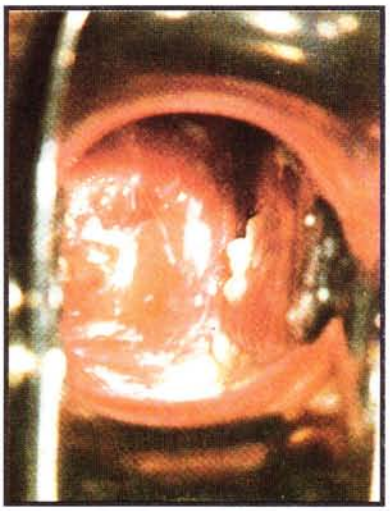


Fig - 12
Cervical and vaginal candidiasis

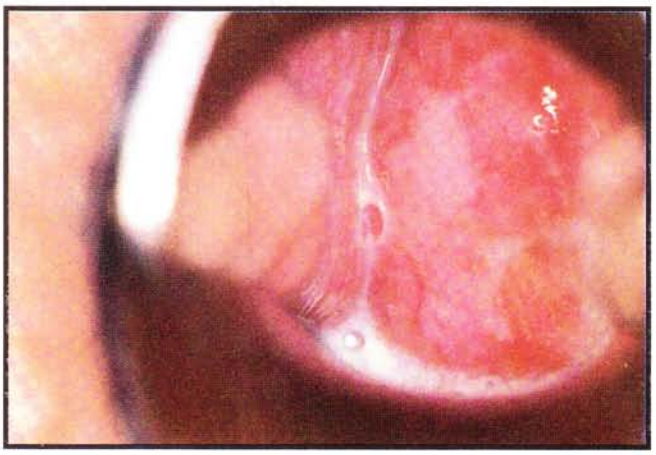
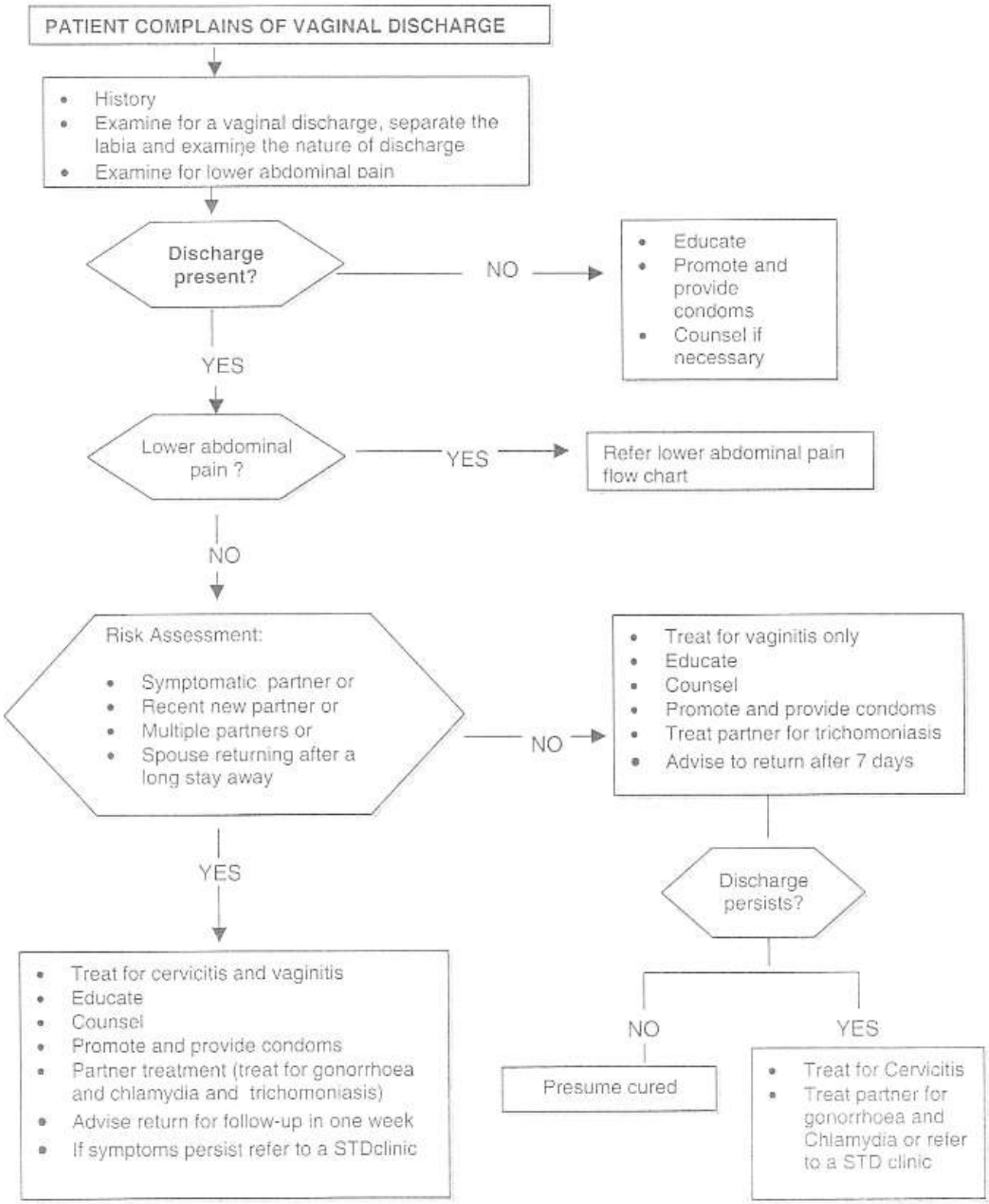


Fig - 13
Trichomonal vaginitis

VAGINAL DISCHARGE FLOW CHART



GENITAL ULCER DISEASE

The patient complains that he or she has noticed a sore on the genitals. The genital ulcers seen commonly in Sri Lanka are those due to herpes simplex virus infection and syphilis.

Syphilis is caused by the spirochete *Treponema pallidum*. The infection is transmitted from an infected person via the skin and mucus membrane at the time of sexual intercourse. It may also be transmitted from an infected, untreated pregnant woman to the foetus and through blood transfusion if the blood donor has untreated syphilis. Primary syphilis is characterized by the appearance of an ulcer, which is found on the genitals, and it is called a **chancre**. The ulcer develops 9 –90 days (usually 21 days) after infection and is typically painless, indurated and is usually associated with enlarged discrete, rubbery, lymph nodes in the inguinal region.

Genital herpes is caused by the *Herpes simplex virus* (HSV). Both HSV type 1 and type 2 may cause genital lesions. The patient may complain of itchiness and redness at the site of infection 3-7 days after initial infection. Within a short period of time these symptoms are followed by the appearance of a crop of small vesicles. The vesicles rupture to form shallow, reddened, multiple ulcers, which are painful.

Chancroid is caused by the gram-negative bacillus *Haemophilus ducreyi*. After an incubation period of 5 to 7 days patient develops painful genital ulcers at the site of infection. Typically ulcers are soft and non-indurated. The base of the ulcer is covered in a necrotic suppurative exudate. The ulcer bleeds readily on contact. Inguinal lymph nodes become enlarged and painful in one or both groins soon after infection occurs. The nodes coalesce together to form an oval mass called a "bubo". The overlying skin of the bubo is hot and red. Suppuration commonly occurs and the mass may become fluctuant. If the patient is untreated the skin breaks down leading to a sinus formation and there is a discharge of pus from the underlying abscess.

All genital ulcers should be referred to the nearest STD clinic. Basic management that should be instituted is given in the flow chart.

GENITAL ULCER

Fig - 3
Syphilitic Chancre in a male

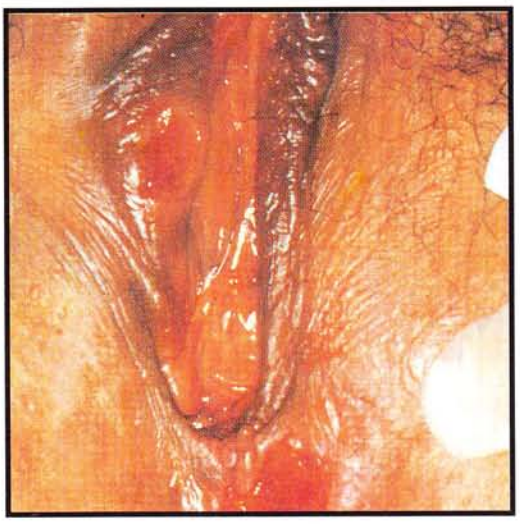


Fig - 4
Syphilitic Chancre in a female

Fig - 5
Chancroid ulcers on the prepuce

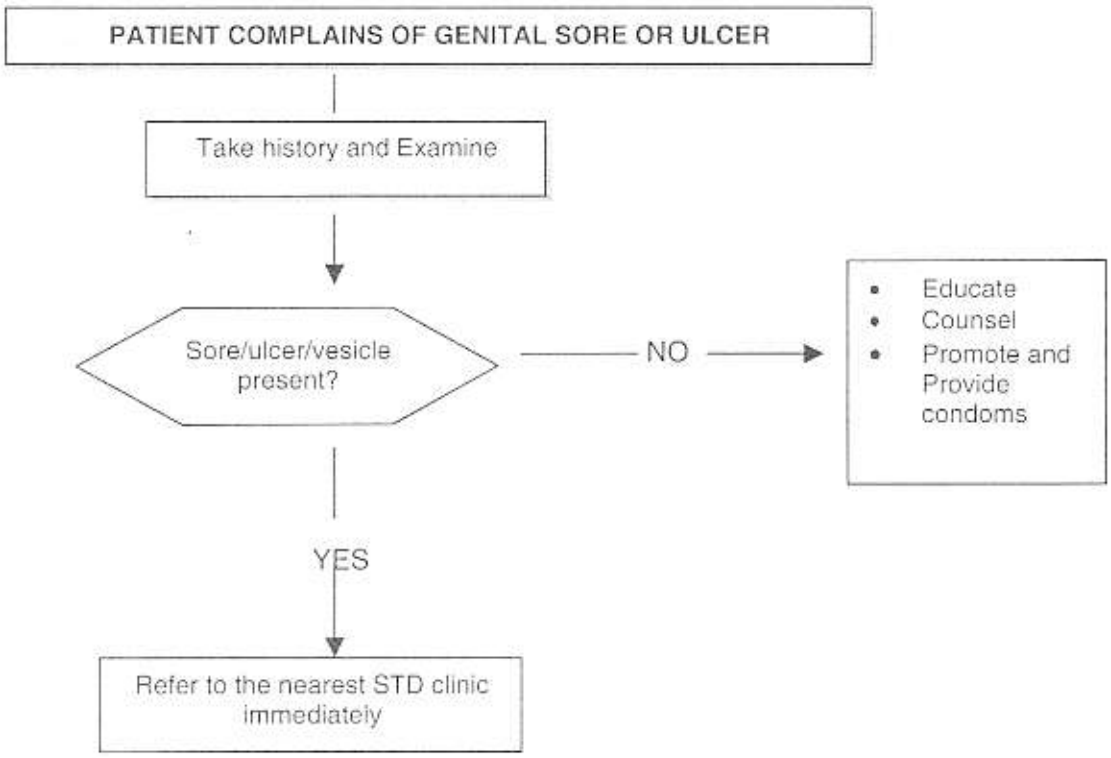
GENITAL ULCER

Fig - 6
Early lesions of herpes genitalis

Fig - 7
Penile herpes genitalis

Fig - 8
Vuivar herpes genitalis

GENITAL ULCER DISEASE FLOW-CHART



Patient not willing to attend STD clinic provide basic care

- Advice bathing the ulcers with weak salt-water solution.[▲]
- Commence on Co-trimoxazole two tablets twice a day for 5 days if secondary infection is present (Co-*trimoxazole is a non- treponemacidal antibiotic. Use of other antibiotics such as Penicillin, tetracycline, erythromycin, will mask the presentations of syphilis)*
- Educate
- Counsel
- Convince to attend STD clinic

[▲] For male patients – take a plastic bowl of warm water and add a teaspoon of table salt and use this to wash the ulcers gently. Thereafter keep it dry.
For women patients, take a basin and pour 1 litre of warm water into it and dissolve two teaspoons of salt water in it. Then sit in this bath and wash the genital area well separating the labia. Dry with a clean cloth.

Pregnant mothers presenting with Genital ulcers

All pregnant mothers presenting with genital ulcers should be referred to the nearest STD clinic for screening for syphilis and herpes infection. If not correctly and adequately managed syphilis infection could be transmitted to the foetus resulting in congenital syphilis which causes congenital defects, mental sub normality etc. Similarly neonatal herpes infection has a high morbidity with central nervous system abnormalities and mortality to the baby.

Thus all babies born to mothers treated for Genital ulcers should be reviewed for symptoms and signs of NEONATAL HERPES and CONGENITAL SYPHILIS .

Prevention of Congenital syphilis

All antenatal mothers should be screened for syphilis. That is a public health requirement. The VDRL test is the screening test for syphilis.

1. Check the mother's antenatal card and see whether the result of the VDRL test is entered.
2. If the VDRL test is positive refer the patient to the nearest STD clinic.

ALL INFORMATION SHOULD BE KEPT CONFIDENTIAL

All neonates born to mothers with Genital Ulcer Disease or who have been tested positive for syphilis infection should be referred to the nearest STD clinic or to a specialized health institution. It is mandatory

Because :

- All babies born to mothers with genital ulcers suggestive of syphilis or were tested positive for syphilis should be evaluated for clinical and serological evidence of congenital syphilis
- All babies born to mothers who have been adequately treated or not for syphilis during pregnancy also should be treated with Benzathine Penicillin as a prophylactic measure
- A baby with signs and symptoms suggestive of Congenital Syphilis should be referred to a Paediatrician / paediatric clinic immediately.

LOWER ABDOMINAL PAIN

Lower abdominal pain is often the presenting feature of women with pelvic inflammatory disease (PID).

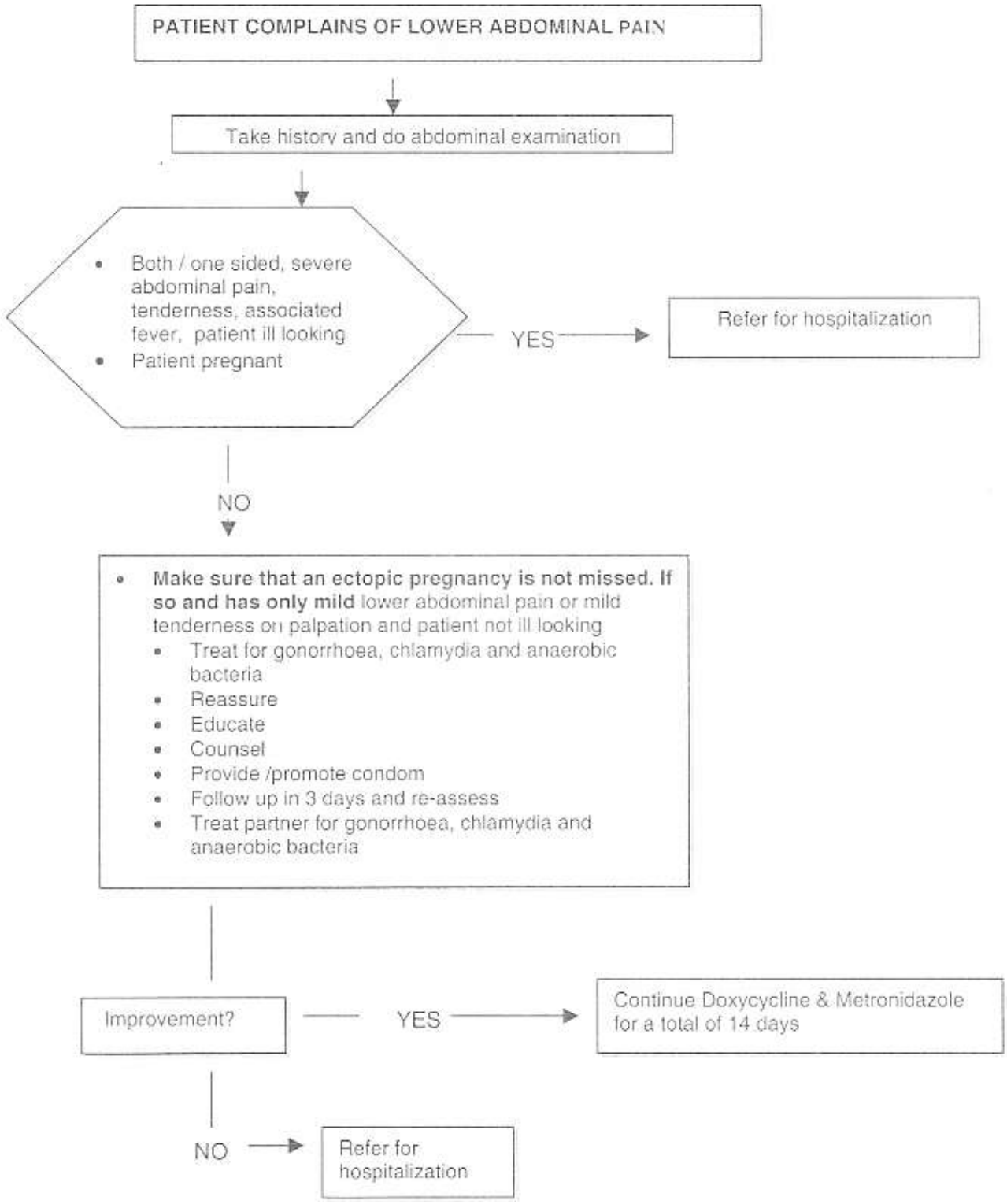
Pelvic inflammatory disease is defined as an infection of the female genital tract above the internal os of the cervix (neck of the womb) and therefore means endometritis, salpingitis, tubo-ovarian abscess and pelvic peritonitis. PID occurs as a result of ascending infection from the cervix and is caused by *N. gonorrhoeae, C. trachomatis* and anaerobic bacteria, usually of the bacteroides species. Occasionally, PID may be caused by *Mycoplasma hominis*.

Ten to fifty percent of women with untreated gonococcal or chlamydial cervical infection will develop acute upper genital tract infection. The seriousness of PID lies in the fact that the condition can lead to salpingitis, pelvic peritonitis, tubo-ovarian abscess and to generalized peritonitis which can be a fatal illness.

An attack of salpingitis may lead to the fallopian tubes becoming blocked, resulting in infertility. It may also lead to partial tubal obstruction, resulting in a tubal pregnancy. The consequence of this is that the tubal ectopic pregnancy eventually ruptures and causes massive intra-abdominal haemorrhage and even death, unless diagnosed promptly and treated in a hospital with surgical facilities.

Women with acute PID will present with acute sudden onset one-sided or both sided abdominal pain, fever, with or without vaginal discharge. Such patients need to be hospitalized. Conditions like acute appendicitis, rupture of tubal pregnancy may also present with similar sins and symptoms. They are both surgical emergencies. Therefore all women presenting with **severe** acute uni or bilateral lower abdominal pain should be referred to hospital. Therefore treat only women with mild abdominal pain who are not ill looking. Pregnant mothers with abdominal pain also should be referred to a hospital.

LOWER ABDOMINAL PAIN FLOW-CHART



LOWER ABDOMINAL PAIN

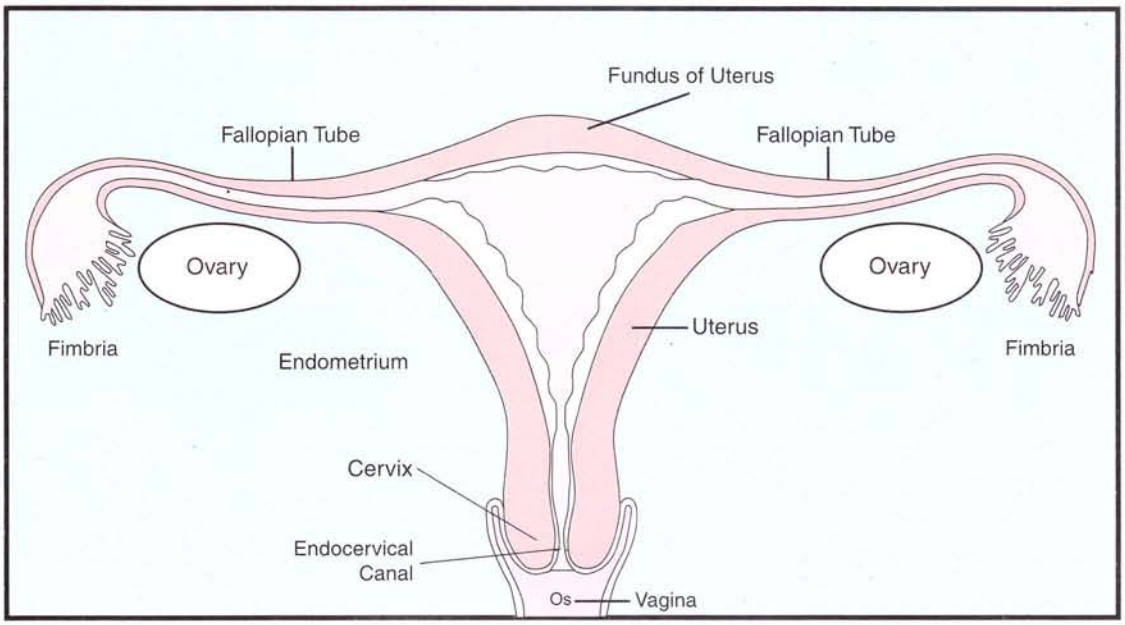


Fig - 14
Anatomic depiction of normal internal female genitalia

Fig - 15
Specimen showing unilateral pyosalpinx.

LOWER ABDOMINAL PAIN
Recommended Therapy

Treatment for gonorrhoea

Cefuroxime Axetil 1g orally + **Probenecid** 1g in a single oral dose and followed by
Cefuroxime Axetil 500 mg orally twice a day for 7 days
OR
Ceftriaxone 250 mg I.M. in a single dose.

Treatment for chlamydia infection

Doxycycline 100 mg orally, twice daily for 14 days,
OR
Tetracycline 500 mg orally, four times daily for 14 days

Alternative Therapy
Erythromycin 500 mg orally four times daily for 14 days
PLUS

Treatment for anaerobic bacterial infection

Metronidazole 400 mg orally, twice daily for 14 days

Note: Metronidazole should not be used in the first trimester of pregnancy. Also caution the patient to avoid alcohol while taking this treatment.. Ciprofloxacin, doxycycline and tetracycline should not be used during pregnancy or lactation.

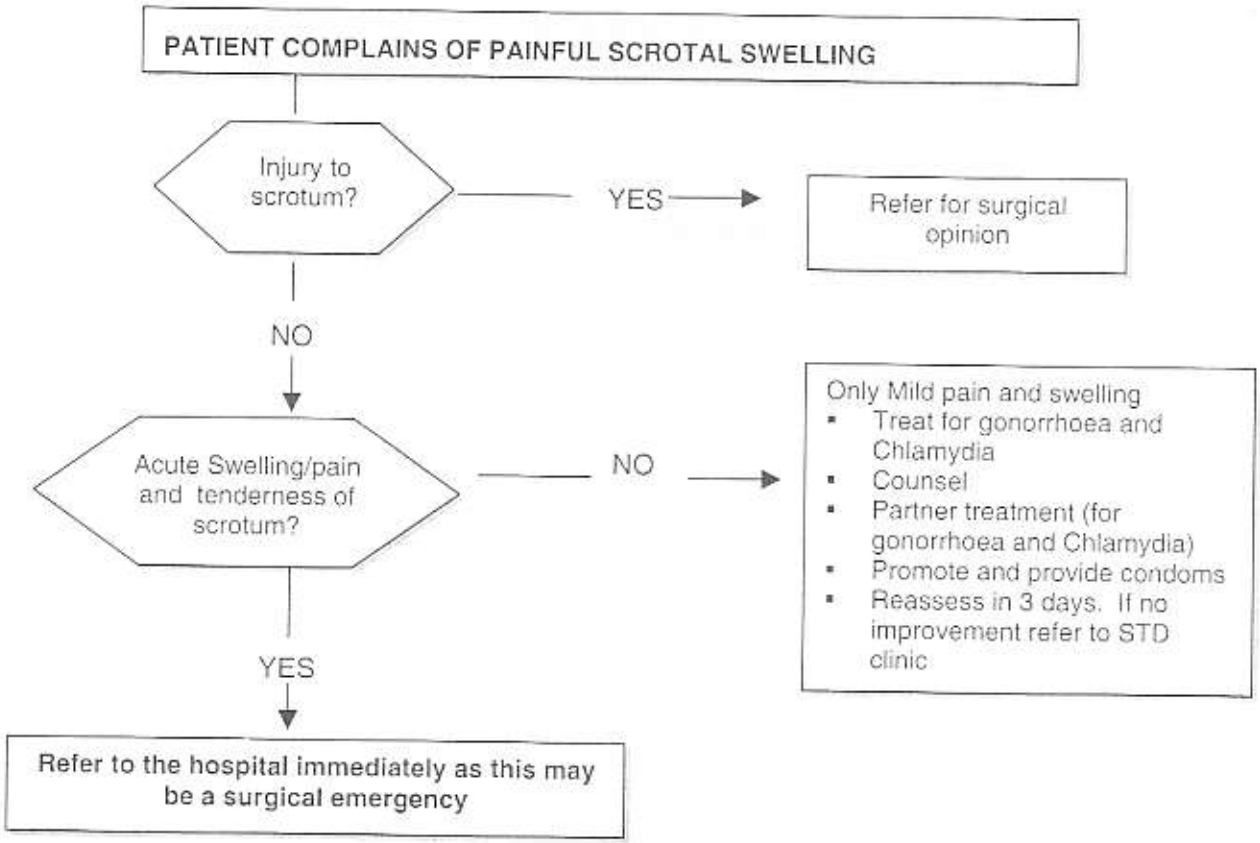
SCROTAL SWELLING

Infection of the testis is a serious complication of **gonococcal urethritis** and **chlamydial urethritis.** When infected, the testis becomes swollen, hot and very painful. If early effective therapy is not given, the inflammatory process will resolve and healing occurs with fibrous scarring and destruction of testicular tissue. This will decrease the patient's fertility.

Other causes of acute epididymo-orchitis include the mumps virus and infection with the bacterium *Escherichia coli.* Infection with *E.coli* may occur as a complication of urinary tract infection.

Torsion of the testes, which is a surgical emergency, may also present with similar signs and symptoms such as acute testicular pain and swelling and tenderness of the scrotum. Therefore it is best that patients with acute pain are referred to the hospital.

SCROTAL SWELLING FLOW CHART



SCROTAL SWELLING

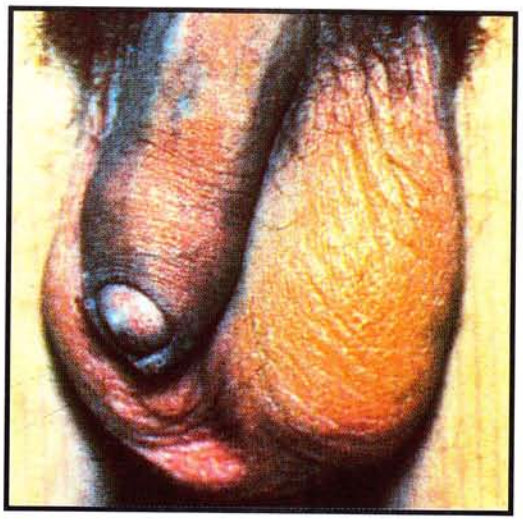


Fig - 16
Red, swollen scrotum in acute epididymo - orchitis

Scrotal Swelling

Recommended Therapy

Treatment for gonorrhoea

Cefuroxime Axetil 1g orally + **Probenecid** 1g in a single oral dose and followed by
Cefuroxime Axetil 500 mg orally twice a day for 7 days
OR
Ceftriaxone 250 mg I.M. in a single dose.

Treatment of chlamydial infection

Doxycycline 100 mg orally, twice daily for 14 days,
OR
Tetracycline 500 mg orally, four times daily for 14 days

If allergic to doxycycline and tetracycline –

Alternative Therapy
Erythromycin 500 mg orally four times daily for 14 days
PLUS

Treatment for anaerobic bacterial infection

Metronidazole 400 mg orally, twice daily for 14 days

Note: Metronidazole should not be used in the first trimester of pregnancy. Also caution the patient to avoid alcohol while taking this treatment.

INGUINAL SWELLING

This is a painful, often fluctuant, swelling of the lymph nodes in the inguinal region (groin).

Inguinal swelling is also called a bubo. They are usually caused by either

Chancroid or
LymphoGranuloma Venereum (LGV).

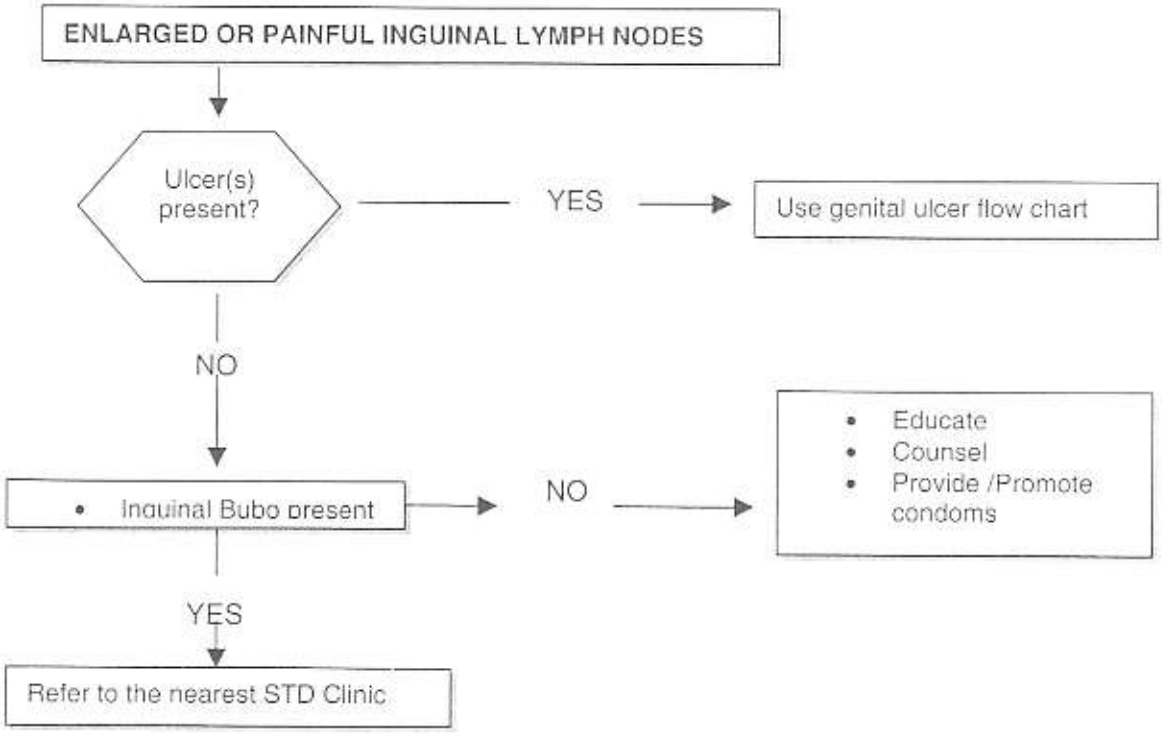
LGV is characterized by a transitory , herpetiform early lesion followed by involvement of the lymphatic channels and the lymph nodes in the groin. Lymphadenopathy is unilateral in about two-thirds of the patients.

A **bubo** is a collection of inflamed inguinal lymph nodes. The lymph nodes in a bubo are acutely inflamed and so they cause pain. As there is an inflammatory process taking place in the lymph nodes, pus form within them and a deep abscess will develop. Occasionally the bubo might have ruptured and a sinus discharging pus will be present.

Enlarged lymph nodes, which are not acutely inflamed, do not fall into the definition of bubo.

If a bubo is present, refer the patient to the nearest STD clinic.

INGUINAL BUBO FLOW-CHART



INGUINAL BUBO

Fig - 17
' Groove sign' in lymphogranuloma venereum (LGV)

OPHTHALMIA NEONATORUM

Ophthalmia neonatorum (ON) is the term used to describe a condition where a neonate develops purulent conjunctivitis in one or both eyes within four weeks of birth.

Examine the baby, looking specifically for a purulent conjunctival discharge. The baby's eyes are swollen and filled with pus and are usually closed. You will notice that, when the eyelids are separated or pressed, pus pours out from beneath them.

The common sexually transmitted infection causing this potentially sight-threatening condition is gonorrhoea and chlamydial infections. It is a medical emergency and unless treatment is initiated within 24 hours, there could be permanent damage to eyes leading to blindness. Ophthalmia Neonatorum is a serious condition that requires systemic therapy with third generation cephalosporins. Therefore the **baby should be referred to the closest hospital immediately.** Clean the eyes with normal saline or with boiled cool sterile water until systemic therapy is commenced.

Recommended Therapy

The Treatment of MOTHER and the FATHER

Should be given treatment for both gonorrhoea and chlamydia infection.

Recommended therapy for Gonorrhoea

Cefuroxime Axetil 1g + **Probenicid** 1g in a single oral dose

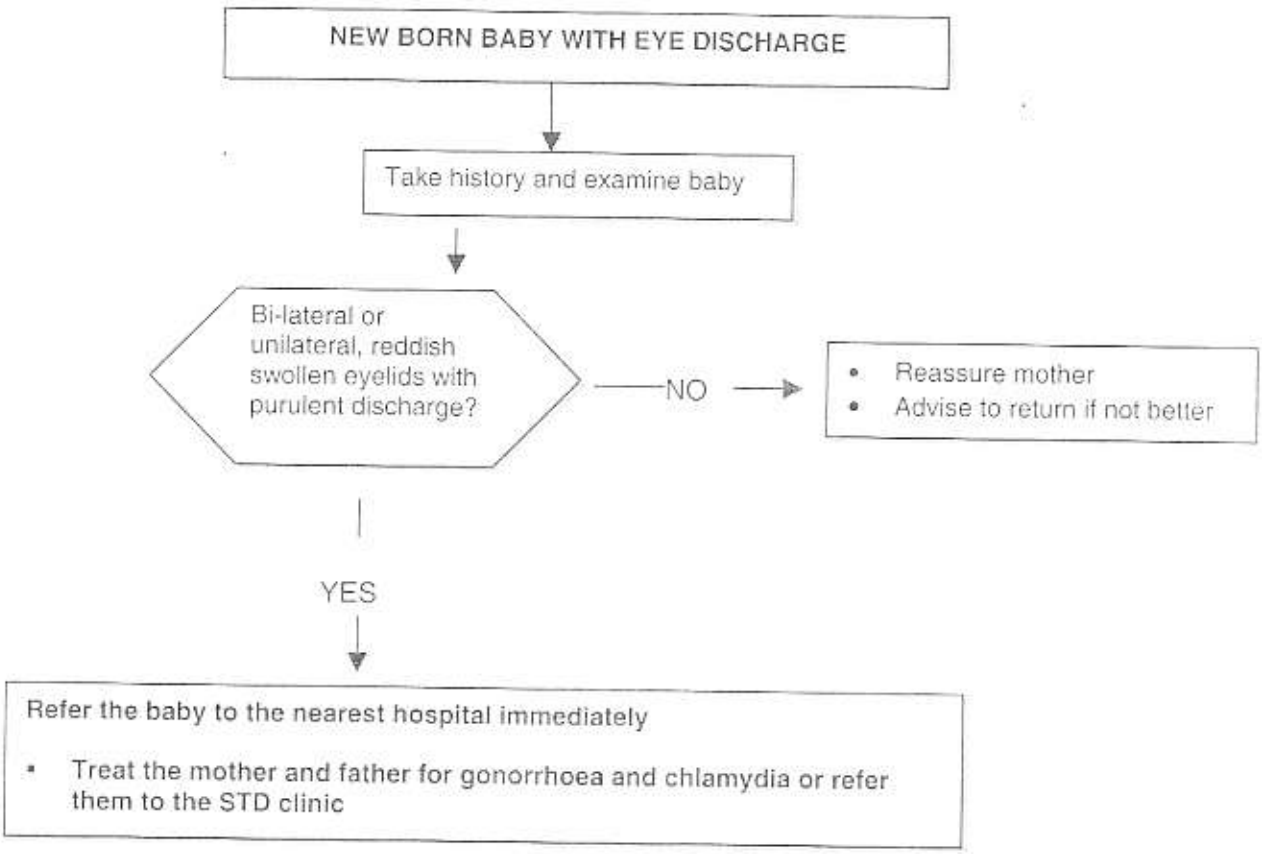
Recommended therapy for Chlamydia infection:

Erythromycin 500 mg orally, four times daily for 7 days

*Note: **Doxycycline and tetracycline should not be used by lactating women.***

- Advice the mother to complete the course of tablets and educate her about the mode of transmission of STD, the nature of the baby's infection, how to clean the baby's eyes and possible complications of infection. Counsel her and promote the use of condoms.

OPHTHALMIA NEONATORUM FLOW-CHART



OPHTHALMIA NEONATORUM

Fig - 18
Bilateral Purulent conjunctivitis in a neonate

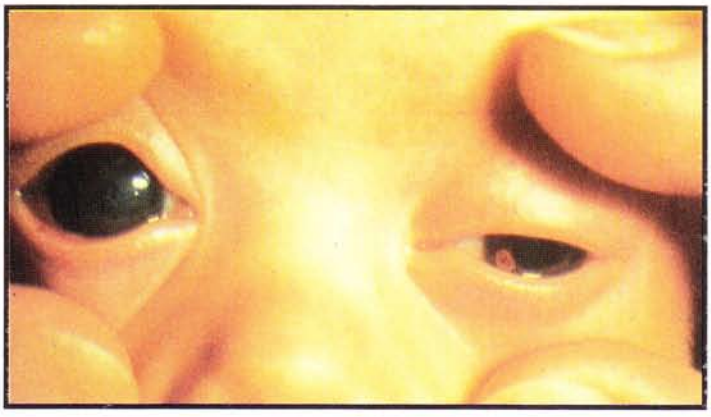


Fig - 19
As shown in the picture separate eyelids
and examine thoroughly

CONTACT TRACING, MANAGEMENT OF SEXUAL PARTNERS AND FOLLOW-UP

This section will cover the following:

1) Explain why contact tracing and partner management is an important part of STD case management
2) The principles in partner management

MANAGEMENT OF SEXUAL PARTNERS

The health provider should interview the patients and make them understand that all those who have had sexual contact with the patient should be brought for treatment. This is important because the sexual partners of STD patients are likely to be infected themselves and should be offered treatment. If not their infections will remain untreated and would lead to complications. In addition the patient himself/herself would get re-infected from sexual intercourse with such untreated partners who have not been brought for treatment.

During the interview the patient should receive the following information :

- How the disease is transmitted
- Information that sexual partner (s) need to obtain appropriate therapy
- Consequences to the health of the patient and partner (s) if not treated
- The likelihood of asymptomatic infection
- The necessity of abstaining from sex until the partner obtains a medical check-up

Partner notification can be by **patient referral.**

Patient Referral

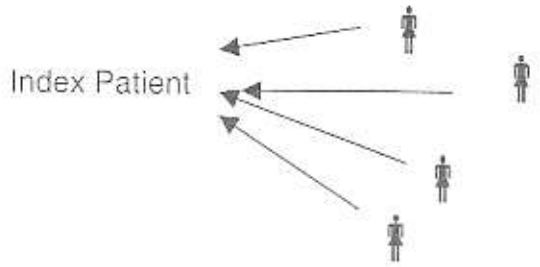
Means whereby an infected patient is encouraged to inform partner(s) of their possible infection and encourage to bring them for treatment. Emphasize that all information remains confidential. This process should be voluntary and non-coercive.

Now understand how the index patient we diagnosed to have a STD has been infected during unprotected sexual intercourse with one or more infected partners:

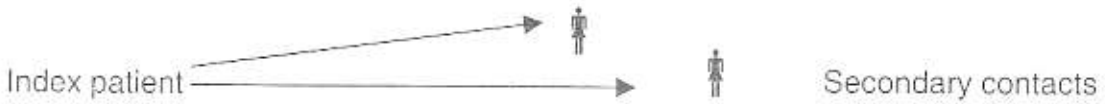
An **index patient** is likely to have two types of partners or contacts.

The person who infected an index patient is referred to as the **source contact** (or the primary). This may be a sex worker or even a casual partner.

But if the patient has more than one sexual partner any of these partners could be the source of the infection.

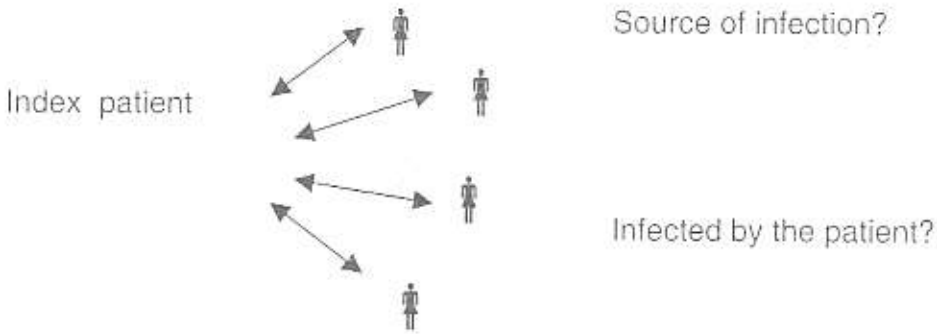


A person/s infected by the index patient is referred to as the **secondary contact** and is usually the spouse or the girl friend.



You will now understand that an **index patient** is likely to have **two types** of partners or contacts. **Primary contact** or source contact is the person who infected the index patient (may often be a sex worker). **Secondary contact** is the person/s who was infected by the index patient and is usually the spouse or the girl friend. From the time that the patient was infected with a STD, the contacts also have been infectious and are able to spread the infection. It is often difficult to identify when the patient was infected. For practical purposes, we can assume the period of infectiousness to be 3 months (treatable bacterial infection with a long incubation period is syphilis)

So we must also assume that at least for 3 months before the patient came for treatment, all of their sexual partners during that period could have been infected.



The management of sexual partners is based on the knowledge of the index patient's diagnosis. Epidemiological treatment should be given to all sexual partners even if the partners have no evidence of STD with the same treatment regimen as used for the index patient.

Syndrome of index patient	Treatment of Partner
Urethral discharge	Treat partner for gonorrhoea and chlamydia
Vaginal discharge: Patient treated for vaginitis and cervicitis Patient treated for vaginitis only	• Treat partner for gonorrhoea and chlamydia • Partner to be treated for trichomoniasis
Ophthalmia neonatorum	Treat both parents for gonorrhoea and chlamydia

EDUCATING THE PATIENT ON RISK REDUCTION, CONDOM PROVISION AND COUNSELLING

The goals of educating a patient with STD are to help the patient resolve the current infection and prevent future ones and also change their risky sexual behaviour.

Why is patient education important?

- The clinic visit is a unique opportunity for patient education as the patient has come to you. It is a time that patients are interested to learn about a disease or its prevention as they are now faced with a disease.
- Treatment is more effective if patients understand their illness and why they should comply with treatment and advice given. Then only can the morbidity due to STDs and their complications could be reduced.
- Some STDs can be cured but others especially viral STI recur. While patients might be willing to comply with treatment for a current infection, they often need education, motivation and emotional support to adopt practices that will prevent a future infection or a recurrence of STD.
- Understand that preventing STI requires sustained behaviour change.

In educating a patient with STDs the six important issues that need to be discussed

1. **About the STD**
   Explain what STD the patient has and its treatment, the name of the drug how much to take and for how long, its common side effects and the importance in complying with treatment

2. **The patient's risk level**

   As you have already taken the patient's history, you may have enough information to assess the risk of the patient becoming infected again. The following list contains issues that may help you confirm the risks.

Assessing the patient's risk of further STD	
Personal sexual behaviour	**Partner/s sexual behaviour**
1. Number of sexual partners in the past year 2. Sex with a new or different partner in the past three months 3. Any other STD in the past 4. Has the patient ever exchanged sex for money, goods or drugs (include both giving and receiving)? 5. Type of sexual practice: e.g. Oral, anal, number of lifetime partners	Does the patient's partner/s : • Have sex with other partners? • Also have a STD? Or have had STDs in the past? • Have HIV infection? • Inject drugs? • If male, have sex with other men? • Been employed outside Sri Lanka
Other personal risk factors: 1. HIV infection? 2. Use of skin-piercing instruments such as: ▪ Needles (injection, tattoos); ▪ Scarification or ear and body-piercing tools; ▪ Acupuncture. 3. Has the patient ever had a blood transfusion? When? 4. For young children, risk of perinatal transmission of STD / HIV means that service providers must question the parents about their possible infections, for example, gonorrhoea, syphilis, chlamydia, HIV. 5. Foreign employment and travel. 6. Travel out of home frequently	**Personal drug use:** The key issue is whether the patient is mixing drugs with sex – which may increase the risk of spreading STD or being re-infected. Sharing needles and syringes carries a high risk of transmitting or being infected with HIV. So: 1. Use of alcohol or other drugs (if so, what?), before or during sex? 2. Exchange of sex for drugs (or drugs for sex)?
	Patient's protective behaviour 1. What does the patient do to protect him/herself from STD / HIV? 2. Use of condoms? When and how? How often? With whom? 3. What kind of low-risk or safe sexual activities does the patient practice? How often? With whom? Why?

Helping the patient identify his/her risk factors

Once you have a clear idea of the patient's risk level, the next step is to help the patient understand what risks they are taking in their present sexual behaviour; what risks he or she has been taking in the past; then work together to explore options for safer sex practices for the future. Safer options might include:

1. Being faithful and having sex with one faithful partner
2. Avoiding commercial and casual sexual partners
3. Using condoms consistently and correctly.
4. Avoiding high-risk penetrative sex (such as unprotected vaginal or anal intercourse) with unknown partners
5. Practicing low-risk non-penetrative sex (such as mutual masturbation) when appropriate.

Discuss the common **misconceptions** about STD / HIV such as :

- The idea that certain people, such as married women, young girls or boys or 'clean' partners, are usually free from infection;

- Taking antibiotics before or after sex offers protection;
- Urinating or washing after sex protects against STD;
- The patient's belief that he/she does not belong to a high-risk group (such as commercial sex workers or homosexual males) so he/she is safe from acquiring STI .
- One STD can turn into another one
- You can only get one STD at a time
- All STDs including HIV are detected using one blood test
- Health care personnel can tell if a patient has STD
- People with STDs always have symptoms
- You can't have STD and HIV at the same time
- You can tell who has a STD / HIV by how he/she looks or feels, by their actions, occupation, social class or number of sex partners.

Make sure that the patient understands that he or she became infected by having unprotected sexual intercourse with an infected partner, and that there are no other causes.

3. The need to change sexual behaviour

The patient now knows how he or she was infected by a STD and is also aware of future risks. Next is about helping the patient to change his or her sexual behaviour – perhaps the service provider's most challenging task.

4. Barriers to changing behaviour

All health providers are aware of the difficulty of changing behaviour, life would be easy if people responded to health messages by doing as they were advised, but many don't. Why? Because awareness of the health message is not enough. To make real changes, we need first to overcome 'barriers' in our life and experience.

A patient may have any number of barriers. These barriers might arise from any aspect of the individual's life and experience. Therefore at this point in the interview discuss them in detail.

1. **Gender** raises real barriers. These arise, essentially from the power imbalance between men and women and from the different expectations and values relating to male and female sexuality. Women often have very little control over when, with whom, and under what circumstances they have sex. They are therefore not in a position to protect themselves, even if they so wish or have the means (eg. a condom).

2. **Cultural practices** may help or hinder the patient's ability to change. Consider the possible barriers relating to age differences at marriage, sexuality, child-rearing and so on, as well as the values of family and community

3. **Religion** may under some circumstances contribute to adoption of safer sexual behaviour. However, it poses major barriers to change in that it discourages open discussion about sexuality and some protective measures.

4. **Poverty, social disruption and civil unrest** force women and girls in particular, but, sometimes, boys into exchanging sex for material favours or even for survival. In some situations, lack of access to education and employment may force women to exchange sex with a number of partners in order to pay for food, shelter and clothing for themselves and their children.

5. **Changes the patient will make in their sexual behaviour**

Having asked the patient to identify ways they might change, and explored any barriers to doing so, you can now help the patient to decide which change would be easiest and / or most effective in their own life and how to put it into practice.

The change most likely to succeed is the one that fits most easily with the patient's present lifestyle, once you have helped the patient to overcome any relevant barriers.

It is not quite enough simply to have the patient agree the chosen safe behaviour. Ask him or her how they will put it into practice, when they will do so and what they will do if for any reason, they do practice risky sex. These are difficult issues, but we will explore some useful skills for you in the next section of this workbook.

6. **The need to treat sexual partners**

Always tell your patient how important it is to have all their known partners treated, and that they risk re-infection. Reassure the patient that you will maintain their confidentiality, and discuss how they can persuade the partner or partners to attend for treatment.

6 VITAL MESSAGES

Every STD patient should leave a clinic, understanding and remembering these six vital messages :

1. Cure your infection
2. Beware of spreading STD including HIV
3. Help your sexual partners get treatment
4. Come back to make sure you are cured
5. Stay uninfected with safer sex practices
6. Protect your baby by not getting infected during pregnancy.

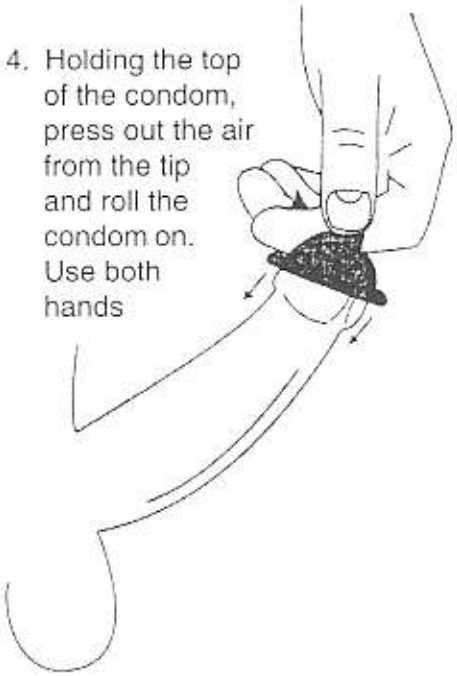
How to use a condom

1. Check the expiry date and the manufacture date.

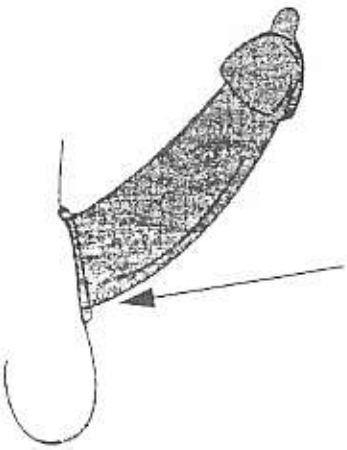
2. Tear the wrapper carefully.

3. Hold the condom this way up, so that it will unravel easily.

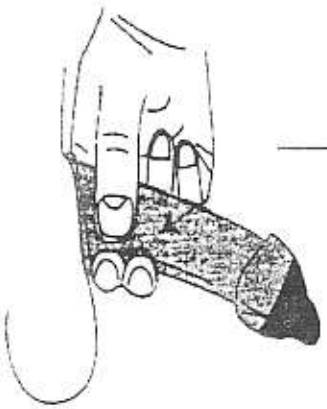
4. Holding the top of the condom, press out the air from the tip and roll the condom on. Use both hands



5. Roll the condom right to the base of the penis, leaving space at the tip of the condom for semen.



6. After ejaculation, when you start losing eraction, hold the condom at the base and withdraw the penis from vagina/anus carefully. Next continue to hold condom at the base and withdraw penis off the condom. Tie a knot at the base of the condom ensuring there is no spillage of seminal fluid.



7. Disposal - throw away or bury the condom

DEMONSTRATING THE USE OF CONDOMS

It is important to first demonstrate its use and then ask the patient to practice the same method, helping him or her to get it right. This means that you will need a supply of condoms and a penis model or something to represent one.

In your demonstration:

- Stress the importance of carrying condoms all the time. The patient should never be without one.
- Show the expiry or manufacture date and explain that the condom should not be out-of-date, smelly, sticky or hard to unroll.
- Explain how to open the package carefully using the tear point
- Show the correct side of the condom to insert over the penis, explaining that it won't roll down if placed the other way
- Show how to hold the tip of the condom to press out air, before rolling it all the way down the erect penis
- Emphasize that the condom must be rolled right down to its base
- Explain that the condom should be removed *just as the penis begins to lose its erection*, and that the persons should hold the condom carefully at the base and slide the penis off slowly
- Explain that, to dispose of it safely, the person should tie the base of the condom and dispose of it safely.

THERE ARE TWO OTHER TIPS YOU MIGHT WANT TO GIVE THE PATIENT

Since condoms are lubricated,

- Do not use oil or oil-based lubricants such as petroleum jelly, which damage latex condoms
- Do not re-use condoms

THERE ARE MANY MYTHS ABOUT CONDOM USE. ✓ THE CORRECT ANSWER

	TRUE	FALSE
Condoms get lost inside the woman		
Condoms don't protect against STD including HIV		
Condoms can be kept in a packet or wallet indefinitely		
Pull the condom right over the head of the penis to ensure a snug fit		
Squeeze the air out of the tip of the condom as you put it on		
Condoms should be stored in a cool, dark, dry place		

Answers :

Condoms can get lost inside the woman	False! There is always the slight possibility that, if the man does not use the condom properly, it could slip off before withdrawal, but it could not get lost inside.
Condoms don't protect against STD including HIV	False! Properly used condoms prevent the transmission of STD including HIV.
Condoms can be kept in a pocket or wallet indefinitely	Again, false! A wallet or pocket is too warm to store a condom for a long period. Advise patients never to use condoms which are dry, dirty, brittle, yellowed, sticky, melted or damaged
It is OK to use glycerin or water-based lubricants with condoms	This one is true! However, remember to advise the patient that it is risky to use grease, oils, lotions or petroleum jelly to make condoms slippery. The oils cause the condoms to break.
Pull the condom tight over the head of the penis to ensure a snug fit.	False! If someone does this, the condom may burst. Always leave space for semen at the tip of the condom
Squeeze the air out of the tip of the condom as you put it on	True! This will leave space for the semen to collect
Condoms should be stored in a cool, dark, dry place	True! Condoms don't like sunlight, moisture or heat, which is why they don't like living in pockets or wallets too long.

Counselling in the management of sexually transmitted infections

Counselling is different from health education. Counselling is a dialogue between a patient and a care provider aimed at enabling the person to cope with the situation that the person has now faced and takes personal decisions related to the issue. The counsellor has to listen and identify the problem, their causes as well as possible solutions.

The knowledge the patient has already acquired during the health education session will help to understand and make decisions of their choice with the help of the counselor. When counseling a client with a STI diagnosis -

- Assure his/her of confidentiality
- Encourage the patient to tell you about any signs and symptoms, recent sexual interactions, fears
- Explain that STI if untreated have serious consequences
- Explain that most STI are curable
- Explain that the patients need to tell all their sexual partners about the infection so that they get treatment. Emphasize the fact that women are most of the time asymptomatic and if both are untreated re-infection can occur.
- Importance of follow-up
- Explain about safer sex practices and how to adopt them in future. You may need to demonstrate how to put on a condom using a model.
- Explain the association between STD & HIV

Counselling aims to help people to:

- Understand their situation more clearly
- Identify a range of options for improving the situation
- Make their own decisions
- Cope better with the problem faced
- Understand the risks to sexual partners and develop skills to talk about the problem they have faced

Regarding HIV antibody testing, help the patient to freely make an informed choice on whether or not to take a test.

- Explore the patient's knowledge of HIV/AIDS and provide correct information
- Explore the advantages and disadvantages of having a test

If the patient wishes to get a test done a detailed pre-test counseling has to be done. If you are not in a position to do so, please refer the patient to the nearest STD clinic. In both pre-test and post-test counselling, you need experience and skills. To develop such skills read the guidelines on counseling.

RECORDING

The number of patients treated and referred by you for urethral discharge, vaginal discharge and mild lower abdominal pain should be entered according to the age group as shown in the Record Sheet. Similarly, the number of patients referred by you with scrotal swelling, inguinal bubo, genital ulcers, lower abdominal pain and ophthalmia neonatorum should also be recorded.

R E C O R D S H E E T

Health Institution:

Name of Officer:

Address:

Designation:

Return for the month of:

Signature:

MALES	10-19 years	20-29 years	30-39 years	40+ years	TOTAL CASES
URETHRAL DISCHARGE					
Treated					
Referred					
GENITAL ULCERS					
Referred					
SCROTAL SWELLING					
Referred					
INGUINAL SWELLING					
Referred					

RECORD SHEET

Health Institution:

Address:

Return for the month of:

Name of Officer:

Designation:

Signature:

FEMALES	10-19 years	20-29 years	30-39 years	40+ years	TOTAL CASES
VAGINAL DISCHARGE					
Treated					
Referred					
GENITAL ULCERS					
Referred					
LOWER ABDOMINAL PAIN					
Referred					
INGUINAL SWELLING					
Referred					

R E C O R D S H E E T

Health Institution:

Address:

Return for the month of:

Name of Officer:

Designation:

Signature:

BABY	----------	----------	----------	----------	TOTAL CASES
OPTHALMIA NEONATORUM					
Referred					
MOTHER					
Treated					
Referred					
FATHER					
Treated					
Referred					