

Comprehensive
Reproductive Health and Family Planning
Training Curriculum

**MODULE 12:
PREVENTION AND MANAGEMENT OF
REPRODUCTIVE TRACT INFECTIONS
(RTIS)**

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NOTES TO THE TRAINER

PURPOSE

This training manual is part of the Comprehensive Reproductive Health and Family Planning Training Curriculum for service providers. It is to be used to train physicians, nurses, and midwives and may be adapted for use with community-based workers.

COMPREHENSIVE REPRODUCTIVE HEALTH AND FAMILY PLANNING TRAINING CURRICULUM

The comprehensive training curriculum consists of 16 modules:

1. Introduction/Overview
2. Infection Prevention
3. Counseling
4. Combined Oral Contraceptives and Progestin-only Pills
5. Emergency Contraceptive Pills
6. DMPA Injectable Contraceptives
7. Intrauterine Devices
8. Breastfeeding and Lactational Amenorrhea Method
9. Condoms and Spermicides
10. Voluntary Surgical Contraception
11. MVA for Treatment of Incomplete Abortion
12. Reproductive Tract Infections
13. Postpartum/Postabortion Contraception
14. Training of Trainers
15. Quality of Care
16. Reproductive Health Services for Adolescents

Included in each module is a set of knowledge assessment questions, competency-based training (CBT) skills assessments checklists, trainer resources, participant materials, training evaluation tools, and a bibliography.

- The modules provide flexibility in planning, conducting, and evaluating the training course.
- The curriculum allows trainers to formulate their own training schedule, based on results from training needs assessments.
- The modules can be used independently of each other.
- The modules can also be lengthened or shortened depending on the level of training and expertise of the participants.
- In order to foster changes in behavior, learning experiences have to be in the areas of knowledge, attitudes, and skills. In each module, general and specific objectives are presented in terms of achievable changes in these three areas.
- Training references and resource materials for trainers and participants are identified.

PREVENTION AND MANAGEMENT OF RTIs

- This module is divided into two volumes, the *Trainer's Manual* and the *Participant's Manual*.
- The *Trainer's Manual* consists of a "Training Guide" and "Appendix" sections.
 - The "Training Guide" presents information in two columns.
 - The first column, "Content," contains the necessary technical information.
 - The second column, "Training/Learning Methods," contains the training methodology (lecture, role play, discussion, etc.) to be used and the estimated time required to complete each activity.
 - The "Appendix" contains:
 - An optional unit, "Infection Prevention in STD Management."
 - "Transparencies" section.
 - "Trainer's Tools" section, including an answer key for the pre- and post-test, physical examination self-assessment questionnaire, competency-based training skills assessment checklists, answer keys for some case studies, and a guide to the color transparencies.
 - "Acronyms" and "Glossary."
- The *Participant's Manual* consists of "Participant Handouts" and "Content" sections.
 - "Participant Handouts" includes case studies, group exercises, competency-based training skills assessment checklists, the pre- and post-test, and participant evaluation form.
 - "Content" includes the necessary technical information and supplemental materials.
- References to participant handouts, transparencies, and trainer's tools occur as both text and symbols in the "Training/Learning Methods" section. The symbols have number designations that refer to units, specific objectives, and the sequence within the specific objectives.

GUIDE TO SYMBOLS



Trainer's Tool



Transparency



Participant Handout

LOGISTICS

- The logistics for a training of this size and complexity are formidable. A person other than the trainer(s), who has comparable skills and will work with the trainer, should be responsible for preparation before and during the training in addition to all other logistics. This includes notifying participants, selecting a training site, making all arrangements for the clinical practicum, having all necessary equipment and materials

ready, and trouble-shooting if necessary during the training. This frees up the trainer(s) to concentrate on the training itself rather than details that could detract from that.

- **Note:** Well before the training begins, make a list of the following as an aid in ensuring that all materials, equipment, and practice sites are ready by the beginning of the training:
 - Resource Requirements
 - Work for the Trainer to Do in Advance

These are located at the beginning of each unit.

- The “Participant’s Manual” should be photocopied, hole-punched, and available by the time training begins. The handouts are to be used during the unit, and the content materials handed out at the end of the unit. Participants should be given a loose-leaf notebook in which to compile the handouts into a reference manual to use in the future and to share with colleagues.
- Transparency masters have been prepared where called for in the text. These should be copied onto clear overhead sheets for display during the training sessions.
- The participant evaluation form should also be copied to receive the trainees' feedback in order to improve future training courses.
- The training should be live-in, if possible, with participants staying near the classroom. If the training is not residential, the time required to complete the course may be longer. The classroom should be large enough to accommodate classroom skills practice using pelvic models. The furniture should be moveable since there is quite a bit of small group work. There is one exercise that asks that trainees visit several pharmacies. So, ideally the training should be in a city or town.
- In selecting the clinical sites there should be sufficient patient volume to permit maximum clinical opportunity. A busy STD clinic would be best. The Px should vary their experience if possible by spending some practicum time in a busy family planning clinic as well, one which is similar to where they work. Trainees need to examine and treat as many patients as possible. All participants should give at least one condom demonstration and one health talk during the practicum.
- Optional exercises are offered, and if the trainers choose to include them, the time for them must be added to the estimated time for the unit. The homework is recommended, but if training is not residential, trainers will decide if participants can manage it or if classroom time should be added to complete it.
- Interactive training techniques, especially group work and a high level of trainee participation, predominate in this training. It is important that the trainers summarize after each exercise or unit, to finally provide the correct information and emphasis. It is also very important to encourage all participants to participate equally and not allow anyone to dominate or take up too much time because of gender, profession or personality.

LENGTH OF TRAINING

- All of the information in the module can be completed in 10 to 12 days, including 2 practicum days. It is important to stick to the allotted times. A shortened version of the training can be offered. Comprised of “key” units, it contains the most standard information on RTI management and should be included to prepare providers to deliver integrated FP/RTI services.
- Key units may differ based on different factors, such as availability of antibiotics or lab capability, level of skill or willingness of the providers, or ability to conduct a physical exam. But all settings can do prevention activities, and prevention should not be optional. An example of a shortened course might be to include units 1, 2, 3, 8, 9 and 10 with units 4, 5, 6, and 7.

If participants have not received recent training in infection prevention, the trainer may include an optional unit between units 7 and 8, or elsewhere during the training. This 4-hour-long unit can be found in the Appendix.

PREVENTION UNITS	SKILLS-BASED UNITS
Unit 1: The Public Health Importance of RTIs	Unit 4: Taking a History and Assessing Risk
Unit 2: Integration of RTI Prevention and Management into Family Planning Programs	Unit 5: Physical Examination for RTIs Unit 6: Using Syndromic Management
Unit 3: Community Education and Prevention	Unit 7: Rational Use of Antibiotics
Unit 8: Patient Counseling and Education	Unit 11: Screening and Use of the Laboratory
Unit 9: Condoms and Other Barrier Methods	Unit 15: Clinical Practicum
Unit 10: HIV/AIDS	Optional: Infection Prevention
Unit 12: Reaching Men	
Unit 13: Reaching Youth	
Unit 14: Reaching Sex Workers	

- Clinical practicum sessions are an important part of this training to ensure appropriate application of what is learned in the classroom setting to clinical practice. For consistency in observing client's rights, the following information should be shared with participants in preparation for their clinical practicum experiences.

INFORMED CHOICE*

Informed choice is allowing clients to freely make thought-out decisions about their reproductive health based on accurate, useful information. Counseling provides information to help the client make informed choices.

“Informed” means that:

- **Clients have the clear, accurate, and specific information that they need to make their own reproductive health choices regarding prevention, testing, and treatment.**

“Choice” means that:

- **Clients have a choice of whether to be tested, whether or how they want to be treated, etc.**
- **Clients make their own decisions.** Providers should give full information on prevention, testing, and treatment of RTIs without putting pressure on their clients to make certain decisions.

CLIENT RIGHTS DURING CLINICAL TRAINING

The rights of the client to privacy and confidentiality should be considered at all times during a clinical training course. When a client is undergoing a physical examination, it should be carried out in an environment in which her/his right to bodily privacy is respected. When receiving counseling, undergoing a physical examination, or receiving surgical contraceptive services, the client should be informed about the role of each individual inside the room (e.g., service provider, individuals undergoing training, supervisors, instructors, researchers, etc.).

The client's permission must be obtained before having a clinician-in-training/participant observe, assist with, or perform any services. The client should understand that s/he has the right to refuse care from a clinician-in-training/participant. Furthermore, a client's care should not be rescheduled or denied if s/he does not permit a clinician-in-training/participant to be present or provide services. In such cases, the clinical trainer or other staff member should perform the procedure. Finally, the clinical trainer should be present during any client contact in a training situation.

Clinical trainers must be discreet with how coaching and feedback are given during training with clients. Corrective feedback in a client situation should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and clinician-in-training.

* Adapted from Hatcher, R.A., W. Rinehart, R. Blackburn, and J.S. Geller. 1997. *The essentials of contraceptive technology*. Baltimore: Johns Hopkins School of Public Health, Population Information

It can be difficult to maintain strict client confidentiality in a training situation when specific cases are used in learning exercises such as case studies and clinical conferences. Such discussions always should take place in a private area, out of hearing of other staff and clients, and be conducted without reference to the client by name.

MODULE PURPOSE

This module is designed to prepare participants to provide quality RTI management and prevention services in the era of HIV/AIDS as an integral part of comprehensive reproductive health service delivery. It contains both learning objectives and clinical skills objectives that relate to the actual provision of RTI services. The field of STD management is changing rapidly, and all involved in RTI prevention and management must stay current with changes in guidelines. Ultimately, it is hoped that this module will help to close the gap between what health services currently exist for women, and the goal of comprehensive reproductive health care for all women described at the International Conference on Population and Development in Cairo.

PARTICIPANT SELECTION

The module is meant for middle level providers of family planning services, as well as doctors who already have some skills and training in women's reproductive health: nurses, nurse midwives, nurse assistants, clinical officers and others. Ideally, trainees would be service providers who will actually manage STD prevention and management in their own clinic situations. Clinic and program managers also need to have a clear idea of the goals, challenges, and resource requirements of an integrated program, so that they will be supportive and appreciative of the providers' efforts. For this reason, inclusion of a member of management staff, either in the training itself or in a separate sensitization, is highly desirable.

TRAINING AND LEARNING METHODOLOGY

This module presents an unusual amount, breadth, and variety of teaching/learning methodologies, including: short lectures, group discussion, experiential learning exercises, role plays, case studies, demonstrations/return demonstrations, mystery shopping exercises, simulated skills practice, and a clinical practicum.

EVALUATION METHODS

- Pre- and post-test (pre-and mid-course evaluation)
- Daily "Where We Are" and "Reflections"
- Observation and assessment during simulated practice and clinic practicum
- Skills checklists
- Trainer feedback
- Participant reaction questionnaire
- Presentation of RTI/FP integration plan for worksite
- Participant response and participation in discussion and group work
- Homework

CLINICAL SKILLS PRACTICE

Clinical skills practice will build on the essential knowledge of RTIs and the process of integration acquired during the didactic portion of training.

Practicum Objectives

During the clinical practicum, trainees will demonstrate the following:

- Counseling
- History taking and risk assessment
- Physical examination, including general (brief), abdominal, visual inspection of external genitalia, speculum and bimanual exams for women, and exam of male genitalia.
- Diagnosis and treatment using syndromic management
- Condom demonstration and patient education—individual and group
- Proper infection prevention practices

Classroom Practice

Prior to the clinical practicum, each Px is expected to demonstrate competence, based on standardized checklists, with some degree of proficiency in performing the skills outlined above on an anatomic model. In the case of counseling skills, history taking, risk assessment, condom demonstration and education for prevention, Px will demonstrate competence through participation in role play. They must also pass the post-test before beginning the practicum with 70% correct answers.

Note: Assessment in simulated situations will be through direct observation by a trainer using standardized skills assessment checklists included in the “Trainer’s Tools.”

TIME REQUIRED

Total: 10–12 days (estimate). This includes 7–9 days of didactic and classroom training and 3 days of clinical skills practice (practicum).

Prevention and Management of Reproductive Tract Infections Training Schedule

TIME	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
8–10AM	Introduction: expectations, training goals, pre-test (2 hrs 30 min)	Where Are We? Unit 2 continued	Where Are We? Unit 4 continued Unit 5: Physical Examination for RTIs (6 hr 15 min)	Where Are We? Unit 6: Using Syndromic Management (5 hr 50 min)	Where Are We? Unit 7: Rational Use of Antibiotics (2 hr 10 min)
10–10:15AM	BREAK				
10:15AM–12:15PM	Introduction continued Unit 1: Public Health Importance of RTIs (4 hr 20 min)	Unit 3: Community Education and Prevention (1 hr 55 min)	Unit 5 continued	Unit 6 continued	Unit 8: Patient Counseling and Education (7 hr 25 min)
12:15–1PM	LUNCH				
1–3PM	Unit 1 continued	Unit 4: Taking a History and Assessing Risk (3 hr 50 min)	Unit 5 continued	Unit 6 continued	Unit 8 continued
3–3:15PM	BREAK				
3:15–4:30PM	Unit 1 continued Unit 2: Integration of RTI Prevention and Management into RH Programs (2 hr 40 min) Reflections	Unit 4 continued Reflections	Unit 5 continued Reflections	Unit 6 continued (Mystery Shopping Exercise) Reflections	Unit 8 continued Reflections

**Prevention and Management of Reproductive Tract Infections
Training Schedule**

TIME	DAY 6	DAY 7	DAY 8	DAY 9	DAYS 10–12
8–10AM	Where Are We? Unit 8 continued	Where Are We? Unit 10 continued	Where Are We? Unit 12 continued Unit 13: Reaching Youth (2 hr 45 min)	Where are We? Unit 14 continued Post-test	Clinical Practicum
10–10:15AM	BREAK				
10:15AM– 12:15PM	Unit 8 continued Unit 9: Condoms and Other Barrier Methods (3 hr 20 min)	Unit 10 continued	Unit 13 continued	Clinical Practicum preparation	Clinical Practicum
12:15–1PM	LUNCH				
1–3PM	Unit 9 continued	Unit 11 Screening and Use of the Laboratory (2 hr 5 min)	Unit 13 continued Unit 14: Reaching Sex Workers (3 hr 30 min)	Clinical Practicum	Clinical Practicum
3–3:15PM	BREAK				
3:15–4:30PM	Unit 10: HIV/AIDS (4 hr 40 min) Reflections	Unit 12: Reaching Men (2 hr 15 min) Reflections	Unit 14 continued Reflections	Case Presentations	Case Presentations

Prevention and Management of Reproductive Tract Infections

Example of a Shortened Training Schedule

TIME	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
8–10AM	Introduction: expectations, training goals, pre-test (2 hr 30 min)	Where Are We? Unit 2 continued	Where Are We? Unit 4 continued Unit 6: Using Syndromic Management (5 hr 50 min)	Where Are We? Unit 7: Rational Use of Antibiotics (2 hr 10 min)	Where Are We? Unit 8 continued
10–10:15AM	BREAK				
10:15AM–12:15PM	Introduction continued Unit 1: Public Health Importance of RTIs (4 hr 20 min)	Unit 2 continued Unit 3: Community Education and Prevention (1 hr 55 min)	Unit 6 continued	Unit 7 continued Unit 8: Patient Counseling and Education (7 hr 25 min)	Unit 8 continued Unit 9: Condoms and other Barrier Methods (3 hr 20 min)
12:15–1PM	LUNCH				
1PM–3PM	Unit 1 continued	Unit 3 continued Unit 4: Taking a History and Assessing Risk (3 hr 50 min)	Unit 6 continued	Unit 8 continued	Unit 9 continued
3PM–3:15PM	BREAK				
3:15–4:30PM	Unit 1 continued Unit 2: Integration of RTI Prevention and Management into RH Programs (2 hr 40 min) Reflections	Unit 4 continued Reflections	Unit 6 continued (Mystery Shopping Exercise) Reflections	Unit 8 continued Reflections	Post-test (30 min) Clinical Practicum Preparation

	DAY 6	DAY 7	DAY 8		
	Clinical Practicum	Clinical Practicum	Clinical Practicum		

DEMONSTRATION TECHNIQUE

The Five-Step Method of Demonstration and Return Demonstration is a useful training technique in the transfer of skills. The technique is used to make sure that participants become proficient in certain skills. It can be used to develop skills in IUD insertion, pill dispensing, performing a general physical examination, performing a breast or pelvic examination, etc. In short, it can be used for any skill that requires a demonstration. The following are the "five steps":

1. **Overall Picture:** Provide participants with an overall picture of the skill you are helping them develop and a skills checklist. The overall picture should include why the skill is necessary, who needs to develop the skill, how the skill is to be performed, etc. Explain to the participants that these necessary skills are to be performed according to the steps in the skills checklist, on models in the classroom and practiced until participants become proficient in each skill before it is performed in a clinical situation.
2. **Trainer Demonstration:** The trainer should demonstrate the skill while giving verbal instructions. If an anatomical model is used, a participant or co-trainer should sit at the head of the model and play the role of the client. The trainer should explain the procedure and talk to the role-playing participant as s/he would to a real client.
3. **Trainer/Participant Talk-Through:** The trainer performs the procedure again while a participant verbally repeats the step-by-step procedure.

Note: *The trainer does **not** demonstrate the wrong procedure at any time. The remaining participants observe the learning participant and ask questions.*

4. **Participant Talk-Through:** A participant performs the procedure while verbalizing the step-by-step procedure. The trainer observes and listens, making corrections when necessary. Other participants in the group observe, listen, and ask questions.
5. **Guided Practice:** In this final step, participants are asked to form pairs. Each participant practices the demonstration with her/his partner. One partner performs the demonstration and talks through the procedure while the other partner observes and critiques using the skills checklist. The partners should exchange roles until both feel competent. When both partners feel competent, they should perform the procedure and talk-through for the trainer, who will assess their performance using the skills checklist.

DO'S AND DON'TS OF TRAINING

The following "do's" and "don'ts" should ALWAYS be kept in mind by the trainer during any learning session.

DO'S

- **Do** maintain good eye contact.
- **Do** prepare in advance.
- **Do** involve participants.
- **Do** use visual aids.
- **Do** speak clearly.
- **Do** speak loud enough.
- **Do** encourage questions.
- **Do** recap at the end of each session.
- **Do** summarize after each group exercise.
- **Do** bridge one topic to the next.
- **Do** encourage participation.
- **Do** write clearly and boldly.
- **Do** summarize.
- **Do** use logical sequencing of topics.
- **Do** use good time management.
- **Do** K.I.S. (Keep It Simple).
- **Do** give feedback.
- **Do** position visuals so everyone can see them.
- **Do** avoid distracting mannerisms and distractions in the room.
- **Do** be aware of the participants' body language.
- **Do** keep the group focused on the task.
- **Do** provide clear instructions.
- **Do** check to see if your instructions are understood.
- **Do** evaluate as you go.
- **Do** be patient.

DON'TS

- **Don't** talk to the flipchart.
- **Don't** block the visual aids.
- **Don't** stand in one spot—move around the room.
- **Don't** ignore the participants' comments and feedback (verbal and non-verbal).
- **Don't** read from the curriculum.
- **Don't** shout at the participants.

TRAINING GUIDE

INTRODUCTION

TIME REQUIRED: 2 hours 30 minutes

WORK FOR TRAINERS TO DO IN ADVANCE

- Copy the following participant handouts:
 - 0.0A: Course Expectations
 - 0.0B: *Where Are We and Reflections*
 - 0.0C: Pre- and Post-test
 - 0.0D: Skills Self-Assessment Questionnaire
- Prepare a sign-up sheet for daily participant volunteers for posting.
- Obtain a loose-leaf binder for each participant.
- Gather a few reference books for participants to use in the classroom on STDs, risk assessment, and other subjects related to the content. Include local material.

Introduction

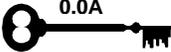
<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introducing Trainers and Participants</p>	<p>Introduction and Expectations of Participants (45 min.):</p> <p>The trainer(s) should:</p> <ul style="list-style-type: none"> • Greet participants; introduce yourself. • Divide participants (Px) and trainers into pairs. Distribute <i>Course Expectations</i>. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Ask Px to form pairs and spend 20 minutes interviewing each other, 10 minutes for each interview. Px may ask any questions for 5 minutes that will help them introduce their partners to the rest of the group. Spend 5 more minutes on the five questions on course expectations. • At the end of 20 minutes, ask each Px to spend one minute introducing her/his partner to the rest of the group, ending with course expectations. • Take notes on all of the expectations so that you can refer to them throughout the course. <p>Name Game (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to stand in a circle. • Explain that the object is to learn everyone's name.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Suggestions for Effective Participation</p> <p>DO</p> <ul style="list-style-type: none"> • Ask a question when you have one. • Feel free to share an illustration. • Request an example if a point is not clear. • Search for ways in which you can apply a general principle or idea to your work. • Think of ways you can pass on ideas to your subordinates and co-workers. • Be skeptical—don't automatically accept everything you hear. • It's OK to pass on a question or activity. • Use "I" statements. 	<ul style="list-style-type: none"> • Begin by each person in turn stating her/his first name or s/he wishes to be addressed. • The trainer starts by giving her/his name and then going around the circle to his/her right giving the correct name of each Px. • When the trainer misses a name, the Px to the right of the trainer begins the process again, naming each person until a name is missed, continuing with each Px until one gets all the names right. That person gets a prize, but the game should continue until ALL Px have attempted to name each Px in the circle. • By the end of the game, everyone should know everyone else's name. <p>Trainer Presentation (10 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask a Px to record the suggestions of the group. • Ask Px for suggestions of "Do's" for effective participation. • Ask Px for suggestions of "Don'ts." • Give Px additional suggestions from the Content.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • Each is entitled to her/his opinion. (Don't be judgmental.) • Be willing to take risks. • Participate in the discussion. <p>DON'T</p> <ul style="list-style-type: none"> • Try to develop an extreme problem just to prove the trainer does not have all the answers. (The trainer does not.) • Close your mind by saying, "This is all fine in theory, but..." • Assume that all topics covered will be equally relevant to your needs. • Take extensive notes; the handouts will satisfy most of your needs. • Sleep during class time. • Discuss personal problems. <p>Workshop Goals and Agenda</p> <p>Unit 1: The Public Health Importance of RTIs</p> <p>Unit 2: Integration of RTI Prevention and Management into Reproductive Health Programs</p> <p>Unit 3: Community Education and Prevention</p> <p>Unit 4: Taking a History and Assessing Risk</p> <p>Unit 5: Physical Examination for RTIs</p> <p>Unit 6: Using Syndromic Management</p> <p>Unit 7: Rational Use of Antibiotics</p>	<p>Review of Goals, Objectives, and Agenda (15 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Review the unit training objectives and specific learning objectives of each unit with Px. • Review the training schedule.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Unit 8: Patient Counseling and Education</p> <p>Unit 9: Condoms and Other Barrier Methods</p> <p>Unit 10: HIV/AIDS</p> <p>Unit 11: Screening and Use of the Laboratory</p> <p>Unit 12: Reaching Men</p> <p>Unit 13: Reaching Youth</p> <p>Unit 14: Reaching Sex Workers</p> <p>Unit 15: Clinical Practicum</p> <p>Where We Are, Reflections, and Px Representation</p> <p>Each day, 2 different Px will take responsibility for necessary group activities, which are:</p> <ol style="list-style-type: none"> 1. Where Are We? At the beginning of each day, one Px will facilitate a brief review of the previous day's work with the group for 5–10 minutes. This is an opportunity to share insights, clarify issues, resolve problems, and review important material we need to remember so that each of us (Px and trainers alike) can get the most out of the course and each day's experiences. 2. Reflections. After a full day of activities, we need to take time to look over what we have done and examine what it means to us individually. The 2nd designated Px will facilitate this discussion for 5–10 minutes. This is an opportunity for the trainers and Px 	<p>Trainer Presentation (10 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask that 2 Px sign up for each day of class to take care of specific tasks for the group. • Distribute <i>Where Are We?</i> and <i>Reflections</i>.  <ul style="list-style-type: none"> • Explain that <i>Where Are We?</i> will be a regular feature of the beginning of each day during the training session. • Explain that <i>Where Are We?</i> requires that one of the designated Px for each day act as facilitator and that all other Px actively participate. • Identifying problems during the <i>Where Are We?</i> session is an important part of the exercise. The problems identified

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>to share general feedback on the training activities and to identify areas that need reinforcement or further discussion. Px should answer the following questions and share responses with the group:</p> <ul style="list-style-type: none"> 🗨️ What did I like about today and why? 🗨️ What did I not like about today and why? 🗨️ What did I learn and experience today that I will be able to use? <p>3. Group Representation The designated Px for the day can carry concerns of Px to trainers and vice versa if any questions or problems arise. There may be other “housekeeping” tasks such as choosing material from flipcharts produced during the day for reproduction and distribution the next day for Px to take home.</p>	<p>should be resolved before continuing with the day's work whenever possible.</p> <ul style="list-style-type: none"> • Explain that at the end of the day's activities, <i>Reflections</i> will be performed. • Explain the role of the Px facilitator. • Take note of the Px and trainers' feedback each day and attempt to address ideas and concerns during the discussion and during the following day's lesson plan. • Explain the function of the group representative and ask for questions or suggestions about this role. <p>Pre-test (40 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Explain to participants that a test will be given before and after the training. Explain that the test before the training helps the trainer focus the training on the right topics. The test after the training is a reflection on how good the training was. • Hand out pre-tests. <div style="text-align: right; margin-top: 20px;">  </div>

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<ul style="list-style-type: none"> • Allow Px 30 minutes to complete the pretest. • Score pre-test as soon as possible using the answer key. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Let Px know their scores, but keep the pre-tests. • Review Px answers so that you know what areas were the most difficult for Px. Be sure to focus on these areas during training. <p>Exercise (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute the <i>Skills Self-Assessment Questionnaire</i> and ask Px to complete it. <div style="text-align: center;">  </div>

UNIT 1: THE PUBLIC HEALTH IMPORTANCE OF REPRODUCTIVE TRACT INFECTIONS (RTIs)

UNIT TRAINING OBJECTIVE:

To define RTIs, including STD, HIV, and AIDS, to explain their public health importance, and to discuss disease control strategies.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

4. Define RTI, STD, HIV, and AIDS.
5. Describe the impact of STDs.
6. Discuss the basic epidemiology of STDs from a global and country perspective.
7. Explain the different ways that STDs affect women.
8. Describe the major factors contributing to the spread of HIV and other STDs.
9. Discuss STD control strategies.

SIMULATED SKILL PRACTICE:

Small group exercise designed to encourage the health worker to act as a community resource for action.

CLINICAL PRACTICUM OBJECTIVES:

None

TRAINING/LEARNING METHODOLOGY:

- Question and answer
- Discussion
- Group work
- Trainer presentation

MAJOR REFERENCES AND TRAINING MATERIALS:

- Burns A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: A health guide for women*. Berkeley, California: Hesperian Foundation.
- Dallabetta G.A., M. Laga, and P.R. Lamptey, eds. 1996. *Control of sexually transmitted diseases: A handbook for the design and management of programs*. Arlington, Virginia: AIDSCAP/Family Health International.
- Joint United Nations Programme on AIDS (UNAIDS) and World Health Organization (WHO). 1998. *Report on the global HIV/AIDS epidemic*. Geneva: WHO.
- United States Agency for International Development (USAID) Office of Population, USAID Office of Health, and USAID Office of Field and Program Support. 1998. *Integration of family planning/MCH with HIV/STD prevention: Programmatic technical guidance, priority for prevention with a focus on high transmitters*. Washington, DC: USAID.
- Van Dam, C.J., K.M. Becker, F. Ndowa, and M.Q. Islam. 1998. Syndromic approach to STD case management. *Sexually Transmitted Infections* 74, Suppl. 1 (June): S175-178.
- World Health Organization (WHO). 1995. *STD Case Management Workbooks*. Geneva: WHO.

RESOURCE REQUIREMENTS:

- Overhead projector
- Flip chart
- Tape
- Markers

EVALUATION METHODS:

- Pre- and post-test
- Continuous assessment of unit objectives
- Participant reaction form (end of module)

TIME REQUIRED: 4 hours 20 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Collect any local or regional data on STD prevalence such as:
 - HIV/STD data from the national AIDS control program
 - HIV sero-prevalence in ANC clients
 - HIV sero-prevalence in sex workers
 - STD rates in men and women of different ages
 - Hospitalizations due to HIV

Use the trainer's tool as a guide for collecting local data.



Note: UNAIDS has regional HIV/AIDS statistics on its website at: <http://www.unaids.org/hivaidsinfo/documents.html#wad> and country-specific “Epidemiological Fact Sheets” that include indicators of prevention, behaviors, etc. at: http://www.unaids.org/hivaidsinfo/statistics/june98/fact_sheets/index.html

- Obtain a copy for each participant of the Pathfinder International publication, *Integrating STD/HIV/AIDS services with MCH/FP programs: A guide for policy makers and program managers*. Contact Pathfinder International (U.S.) by telephone (617-924-7200), fax (617-924-3833), or through its website (www.pathfind.org).
- Prepare the following as transparencies or on a flipchart:
 - 1.1A: RTIs, STDs, and HIV
 - 1.2A: Acute and Long-term Consequences of STDs
 - 1.3A: Regional Prevalence of Curable STDs
 - 1.3B: Adults with HIV/AIDS by Region
 - 1.4A: STD Patients: Age and Sex
 - 1.5A: Case Study Diagrams
 - 1.6A: Total STDs are Reduced Very Little by Classic Clinical Diagnosis and Treatment
- Copy the following participant handouts for distribution:
 - 1.2A: Acute and Long-term Consequences of STDs
 - 1.2B: Scenarios (4 copies only)
 - 1.3A: STD Patterns and Cofactors
 - 1.3B: Prevention Message
 - 1.5A: Case Studies
 - 1.5B: Prevention Message
- Write unit objectives on a flipchart.

WORK FOR TRAINERS TO DO IN ADVANCE continued

- Practice drawing the RTI circles (see Txp 1.1A) (S.O #1.1).
- Prepare 2 sheets of newsprint, one with the heading “Biologic Differences,” and the other with the heading “Socioeconomic and Cultural Differences.”
- Write the definitions of RTIs, STDs, and HIV/AIDS on newsprint, with one definition per page.
- Copy and punch (for a ring binder) the Unit 1 content section (Px Manual) for distribution at the end of the unit.

Introduction to Unit 1

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Introduction</p> <p>The World Health Organization (WHO) estimates that 333 million new cases of curable sexually transmitted diseases (primarily trichomonas, chlamydia, gonorrhea and syphilis) occur worldwide each year. This means about 10% of adults are newly infected with curable sexually transmitted disease (STD) each year. As of the beginning of 1998, UNAIDS estimated there were over 30 million people infected with HIV, the virus that causes AIDS, and that 11.7 million people had already died of AIDS. An estimated 16,000 people are being infected with HIV every day.</p> <p>Each new STD infection can cause serious complications for the infected person, and it increases the risk of HIV transmission for his/her partner(s). Each untreated infection also increases the chances of further transmission in the community. Health workers have an important role to play in correctly managing STDs and other RTIs for those who use their services. Control of STDs, however, requires more than just treatment. People in the community—not just those using the clinic—must be made aware of STDs and the importance of prompt treatment. Most importantly, in order for STD control efforts to have an impact on STD transmission in the community, quality services for prevention and care must be available to and used by persons at the highest risk of infection.</p> <p>This unit reviews some basic facts about RTIs and their importance as health problems and discusses strategies for STD control at the clinic and community levels.</p>	<p>Trainer Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Discuss the unit objectives using the prepared flipchart. • Explain to Px that the purpose of this session is to provide an overview of the problem of RTIs, and that more specific information and skill development will be covered in later sessions.

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Define RTI, STD, HIV, and AIDS. 2. Describe the impact of STDs. 3. Discuss the basic epidemiology of STDs from a global and country perspective. 4. Explain the different ways that STDs affect women. 5. Describe the major factors contributing to the spread of HIV and other STDs. 6. Discuss STD control strategies. 	

Specific Objective #1: Define RTI, STD, HIV, and AIDS

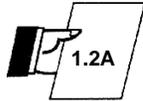
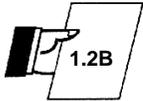
CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Introduction</p> <p>Reproductive tract infections (RTIs) are major health problems for women, men, and children worldwide. HIV, which causes AIDS, is a viral STD that is a leading cause of death in many countries.</p> <p>RTIs in women include sexually transmitted diseases (STDs), as well as infections caused by disturbances of the normal vaginal flora and by medical procedures related to pregnancy, birth, or abortion. RTIs in men include STDs, prostatitis, and epididymitis.</p> <p>Definitions</p> <p>What are RTIs? The term RTI refers to any infection of the reproductive tract. In women, this includes infections of the outer genitals, vagina, cervix, uterus, tubes, or ovaries. In men, RTIs involve the penis, testes, scrotum, or prostate.</p> <p>RTIs in both men and women include:</p> <ul style="list-style-type: none"> • STDs <p>RTIs in women also include:</p> <ul style="list-style-type: none"> • Disruption of normal vaginal flora (candida and bacterial vaginosis) • Postpartum and postabortion infections • Infections following procedures (e.g. IUD insertion) 	<p>Trainer Presentation/Discussion (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the introduction to S.O.#1. • Review the definitions by presenting them one by one on a flipchart. • Draw the circular illustration. • Starting with the outer part of the circle (RTIs) and working inward, ask Px at each ring of the circle to name as many categories of RTIs as they can, write them on the drawing, and add any content material not covered. • Working inwards, define STDs and ask Px to list them, ending with HIV/AIDS. Make sure all content is presented • When finished, display: <div style="text-align: center;">  </div> <p>🔍 Ask Px: What is the difference between HIV and AIDS and why is this important when counseling clients?</p> <p><i>Possible response: A person can be HIV-infected for years with no signs of illness, and can continue a normal life, of course always practicing prevention because he/she can infect another person. A person with AIDS must deal with illness that is often severe and eventually terminal.</i></p>

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>RTIs in men also include:</p> <ul style="list-style-type: none"> • Prostatitis and epididymitis <p>This training focuses on STDs. The others are covered in other Pathfinder training modules (<i>Module 7: IUDs and Module 13: Postpartum and Postabortion Care</i>).</p> <p>Note: <i>Because almost all HIV is sexually transmitted (90%), HIV and AIDS are always included when we speak of STDs in this training.</i></p> <p>What are STDs? STDs are infections caused by germs such as bacteria, viruses, or protozoa that are passed from one person to another through sexual contact. The term “sexually transmitted infection” (STI) is sometimes used to indicate that infections do not always result in a disease. We consider these terms interchangeable in this training and will use the term STD for the sake of simplicity.</p> <p>More than 20 different STDs, including gonorrhea, chlamydia, herpes, syphilis, and HIV/AIDS, have been identified. Some STDs such as syphilis, HIV, and hepatitis can also be transmitted through infected instruments during a medical procedure or during a blood transfusion. HIV, along with hepatitis, can be passed by mother-to-child-transmission, which is sometimes called vertical transmission. It includes transmission:</p> <ol style="list-style-type: none"> 1. during pregnancy. 2. during birth. 3. via breast milk. 	<ul style="list-style-type: none"> • Add any content material not covered.

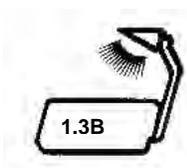
CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>We will discuss specific STDs and their signs, symptoms, and treatment in later sessions.</p> <p>What are HIV and AIDS? HIV stands for <u>H</u>uman <u>I</u>mmunodeficiency <u>V</u>irus, a retrovirus transmitted from an infected person through unprotected sexual intercourse, or by exchange of body fluids such as blood, or from an infected mother to her infant. AIDS stands for <u>A</u>cquired <u>I</u>mmunodeficiency <u>S</u>ndrome. AIDS is the stage of HIV infection that develops some years after a person is infected with HIV. Since HIV is a STD and is transmitted through the same behavior that transmits other STDs, whenever there is risk of STD, there is risk of HIV infection as well. (We will have a complete session on HIV/AIDS later in this training.)</p>	

Specific Objective #2: Describe the impact of STDs

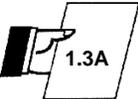
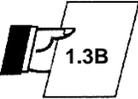
<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>What Makes A Health Problem Important?</p> <ol style="list-style-type: none"> 1. The problem is common. 2. The problem has serious effects on a person's health. 3. The problem has an impact on the welfare of the person's family. 4. The problem has an impact on a community, country, or region. <p>Why Are STDs An Important Health Problem?</p> <ul style="list-style-type: none"> • STDs are among the major causes of ill health in developing countries. STDs are increasing. • STD infection increases the risk of HIV transmission. • STDs cause serious complications in men and women, including infertility. • STDs are responsible for reproductive loss: stillbirth, prematurity, neonatal infections. • STDs affect the larger community: <ul style="list-style-type: none"> – Social impact of infertility – Mother-to-child transmission, disabilities, orphans – Socioeconomic impact of AIDS – Cost to national productivity – Decreased life expectancy – Increased cost to health systems 	<p>Large and Small Group Work (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px what makes a health problem important. Write responses on a flipchart, trying to elicit content answers 1-4. • Divide Px into 4 groups and give each a piece of newsprint. • Ask each group to pick a spokesperson, discuss in 5 minutes one of the following questions, and list its responses: <ul style="list-style-type: none"> • What are some of the consequences of STDs for women? • What are some of the consequences of STDs for men? • What are the consequences of STDs for the newborn? • What are the consequences of STDs for your community? • After 5 minutes, ask the spokesperson from each group to display, read, and explain the group's list very briefly. • Using the transparency, discuss the acute and long-term consequences of the major STDs for 5 minutes. Note that this material will be covered in more detail later. <div style="text-align: right; margin-top: 20px;">  </div>

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
	<ul style="list-style-type: none"> • Distribute: <div style="text-align: center; margin: 10px 0;">  </div> <p>Group Exercise (35 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to return to their 4 groups. • Explain that the purpose of the exercise is to discuss the impact of a major STD like HIV on a family, a community, and a country. • Distribute handout and assign one scenario to each group. <div style="text-align: center; margin: 10px 0;">  </div> <p>Allow the groups 15 minutes for discussion.</p> <ul style="list-style-type: none"> • Each group should be allowed 3 minutes to present its discussion. Give Px the opportunity to comment. • Summarize the activity by emphasizing the severe impact of STD/HIV on all levels of society in affected countries. • Add any content not covered.

Specific Objective #3: Discuss the basic epidemiology of STDs from a global and country perspective

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Important Terms</p> <p>Prevalence: Measure of how common a disease is in a population (usually expressed as a percent). E.g. “10% prevalence of chlamydia among pregnant women” = “10% of pregnant women have chlamydia.”</p> <p>Incidence: Number of new cases of disease occurring (usually each year). WHO estimates that about 333 million curable STDs occur globally each year including:</p> <ul style="list-style-type: none"> • 12 million new cases of syphilis • 62 million new cases of gonorrhea • 89 million new cases of chlamydia • 170 million new cases of trichomonas <p>According to UNAIDS data, the regions with the largest number of HIV infections include Sub-Saharan Africa, Asia, and Latin America. These are also the regions with the highest prevalence of curable STDs.</p> <p>Factors That Contribute to High STD/HIV Prevalence</p> <p>The many reasons include lack of access to health care and medicines, lack of awareness of STDs, and in-out migration.</p> <p>In most communities there are certain people who may be more vulnerable to</p>	<p>Presentation/Discussion/Group Work (35 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the concepts of prevalence and incidence. • Present WHO estimates of global incidence of curable STDs. • Present information on regional prevalence of curable STDs. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Present information on the number of adults with HIV/AIDS by region. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Present local statistics on disease trends such as STD/HIV incidence and prevalence in ANC/FP clinics in country. <p>Note to the trainer: It is best to find local statistics from your MOH, or your National Aids Prevention Program. However, if this is not possible, go to the UNAIDS web site (see p. 3). These provide excellent detailed information on the demographics</p>

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>STDs. These may vary in different communities, but they usually include:</p> <ul style="list-style-type: none"> • teenage girls who are sexually active • women who have several partners “in order to make ends meet” • 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 <p>Fortunately, prevention of STDs involves much the same behavior as prevention of HIV, and prevention works. In addition, since HIV spreads more easily when other STDs are present, HIV transmission can be reduced by improving the recognition and management of curable STDs at the primary health care level.</p> <p>The Link Between HIV and STDs</p> <p>Studies have shown that the spread of HIV and other STDs are closely related. Similar behavior puts people at risk for any sexually transmitted disease. Prevention campaigns to educate people about the link between behavior and infection with STDs are needed.</p>	<p>of the AIDS epidemic by country. The statistics are usually dated no earlier than 1998 and may be more current.</p> <ul style="list-style-type: none"> • Ask Px to return to their same groups. Divide the 4th group quickly among the other 3. Ask each of the 3 groups to discuss one of the following questions with one person recording for 5 minutes. <ul style="list-style-type: none"> 🔍 What are the reasons for high rates of curable STDs? 🔍 What are the reasons for regional differences in STD prevalence? 🔍 What are the reasons for large numbers of people with AIDS in regions with high STD prevalence? <p><i>Reasons may include in-out migration, political instability, war, drought, famine, and migrant worker populations.</i></p> <ul style="list-style-type: none"> • Ask Px to return to the large group. Recorders should present content of group discussions. • Summarize the exercise and include any content not covered. <p>Discussion (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> 🔍 Ask Px if they think there is a link between STDs and HIV and if yes, why this might be true. Using the content section, emphasize behavioral and biological aspects that increase transmission.

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>It is more likely that HIV will be passed from an infected person to an uninfected person if either of them already has a STD. Biologically this makes sense because STDs cause inflammation and open sores that allow easier transmission of HIV from person to person. For example, genital ulcers allow HIV to pass through the skin (or mucous membrane) barrier, and discharges and inflammation increase the amount of HIV present in the genital fluids of someone with HIV.</p> <p>What are the chances of HIV transmission between an HIV-positive person and an HIV-negative person when either person is also infected with another STD? The risk of HIV transmission can be increased as much as 2–5 times. Some studies suggest much higher risk levels. The increases in transmission may explain why HIV has spread so rapidly in regions where other STDs are poorly controlled.</p> <p>In addition to the role of STDs in HIV transmission, HIV has an effect on STDs, and may make treatment more difficult, especially for chancroid. Unless something is done to break this vicious cycle, it is likely that the two epidemics will continue to expand.</p>	<ul style="list-style-type: none"> • After the discussion, distribute: <div style="text-align: center;">  </div> <p>Presentation (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Explain “prevention messages” by telling Px: To remind ourselves that prevention of STDs and HIV is an extremely important part of STD management, we will occasionally present an important prevention message and post it on the classroom wall. Px will receive copies which they can adapt or post “as is” where they work. • Distribute and present the first prevention message and post it on the wall. <div style="text-align: center;">  </div>

Specific Objective #4: Explain the different ways that STDs affect women

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>STDs in Women–How Are They Different From STDs in Men?</p> <p>The reasons why women are vulnerable to infection with STDs and why management may be more difficult than it is for men, fall into two major categories: biological and sociocultural.</p> <p>Biological Differences</p> <ul style="list-style-type: none"> • Biological differences make male-to-female transmission easier than female-to-male transmission. <ul style="list-style-type: none"> – Women are the receptive partners during intercourse. – Semen (thus bacteria or viruses which may be present in semen) stays in contact with the vagina for a longer time than vaginal fluids stay in contact with male genitals. – Younger women may be more susceptible biologically due to an immature genital tract. – Symptoms are less reliable indicators of disease in women. – Women with STD are less likely than men with STD to have symptoms. – When women do have symptoms such as vaginal discharge, they are not necessarily due to STD. • Complications in women are more frequent, numerous, and severe. <ul style="list-style-type: none"> – Infection may ascend to uterus, 	<p>Discussion (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Show transparency and discuss the following: <div data-bbox="1071 651 1234 798" style="text-align: center;">  </div> <ul style="list-style-type: none"> ❓ Why do you think STD incidence is so high in younger age groups compared with older groups? ❓ Why do you think incidence of STDs in females age 15-24 is so much higher than in males in the same age group? ❓ What might account for higher incidence of STDs among men in older age groups? • Add any content not covered. <p>Group Exercise (25 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Divide Px into two groups by merging existing groups 1 and 2 and groups 3 and 4. • Give one group the newsprint with the heading “Biological Differences” and the other the sheet with the heading “Social and Cultural Differences.”

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>tubes, and ovaries.</p> <ul style="list-style-type: none"> - Consequences include PID, infertility, ectopic pregnancy, spontaneous abortion, and cervical cancer. <p>Sociocultural Norms for Men</p> <ul style="list-style-type: none"> • Accepted male behavior that is the norm in many countries puts women at risk of infection. <ul style="list-style-type: none"> - Older men often seek younger women as sex partners. - Older men are more likely to have been exposed to STD because over time, they have more partners and therefore more opportunities to transmit infections such as HIV and HPV, which remain for life. Women more often settle into more stable relationships by their mid-20s. - Younger men have more partners over a shorter time period and thus are at increased risk of STDs. - Younger men are still single, are more likely to have new or multiple partners, and are less likely to know about or use condoms. <p>Sociocultural Norms for Women</p> <ul style="list-style-type: none"> • Certain factors reduce women’s options for protection against STDs. <ul style="list-style-type: none"> - Women can’t always insist on condom use. - Women lack power in the family and community to influence male sexual 	<p>🗣️ Ask each group to list as many differences as possible between STDs in men and STDs in women relating to their topic in 10 minutes. The trainer should give one example for each from the content, such as:</p> <ul style="list-style-type: none"> - Biological: complications of STDs are more severe in women than men. - Social and cultural: women can’t insist on condom use to protect themselves. <ul style="list-style-type: none"> • After 10 minutes, a spokesperson for each group should display and briefly present the lists. • Trainer should lead discussion. Add any content not covered, and summarize the main points of the exercise.

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>behavior.</p> <ul style="list-style-type: none"> - Women cannot always refuse unwanted sex. - Women may be forced into exchanging sex for money or favors out of financial need. - For women, stigma attached to genital tract infections can prevent health care seeking behavior. - Social stigma resulting from STDs and their consequences can prevent marriage, cause divorce, and lead to domestic abuse. 	

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)

Specific Objective #5: Describe the major factors contributing to the spread of HIV and other STDs

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Factors Affecting Transmission</p> <p>STDs are infectious diseases. More than with other infectious diseases, however, STD transmission depends on human behavior. A person with many sexual partners is much more likely to acquire a STD than a person with one partner. A person with many partners also has more opportunity to infect others.</p> <p>In fact, most STD transmission occurs within a small part of the population that has multiple sex partners. This does not mean, however, that the rest of the community is not at risk for STD infection. A woman who has sex with only her husband can still get a STD if her husband has other partners.</p> <p>For these reasons, control of STDs in any community requires effective strategies that reach those with the greatest number of sex partners. Clinical services can contribute to STD control, but they are not enough. Often, those at highest risk of STD infection are least likely to use services.</p>	<p>Presentation (5 min.)</p> <p>Trainer should present content.</p> <p>Case Studies (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> Distribute the handout and display the transparency. <div data-bbox="982 835 1328 997" data-label="Image"> <p>The image shows a projector screen on the left and a handout on the right. Both are labeled '1.5A'.</p> </div> <ul style="list-style-type: none"> Using the trainer's tool, introduce case study 1 and ask the questions for discussion. <div data-bbox="1068 1213 1242 1270" data-label="Image"> <p>The image shows a key with the label '1.5A' above it.</p> </div> <p>Note: There are not always correct answers—the point is to look at how STDs are spread and the effectiveness of control methods.</p> <ul style="list-style-type: none"> Introduce case study 2 and ask the questions for discussion. Summarize the main points of the exercise.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
	<p>Presentation (2 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none">• Distribute and present the prevention message and post it on the wall. 

Specific Objective #6: Discuss STD control strategies

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>A Model of STD Control</p> <p>The pyramid illustrates some obstacles to STD control. The top bar represents all women with STD in a community. The lower bars show how many people are identified at each step, and the differences between the bars illustrate lost opportunities for stopping STD transmission. Comparison of the small bottom bar with the top one shows the proportion of all people with STD in the community who are identified and correctly managed at health facilities. In the typical clinical approach to the control of STDs, the contribution of clinical services is small.</p> <p>For example, suppose that 10 percent of the women in your community have STDs. Of these women, less than half are likely to have symptoms. Even among symptomatic women, however, perhaps only half will seek or have access to care from a clinic. In this example, already less than one-quarter of the women with STDs are seeking care from a qualified health worker.</p> <p>There are other obstacles. How many of the symptomatic women who come to your clinic are accurately diagnosed? Even when diagnosed correctly, do the women leave with effective medications and take all of them? Finally, do women treated for STD have their partners treated successfully at the same time to ensure that they are not reinfected? These can be difficult steps to achieve and are some of the things to consider when deciding whether your STD services will make a difference in your community.</p>	<p>Trainer Presentation/Discussion (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Display the transparency throughout the specific objective. <div data-bbox="1071 619 1234 787" style="text-align: center;">  </div> <ul style="list-style-type: none"> • Present content: “A Model of STD Control.” • Ask Px: <ul style="list-style-type: none"> ☞ Could all those with STDs, both with and without symptoms, be identified in some way? <p><i>Possible response: Perhaps, if there were inexpensive screening tests.</i></p> ☞ For the next bar, what could be done to encourage more people with STD symptoms to use clinic services, or to improve services at other places (like pharmacies) where people go for treatment? • Encourage participants to think about solutions involving both the clinic (the lower bars) and the community (the upper bars).

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Improving STD case management at clinics expands the smallest bar, resulting in higher cure rates among those who seek care. Still, it is apparent that improving services has its limits. Patients do not usually come to health centers unless they have symptoms, and many don't. Even among people with symptoms, some choose to seek care from places other than clinics and hospitals. Self-treatment, direct purchase of antibiotics from pharmacists or drug peddlers, and consultation with traditional healers are among the many options available to someone with STD symptoms.</p> <p>In order to convince people to use clinic services, information about STDs and the importance of prompt treatment must be available at the community level.</p> <p>Control Strategies</p> <p>There are two main elements of STD control:</p> <ul style="list-style-type: none"> • Prevention is the primary strategy for controlling STD/HIV/AIDS since most STDs cannot be treated, either because there is no cure or because there are insufficient means (clinics, labs, medications) to deal with most cases of curable STDs. Prevention means using community education and other strategies to prevent infection from occurring. In order to raise community awareness, messages should be included about STDs and their consequences, reducing the number of sex partners, using condoms, and having safer sex. As a strategy, prevention works. 	<p>Group Exercise (45 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to return to their 4 groups. • Ask each group to spend 20 minutes discussing control strategies that address each level of the diagram, with the goal of expanding each bar as much as possible (except the first). • Ask each group to list the strategies on newsprint and choose a spokesperson to present them. • Back in the large group, have each spokesperson present the group's strategies (4 min. each) and guide the discussion. Ask them not to repeat strategies others have already presented.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<ul style="list-style-type: none"> • Case management means correctly diagnosing and treating symptomatic patients, and providing patient education and partner management to prevent reinfection and transmission to others. <p>Control strategies are often different for those who are at high risk and those at lower risk of contracting and transmitting infection. Reaching those at high risk will provide the greatest overall reduction of STDs in the community.</p>	<ul style="list-style-type: none"> • Spend 5 minutes summarizing the activity. Present the control strategies of prevention and case management, noting that the top two bars of the pyramid represent the opportunity for and the necessity of prevention. The pyramid can be inverted (small bar at the top, large at the bottom) only if the community is successfully reached with prevention messages. Px should continue thinking throughout the course about which level to focus on in their workplace, and how.

Unit 1 Summary

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Summary</p> <p>STDs:</p> <ul style="list-style-type: none"> • Are among the major causes of ill health in developing countries • Lead to an increase in HIV transmission • Cause serious complications, especially in women • Affect the larger community and the nation <p>Effective STD control starts with prevention and proceeds to effective management.</p>	<p>Presentation (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit summary. • Distribute Px Manual content for Unit 1. <p>Homework Assignment</p> <ul style="list-style-type: none"> • Hand out the Pathfinder publication <i>Integrating STD/HIV/AIDS Services with MCH/FP Programs</i>, and ask Px to read it before class the next day.

UNIT 2: INTEGRATION OF RTI PREVENTION AND MANAGEMENT INTO REPRODUCTIVE HEALTH PROGRAMS

UNIT TRAINING OBJECTIVE:

To define reproductive health, understand the concept of integration, and discuss the advantages and limitations of the integration of STD prevention and management into reproductive health programs.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Define reproductive health and list components of reproductive health services.
2. Define integration as it relates to family planning and the prevention and management of STDs.
3. Discuss the overlapping needs of women to prevent both pregnancy and STDs.
4. List and discuss the benefits and drawbacks of integrating STD prevention and management into reproductive health programs.

SIMULATED SKILL PRACTICE:

None

CLINICAL PRACTICUM OBJECTIVES:

None

TRAINING/LEARNING METHODOLOGY:

- Question and answer
- Trainer presentation
- Group exercise
- Discussion
- Case study

MAJOR REFERENCES AND TRAINING MATERIALS:

- Cates, W., and K. Stone. 1992. Family planning, sexually transmitted diseases and contraceptive choice: A literature update. Part I. *Family Planning Perspectives* 24(2): 75-84.
- Center for Development and Population Activities (CEDPA). 1997. *Integrating STDs and AIDS services into family planning programs: Training community workers*. Washington, DC: CEDPA.
- Dehne, K., and R. Snow. 1999. *Integrating STI management into family planning services: What are the benefits?* Occasional Paper #1. Geneva: WHO, Department of Reproductive Health Services.
- Germain, A. and R. Kyte. 1995. *The Cairo consensus: The right agenda for the right time*. New York: International Women's Health Coalition (IWHC).
- Germain, A., K. Holmes, P. Piot, and J.N. Wasserheit. 1992. *Reproductive tract infections: Global impact and priorities for women's reproductive health*. New York: Plenum Press.
- Grosskurth, H., F. Mosha, J. Todd, E. Mwijarubi, A. Klokke, K. Senkoro, P. Mayaud, J. Changalucha, A. Nicoll, G. Ka-Gina, et al. 1995. Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: Randomized controlled trial. *The Lancet* 346(8974): 530-536.
- Kisubi, W., E. Lule, C. Omondi, P. Onduso, P.S. Shumba, F. Farmer, and M. Crouch. 1999. *Integrating STD/HIV/AIDS services with MCH/FP services: A guide for policy makers and program managers*. Nairobi, Kenya: Pathfinder International.
- Kisubi, W., F. Farmer, and R. Sturgis. 1997. *An African response to the challenge of integrating STD/HIV-AIDS services into family planning programs*. Nairobi, Kenya: Pathfinder International.
- Mayhew, S. 1996. Integrating MCH/FP and STD/HIV services: Current debates and future directions. *Health Policy and Planning* 11(4): 339-353.
- Shelton, J. 1999. Prevention first: A three-pronged strategy to integrate family planning program efforts against HIV and sexually transmitted infections. *International Family Planning Perspectives* 25(3): 147-152.
- United States Agency for International Development (USAID). Office of Population; Office of Health; Office of Field and Program Support. 1998. *Integration of family planning/MCH with HIV/STD prevention: Programmatic technical guidance, priority for prevention with a focus on high transmitters*. Washington D.C.: USAID.
- Wawer, M.J., N.K. Sewankambo, D. Serwadda, T.C. Quinn, L.A. Paxton, N. Kiwanuka, F. Wabwire-Mangen, C. Li, T. Lutalo, F. Nalugoda, C.A. Gaydos, L.H. Moulton, M.O. Meehan, S. Ahmed, and R.H. Gray. 1999. Control of sexually transmitted diseases for AIDS prevention in Uganda: A randomized community trial. *The Lancet* 353(9152): 525-535.

RESOURCE REQUIREMENTS:

- Transparencies
- Markers
- Tape
- Newsprint

EVALUATION METHODS:

- Pre- and post-test
- Continuous assessment of unit objectives
- Participant reaction form (end of the module)
- Optional homework assignment

TIME REQUIRED: 2 hours 40 minutes; with optional homework, 3 hours 15 minutes

WORK FOR TRAINERS TO DO IN ADVANCE

- Copy participant handouts:
 - 2.1A: Prevention Message
 - 2.3A: Case Study
 - 2.3B: Associations Between RTIs and Specific Contraceptive Technologies
 - 2.4A: Feasibility of Integration of STD Services
- Write unit objectives on a flipchart.
- Copy the Unit 2 content section (Px Manual) for distribution at the end of the unit.

Introduction to Unit 2

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Introduction</p> <p>With the emergence of the AIDS epidemic, most reproductive health programs cannot offer high-quality services without including HIV/AIDS prevention. At a minimum, family planning and reproductive health providers should inform clients about HIV and STD protection through safer sex practices and behavior change as well as which contraceptive methods do and do not give protection. Integrating the management of STDs by improving diagnosis and treatment may be appropriate in some settings and not in others, depending on available resources, training, and prevalence of STDs in the community.</p> <p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Define reproductive health and list components of reproductive health services. 2. Define integration as it relates to family planning and the prevention and management of STDs. 3. Discuss the overlapping needs of women to prevent both pregnancy and STDs. 4. List and discuss the benefits and drawbacks of integrating STD prevention and management into reproductive health programs. 	<p>Trainer Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objective using the prepared flipchart.

Specific Objective #1: Define reproductive health and list components of reproductive health services

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Definition of Reproductive Health</p> <p>The International Conference on Population and Development (ICPD) in Cairo defined reproductive health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system.” Women’s reproductive health needs change throughout their lives from adolescence to old age, and according to their life circumstances (single or married, with or without children, fertile or infertile, pregnant, postabortion, circumcised, etc.). The reproductive health needs of men is a concern in its own right.</p>	<p>Buzz Group/Discussion (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> ➤ Ask Px to turn to the person next to her/him and spend 5 minutes discussing the question: How would you define reproductive health (RH)? <p>If needed, ask a few starting questions such as:</p> <ul style="list-style-type: none"> ➤ Does RH simply mean the absence of disease of the reproductive parts? ➤ Does RH mean safe childbirth? <ul style="list-style-type: none"> • Reconvene the large group for a 10-minute discussion, and ask a Px volunteer to record the main points on a flipchart. • Read out loud the ICPD definition of RH. • Ask the group to further refine their definition and have the recorder copy the final definition onto a new piece of paper. Post the definition on the wall for the rest of the training. <p>Brainstorm (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> ➤ Ask Px to brainstorm the components of RH services for women and men. Write list on flipchart. <ul style="list-style-type: none"> • Add any missing content.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>The components of reproductive health (RH) services may include:</p> <ul style="list-style-type: none"> • Antenatal care • Postnatal care • Breastfeeding • Family planning • Sex education • STD prevention and treatment • Abortion/postabortion care • Domestic violence prevention • Prevention and treatment of genital cancers • Gynecological care • Infertility treatment • Sexuality counseling <p>STD prevention and treatment can improve RH in the following ways for both men and women:</p> <ul style="list-style-type: none"> • Increased awareness, behavior change, and prevention of STD/HIV • Better pregnancy outcomes • Safer postabortion care • Improved diagnosis of genital cancer • Decreased infertility • Access to sexuality education • Access to dual protection with condoms against pregnancy and STDs <p>Other benefits of integration may include the opportunity to address domestic abuse and improved communication within couples.</p>	<p>Discussion (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px which services can be added to already existing FP or other services to prevent and manage RTIs. • Ask Px how RTI prevention and treatment can improve and support RH. • Ask a Px volunteer to write responses on newsprint. • Fill in any content not covered. <p>Prevention Message (2 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute and present the prevention message and post it on the wall. <div style="text-align: center;">  </div>

Specific Objective #2: Define integration as it relates to family planning and the prevention and management of STDs

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Integration</p> <p>Integration means the addition of services to prevent and manage STDs to an already existing RH program. Integration can include one or more of the following:</p> <ul style="list-style-type: none"> • Information for clients on avoiding infection with HIV or other STDs. • Community education on awareness and prevention of STDs, behavior change, and early treatment. • Condom promotion with or without other FP methods. • Counseling for behavior change and reduction of high-risk behavior. • Special services for youth, men, and high-risk women. • Voluntary HIV counseling and testing and referral for AIDS-related problems. • Screening for selected STDs (e.g. syphilis screening during pregnancy). • Diagnosis and treatment of symptomatic RTI or STD. 	<p>Discussion (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> ☞ Ask Px for their definition of the term “integration” as it relates to FP and the prevention and management of STDs. Write responses on newsprint and make sure key points are included. ☞ Ask participants which services can be added to already existing FP or other services to prevent and manage RTIs. • Summarize discussion and add any content material not covered.

Specific Objective #3: Discuss the overlapping needs of women to prevent both pregnancy and STDs

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Dual Protection</p> <p>It is possible to prevent both pregnancy and STDs by using condoms.</p> <p>Given the STD and AIDS epidemics, RH programs today need to protect clients against both pregnancy and STDs. Unfortunately, the most effective contraceptives—voluntary sterilization, injectables, Norplant, IUDs, oral contraceptives—do not protect against STDs. Condoms, however, do protect against a variety of STDs, including HIV infection. All family planning clients at risk for STDs, regardless of their contraceptive choices, should leave a family planning clinic knowing how to use condoms. They need tips on how to negotiate use with a partner and where to get more. They should leave the clinic with some condoms in hand.</p> <p>Dual Protection: Preventing Pregnancy with Condoms</p> <p>With typical use, 15% of women who rely on condoms become pregnant in the first year of use, mainly because they and their partners do not use condoms consistently or correctly. Clients need instruction and your help and encouragement to use condoms consistently and correctly. Also, advance supplies of emergency contraceptive pills (ECPs) may be given to condom users to reduce the chance of unwanted pregnancy. (See Unit 9.)</p> <p>Condoms are the only barrier method proven highly effective against STD</p>	<p>Presentation/Case Study/Small Group Work/Discussion (30 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present content (5 min.). • Distribute handouts. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Ask a Px to read the case study aloud. • Ask Px to form 4 new small groups. • Ask Px to discuss the following questions for 10 minutes, listing problems they identify for each and discussing how they might approach solving those problems. <p>? What problems does this case present for the provider?</p> <p><i>Answer: Provider has difficulty discussing sexual issues; the woman is married and presents only for contraception; she may not be open to discussing her husband's possible risky behavior.</i></p> <p>? What problems does this case present for the patient?</p> <p><i>Answer: She may not be comfortable talking about this with the provider; she may be aware of her risk but she may not feel able to address the issue with her partner, she may feel she is at risk of domestic problems or violence if she brings</i></p>

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>transmission if they are used consistently and correctly.</p> <p>Clients who want a very reliable, effective method for pregnancy prevention and are at risk for STDs should use condoms in addition to another method. But without strong motivation, clients may find it difficult to use two methods—condoms for STD prevention and some other method for pregnancy prevention—because using even one method consistently is hard enough.</p> <p>Family planning providers, like STD service providers, need to counsel clients about STDs, condom use, and possibly other barriers that may protect them against STDs. What about other family planning methods?</p> <ul style="list-style-type: none"> • There is little evidence thus far that diaphragms, cervical caps, or spermicides help prevent HIV, although they may help prevent other STDs. The IUD is not a recommended method if a client is at risk of a STD. A woman is at risk if she has more than one partner, if her sexual partner has other partners, or if she has had a previous STD. • Spermicides have been found to be relatively ineffective at protecting against STDs¹, and may increase the risk of STD and HIV transmission with frequent use. <p>The more we promote and offer condoms during any reproductive health visit, the greater the possibility they will eventually be used.</p>	<p><i>up the subject; she may not be able to afford the cost of two methods together; she may believe that condoms are only used by sex workers.</i></p> <ul style="list-style-type: none"> • Each group should present its list of problems and possible solutions. • The trainer should summarize the information found in the content section after all groups have presented, acknowledging the challenges of promoting dual protection and the unique position of family planning providers to be able to do so.
<p>¹ Shelton, J. 1999. Prevention first: A three-pronged strategy to integrate family planning program efforts against HIV and sexually transmitted infections. <i>International Family Planning Perspectives</i> 25(3): 147-152.</p>	

Specific Objective #4: List and discuss the benefits and drawbacks of integrating STD prevention and management into reproductive health programs

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Why Integrate?</p> <p>Advantages</p> <ul style="list-style-type: none"> • Helps individual women and men avoid infection with STDs and HIV. • Increases the use of dual methods for protection against STDs and pregnancy when women choose contraceptive methods other than condoms. • Serves the many people who seek care for STDs and who have concerns about HIV infection. • Reduces levels of STDs and HIV infection in the population served. • Helps women take more control over their sexual relationships. • Saves money by not duplicating services already offered. • Makes use of the community-based outreach that exists in many FP programs. • Provides alternatives to the social stigma of attending a STD clinic. • Provides an opportunity to attract youth and men to FP clinics where feasible. • Increases condom use for dual protection. • FP/MCH services are where women get their health care. • Provides links to obstetrical and gynecological services. 	<p>Debate (40 min.)</p> <p>The debate depends on Px having read the integration pamphlet assigned as homework at the end of Unit 1.</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Combine the 4 previous groups into 2. • Explain that the groups will have 15 minutes to prepare for a debate on the advantages and disadvantages of integrating RTI services into RH programs, and that even if Px assigned to one side agree with the opposite side, they should try to make a good argument for their side. Px may want to decide beforehand who will make which points. • After 15 minutes, ask the groups to be seated on opposite sides of the room. • Ask a Px to read the rules of the debate and ask the Px to follow them. <p>Rules:</p> <ul style="list-style-type: none"> – The debate will go on for 25 minutes. – Only 1 person may speak at a time. – A person from the “for integration” side should speak first, and a person from the “against integration” side should respond to/debate the particular point made.

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Disadvantages</p> <ul style="list-style-type: none"> • Typical clients in FP/MCH settings are at relatively low risk of having a STD or HIV infection (compared with, for instance, sex workers and men who visit them). • Integration means less time for family planning and other services. • Integration will require additional training of providers. • Provider attitudes can be judgmental. • Adding new services costs money. • Integrated programs may not effectively reach core transmitters. • The quality of FP services may decline as limited resources are diverted for STD management. <p>Barriers to Integration</p> <p>STD prevention and management is difficult.</p> <ul style="list-style-type: none"> • Providers and clients may be reluctant to discuss sensitive issues such as sexual practices, multiple partners, etc. • Treating sexual partners is difficult. • Most women with STDs have no symptoms. • Syndromic management of vaginal discharge to treat gonorrhea and chlamydia is ineffective. • Antibiotics are often not available or not affordable. • There is risk of domestic violence when women tell partners they need treatment. 	<ul style="list-style-type: none"> - One of the trainers will facilitate and one will be the scorekeeper. The scorekeeper decides which side wins the point being argued and keeps score on a flipchart. The teams may advise the scorekeeper. - At the end of the 25 minutes, the team with the most points wins the debate. <ul style="list-style-type: none"> • The trainer should briefly summarize the points made. <p>Discussion (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute: <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Begin a discussion by asking Px how the idea for integration came about in their organization, if it has. • List Px's points on newsprint. Then go over the questions on the handout as they relate to Px's place of work.

Unit 2 Conclusion and Summary

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Conclusion</p> <p>Integration has advantages but requires considerable effort and resources. Before integration of STD services into FP/MCH programs is attempted, careful assessment and planning is necessary to determine need, cost, required resources, and feasibility. Integration can begin with preventive measures such as condom education and distribution. When thinking about actual management of STDs, an antenatal syphilis program might be the best way to begin.</p> <p>Summary</p> <ol style="list-style-type: none"> 1. RH services must respond to changing reproductive health needs throughout life. 2. Before integrating services, assess need, cost, resources, and feasibility. 3. Integration activities can begin with community outreach and prevention. 4. The most effective contraceptives don't protect against STDs. 5. Family planning programs today must protect clients against both pregnancy and STDs. 6. Focus on condom promotion and dual protection as the first step in integration. 	<p>Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask for any questions about the integration pamphlet that Px read for homework. • Present the conclusion. • Present the unit summary. • Distribute Px Manual content for Unit 2. <p>Homework Assignment (5 min.)/Optional Next-day Presentation/ Discussion (35 min.)</p> <p>This assignment can be turned in, or the presentation can be done if time permits.</p> <p>The trainer should give Px the following instructions:</p> <ul style="list-style-type: none"> • Using the handout, write answers based on the situation in your workplace and community on the feasibility of integration of STD services. Do not write yes or no answers. Turn them in to the trainer the following day. The trainer will review, comment, and return them before the end of the course. <p>If time permits, the trainer should ask 5 persons to present their "feasibility study" to the group for discussion. Allow 5 minutes for each presentation and 10 for discussion.</p>

UNIT 3: COMMUNITY EDUCATION AND PREVENTION

UNIT TRAINING OBJECTIVE:

To demonstrate an understanding of the provider's role in promoting community awareness and preventing STDs and AIDS in the community.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Explain the importance of STD prevention in the community.
2. Explain the steps of behavior change communication (BCC).
3. List at least 5 ways that health workers can raise community awareness and develop prevention strategies.

SIMULATED SKILL PRACTICE:

None

CLINICAL PRACTICUM OBJECTIVES:

None

TRAINING/LEARNING METHODOLOGY:

- Presentation
- Discussion
- Small group work

MAJOR REFERENCES AND TRAINING MATERIALS:

- Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: a health guide for women*. Berkeley, California: Hesperian Foundation.
- Dallabetta, G.A., M. Laga, and P.R. Lamptey, eds. 1996. *Control of sexually transmitted diseases: a handbook for the design and management of programs*. Arlington, Virginia: AIDSCAP/Family Health International.

RESOURCE REQUIREMENTS:

- Tape
- Markers
- Flipchart
- Prizes (condoms, key chains, etc.)

EVALUATION METHODS:

- Pre- and post-test
- Continuous evaluation of unit objectives
- Participant reaction (end of module)

TIME REQUIRED: 1 hour 55 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Copy the following participant handouts:
 - 3.1A: Why Community Prevention?
- Write unit objectives on a flipchart.
- Prepare flipchart for Specific Objective #3. Using four sheets of the flipchart, write two different subjects from the list on each sheet.
- Copy the Unit 3 content section (Px Manual) for distribution at the end of the unit.

Introduction to Unit 3

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>Good management of STDs in the clinic is necessary, but it alone will not prevent the spread of STDs. An urgent need to increase community awareness of STDs and AIDS exists because of the general lack of knowledge and motivation for behavior change and the stigma associated with STDs, particularly HIV.</p> <p>Health workers have an important role to play in disseminating health messages and promoting community involvement in the fight against STDs and HIV. Providers can support the prevention efforts of groups outside the clinic (peer educators, CBDs, religious groups, schools, and others) by providing consistent messages that contain accurate information.</p> <p>Research shows that prevention in the community works and ultimately can reduce the incidence of STD and AIDS that require treatment from the clinic.</p> <p>Developing and disseminating messages for behavior change, both on a regional or country basis and at the community level, is an undertaking that requires many resources and specially trained health education and communications staff.</p> <p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Explain the importance of STD prevention in the community. 2. Explain the steps of behavior change communication (BCC). 3. List at least 5 ways that health workers can raise community awareness and develop prevention strategies. 	<p>Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objectives using the prepared flipchart.

Specific Objective #1: Explain the importance of STD prevention in the community

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Health Care Providers and Community Prevention</p> <p>Much of health care providers' work involves providing information, skills, and motivation that clients need for making decisions to improve their health. Viral STDs, including HIV, cannot be cured—prevention is our only hope. And even when STDs are curable, working to prevent infection in the first place is of utmost importance because reproductive health services are not accessible to all and, in the best of circumstances, cannot reach everyone at risk in the community.</p> <p>Why Community Prevention?</p> <ol style="list-style-type: none"> To increase awareness of the symptoms and consequences of STDs. Awareness of the signs of STDs, knowledge about STD transmission and the serious consequences of STDs, and perception of risk is low in many communities, especially among certain populations. Increasing knowledge and awareness is the first step toward changing behavior. To counter myths and rumors. Myths and rumors about AIDS and STDs abound, often causing stigmatization of people known to be infected. Negative community attitudes based on misunderstandings prevent people from openly seeking information and health care and using condoms to protect themselves. 	<p>Presentation (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> Present the material from the first paragraph of the content section. <p>Small Group Work (25 min.)</p> <ul style="list-style-type: none"> Ask Px to break into four new small groups. Distribute: <div data-bbox="1068 993 1211 1094" data-label="Image"> </div> Assign each group 2 (the 4th group will get only one) of the reasons listed under “Why Community Prevention?” Ask Px to discuss the importance of each of their two reasons, whether their facilities support such activities and how this is done. Display “Total STDs are Reduced Very Little by Classic Clinical Diagnosis and Treatment” and ask Px to refer to the pyramid in their discussions. <div data-bbox="1076 1688 1230 1822" data-label="Image"> </div>

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>3. To encourage risk-reducing behaviors. People need to know which behaviors are safe and how to reduce unsafe behavior. Awareness of the consequences of unsafe behavior can lead to motivation for change.</p> <p>4. To increase use of available health services. Advertising clinic hours with clear messages about services offered and populations served can increase the use of available services. The quality of an individual’s experience can be greatly improved by creating a welcoming, supportive, educational atmosphere.</p> <p>5. To start a process of social change. Many women are at risk for STDs or HIV/AIDS because of social norms, such as taboos on sexuality, male behavior, double standards, and economic dependency. Social and cultural norms can change, and this change may be essential for STD prevention.</p> <p>6. To gain public support for STD services. In order to familiarize people with clinic services, links between the community and the health center should be created through outreach activities. If community members see that prevention efforts are backed up by quality health services, they will be more willing to support such services.</p> <p>To increase community leaders’ support for STD services. Active engagement of the community in STD prevention that yields positive results can make it easier for leaders to support STD control efforts publicly, continuing a</p>	<ul style="list-style-type: none"> • After 10 minutes of small group discussion, have the large group come together. Ask a spokesperson from each small group to present its conclusions. • Record key points on the flipchart. • Add any missing content • Summarize the exercise.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
positive cycle of prevention activities.	

Specific Objective #2: Explain the steps of behavior change communication (BCC)

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Steps to Changing Community Behavior</p> <p>Changing behavior is difficult. Especially at the community level, social norms are deeply embedded in institutions such as schools and churches. Going against the norms may be objectionable to certain groups. Putting messages out into the community requires thoughtful planning. These are the steps toward bringing about behavior change in a community.</p> <ol style="list-style-type: none"> 1. Define target groups. Think about targeting groups at highest risk or in greatest need. Who needs information most urgently? Who can be reached using resources you have available? What links can be made with other organizations already targeting groups in need? Research and common sense show that different messages are required to reach different groups. Sex workers, youth, men, rural and urban women, community leaders, religious leaders—all need messages and information tailored to their different situations. 2. Understand community beliefs and practices. To understand what messages will reach people, one needs to understand why they behave the way they do. 3. Set communication objectives and activities. What do people already know about STDs? What do they need to know? What are their attitudes and prejudices about STDs? Who are their leaders, or who has influence over them? What cultural 	<p>Question and Answer/Message Competition (30 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Lead a discussion using the information found in the content section. ☞ Ask Px how we can find out what the beliefs and practices of a specific target group are. <p><i>Possible responses: focus group discussions, surveys of people from the clinic or elsewhere in the community, general knowledge, interviews</i></p> <ul style="list-style-type: none"> • Divide Px into the same 4 groups. Allowing 10 minutes for discussion, ask each one to come up with a message encouraging safe sex for a different target group (e.g. in-school youth, married women, truck drivers). • Explain that Px can choose any target group they want, but not the same one as the other Px groups. After 1 minute, check to make sure each group has chosen a different target group. • After 10 minutes, ask each group to present its slogan. • When everyone has presented, the Px vote on which slogan is the best. First prize can be key chains, condoms, etc. <p><i>Messages might include:</i></p> <p><i>For school youth—Delay sex until you're really ready, unprotected sex can mean the end of your school days.</i></p>

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>and language barriers exist?</p> <p>4. Develop strategies to reach target groups. Can you use peer educators to reach marginal groups? Can you attract people by offering clinical services?</p> <p>5. Evaluate the strategies' impact. How well did the strategies work? Can you monitor condom use in your clinic? Can you track numbers of condoms dispensed in a given period of time?</p>	<p><i>For married women—Tell your husband that he is welcome at the clinic for a STD check-up, or ask your husband to protect his family by using condoms.</i></p> <p><i>For truck drivers—When you're away from home, drive carefully and love carefully.</i></p> <p>👉 Ask Px how they can involve community leaders in prevention activities.</p> <p><i>Possible responses: a message on the radio, a song endorsing a brand of condoms, speaking at gatherings, sports events.</i></p>

Specific Objective #3: List at least 5 ways that health workers can raise community awareness and develop prevention strategies

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Making Connections to Increase Community Awareness</p> <p>Providers are very often in a position of influence in the community. Making connections with NGOs, community-based health workers, government health workers, community groups, and others who are working on reproductive and sexual health issues can have an impact and make change happen.</p> <ul style="list-style-type: none"> • Help community workers look for opportunities to do health talks explaining how STDs are transmitted and how to prevent them at places where women gather together in groups, such as market places or health centers. • Work toward targeting men to make condom use socially desirable and to give men the opportunity to participate in reproductive health. • Make sure condoms are available in your community. Link up with local social marketing programs to ensure that condoms can be found in local shops, bars, and cafes, as well as at health centers. • Train men to be peer educators for increased STD awareness and condom use. • Be available to speak at gatherings. Organize community groups to talk about health problems, including STDs and AIDS, and explain how early detection and treatment of STDs help prevent HIV infection. 	<p>Presentation/Discussion/Group Work (40 min.)</p> <ul style="list-style-type: none"> • Present the information in the content section, asking for Px discussion on the feasibility of raising awareness of STDs in their community. • Ask Px to rejoin their same 4 groups. • Give each group a sheet of newsprint with two of the subjects listed below on it. Ask Px to give two examples of educational messages for each of their two subjects and record their messages on the sheet of newsprint. <p style="margin-left: 20px;">Subjects:</p> <ol style="list-style-type: none"> 1. Increasing STD awareness 2. Possibility of asymptomatic infection 3. Consequences for self, partner, and newborn 4. Importance of early treatment 5. Importance of partner treatment 6. Risk reduction 7. Anyone can have AIDS 8. Proper condom use <ul style="list-style-type: none"> • After 20 minutes, ask the Px to return to the larger group. Each group should take a turn presenting its messages.

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • Support sex education in schools so that children have the information and skills they need to postpone sexual activity and to make safe choices later on when they become sexually active. • Encourage peer education programs for youth on STDs and HIV. 	

Unit 3 Summary

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Summary</p> <ul style="list-style-type: none"> • Health care providers need to prevent as well as treat STDs. • Viral STDs, including HIV, cannot be cured—prevention is our only hope. • Providers are needed in community education and prevention efforts. • Because reproductive health services are not accessible to all and, in the best of circumstances, cannot reach everyone at risk, working to prevent infection in the first place is of utmost importance. 	<p>Summary (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit summary. • Distribute Px Manual content for Unit 3.

UNIT 4: TAKING A HISTORY AND ASSESSING RISK

UNIT TRAINING OBJECTIVE:

To take an accurate history and assess the risk of STD infection in the RH setting.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. List the goals of taking a history for STD.
2. Identify information and skills necessary for accurate history taking.
3. Define risk assessment and understand its use for STD prevention and its limitations in STD management.
4. Demonstrate history taking and risk assessment using a standardized checklist.

SIMULATED SKILL PRACTICE:

Using the role-play checklist, take a history and do a risk assessment during role plays in the classroom.

CLINICAL PRACTICUM OBJECTIVES:

Take a history and assess risk during patient encounters.

TRAINING/LEARNING METHODOLOGY:

- Trainer presentation
- Role play
- Group work
- Brainstorming
- Homework

MAJOR REFERENCES AND TRAINING MATERIALS:

- Lazcano Ponce, E.C., N.L. Sloan, B. Winikoff, A. Langer, C. Coggins, A. Heimbürger, C.J. Conde-Glese, and J. Salmeron. 1999. *The power of information and contraceptive choice in a family planning setting*. Unpublished.

- Solter, C. 1998. *Module 3: Counseling for family planning services*. Watertown, Massachusetts: Pathfinder International.

RESOURCE REQUIREMENTS:

- Flipchart
- Markers
- Tape
- Overhead projector
- WHO practice and workbook exercises
- Condoms, male and female
- Contraceptive method samples
- Poster board, paper, and markers for homework project

EVALUATION METHODS:

- All of the methods mentioned previously
- CBT checklist for risk assessment

TIME REQUIRED: 3 hours 50 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Locate and copy the National Standards for the Syndromic Diagnosis and Treatment of STDs, if available.
- Prepare the following as transparencies or flipchart:
 - 4.1A: The Goals of Taking a History
- Prepare the following handouts:
 - 4.2A: Competency-Based Training (CBT) Skills Assessment Checklist for History Taking
 - 4.3A: Case Study
 - 4.3B: Risk Assessment Questions
 - 4.3C: Prevention Message
 - 4.4A: Role Plays
- Write the unit objectives on a flipchart.
- Prepare 4 sheets of newsprint with the headings of the 4 categories of information needed for history taking: 1) general information, 2) present illness, 3) medical history, and 4) sexual history.
- Copy the Unit 4 content section (Px Manual) for distribution at the end of the unit.

Introduction to Unit 4

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>A patient history is taken to get the information needed to make an accurate assessment of the problem and to provide appropriate treatment. It is one of the most important and sensitive parts of the patient encounter, since we ask and probe about private sexual behaviors and concerns. Risk assessment involves asking how likely it is that someone has been or will be exposed to a STD. In this unit we will cover the elements of history taking and risk assessment required to counsel patients on STD prevention, and for syndromic management of STDs. Counseling and communication skills will be covered in more depth in Unit 8: Patient Education.</p> <p>Unit Objectives</p> <ol style="list-style-type: none"> 1. List the goals of taking a history for STD. 2. Identify information and skills necessary for accurate history taking. 3. Define risk assessment and understand its use for STD prevention and its limitations in STD management. 4. Demonstrate history taking and risk assessment using a standardized checklist. 	<p>Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objective using the prepared flipchart.

Specific Objective #1: List the goals of taking a history for STD

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>The goals of taking a history are:</p> <ul style="list-style-type: none"> To efficiently collect essential information that will help in prevention, diagnosis, and treatment of STDs. To establish the patient's risk of contracting or transmitting a STD. To determine if the patient has had any partners who may have been infected. <p>Confidentiality</p> <p>While taking a history, the provider must reassure the patient that confidentiality will be maintained and explain the reason for asking certain questions. Patients are often embarrassed and may withhold important information if they think that what they say will become known to others.</p>	<p>Presentation/Buzz/Large Group Discussion (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> Present the goals of history taking using: <div data-bbox="1047 625 1242 808" data-label="Image"> </div> Buzz: Ask Px to turn to their neighbors and discuss for 5 minutes the topic "Why is confidentiality important in history taking?" Large group discussion: After 5 minutes, ask Px: <ul style="list-style-type: none"> Why is confidentiality important? What problems exist in your clinic regarding issues of confidentiality? <p><i>Be sure the following responses are included: lack of privacy, lack of clear guidelines about maintaining confidentiality, and lack of security in areas where confidentiality can be breached, such as the lab or patient record room.</i></p> <ul style="list-style-type: none"> How can you address these problems? Write answers on a flipchart. Summarize using content.

Specific Objective #2: Identify information and skills necessary for accurate history taking

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Although family planning providers are familiar with most aspects of history taking, they are often uncomfortable asking the sensitive questions needed to obtain a sexual history.</p> <p>History Taking Information</p> <ul style="list-style-type: none"> • General information: age, married or single, number of children, address, employment, marital status, contraceptive method if any, and date of last menstrual period. • Present illness: signs, symptoms, and their duration. • Medical history: RTIs and STDs in the past, other illnesses, and drug allergies. • Sexual history: currently sexually active, age at first intercourse, new partner, and risky sexual behaviors. <p>Good Rapport in History Taking</p> <p>In history taking, the provider needs to establish good rapport with the patient from the start. This means:</p> <ul style="list-style-type: none"> • Providing the patient with privacy • Establishing eye contact • Being attentive 	<p>Group Discussion (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Have written the 4 areas of information (general information, present illness, medical history, and sexual history) needed for a STD history on 4 separate sheets of newsprint. • Ask Px to brainstorm what information is needed in each and record it on the newsprint . • Distribute the CBT Skills Assessment Checklist for History Taking for Px’s reference and ask them to read it. <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <ul style="list-style-type: none"> • Ask Px if they have any questions or comments on the checklist. • Fill in any omitted content. • Post lists on the wall. <p>Brainstorm (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px what skills are needed to establish a good rapport with patients and take a history. <p>Note: The trainer may need to provide some of this information from the content to help Px along.</p>

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<ul style="list-style-type: none"> • Sitting if s/he is sitting, and standing if s/he is standing—try not to put a desk between you. <p>Good Interpersonal Skills</p> <p>An effective provider is able to apply good interpersonal communication skills when taking a history, during an examination, and while providing information and counseling. An effective provider:</p> <ul style="list-style-type: none"> • Empathizes with the patient • Listens actively • Poses questions clearly • Has a non-judgmental attitude • Recognizes and correctly interprets nonverbal cues and body language • Paraphrases, interprets, and summarizes patient's comments and concerns • Offers praise and encouragement • Uses language the patient understands <p>Communication skills are discussed in more detail in Unit 8 and in Pathfinder <i>Module 3: Counseling</i>.</p> <p>Common Problems</p> <p>Common problems encountered when taking a history related to RTIs:</p> <ul style="list-style-type: none"> • Not enough time is available. • The provider is uncomfortable talking about sex. 	<ul style="list-style-type: none"> •  Ask Px what interpersonal communication skills are needed in history taking. • Ask Px what common problems are encountered when taking a RTI history. • Fill in any content omitted. • Ask Px to: <ul style="list-style-type: none"> – Give an example of a nonverbal cue by a client: for example, talking very softly or not looking at the provider may indicate fear or embarrassment. – Give an example of a nonverbal cue by a provider: for example, the provider looks directly at the patient, nods when she speaks showing that she is focused on her. – Give an example of ways to show you are listening attentively: for example, the provider paraphrases the patient's concerns accurately in understandable language. <p>Small Group Work (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to form 3 groups. • Ask each group to discuss for 15 minutes how they can address one of the following commonly encountered problems when taking RTI histories:

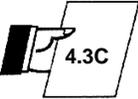
<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • The patient is uncomfortable talking about sex, especially if s/he knows the provider feels uncomfortable about a difference in social status between them. 	<ul style="list-style-type: none"> - Group 1: There is not enough time available for the interview. - Group 2: The provider is uncomfortable him/herself, talking about sexual matters. - Group 3: The patient is uncomfortable talking about sex, partly because of the difference in social status between her/him and the provider. • Ask one person from each group to briefly report on the results of the discussion. Make sure the following are included: <ul style="list-style-type: none"> - Practicing and using interpersonal communication skills. - Willingness to acknowledge personal levels of comfort/discomfort with sexual issues and striving to become more at ease with these issues. - Ensuring the patient's privacy and confidentiality. - Working within time limits. - Treating the patient respectfully and supportively at all times. • Summarize exercise.

Specific Objective #3: Define risk assessment and understand its use for STD prevention and its limitations in STD management

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Risk assessment is a process of confidentially asking a patient particular questions to determine his or her chance of contracting or transmitting a STD (e.g. many women may be at risk due to the behavior of their husbands or boyfriends). Health workers everywhere use risk assessment to diagnose many kinds of problems. For example:</p> <ul style="list-style-type: none"> • A man with a fever tells you he has just returned from a visit to his home where malaria is common. The provider assumes there is a high risk of malaria. • A 50-year-old woman complains of irregular vaginal bleeding. The provider knows there is a risk of uterine cancer in women of this age who experience irregular bleeding. • A 30-year-old woman comes to you complaining of vaginal discharge. She occasionally picks up casual partners in a local bar to supplement her small income. Her last sexual contact was with a truck driver one week ago. The provider assumes STD risk. <p>General scenarios such as these do not apply equally to women in different situations and countries.</p> <p>Risk assessment is most effective when the questions are developed according to local needs and conditions.</p>	<p>Presentation/Large Group Discussion/ Small Group Work (25 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Define the term “risk assessment.” Give the examples found in the content section. •  Ask the following question: Even if you were to examine the 30 year old woman and find no discharge or other signs of STD, would you send her away without treatment? Why, or why not? • Buzz: Ask Px to turn to their neighbors and list possible reasons to assess risk for 5 minutes. • Then ask Px for their reasons and write on a flipchart. Refer to the content section to supplement their answers. • Discuss the limitations of risk assessment and how to improve risk assessment. • Ask a few Px directly and pointedly: <ul style="list-style-type: none"> – How many sexual partners have you had in the last 3 months? – Do you think your husband has other sexual partners? – Have you ever had a STD? • Then ask those Px how they felt being asked these questions: violated, embarrassed, angry?

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Possible Reasons to Assess Risk</p> <p>Some countries have developed national guidelines which make use of certain questions to:</p> <ul style="list-style-type: none"> • Determine whether the IUD is appropriate. • Advise appropriately on dual protection. • Determine whether a speculum exam might aid in STD diagnosis (e.g. if cervical mucopus were visible, a diagnosis of cervicitis [gonorrhea and/or chlamydia] is more likely). • Determine STD treatment. • Determine who should have limited `testing or screening for STD. • Determine who may need voluntary counseling and testing (VCT) for HIV. • Tailor prevention and risk reduction messages to the needs of the patient. <p>Assessing risk may be improved by:</p> <ul style="list-style-type: none"> • Tailoring questions to reflect local STD prevalence. • Making questions more culturally appropriate. • Devising ways to help clients assess their own risk (self-assessment). <p>Other situations that might put a woman at greater risk:</p> <ul style="list-style-type: none"> • Her husband is a migrant worker. • Her husband is in the military. 	<ul style="list-style-type: none"> • Distribute and describe the case study to Px and ask the following questions: <div style="text-align: center;">  </div> <ul style="list-style-type: none"> •  Is this surprising to you? •  What factors would account for a less than accurate risk assessment done by the doctors? <p>Small Group Exercise (45 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Divide Px into same 3 small groups. • Give out the risk assessment questions. Ask each group to discuss and answer all the questions. Allow 25 minutes for the small group discussion. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Ask the small groups to return and form one large group. Taking turns, one person from each group should contribute key points for each of the questions. Allow 15 minutes for the large group discussion. • Summarize the discussion.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<ul style="list-style-type: none"> • Her husband has other partners. • She is a recent immigrant to the city. • She is young, single, and lives on her own. • She works as a maid. • She works as a bar girl. • She is a street child. • She is a sex worker. • She has a known history of STD. • She has chronic lower abdominal pain. • Her partner has had STDs. • She has problems becoming pregnant. <p>Risk Assessment in Men</p> <p>It is equally important to assess men's risk (or to help them assess their own risk) for the same reasons: STD prevention, treatment, and partner management. (See Unit 12: Reaching Men.)</p> <p>Limitations of Risk Assessment:</p> <ul style="list-style-type: none"> • It may require asking difficult, sensitive questions. • Clients may feel embarrassed about answering such questions. • Clients may not understand the questions being asked. • Information given may be inaccurate, poorly recalled, or untruthful. 	<p>Presentation (5 min.)</p> <p>The trainer should present the content on risk assessment in men and limitations of risk assessment and answer any questions.</p>

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>There is some evidence that self risk assessment can provide information that is more accurate because it avoids the difficulties of face-to-face questioning on sexual behavior. Self-assessment of risk requires the health care worker to provide the client with sufficient information to allow the client to decide whether s/he is at risk. Often people suspect they are at risk but are reluctant to discuss their situations; and they need encouragement to ask any questions they may have.</p>	<p>Homework (3 min.)</p> <p>Ask the 3 Px groups to design either a poster for the clinic or brochure to give to clients for self risk assessment for STDs and bring it to be displayed the following day. Make 20 minutes available the next day for a short discussion of the materials and have Px vote on the one they think does the best job of assessing risk. Award a prize to the winning group.</p> <p><i>Note to Trainer: This exercise needs 30 minutes for Px to work together. If the training is residential, this can be done in the evening. If not, the trainer must decide whether there is class time to allocate for the exercise, and whether some of the work can still be done in the evening.</i></p> <p>Prevention Message (2 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute and present the prevention message and post it on the wall. <div style="text-align: center;">  </div>

Specific Objective #4: Demonstrate history taking and risk assessment using a standardized checklist

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Simulated Skill Practice & Clinical Practicum Objective</p> <p>Objectives of Demonstration and Role Play</p> <ol style="list-style-type: none"> 1. To demonstrate to Px the interpersonal communication skills needed to take a patient history and assess risk for RTI complaints. 2. To enable Px to practice interpersonal communication (IPC) skills and apply them to history taking and risk assessment. 	<p>Demonstration and Practice of History Taking (1 hour 10 min. or more depending on allowable time)</p> <ul style="list-style-type: none"> • The trainer should ask another trainer to assist. • Instruct Px to refer to the checklist for history taking (<i>PxH 4.2A</i>) when evaluating the history taking performed in the role plays. • The two trainers should use one of the role plays found in <i>Px Handout 4.4A</i> to demonstrate examples of what constitutes “bad” history taking, and what constitutes “good” history taking. • When performing the “bad” role play, you may ask the questions out of order and not use some of the needed skills. • Allow time for Px analysis and feedback. • Next, demonstrate the “good” role play. You should follow the correct sequence of questioning and use good IPC skills. Ask Px to provide feedback on what was positive or negative, what questions were missing, and what was done skillfully. • Distribute the role plays. <div data-bbox="1084 1717 1230 1822" style="text-align: right;">  </div>

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<ul style="list-style-type: none"> • After the trainer demonstration, divide Px into 2 groups. With the remaining time, ask for 2 Px in each group to perform a “good” role play using another of the role plays within their own group. The rest of the group should be observers, follow with their checklists, and provide feedback after the demonstration. In each group, one trainer should observe and comment during the roles plays. • As many Px as possible should practice being either the patient or the provider, as time allows.

Unit 4 Summary

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Summary</p> <ol style="list-style-type: none"> 1. The goal of history taking is to obtain the information needed to: diagnose and treat STDs, establish risk, and counsel on prevention. 2. Taking a sexual history is essential to RTI management. 3. Providers need to become more comfortable talking about sex. 4. When taking a history, the provider should apply good interpersonal communication skills. 5. Risk assessment guides the provider in counseling about prevention and treatment. 	<p>Unit Summary (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit summary. • Distribute Px Manual content for Unit 4.

UNIT 5: PHYSICAL EXAMINATION FOR RTIs

UNIT TRAINING OBJECTIVE:

Participants will be able to conduct directed physical examinations, including external inspection of the genitals and groin and female abdominal examination to aid in the diagnosis of RTIs. Conducting speculum and bimanual examinations are also objectives of this unit, where local conditions and time permit.

SPECIFIC LEARNING OBJECTIVES:

By the end of this unit, participants will be able to:

1. Explain the reasons for doing a physical examination and list the needed resources.
2. Review male and female reproductive anatomy using diagrams and models.
3. Describe the 8 major STDs other than HIV.
4. Identify the STDs covered by syndromic management.
5. Demonstrate how to gain the necessary confidence and cooperation of the patient in order to conduct an examination.
6. Demonstrate directed physical examinations of male and female patients following a standardized checklist and using appropriate infection prevention procedures.

SIMULATED SKILL PRACTICE:

Participants will demonstrate competency according to standardized checklists for the following activities before moving on to the clinical practicum.

- Using role play, explain to the patient reasons for doing a physical examination to reassure and put her/him at ease, and ensure privacy and confidentiality.
- Using a pelvic model, practice speculum, bimanual, and abdominal examinations.
- Using a male model, practice and demonstrate an examination of the penis and scrotum.

CLINICAL OBJECTIVES:

Participants will demonstrate competency, based on standardized checklists, in conducting the appropriate physical examinations related to RTIs in the classroom on male and female models.

TRAINING/LEARNING METHODOLOGY:

- Lecture with slides or transparencies
- Discussion
- Simulated practice
- Role play
- Clinical practicum using competency-based training checklists
- Group work
- Case study
- Demonstration/return demonstration

MAJOR REFERENCES AND TRAINING MATERIALS:

- Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: A health guide for women*. Berkeley, California: Hesperian Foundation.
- Dallabetta, G., F. Behets, G. Lule, I. Hoffman, H. Hamilton, A.M. Wangel, S. Moeng, M. Cohen, and G. Liomba. 1998. Specificity of dysuria and discharge complaints and presence of urethritis in male patients attending an STD clinic in Malawi. *Sexually Transmitted Infections* 74 (Suppl. 1): S34-37.
- Decherney, A.H., and M.L. Pernoll, eds. 1994. *Current obstetric and gynecologic diagnosis and treatment*. 8th ed. USA: Appleton and Lange.
- Department of Health, HIV/AIDS Directorate. 1996. *Training manual for the management of a person with a sexually transmitted disease*. Pretoria, South Africa: Department of Health.
- Jacobs, L.A. 1985. *Female reproductive organs—in health and illness*. Warner-Lambert Company, distributed by Parke-Davis.
- Maggwa, N., and I. Askew. 1997. *Integrating STI/HIV management strategies into existing MCH/FP programs: Lessons from case studies in East and Southern Africa*. Nairobi, Kenya: The Population Council OR/TA Project II.
- Solter, C. 1998. *Module 3: Counseling for family planning services*. Watertown, Massachusetts: Pathfinder International.
- Wisdom, A., and D.A. Hawkins. 1997. *Diagnosis in color: Sexually transmitted diseases*. 2nd edition. London: Mosby-Wolfe.
- World Health Organization (WHO). 1995. *STD case management workbook 3: History-taking and examination*. Geneva: WHO.
- World Health Organization (WHO). 1995. *STD case management workbook 4: Diagnosis and treatment*. Geneva: WHO.

RESOURCE REQUIREMENTS:

- Water and soap for handwashing
- Pelvic and male models (one per 4–5 participants); if possible, live models
- Transparencies
- Life-size illustrations of male and female reproductive systems.

- Light source (torch [flashlight])
- Specula, gloves, drapes, examination tables
- Slide projector and STD slide set or transparencies from Pathfinder
- Bucket, water, and bleach or prepared solution for decontamination
- Newsprint
- Black, blue, and red markers

EVALUATION METHODS:

- Observation and assessment of participant during clinical practicum using CBT skills assessment checklist
- Feedback from live models
- Verbal trainer feedback
- Pre- and post-test

TIME REQUIRED: 6 hours 15 minutes

The whole group or particular individuals may need more practice time for physical examinations depending on their experience.

Special Note to the Trainer:

This unit has material on 5 areas of the directed physical examination to assess STD symptoms: external inspection of the female and male genitals, and abdominal, speculum, and internal bimanual exams of the female. Some of these may be optional and others are not.

Use the physical examination self-assessment forms completed during the course introduction to form groups combining Px with experience in physical assessment of STD with others who have less or no experience.

Key areas: Examination of the external genitalia is an essential part of syndromic management of STD, with the possible exception of vaginal discharge syndrome. An abdominal examination is essential in the management of lower abdominal pain to rule out an acute life-threatening condition that requires immediate referral, and can sometimes help in the diagnosis of STD in a woman presenting with vaginal discharge.

Optional areas: While speculum and bimanual examinations are desirable when possible for vaginal discharge syndrome, they may not be feasible because of lack of private examination space, running water, specula, ability to sterilize or disinfect instruments, time, and other resources.

WORK FOR TRAINERS TO DO IN ADVANCE:

- Obtain large, labeled drawings of internal and external female and male anatomy. Two companies in the U.S. that carry charts are:
 - The Anatomy Chart Company in Skokie, Illinois. Phone 847-679-4700; fax 847-674-0211; and on the internet at <http://www.anatomical.com>.
 - NASCO in Fort Atkinson, Wisconsin. International orders phone 920-563-2446 and ask for the Export Department; fax 920-563-6044 and include "Export Department" as the destination; e-mail: export@eNASCO.com; and on the internet at <http://www.enasco.com>.
- Obtain life-size pelvic model(s) and male model(s) of penis and scrotum (one per 4–5 participants). If it is not possible to find male models, the Px can talk through the male exam using a penis model.
- Prepare as transparencies or on a flipchart:
 - 5.2A-D: Reproductive Anatomy (Use only if large color posters are not available.)
 - 5.5A: Reassuring Patients About an Examination
- Copy the following participant handouts:
 - 5.1A: Case Study
 - 5.2A: Female and Male Anatomy List
 - 5.3A: Major STDs Other Than HIV (3 or 4 copies of each disease – for small group use)
 - 5.4A: Prevention Message
 - 5.5A: Role Play
 - 5.6A: CBT Skills Assessment Checklist for Physical Examination
- Write the unit objectives on a flipchart.
- Check the slide projector and review slides (or transparencies) and the accompanying text carefully.
- The trainer should wear clothing in which s/he is comfortable lying on the exam table in the lithotomy position.
- Determine Px groups for the directed physical examination based on the results of the Physical Exam Self-Assessments. (See *Special Note to the Trainer*.)
- Copy the Unit 5 content section (Px Manual) for distribution at the end of the unit.

Introduction to Unit 5

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>In a family planning setting there are several reasons to perform a physical examination. In settings where physical examination is difficult or impossible, much can still be accomplished with a simple examination of the external genitals. Many national family planning guidelines require that a physical examination be done to determine suitability of the method if a first-time client chooses a modern contraceptive method such as the IUD or sterilization.</p> <p>For a woman with RTI symptoms, an examination can provide information for clinical or syndromic diagnosis of STD. A physical examination may help in <i>case finding</i>, that is finding a STD when a client has come to you for other reasons, such as family planning. Since so many STDs do not produce visible symptoms in women, this is one important way to identify and treat STDs in such patients. It can also provide the opportunity to educate on prevention. During physical examination, women can also be screened for abnormal changes of the cervix (dysplasia), an early sign of cancer that is caused by the STD human papilloma virus (HPV).</p> <p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Explain the reasons for doing a physical examination and list the needed resources. 2. Review male and female reproductive anatomy using diagrams and models. 	<p>Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objectives using the prepared flipchart.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ol style="list-style-type: none"> 3. Describe the 8 major STDs other than HIV. 4. Identify the STDs covered by syndromic management. 5. Demonstrate how to gain the necessary confidence and cooperation of the patient in order to conduct an examination. 6. Demonstrate directed physical examinations of male and female patients following a standardized checklist and using appropriate infection prevention procedures. 	

Specific Objective #1: Explain the reasons for doing a physical examination and list the needed resources

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>The Purpose of a Physical Examination (PE) in the Management of RTIs</p> <ol style="list-style-type: none"> To confirm any RTI symptoms the patient has described by checking for signs To look for signs the patient may not have noticed if you think s/he is at risk <p>Remember: A normal PE does not mean that the patient does not have a STD.</p> <p>Elements of a Directed Physical Examination for RTIs</p> <ul style="list-style-type: none"> General examination Abdominal examination (female) Inspection of the external genitalia (male and female) Speculum examination (female) Bimanual examination (female) <p>If a patient has RTI symptoms, a complete exam should be done when possible. If it is not possible, parts of the examination (for example visual inspection and bimanual exam) can still yield valuable information.</p> <ul style="list-style-type: none"> Visual inspection of the vulva should include separation of the labia to look for ulcers and to determine the color of the vaginal discharge, if present. If a glove is not available, the patient can be asked to assist with external examination by spreading her labia. 	<p>Discussion (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> Ask Px about physical examinations in their own clinics: <ul style="list-style-type: none"> For what reasons are they performed? How often are they performed (annually, at first visit only, problems)? Present content on the purpose of a physical exam and elements of directed physical exam. <p>?</p> <p>Case Study (10 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> Distribute the case study and ask a Px to read it to the group. <div data-bbox="1084 1675 1230 1780" style="text-align: center;"> </div> <ul style="list-style-type: none"> Ask Px how M___ can make the best use of the resources she has to conduct the examination.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • A speculum examination should be done when cervical feasible for visual inspection of the vaginal mucosa and cervix. • If a woman complains of vaginal discharge or lower abdominal pain, a bimanual examination should be performed, if feasible, to determine whether there is motion tenderness or adnexal masses and to determine the color of the vaginal discharge on the gloved finger. <p>To determine how much of an examination to do, consider:</p> <ul style="list-style-type: none"> • What are the patient’s complaints? • Is she at risk of contracting a STD? • What will you gain from doing an examination? Note that if you have already decided to treat the patient, she may not need an examination at all. • What resources are available for an examination? <p>Resources Needed to Conduct a Physical Examination</p> <ul style="list-style-type: none"> • Private room. • Light source. • Examination table for patient to lie on. • Chair. • Speculum and clean gloves that have been high level disinfected, not necessarily sterilized. • Water for handwashing. 	<p><i>Possible responses:</i> <i>She can use the ANC room with exam table for inspection of the external genital area in order to look for the source of pain (ulcers and irritation).</i></p> <p><i>H___’s clothing can be used as a drape in place of a special cloth.</i></p> <p><i>She can use a torch (flashlight) for a light source.</i></p> <p><i>She can ask H___ to pull the folds of her labia apart so that she can better view the area.</i></p> <p><i>Gloves are scarce but she needs only one to do a bimanual examination. (The abdominal hand does not need a glove.)</i></p> <p><i>She can use a basin and pitcher of water for handwashing before and after the exam.</i></p> <p>❓ Ask Px to comment briefly on what resources exist in their clinics and if and how they can adapt existing resources to do examinations.</p>

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • Cloth drape or patient's clothing for female exam. • Lubrication or water for speculum exam. • TIME! 10–15 minutes for a complete exam. 	

Specific Objective #2: Review male and female reproductive anatomy using diagrams and models

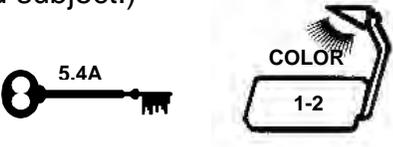
<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Female External Anatomy</p> <ul style="list-style-type: none"> • Vulva • Vagina • Introitus • Urethral opening • Labia majora • Labia minora • Clitoris • Clitoral hood • Perineum • Anus <p>Female Internal Anatomy</p> <ul style="list-style-type: none"> • Vaginal walls • Cervix • Cervical os • Uterus • Fallopian tubes • Ovaries • Adnexa • Bladder <p>Male Anatomy</p> <ul style="list-style-type: none"> • Glans penis • Shaft • Urethral meatus • Foreskin • Scrotum • Testes • Prostate gland • Epididymus • Vas deferens • Bladder • Anus 	<p>Group Work (40 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute lists of anatomical words. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Divide Px into 4 small groups. Try to put someone with physical exam experience and someone who likes to draw in each small group. • Ask each group to make 3 drawings on large, blank sheets of newsprint: <ul style="list-style-type: none"> – female internal reproductive parts – female external reproductive parts – male reproductive parts <p>The anatomical parts should be labeled from the lists. Tell Px to use black pens for the drawing, blue for external parts, red for internal parts.</p> <ul style="list-style-type: none"> • After 20 minutes, each small group should briefly present its 3 drawings. Any mistakes should be corrected by the trainer and Px from the other small groups. • Display the large color posters of female (internal and external) and male reproductive anatomy for comparison. (Trainer may use <i>Txp 5.2A-D</i> if color posters are not available.)

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<ul style="list-style-type: none"> • Px should vote on the clearest set of Px drawings, which should remain on the wall for the duration of the training for reference, along with the color posters. • Present a prize to the small group(s) with the clearest drawings.

Specific Objective #3: Describe the 8 major STDs other than HIV

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>The 9 Major STDs</p> <p>Clinicians should have an understanding of the major bacterial and viral STDs. Although this knowledge is not needed for syndromic management (the diagnosis and management of STDs by groups of specific symptoms), thorough patient education, treatment, and follow-up will be greatly enhanced by it.</p> <p>There are over 20 STDs. The 9 that are common in most of the world are:</p> <ul style="list-style-type: none"> • gonorrhea • chlamydia • trichomoniasis • syphilis • chancroid • herpes simplex virus (HSV) • genital and cervical warts or human papilloma virus (HPV) • hepatitis B (HBV) • human immunodeficiency virus (HIV) <p>HIV/AIDS is covered extensively in Unit 10.</p> <p>Note: Two non-STDs, bacterial vaginosis and candidiasis, may accompany some of the above. Bacterial vaginosis is implicated in problems with pregnancy and birth and is a factor in HIV transmission and acquisition.</p>	<p>Search and Learn (20 min):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present content. • Divide the group into 7 smaller groups. • Assign each group a disease, excluding HIV. One group should do chancroid <u>and</u> hepatitis B. Px will act as “experts” on their assigned diseases and supply information on them during the case studies exercise that follows in S.O. #4. • Distribute to each group 3-4 copies of its assigned STD information sheet. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Ask the Px to: <ul style="list-style-type: none"> – Share information and practice giving facts on their assigned diseases. – Prepare to identify and discuss their assigned diseases during the slide or transparency presentation. • Ask Px if they have any questions.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Scant clear discharge is more characteristic of chlamydia, and more copious yellow purulent discharge is characteristic of gonorrhea. However, they often occur together.</p> <p>Urethritis causes discharge from the meatus (the opening of the penis). In uncircumcised men, discharge from the glans or foreskin may appear to come from the meatus. The provider should perform a physical examination to determine the source of the discharge.</p> <p>Examination Tips</p> <ul style="list-style-type: none"> • Always wear a glove or gloves if you touch the penis. • Make it a habit to examine under the prepuce. <p>If no discharge is visible, the penis should be milked. This is done by applying gentle pressure to the penis. Hold the head of the penis between the thumbs and gently roll the thumbs up and down. It may be necessary to milk the urethra, starting at the base of the penis. Place one finger or the palm of the hand beneath the penis and one or two fingers on top at the base. Applying gentle pressure, move the hands outward towards the tip of the penis. Repeat the process if necessary. If the patient is reluctant or afraid, allow him to milk the penis himself.</p> <p>If you see no discharge, but the patient complains of discharge and/or dysuria and describes a history suggestive of STD, treat him. This is because: 1) if the patient urinated shortly before the examination, he could have rinsed the discharge from the</p>	<ul style="list-style-type: none"> • Before showing slides and during explanations and descriptions of each STD, the trainer should emphasize the difficulties of diagnosis by clinical signs. Discharge won't prove the existence of gonorrhea and/or chlamydia. • Show color transparencies 1 and 2. (The trainer's tool lists slides by number and subject.) <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • For each transparency, ask Px which syndrome is present, and which diseases might cause it. • Ask the "experts" on these diseases for information. • Present any content not covered and examination tips. • Ask Px for comments and questions.

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<p>urethra, or 2) the patient may have partially treated the problem and no longer has discharge.¹</p> <p>Genital Ulcer Syndrome</p> <p>Causes and Symptoms</p> <p>The more common causes of genital ulcer are syphilis, chancroid, HSV.</p> <p>Syphilis. 3–5 weeks after infection, primary syphilis appears as one or more round, painless ulcers, 1–2 cm in diameter. These often go undetected. The base of the lesion feels hard on palpation, and the lesions are often “kissing.” There is often swelling in adjacent tissue and swollen lymph nodes or syphilitic buboes. These heal in 4–8 weeks.</p> <p>Chancroid. The lesions begin as painful papules and rapidly progress to painful ulcers with round or irregular edges, and shelving margins creating a crater effect. They have a bright red areola. In about half the cases, painful enlargement of the lymph nodes occurs (chancroid bubo).</p> <p>Herpes ulcers usually differ from chancroid and syphilis ulcers. Early in the infection, they appear as multiple vesicles (blisters) or open sores, grouped together and are painful. There is usually a history of recurrence of these lesions. Herpes ulcers with a secondary bacterial infection, however, may resemble syphilis and chancroid ulcers.</p>	<ul style="list-style-type: none"> • Present Case Study #2: <ul style="list-style-type: none"> <i>A 20-year-old, unmarried university student complains of painful sores on her labia. She denies past history of this problem and has had a regular partner for 2 months.</i> • ? Ask Px which syndrome is present, and which diseases might cause it. <ul style="list-style-type: none"> <i>Answers should include: syphilis, chancroid, herpes, and HPV, which causes cervical cancer.</i> • Show color transparencies of diseases causing genital ulcers in men and women. <div style="text-align: center;">  </div> • For each transparency, ask Px which syndrome is present and which diseases might cause it.
<p>¹ Although 1995 WHO STD case management flowchart for urethral discharge states that men without visible evidence of discharge should not be treated, there is now evidence to the contrary, e.g. Dallabetta, G. et al. 1998. Specificity of dysuria and discharge complaints and presence of urethritis in male patients attending an STD clinic in Malawi. <i>Sexually Transmitted Infections</i>. 74 Suppl. 4.</p>	

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<p>Genital warts look like warts elsewhere on the body. They are light-colored, rough bumps that can be found on the folds of the vulva, inside the vagina, and around the anus. In a man, they usually grow on the penis, sometimes just inside the opening, and on the scrotum or anus. They can be quite small or grow together into larger warts. Infection with different strains of human papilloma virus (HPV), which causes genital warts, can cause cancer of the cervix.</p> <p>Note: <i>450,000 new cases of cervical cancer occur each year and, if not detected early, result in death. Ideally, all women over 35 years of age should be screened for cancer of the cervix by speculum exam, and /or with a Pap smear every three years.</i></p> <p><i>It is estimated by the International Agency for Research on Cancer that screening women aged 35-64 once every 5 or 10 years would reduce invasive cervical cancer by 84% and 64% respectively. A woman with an abnormal appearing cervix or Pap smear should be referred for further testing or treatment if needed and if it is available.</i></p> <p>Cervical cancer can be prevented by a provider with a trained eye detecting and treating pre-cancerous changes on the cervix at an early stage. There are no symptoms of these cancer-producing strains. Practically speaking, cervical cancer is a STD.</p>	<ul style="list-style-type: none"> • Ask the “experts” to offer information on each of disease is it identified. • Present any content not covered and examination tips. • Ask Px for comments and questions.

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<p>or consistency of the discharge, a foul odor, itching and soreness, painful urination, or pain during intercourse. Vulvar itching is a symptom of candidiasis, trichomoniasis, and pubic lice. It is often very difficult to determine what the cause of vaginal discharge is, but the most common causes are <i>not</i> sexually transmitted.</p> <p>Trichomonas symptoms include redness and inflammation of the vagina and sometimes vulva, frothy discharge from the vaginal wall, and the appearance of red speckles on an otherwise normal-looking cervix. It is usually sexually transmitted but men usually have no symptoms. Trichomonas may cause pre-term labor and facilitate transmission of HIV.</p> <p>Candida symptoms include pruritis, redness and inflammation of the vagina and often the vulva, with a white curdy, clumpy discharge from the vaginal wall. It is not sexually transmitted. It is common after antibiotic therapy, in pregnancy, and sometimes with oral contraceptive use. It does not cause complications</p> <p>Gonorrhea is a sexually transmitted disease that usually produces no visible symptoms in women. A green-yellow discharge seen on a cotton swab of the cervix is the most reliable indicator of cervical infection with gonorrhea and chlamydia. The vagina appears normal, the cervix may be red and bleed easily when touched with a swab, although this is a nonspecific sign. Cervical motion tenderness, lower abdominal pain, and fever are signs of PID caused by gonorrhea or chlamydia.</p>	<p>❓ For each transparency, ask Px which syndrome is present, and which diseases might cause it.</p> <ul style="list-style-type: none"> • Ask the “experts” to offer information on each of the diseases as they are identified. • Present any content not covered and examination tips. • Ask Px for comments and questions.

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<p>Chlamydia usually has no visible symptoms but, as with gonorrhea, the vagina looks normal. The cervix may be red and bleed easily when touched with a swab, with purulent discharge from the os, and possible cervical motion tenderness, lower abdominal pain, and fever. Chlamydia is sexually transmitted and causes PID and related complications.</p> <p>Remember: <i>It is not uncommon for infections to be mixed. For example, a woman may have gonorrhea and chlamydia at the same time, or trichomonas, candida, and BV. Often there are no signs.</i></p> <p>Examination Tips for Vaginal Discharge</p> <p>Check the appearance of the vagina and vulva. If they are inflamed, candidiasis or trichomoniasis may be the cause. BV usually does not cause inflammation.</p> <p>The origin of the discharge can help to identify the disease. A purulent discharge from the cervix can indicate a probable gonorrheal or chlamydial infection, and often indicates both.</p> <p>Discharge from the vaginal wall indicates trichomoniasis, candidiasis, or bacterial vaginosis. Trichomoniasis also can cause urethral discharge.</p> <p>However, identifying the origin of discharge in the vagina may be difficult. Wiping off the cervix with a swab can help. Discharge from the cervix may then be observed.</p>	

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<p>Check the patient for lower abdominal pain by doing a bimanual exam. If moving the cervix with the fingers causes pain, use the flowchart for lower abdominal pain. Take the patient's temperature if possible. If the patient has fever, use the flowchart for lower abdominal pain.</p> <p>Note that patients who return often with candidiasis may have HIV infection or diabetes. Refer them for counseling and testing if possible. BV, even if properly treated, tends to recur within 9 months.</p> <p>Lower Abdominal Pain</p> <p>Causes and Symptoms</p> <p>Lower abdominal pain can be caused by PID, which is a complication of untreated gonorrhea or chlamydia infection and/or anaerobic bacteria. Start by ruling out these acute abdominal emergencies in any patient presenting with lower abdominal pain, and refer the patient to a hospital if you suspect septic abortion, intestinal obstruction, ruptured bowel, appendicitis, ectopic pregnancy, or other surgical or gynecological emergencies. Postpartum infection and postabortion infection often present with the same symptoms and are often treated in the same way as PID. In addition to lower abdominal pain, PID can cause pain during intercourse or urination, heavy or prolonged menstrual bleeding, pain during menses, nausea, and vomiting. A woman using an IUD has a higher risk of PID than a woman using no contraception, particularly if the IUD was inserted in the past 3 months.</p>	<ul style="list-style-type: none"> • Present Case Study #4: <p><i>A 20-year-old woman complains of lower abdominal pain worsening over 2 weeks. She denies vaginal discharge, her last menstrual period was 2 weeks ago, and she has had 2 partners in the past 12 months. What are the possible causes of her pain?</i></p> • Ask Px which syndrome is present and which diseases might cause it. • Ask the “experts” to offer information on each of the diseases. • Present any content not covered and examination tips. • Ask Px for comments and questions.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Examination Tips</p> <p>On speculum exam, an open cervix can indicate pregnancy or abortion. Look for signs of STDs—ulcer or vaginal discharge. Do a bimanual examination and check for tenderness with cervical motion, a fixed uterus, and a tender or enlarged uterus or ovaries.</p>	<p>Presentation (2 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute and present the prevention message and post it on the wall.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

Specific Objective #5: Demonstrate how to gain the necessary confidence and cooperation of the patient in order to conduct an examination

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Reasons Why Patients Might Not Want to be Examined</p> <ul style="list-style-type: none"> • They may be shy or culturally prohibited to show genitals, especially to someone of the opposite sex or of a different age. • They may be ashamed of symptoms. • They may be afraid of pain. • They may be afraid of lack of confidentiality. • They may be afraid of being treated badly by the examiner. <p>Reassuring The Patient About an Examination</p> <ul style="list-style-type: none"> • Ensure privacy and confidentiality. • Explain reasons for the examination and what the patient should expect. • Emphasize that the examination will be brief and that you will be gentle. • If the provider is not the same sex as the patient, have a medical coworker present or friend of the patient who is the same sex. <p>Remember – you cannot force a person to be examined.</p>	<p>Discussion/Role Play (30 min.)</p> <p>The trainer should :</p> <ul style="list-style-type: none"> • Ask the following questions and lead discussion (10 minutes). ❓ What fears do people have about being examined? ❓ What must you do in order to reassure all patients before an examination? ❓ What fears would Px themselves have about being examined? • If Px themselves have had pelvic examinations, ask them if they are willing to share their feelings about those experiences and speak about what was positive or negative. • Present content using transparency. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Distribute the role play. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • How does a provider persuade a reluctant patient? The trainer should ask for a volunteer for the role play in front of the group. The trainer should play the part of the provider.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	<ul style="list-style-type: none"> • Ask the Px to comment on the provider's persuasion and reassurance, acknowledging that counseling issues have not yet been covered in the training. • Say directly to a Px: <i>Just undress from the waist down and lie on the table. Quickly now, quickly!</i> • Ask the Px how s/he felt being spoken to like that. • The trainer should climb onto the exam table, placing her/himself with her/his legs or feet in the stirrups in the proper manner as if for a pelvic exam. The second trainer can drape the "patient" so that s/he is covered from the waist down. It is important that the trainer lie so that the buttocks come to the very end of the table with her/his legs up. Note this to Px. The trainer should comment on what it feels like to be in this position. • Ask for volunteers to come and lie briefly on the table, particularly those who have never had a pelvic exam. <ul style="list-style-type: none"> – Px should be put in the correct position (buttocks at the end of the table, legs bent at the knees, knees open, in stirrups if possible, properly draped with a cloth for modesty) and asked to describe briefly what it feels like to be in this position. <p>It is particularly important for all male Px to lie briefly on the table if this is culturally acceptable. This is a unique opportunity to become sensitized to what a woman is</p>

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	<p>feeling in this vulnerable position.</p> <ul style="list-style-type: none"> - Although no one should be forced to lie on the table, the trainer should emphasize that this experience builds empathy and helps underscore the importance of treating the patient with respect and ensuring her privacy during this examination. If no one is willing, comment that the fact that no one is willing makes the point about how difficult it is. - Each person willing to lie on the table should receive a small prize like candy or a condom. • Summarize the discussion and exercise.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

Specific Objective #6: Demonstrate directed physical examinations of male and female patients following a standardized checklist and using appropriate infection prevention procedures

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>General Examination of Males and Females</p> <p>Before doing a genital/pelvic examination related to RTIs, always look at the patient in an overall way for clues about general health. Be alert to the possibility of AIDS, TB, hepatitis, and other systemic STDs. You can do some of this as you are taking a history.</p> <ul style="list-style-type: none"> • Does s/he look ill? • Is walking difficult because of pain or weakness? • Is s/he thin, wasted, pale, flushed, or feverish looking? • Does s/he have any unusual sores or rashes? • Is s/he coughing? • Ask her to open her mouth and look for mouth ulcers or signs of thrush (white patches on back and sides of mouth). • Look for detectable signs of HIV/AIDS: <ul style="list-style-type: none"> - Weight loss, thin wasted appearance - Generalized swelling of lymph nodes - Thrush - Fever - Chronic cough - Chronic diarrhea - Shingles and other rashes <p><i>Note also that a person may have some of these signs and NOT be HIV-infected.</i></p>	<p>Demonstration (30 min.)/Return Demonstration (2 hours)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute the checklist for male and female genital examinations and the female abdominal examination. Explain that the checklists will also be used during the practicum with real patients. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Place the female model on the gynecological exam table. A second trainer or Px should stand at the head of the table and play the role of the patient, asking questions, expressing fear or pain, etc. The first trainer should conduct a complete abdominal plus genital examination on the model, explaining each step. • Remove the female model from the exam table, and place the male model on the table. Conduct a complete genital exam on the male model, explaining each step. If no male model is available, use a penis model and talk through the exam.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>The Genital Examination</p> <p>Examine patients in good light, and have them undress sufficiently to expose the entire genital, inguinal, lower abdominal, and anal area.</p> <p>The examination of the male genital area includes:</p> <ul style="list-style-type: none"> • Visual inspection of the genital area, including the anus, for ulcers, warts, or discharge. • In uncircumcised men, foreskin retraction to look for ulcers on the glans penis. • Milking of the urethra for discharge. • Palpation of the scrotum and testes for swelling and pain. • Examination of the inguinal lymph nodes. <p>The examination of the female genital and pelvic areas includes:</p> <ul style="list-style-type: none"> • An external examination of the genitals and anus, including separation of the labia to look for ulcers or discharge. • A speculum examination of the vagina and cervix, where possible. • An external examination of the abdominal area. • A bimanual (internal) examination of the urethra, vagina, cervix, uterus, tubes, and ovaries. • Palpation of the inguinal region (groin) to look for swollen lymph nodes or buboes. 	<p>Practice with Models</p> <ul style="list-style-type: none"> • Px should work in groups of 3 or 4, depending on the number of models available. The first Px is the provider/examiner. The second Px, at the head of the table, is the patient who can ask questions, express fear or pain, etc. The third Px uses the checklist. S/he may prompt the examiner, but only if s/he is truly stuck. • If there is time, follow steps 3 and 4 of the "Demonstration Technique" detailed in "Notes to the Trainer" at the beginning of the module. If not, proceed to the next step. • The examiner should go through the steps necessary to put the patient at ease, and the patient should cooperate as long as the provider is being respectful and explaining things as s/he goes along. • After about 15-20 minutes, the examiner should finish, and the patient and Px with the checklist should give feedback. Px should switch roles until each has been the examiner. • After each Px has done the female exam, each should do the male exam. • Time should be set aside during an afternoon and evening for Px who need more practice. <p>Note: Before the clinical practicum begins, it is the trainer's responsibility to assess the competency of each Px using direct observation of the simulated exams and the checklists, either during the practice time or at other times arranged with Px.</p>

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Steps in Examination of the Female Patient</p> <p>A. Examination of the Abdomen</p> <ol style="list-style-type: none"> 1. Before you start, ask the patient to empty her bladder if she hasn't done so in the last half hour. (Make sure this happens in your clinic before patients are brought to the examination room.) 2. Explain to her what you are going to do. Ask her to undress or to pull up her clothing so that you can see her abdomen from just below her breasts down to her pubic hair. If possible, cover her from the public hair down to save her embarrassment. Use a cloth or her own clothing. 3. Ask her to lie flat on her back on a firm bed or table with knees comfortably bent. Ask her to relax her abdominal muscles as much as she can. This may be difficult for someone who is in pain. 4. Listen for bowel sounds by putting a stethoscope or your ear on her abdomen. If you do not hear anything for 2 minutes, this is a sign of danger. 5. Ask her to point to the area that hurts the most. Then begin pressing gently on the other side. Keep pressing gently as you move around her abdomen to see where it hurts most. 6. As you press her abdomen, feel for lumps or masses. Also, check to see if she has guarding, if her abdomen is soft or hard, and if she can relax it under your hand. 7. To make sure she does not have a life-threatening problem like appendicitis, 	

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<p>an infection in her gut, or PID, slowly but firmly press on her abdomen on the left side, then her right side, just above where the leg joins the body (the groin).</p> <p>8. Press until it hurts a little. Then quickly remove the hand. If a very sharp pain (rebound pain) happens when the hand is removed, she may have a serious infection. Refer her immediately. If she does not have rebound pain, complete the exam and move on to examine the genitals.</p> <p>B. Examination of the External Genitals</p> <p>1. Explain to her what you are going to do and what she might feel at each step of the examination.</p> <p>2. Cover the parts of the body you are not examining to save her embarrassment. Use a cloth or her own clothing.</p> <p>3. While she is lying flat on her back on a firm bed or table, ask her to bend her knees and put her feet next to her buttocks and let her knees fall apart.</p> <p>4. Put a clean glove on the hand you will put inside her vagina. (It does not need to be sterile.) Usually this is the hand you write with.</p> <p>5. Point your light source towards the vagina. (If it is a torch, you will need someone to hold it for you.)</p> <p>6. Using your gloved hand to pull back the skin folds of the vulva and labia, examine the labia majora and minora, clitoris, urethra, vaginal opening, anal area, and inner thighs for sores, abscesses, warts, vesicles, discharges, and rashes.</p>	

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<p>C. Speculum Examination</p> <ol style="list-style-type: none"> 1. Be sure the speculum has been high-level disinfected or sterilized, warmed if possible, and lubricated with clean water.³ 2. Be sure the light source is pointed towards the vagina. 3. Insert the index (first) finger of your gloved hand in the vagina, pushing gently downward towards the anus. Advance your finger slowly inward until it reaches the cervix, which feels like the tip of your nose. Ask the woman to relax her muscles around your finger. 4. With your ungloved hand, hold the speculum blades together between the index and middle finger. Turn the blades sideways and slip them into the vagina, over your gloved finger. Be careful not to press on the urethra or clitoris above. When it is halfway in, turn the speculum so the handle is down. Remove your gloved finger. 5. **Gently open the blades a little and look for the cervix. Move the speculum slowly and gently until you can see the cervix between the blades. Tighten the screw on the speculum so it will stay open. 	
<p>³ Specula do not need to be sterilized for a normal vaginal exam. They should be high-level disinfected in a 3-step process:</p> <ol style="list-style-type: none"> 1. Soak in chlorine bleach solution for 10 minutes immediately after use. 2. Wash with soapy water and a brush until clean. 3. Boil or steam in a covered pot for 20 minutes. <p>For complete information, see Pathfinder <i>Module 2: Infection prevention</i>.</p>	

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<p>6. Look at the cervix. Note any abnormality such as discharge from the os, inflammation, or bleeding. Strange-looking, white or fungating lesions or sores could be cancerous and should be referred.</p> <p>7. **Pull back slightly on the speculum, bring the blades together just a little, and turn the speculum sideways so you can see the walls of the vagina. Look for inflammation or discharge along the vaginal walls.</p> <p>8. **To remove the speculum, gently pull it toward you until the blades are clear of the cervix. Then loosen the screw and bring the blades almost together and gently pull back.</p> <p>9. Examine the blades of the speculum and note the color, odor, consistency, and amount of any discharge.</p> <p>10. Be sure to disinfect the speculum again before using.</p> <p>**These steps take practice with the speculum alone—if you don't bring the blades almost together as you pull out, it will cause the woman pain. If you close them completely you may pinch the vaginal tissue and cause pain.</p> <p>D. Bimanual Pelvic Examination</p> <p>1. Put the index finger of your gloved hand in the woman's vagina. As you put your finger in, push gently downward on the muscles surrounding the vagina. When the woman's body relaxes put the middle finger in also. Turn the palm of your hand up and advance gently until you reach the cervix.</p>	

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<p>2. Feel the opening of the cervix to see if it is firm and round. Then put one finger on either side of the cervix and move the cervix gently from side to side. It should move easily, without causing pain. If it does cause pain, she may have an infection of the uterus, tubes, or ovaries. If her cervix feels soft, she may be pregnant.</p> <p>3. Feel the uterus by gently pushing on her lower abdomen with your outside hand– this moves the uterus, tubes, and ovaries closer to your inside hand. The uterus may be tipped forward or backward. If you do not feel it in front of the cervix, gently lift the cervix with your inside hand and feel around it for the body of the uterus. If you feel the uterus under the cervix, it is pointed to the back.</p> <p>4. When you find the uterus, feel for its size and shape. Do this by moving your inside fingers to the sides of the cervix. Then ‘walk’ the fingers of your outside hand around the uterus, feeling the uterus between your two hands. It should feel firm, smooth, and smaller than a lemon.</p> <p>If the uterus:</p> <ul style="list-style-type: none"> – feels soft and large, she is probably pregnant. – feels lumpy and hard, she may have a fibroid or other growth. – hurts when you touch it, she probably has an infection inside. – does not move freely, she could have scars from an old PID infection. 	

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<p>5. Feel for the tubes and ovaries. If these are normal, they will be hard to feel. But if you feel any lumps that are bigger than an almond or that cause severe pain, she could have an infection or other emergency. If she has a painful lump and her period is late, she could have an ectopic pregnancy.</p> <p>6. Feel along the inside of the vagina for unusual lumps or sores.</p> <p>7. If anything feels abnormal and you don't know what the problem is or how to treat it, refer the patient.</p> <p>8. On completion of the exam, record data regarding the presence or absence of findings relevant to your diagnosis.</p> <p>Steps in the Examination of the Male Patient</p> <p>The male patient can be examined standing or lying down on an examination table.</p> <ol style="list-style-type: none"> 1. Reassure him that you will be gentle and explain everything you are doing and what you find. 2. Ask him to lower his pants so that he is stripped from the chest down to the knees. Palpate the inguinal region (groin), looking for enlarged lymph nodes and buboes. 3. Palpate the scrotum, feeling for individual parts of the anatomy (the testis, epididymis, and spermatic cord on each side). 	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>4. Examine the penis, noting any rashes or sores. Ask the patient to pull back the foreskin if present, and look at the glans penis and the urethral meatus. If you cannot see an obvious urethral discharge, ask the patient to milk the urethra in order to express any discharge.</p> <p>5. Have the patient turn his back to you and bend over while spreading his buttocks slightly. Look at the anus for the presence of ulcers, warts, rashes, or discharge.</p> <p>6. Record the presence or absence of ulcers, buboes, genital warts, and urethral discharge, noting color and amount.</p>	

Unit 5 Summary

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Summary</p> <ul style="list-style-type: none"> • Knowledge of the most common STDs enhances the provider's ability to provide patient education, treatment, and follow-up. • Physical examination can help in the management of RTIs by confirming symptoms the patient has described and finding signs the patient might not have noticed. • Physical examination is desirable but not essential in the syndromic management of vaginal discharge. • Patients need to be reassured about physical examinations and providers' commitment to their privacy and confidentiality. • Use appropriate infection prevention procedures for your patient's protection, and for your own. 	<p>Presentation (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit summary. • Distribute Px Manual content for Unit 5.

UNIT 6: USING SYNDROMIC MANAGEMENT

UNIT TRAINING OBJECTIVE:

To identify and manage four STD syndromes (urethritis syndrome, genital ulcer syndrome, lower abdominal pain syndrome, and vaginal discharge syndrome) in RH settings.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Define the term "STD case management" and describe the three main approaches to STD management.
2. Demonstrate the use of flowcharts for decision making.
3. Explain the limitations of syndromic management for women with vaginal discharge.
4. Discuss a new approach to syndromic management of vaginal discharge.
5. Demonstrate the syndromic management of urethritis, vaginal discharge, lower abdominal pain, and genital ulcers.

SIMULATED SKILL PRACTICE:

Using case studies and role plays, participants will practice syndromic management using standardized checklists.

CLINICAL PRACTICUM OBJECTIVES:

During the clinical practicum, participants will be able to interview clients, assess their risk of STD, take histories, perform physical examinations as needed, make a diagnosis, treat according to flowcharts, and educate about prevention and partner management.

TRAINING/LEARNING METHODOLOGY:

- Lecture
- Case study
- Discussion

MAJOR REFERENCES AND TRAINING MATERIALS:

- Behets, F.M., E. Ward, L. Fox, R. Reed, A. Spruyt, L. Bennett, L. Johnson, I. Hoffman, J.P. Figueroa. 1998. Sexually transmitted diseases are common in women attending Jamaican family planning clinics and appropriate detection tools are lacking. *Sexually Transmitted Infections* 74, Suppl. 1 (June):S123-7.
- Dallabetta, G., A. Gerbase, and K. Holmes. 1998. Problems, solutions, and challenges in syndromic management of sexually transmitted diseases. *Sexually Transmitted Infections* 74, Suppl. 1 (June):S1-11.
- Van Dam, C.J., K.M. Becker, F. Ndowa, and M.Q. Islam. 1998. Syndromic approach to STD case management. *Sexually Transmitted Infections* 74, Suppl. 1 (June):S175-178.
- World Health Organization (WHO). 1995. *STD case management workbook 2: Using flow-charts for syndromic management*. Geneva: WHO.

RESOURCE REQUIREMENTS:

- Newsprint
- Tape
- Markers
- Overhead projector
- Anatomical wall charts and models of male and female reproductive systems
- Male and female condoms
- Partner notification cards
- National guidelines for STD control or syndromic management (poster if available)
- Signed prescriptions for "Mystery Shopping Exercise"
- Money for "Mystery Shopping Exercise."

EVALUATION METHODS:

- Pre- and post-test
- Verbal feedback
- Evaluation of clinical skills using standardized checklists
- Continuous assessment of unit objectives
- Participant reaction form (end of training)

TIME REQUIRED: 5 hours 50 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare the following as transparencies or on a flipchart:
 - 6.1A: Define STD Case Management
 - 6.1B: The Three Approaches to STD Management
- Make copies of the following participant handouts:
 - 6.1A: Prevention Message
 - 6.2A-E: Flowcharts
 - 6.2F: Case Studies
 - 6.5A: Case Studies
 - 7.1A-F: Mystery Shopping Exercise (1 copy of each)
 - 7.1G: Mystery Shopping Reporting Form (3 for each group)

Note: The treatment regimens suggested for the "Mystery Shopping Exercise" may have to be changed according to the availability of the drugs in your region. Use the existing instructions as a guide for the exercise. Be sure the drug regimens follow national treatment guidelines. It will be best to make needed changes and then have the exercise retyped and copied for participants with the correct, locally available medicines you want them to search for. Time needed for the trainer to modify this exercise may be about 4 hours to make sure doses, names, etc. are all correct. The amount of money (equivalent to about \$12 U.S. per group of 2-3 participants) will depend on local costs. The idea is for participants not to have enough money to buy the medication, as will be the situation for many of their clients. The trainer should budget and requisition the money needed for this exercise. It will be necessary to do this in advance, since the money will be distributed at the beginning of the assignment.

- Prepare prescriptions for the drugs in the "Mystery Shopping Exercise" and obtain authorized signatures.
- Obtain anatomical wall charts and models of male and female reproductive systems.
- Obtain national guidelines and flowcharts for STD control. Use a poster if one is available, and prepare individual copies of guidelines for each participant.

Note: Where national flowcharts exist and are in use, the trainer should use them and adapt these instructions accordingly. The trainer can use the flowcharts included in the module along with local flowcharts, or instead of local flowcharts. The decision is up to the trainer.

- Write the unit objectives on a flipchart.
- Prepare flipchart with definitions of the 3 methods of STD management.
- Write the steps to follow when using a flowchart on a flipchart.
- Copy the Unit 6 content section (Px Manual) for distribution at the end of the unit.

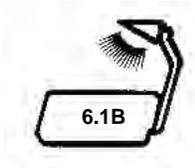
Introduction to Unit 6

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>Introduction</p> <p>Physicians and other health providers have traditionally been trained to diagnose STDs based on the results of laboratory tests that can identify the specific organism causing the infection (etiologic diagnosis). Another approach is to try to identify STDs based on the provider's judgment of the patient's signs and symptoms (clinical diagnosis). Because of the limitations of these methods, particularly in low-resource settings, the syndromic approach was developed. Through this approach, symptoms and easily identified physical signs are used to diagnose and treat patients for all possible STDs that may cause this syndrome rather than for specific STDs. Syndromic management should be used only when a patient presents with a STD complaint; it should not be used to screen for STDs because it is not accurate in this situation.</p> <p>This unit presents an overview of the use of syndromic management. We covered risk assessment in Unit 4 and the signs and symptoms that are associated with four major STD syndromes in Unit 5. Now we will use that knowledge to practice syndromic management.</p> <p>Syndromic management has been widely adopted and has proven useful for most syndromes. However, syndromic management of vaginal discharge is an exception because vaginal discharge is poorly correlated with the major causes of cervicitis, gonorrhea, and chlamydia.</p>	<p>Trainer Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objectives using the prepared flipchart.

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Define the term "STD case management," and describe the three main approaches to STD management. 2. Demonstrate the use of flowcharts for decision making. 3. Explain the limitations of syndromic management for women with vaginal discharge. 4. Discuss a new approach to syndromic management of vaginal discharge. 5. Demonstrate the syndromic management of urethritis, vaginal discharge, lower abdominal pain, and genital ulcers. 	

Specific Objective # 1: Define "STD case management" and describe the three main approaches to STD management

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>STD Case Management</p> <p>STD case management means:</p> <ul style="list-style-type: none"> • Correctly diagnosing and treating symptomatic patients. • Providing patient education and partner management. • Preventing re-infection and transmission to others. <p>The 7 steps of comprehensive STD case management are:</p> <ol style="list-style-type: none"> 1. Take history. 2. Conduct physical examination. 3. Provide treatment. 4. Provide health education on prevention. 5. Provide condoms and demonstrate use. 6. Offer partner treatment. 7. Follow up or refer as needed. <p>The 4 Cs</p> <p>STD management steps 4–7 are often called the 4 Cs, which stand for:</p> <p>C = Condoms C = Contact tracing C = Counseling C = Compliance with treatment</p>	<p>Presentation/Discussion (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Define STD case management. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Present the 7 steps interactively and step by step. • Ask a Px volunteer to record answers on a flipchart. • Ask Px: <ul style="list-style-type: none"> ❓ How does one diagnose a STD? <p><i>Response: Take a history and do a physical exam (PE).</i></p> <ul style="list-style-type: none"> ❓ How does one treat a STD? <p><i>Response: Provide drugs and information on how to take them (steps 3 and 4).</i></p> <ul style="list-style-type: none"> ❓ How do we prevent another STD? <p><i>Response: Educate the patient about disease and transmission, and promote and provide condoms (4 and 5).</i></p> <ul style="list-style-type: none"> ❓ How do we ensure the patient is cured? <p><i>Response: Offer partner treatment (6).</i></p> • Add any omitted steps.

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>The Three Approaches to STD Management</p> <p>Etiologic: A diagnosis is based on the results of laboratory tests that can identify the specific organism causing the infection. Thus, it is possible to treat only for one infection.</p> <p>Clinical: Provider makes a diagnosis (or educated guess) about which organism is causing infection based on the patient's history, signs, and symptoms.</p> <p>Syndromic: The patient is diagnosed and treated based on groups of symptoms or syndromes, rather than for specific STDs. All possible STDs that can cause those symptoms are treated at the same time.</p>	<p>Presentation/Brainstorming/Group Discussion (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> Using the transparency, present each approach to STD management. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> Ask Px: <ul style="list-style-type: none"> What is needed for the etiologic approach? <p><i>Responses: Patient must have symptoms, provider must be able to take laboratory samples, there must be skilled laboratory technicians, the lab must have working equipment and reagents, and the patient must return for results later.</i></p> What is needed for the clinical approach? <p><i>Responses: The patient must have symptoms, and a trained provider must be able to take a history and do a complete physical examination.</i></p> <ul style="list-style-type: none"> What is needed for the syndromic approach? <p><i>Responses: The patient must have symptoms,. The provider must have knowledge of the prevalence of various STDs in the region, training in the use of flowcharts, or a guide to what signs and symptoms make up each syndrome, and, ideally, the ability and private space to do a physical examination.</i></p>

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>STD Management</p> <p>A 20-year-old male comes to the clinic for treatment.</p> <p>Using Etiologic Management</p> <p>The provider takes a history, does a physical exam, and notes a thick discharge from the penis. With a drop of the discharge, s/he makes a slide so a gram stain can be conducted immediately. The provider takes another sample of discharge to be tested later for chlamydia, the results of which will be ready in one week. The patient waits for two hours for the results of the gram stain, which is positive for gonorrhea. The provider gives treatment for gonorrhea and asks the patient to return in one week for results of the chlamydia test. The patient is asked to bring his partner for treatment and is given condoms.</p> <p>Using Clinical Management</p> <p>The provider takes a history and does a physical exam. If s/he sees a urethral discharge, s/he may diagnose gonorrhea because the discharge is thick and yellow in color. S/he treats the patient for gonorrhea, asks the patient to bring his partner(s) in for treatment, and gives him condoms.</p> <p>Using Syndromic Management</p> <p>The provider takes a history and does a visual inspection of genitals. There is a thick, yellow urethral discharge. S/he treats the patient for the urethritis syndrome which, according to her/his</p>	<p>Small Group Work/Large Group Discussion (50 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Describe the following case to Px: <p style="margin-left: 20px;"><i>A 20-year-old single man complains of burning on urination, discharge from his penis, and says he has had a new sexual partner in the past month. On examination of the urethra, a thick, yellowish discharge can be seen.</i></p> • Divide Px into 3 groups. Assign etiologic management to group 1, clinical management to group 2, and syndromic management to group 3. • Ask each group to do the following (20 min.): <ul style="list-style-type: none"> – Choose one person to write on a piece of newsprint and another to present to the large group. – Discuss and describe the diagnosis and treatment of the patient in the case study. – Discuss and list the advantages and disadvantages of each group's assigned STD management approach. Include time, resources, and training that are needed. • Reconvene the large group and ask the spokesperson from each group to present its conclusions. Provide more information as needed from content. (20 min.) • Ask participants to offer descriptions of the approach, if any, that is used in their workplace.

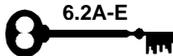
<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>national guidelines, includes treatment for gonorrhea and chlamydia. S/he asks the patient to bring his partner for treatment and gives him condoms.</p> <p>Advantages and Disadvantages of the 3 Approaches</p> <p><i>Etiologic Management: Advantages</i></p> <ul style="list-style-type: none"> • Possible to get an exact diagnosis using laboratory tests. • Avoids over-treatment. • Avoids wrong treatment. • May avoid antibiotic resistance. • Avoids the negative consequences of telling someone s/he has a STD if s/he does not. <p><i>Etiologic Management: Disadvantages</i></p> <ul style="list-style-type: none"> • Expensive. • Trained laboratory technicians are needed. • Infrastructure and supplies are needed. • Patient must return for test results. • Patient must wait for treatment. • Most women with gonorrhea or chlamydia have no symptoms, so they don't seek care. <p>There are advantages to etiologic management if a program can afford the cost, time, and trained personnel.</p>	<p>Small Group Work (30 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Divide participants into 3 new groups, one for each approach to STD management. • Instruct each group to spend 15 minutes listing on newsprint the advantages and disadvantages of the assigned approach, using the patient example discussed earlier as a starting point. • Reconvene the large group, and ask a spokesperson for each group to present its list. • Add to lists, if necessary, using information in the content section.

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p><i>Clinical Management: Advantages</i></p> <ul style="list-style-type: none"> • Immediate diagnosis. • Immediate treatment. • No lab expense. <p><i>Clinical Management: Disadvantages</i></p> <ul style="list-style-type: none"> • Diagnosis is often wrong. (A South African study showed that trained veneriologists were right about clinical diagnosis only two-thirds of the time.) • More than one STD is often present at the same time. • Most women with gonorrhoea or chlamydia have no symptoms. <p>Clinical skills can aid in both etiologic and syndromic management, but are not as effective when used alone to manage STDs.</p> <p><i>Syndromic Management: Advantages</i></p> <ul style="list-style-type: none"> • Fast—the patient is diagnosed and treated in one visit. • Highly effective for selected syndromes, especially urethritis and genital ulcer disease (GUD). Also good for lower abdominal pain/PID. • Relatively inexpensive since it avoids use of laboratory. • No need for patient to return for lab results. • Avoids the wrong treatment since all possible STDs causing signs and symptoms are treated at once. 	

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<ul style="list-style-type: none"> • Easy for health workers to learn. • Integrated into other PHC services more easily. • Can be used by providers at all levels. <p>Syndromic Management: Disadvantages</p> <ul style="list-style-type: none"> • Most women with gonorrhoea or chlamydia have no symptoms. • Over-treatment if patient has only one STD that causes a syndrome. • Financial cost of over-treatment, side-effects, and social stigma. • Increases potential for creation of antibiotic resistance especially if full course not completed. • Not effective for vaginal discharge syndrome to manage gonorrhoea and chlamydia. • Increases risk of stigma and domestic violence when women may not even have STD. • Training providers may be difficult. <p>Syndromic management is advocated by the WHO and by many ministries of health (MOHs) in developing countries, as well as developed countries. Used properly by well-trained providers who have access to effective drugs, it is a powerful tool in the management and control of STDs.</p>	

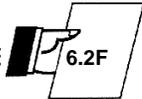
<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>Common Criticisms of the Syndromic Approach</p> <ul style="list-style-type: none"> • It is not scientific. <i>Response: Although an exact cause for symptoms is not sought as with etiologic diagnosis, many flowcharts for syndromic management have been scientifically validated and shown to work.</i> • It is better to treat for the most common cause of a symptom first and ask the patient to return if s/he does not improve. <i>Response: This may work in some cases, and some flowcharts are written this way. But patients often do not return for another visit. In other cases, patients may develop serious complications because they were not treated adequately at the first visit.</i> • It is a waste of drugs because patients are over treated. <i>Response: This may be true in some cases, but the cost of those drugs needs to be balanced with the consequences of untreated STDs, such as infertility, ectopic pregnancy, and HIV/AIDS.</i> • Effective, simple laboratory tests should be included to improve diagnosis. <i>Response: While effective, simple lab tests do exist, they are often expensive or unavailable.</i> 	<p>Discussion (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Discuss and respond to the common criticisms of the syndromic approach found in the content section. • Ask participants to share their own doubts and questions about the role of syndromic management of STDs at this time. Discussion should end with the trainer stressing the main points in the content section. <p>Presentation (2 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute and present the prevention message, and post it on the wall. <div style="text-align: right; margin-top: 20px;">  </div>

Specific Objective #2: Demonstrate the use of flowcharts for decision making

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>Introduction</p> <p>A flowchart is like a map (or a decision tree) that goes carefully through the decisions and actions needed to make a diagnosis of the patient's condition, to treat the condition, and to prevent future infection. There is a flowchart for each STD syndrome. National flowcharts should also be used where they exist. The flowcharts used in this training were developed from standardized WHO flowcharts. If no national flowcharts exist, the training flowcharts can be adapted according to national guidelines and conditions for each country.</p> <p>The 3 Main Components of a Flowchart</p> <p>(Example from the WHO flowchart for genital ulcer)</p> <ol style="list-style-type: none"> 1. The clinical problem—the patient's presenting symptom, such as genital sores. The flowchart always begins with this. 2. The decision that needs to be made. 3. The action that needs to be carried out. <p>Flowcharts must be used step by step, without ever skipping a step.</p>	<p>Trainer Presentation (25 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Introduce the use of flowcharts. Distribute the handouts as examples. <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <ul style="list-style-type: none"> •  Ask Px if anyone has used flowcharts and how they have used them. • Discuss the 3 main components of a flowchart using Flowchart #1 (<i>Px Handout 6.2A</i>) and/or country flowcharts if available. • On a flipchart, draw a simple flowchart of diarrhea management for children. <div style="text-align: center;"> <p>Management of Diarrhea</p> <pre> graph TD A[Assess dehydration status] --> B[None or mild] A --> C[Moderate or severe] B --> D[oral rehydration therapy (ORT)] C --> E[Refer] </pre> </div> <ul style="list-style-type: none"> • Present on previously prepared flipchart the steps to follow when using a flowchart. • Discuss the general guidelines for the use of flowcharts found in the content section.

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>Steps in Using Flowcharts</p> <ol style="list-style-type: none"> 1. Ask the patient for his or her symptoms. ("What seems to be the trouble?") 2. Find the appropriate flowchart with the patient's complaint stated in the clinical problem box. 3. The clinical problem box usually leads to an action box, which asks you to examine the patient and/or take a history. Do as the box directs. 4. Next, move to the decision/action box. After taking the history and examining the patient, you should have the necessary information to choose YES or NO accurately. 5. Depending on your choice, there may be further decision boxes and action boxes. <p>General Guidelines for Using Flowcharts¹</p> <p>At the end of every flowchart is a box listing basic issues on which patients need advice and education, such as:</p> <ul style="list-style-type: none"> • Treat for the cause or causes of the problem. We recommend a variety of medications in Unit 7 of this module, but choices should be made according to national guidelines. • Educate the patient on the problem s/he has, how and why drugs must be taken, how STDs are transmitted, safe sexual behavior, and partner treatment. (Patient education is discussed fully in Unit 8.) 	<p>Note to the Trainer: Where national flowcharts exist and are in use, the trainer should use them and adapt these instructions accordingly. The trainer may use the flowcharts included in the module along with local flowcharts or instead of local flowcharts. The decision is up to the trainer.</p>
<p>¹ World Health Organization (WHO). 1995. "Using flow-charts for syndromic management." <i>STD case management workbook 2</i>. Geneva: WHO.</p>	

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<ul style="list-style-type: none"> • Counsel the patient if needed. This may include more sensitive topics such as fears about refusing sex. Counseling requires interpersonal communication skills, which are covered in Unit 8. • Promote and provide condoms, show clients how to use them, and allow clients to practice. (Condom and barrier promotion is discussed in Unit 9.) • Partner management. You can teach clients skills to help them talk to partners or use referral cards. (Partner management is covered in Units 8 and 9.) <p>Notes on the Use of Flowcharts Urethral Discharge/Burning</p> <ul style="list-style-type: none"> • When a man complains of urethral discharge or burning on urination, go to the urethritis flowchart. • Examine him. Burning could also be caused by genital ulcers or other problems. You should be able to see a discharge, but even if you do not, he should be treated for genital discharge as discussed in Unit 5: "Physical Examination for STDs." • If he does have ulcers, go to the flowchart for ulcer management, and don't treat for discharge, unless that is also visible. <p>Genital Ulcer Disease (GUD)</p> <ul style="list-style-type: none"> • When a man or woman complains of genital sores or ulcers, go to the "sore 	<p style="text-align: center;">Discussion/Case Studies (40 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Introduce the flowcharts briefly, asking Px to look at them in their handouts. • Note that a flowchart always begins with the patient's present symptom, such as "the patient complains of urethral discharge." • Ask Px to take 5 minutes to look through the different flowcharts. Stress that practice is needed to become comfortable with the flowcharts and to learn how to use them. • Instruct a Px to read through the first flowchart in the order indicated by the arrows and describe in his/her own words the steps to be performed.

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>or ulcer" flowchart.</p> <ul style="list-style-type: none"> • Syphilis and chancroid are the most common cause of curable ulcers in men and women in most places in the world, so we treat for those unless lesions that look like herpes are present. • The grouped, vesicular, and painful lesions of herpes are usually distinctly different from the lesions of syphilis and chancroid. If you are unsure, treat for syphilis and chancroid because their consequences are more serious than herpes and they can be cured. • If you find only genital warts, you do not need to treat for syphilis and chancroid. Treat the warts if it is possible in your facility, or refer if necessary. Small genital wart infections may resolve themselves without treatment, but they are contagious. <p>Lower Abdominal Pain (LAP)</p> <ul style="list-style-type: none"> • Go to flowchart #3 (<i>Px Handout 6.2C</i>) if a woman presents with LAP, or if she presents with vaginal discharge, tells you she also has LAP, and appears ill or feverish. • The history is important. Anyone with recent delivery, abortion, IUD insertion or other intrauterine procedure within the last 3 weeks could have serious infection or sepsis and should be referred. Anyone with a missed period or intermittent vaginal bleeding along with LAP could have an ectopic pregnancy and should be referred immediately. • A temperature over 38°C, cervical 	<p>?</p> <ul style="list-style-type: none"> • Ask for additional information from the group and provide any missing information from the content section. This should be done for all 5 STD flowcharts. • Distribute the  lies. <ul style="list-style-type: none"> • Ask a different Px to present each of the 4 case studies to the group. • Ask Px to choose which flowchart they would use for each case and how they would treat the patient. Tell them not to be concerned with specific antibiotic treatment at this point. (Antibiotics are covered in Unit 7.) <p><i>Responses: 1. Urethritis flowchart; 2. genital ulcer flowchart; 3. lower abdominal pain flowchart; and 4. vaginal discharge flowchart.</i></p> <ul style="list-style-type: none"> • Include flowcharts 4 and 5 on vaginal discharge in this exercise. Defer major discussion since this topic will be covered extensively in specific objectives 4 and 5. • Discuss correct answers and problems that arise in using the flowcharts. Explain that later in the course there will be more intense small group practice with flowcharts.

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>motion tenderness, and vaginal discharge all indicate acute PID and the patient should be managed as indicated on the flowchart. If the patient appears extremely ill (fever of 40°C, cannot walk, vomiting, and cannot tolerate oral medication), then she may need inpatient treatment and should be referred.</p> <ul style="list-style-type: none"> • Otherwise, treat as an outpatient, but make sure she returns if she does not clearly improve on the medication. 	

CONTENTS Knowledge/Attitude/Skills	Training/Learning Methodology (Time Required)

Specific Objective #3: Explain the limitations of syndromic management for women with vaginal discharge

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>Management of vaginal discharge has the following problems:</p> <ol style="list-style-type: none"> 1. Vaginal discharge most often indicates vaginitis. A number of studies have shown that the most common causes of vaginal discharge are bacterial vaginosis (BV), Trichomonas vaginalis (TV), and candidiasis. Of these, only TV can be sexually transmitted. Signs and symptoms previously thought to be associated with STDs such as yellow vaginal discharge are not specific for STDs and may be more common with non-sexually transmitted vaginitis. 2. Many women with cervicitis do not have vaginal discharge or lower abdominal pain. In fact, most women with cervicitis do not have any symptoms. 3. Syndromic management of vaginal discharge has been misused as a screening tool. This happens when women, who present to a health facility for other reasons, are asked if they have vaginal discharge and then managed as if they came initially to complain of discharge. We know that often vaginal discharge is either normal or related to vaginal infections. In many settings, 40-50% of women will say "yes" when asked if they have discharge. This can lead to massive overtreatment of STDs. Studies of the validity of syndromic management have shown that vaginal discharge should not be used as a routine screening tool. 	<p>Discussion (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> 🔍 Ask Px for other management options besides syndromic management. Ask for any perceived problems with each option. <p><i>Possible responses: laboratory tests for all with vaginal discharge; speculum exam to determine where discharge is coming from; treatment for vaginitis only, and if symptoms persist, treat for cervicitis; and risk assessment.</i></p> <ul style="list-style-type: none"> • Stress that there are no easy answers. • Discuss what Px think are the problems associated with the syndromic management of vaginal discharge. <ul style="list-style-type: none"> 🔍 Ask if Px have encountered similar problems in the management of vaginal discharge. <ul style="list-style-type: none"> • Discuss how the approach to syndromic management of vaginal discharge is evolving. • Explain that we will examine laboratory testing closely in Unit 11. • Ask the following questions: <ul style="list-style-type: none"> 🔍 Do you think examination of the vagina, cervix, and bimanual exam of the uterus and adnexa can be helpful?

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>4. The cervix is not easily accessible. There is some evidence that syndromic management of vaginal discharge can be improved by examination of the cervix to determine whether there is a cervical discharge or inflammation, but this requires training, tools, time, and supplies.</p> <p>The Evolution of the Approach to Syndromic Management of Vaginal Discharge</p> <p>As a result of these continuing problems, the approach to vaginal discharge is evolving. The original aim of the WHO vaginal discharge flowcharts was to provide a simple tool for providers to manage vaginal discharge when this is the woman's chief complaint. The serious effects of gonorrhea and chlamydia infection in women and the perception that these infections often go untreated led to a flowchart where all women with vaginal discharge were treated for all possible infections of the vagina and cervix. This strategy does have the advantage of treating more women with vaginal discharge who might have a cervical infection. But because cervical infection is much less common than vaginal infection, many women are treated for cervicitis unnecessarily.</p>	<p>❓ Do you think that asking questions to assess the patient's risk of STD may give more information? If so, how?</p> <p>❓ Is it useful to know the prevalence of specific STDs in your area? If so, why?</p>

Specific Objective #4: Discuss a new approach to syndromic management of vaginal discharge

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>A New Approach to Syndromic Management of Vaginal Discharge</p> <ol style="list-style-type: none"> 1. We now know that vaginitis itself may have serious consequences. Bacterial vaginosis is associated with PID. BV and trichomoniasis are associated with preterm labor and also with an increase in HIV transmission. There is more benefit from treating vaginitis than previously thought. 2. Assess the STD risk of anyone with vaginal discharge carefully. If you or she suspect high risk based on prevalence of STDs in your patient population, her occupation, or her partner's symptoms, occupation or behavior; treat her for cervicitis and vaginitis and try to ensure partner treatment. The higher her risk, the greater the need to treat her immediately at the first visit. Since you are going to treat her anyway, there is less need to examine her. If she is at high risk, you might also find ulcers or another STD. 3. Treat vaginal discharge as vaginitis only, unless you have convincing reasons to believe the patient is at high risk for STD. This means not treating her partner initially. Treat with an antifungal if she has evidence of candida. 4. Use every method you have to make a better, more specific diagnosis of STD in those women who have symptoms but are lower risk. If you have the time and privacy to do an external 	<p>Trainer Presentation/Discussion (25 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Explain to Px that the approach to syndromic management of vaginal discharge has changed. ❓ Ask Px whether they think the problems regarding diagnosis of vaginal discharge reflect on syndromic diagnosis in general. <p><i>Response: No! The same problems exist with clinical and etiologic diagnosis unless rapid and accurate diagnostic tests are available, which is not the case in most developing countries.</i></p> <ul style="list-style-type: none"> • Instruct Px to refer to Flowchart #4 (Px Handout 6.2D). • Follow the steps in the flowchart as you discuss the information in the content section, "A New Approach to Syndromic Management of Vaginal Discharge." <p>❓ Ask Px how they can make a more specific diagnosis of STDs in those women who have symptoms but are at lower risk.</p> <p><i>Responses: Doing external inspection, abdominal exam, and bimanual exam if you have the time and resources. Speculum exam would provide more information, especially if a woman returns with persistent symptoms or her history is confusing at the first visit.</i></p>

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
<p>inspection for vaginal discharge and to palpate the abdomen, do so. If you have one glove and can check for cervical motion tenderness and do a bimanual exam, do</p> <p>so. It may conserve your resources to save speculum exams for women who return with persistent symptoms or whose history is confusing. All of this may add to the accuracy (increased sensitivity, specificity, and predictive value) of your diagnosis.</p> <p>5. Tailor your approach to syndromic management of vaginal discharge according to your clinical setting. Consider how high the risk to your population is (prevalence), how much of an exam you are capable of doing well, and whether or not useful diagnostic tests and effective treatment are available. Also consider the reason for a woman's visit: does she have vaginal discharge or has she come for another reason? Is she going to have a procedure (IUD or abortion) which puts her at increased risk if she is infected with a STD?</p> <p>6. One of the best ways to reach women at risk who are without symptoms is to target their partners. Find ways to welcome men to your clinic, reach out to men in the community, and make sure any men you treat for STDs have their partners treated and know how to use condoms.</p>	<p>❓ Ask what can be done about women with asymptomatic infection.</p> <p><i>Responses should include: targeting the female partners of infected men, increasing awareness of STD risk in the community, and targeting high-risk groups and individuals for screening or treatment.</i></p> <ul style="list-style-type: none"> • Present summary of the discussion. <ul style="list-style-type: none"> – The management of vaginal discharge is problematic regardless of the approach. – In general, treat vaginal discharge as vaginitis unless you believe the patient is at high risk. – A careful risk assessment can add to the accuracy of the diagnosis.

Specific Objective #5: Demonstrate the syndromic management of urethritis, lower abdominal pain, genital ulcers, and vaginal discharge

<p>CONTENTS Knowledge/Attitude/Skills</p>	<p>Training/Learning Methodology (Time Required)</p>
	<p>Case Studies/Flowchart Practice (1 hr. 30 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> Distribute the case studies. <div style="text-align: center;">   </div> <ul style="list-style-type: none"> Divide Px into groups of 4-5. There are 13 case studies for each syndrome. Ask Px in each group to take turns reading cases aloud within the group. Keeping track of time and using the flowcharts, the groups should discuss the cases and the management for 5 min. per case. For each case, they should answer the following questions: <ul style="list-style-type: none">  What is your diagnosis?  What is the correct management? Caution them to follow the flowcharts and not be side-tracked by clinical diagnosis. Ask the groups to write down questions, problems, and comments on specific cases or syndromes for discussion with the large group. The trainer(s) should circulate among the small groups to facilitate and answer questions as needed.

<p style="text-align: center;">CONTENTS Knowledge/Attitude/Skills</p>	<p style="text-align: center;">Training/Learning Methodology (Time Required)</p>
	<ul style="list-style-type: none"> • After 60 minutes, take a short break and then reconvene the large group. • Ask a spokesperson from each group to present the problems or comments the groups have noted for discussion.

CONTENTS Knowledge/Attitude/Skills	Training/Learning Methodology (Time Required)
	<ul style="list-style-type: none"> • Give each group 3 copies of the reporting forms. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Give each group the equivalent of \$12 U.S. • Give each group signed prescriptions for each drug listed in the case. • Instruct Px: <ul style="list-style-type: none"> - Each small group should go out and search for medications together. - There is a choice of 3 different treatments for each syndrome. (Treatments for most syndromes will include more than one medication.) - If possible, go to 3 places including a pharmacy, market, clinic, or hospital to get prices for the medications. - Using the form below write the name of the drug, the price, and the kind of establishment you visited on the form provided, and bring it to the next session. <p>Note to Trainer: The drug regimens suggested here may have to be changed according to availability in the particular region of the training.</p>

UNIT 7: RATIONAL USE OF ANTIBIOTICS

UNIT TRAINING OBJECTIVE:

To understand the rationale for using the most appropriate, low-cost, and locally available antibiotics for each RTI or syndrome.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Compare the local cost and availability of recommended antibiotics.
2. Select effective, alternative drug treatment when necessary.
3. Explain what causes antibiotic resistance and how to prevent it.
4. Demonstrate how to counsel patients on proper use of medicines, side effects, drug interactions, and dangers.

SIMULATED SKILL PRACTICE:

- Role play and mystery shopping
- Comparative drug pricing exercise

CLINICAL PRACTICUM OBJECTIVES:

Demonstrate correct choices of drugs for each syndrome according to national guidelines, patient need, availability, and cost.

TRAINING/LEARNING METHODOLOGY:

- Trainer presentation
- Discussion
- Role play
- Learning game
- Mystery shopping exercise

MAJOR REFERENCES AND TRAINING MATERIALS:

- Burdin, P., A. Taddio, O. Ariburnu, T.R. Einarson, and G. Koren. 1995. Safety of metronidazole in pregnancy: A meta-analysis. *American Journal of Obstetrics and Gynecology* 172(2 Pt 1): 525-529.

- Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: A health guide for women*. Berkeley, California: Hesperian Foundation.
- Holmes, K.K., P.F. Sparling, P.A. Mardh, S.M. Lemon, W.E. Stamm, P. Piot, and J.N. Wasserheit, eds. 1999. *Sexually transmitted diseases*. 3rd ed. New York: McGraw-Hill.
- Levy, S. 1997. The antibiotic paradox: how miracle drugs are destroying the miracle. *Management of sexually transmitted diseases*. Geneva: World Health Organization.
- McFadyen, J.E., ed. 1999. *International drug price indicator guide*. Arlington, VA: Management Sciences for Health, with support from the Norwegian Agency for Development Cooperation.
- World Health Organization (WHO) and Global Programme On Aids. 1997. *Management of sexually transmitted diseases*. Geneva: WHO.

RESOURCE REQUIREMENTS:

- Packaging material from locally available drugs
- Calculator

EVALUATION METHODS

- Pre- and post-test
- Observation using counseling checklist during clinical practicum

TIME REQUIRED: 2 hours 10 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare as a transparency or on a flipchart:
 - 7.4A: What Patients Need to Know About Their Treatment
- Make copies of the following participant handouts:
 - 7.1H: Treatment Options for Management of RTIs
 - 7.1I: Some Important STD Medications
 - 7.1J: Drug Price Comparisons (Optional)
 - 7.3A: Prevention Message
 - 7.4A: What Patients Need to Know About Their Treatment
 - 7.4B: Counseling Low-Literate Patients on How to Take Medication
 - 7.4C: Role Play
 - 7.4D: CBT Skills Assessment Checklist for Counseling Patients on the use of Medications
 -
- Copy the Unit 7 content section (Px Manual) for distribution at the end of the unit.
- Write the unit objectives on a flipchart.
- For the shopping exercise, prepare pieces of newsprint in advance with the names of each of the 6 cases at the top.
- For the generic name game, obtain from local pharmacies the packaging material for as many drugs in the treatment options as possible. (e.g. tetracycline, doxycycline, norfloxacin, metronidazole, nystatin, miconazole, gentian violet, amoxicillin, erythromycin, and trimethoprim sulfamethoxazole).

Introduction to Unit 7

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>Different kinds of medications are sold in different parts of the world. Prices, antibiotic effectiveness, and resistance vary from one region to another. Bacterial resistance to antibiotics has become a major barrier to the effective control of some STDs. Bacterial resistance can be attributed to natural resistance and to the misuse of medicines, particularly not taking the full recommended dose or buying wrong, insufficient, or expired medications on the street</p> <p>Good counseling on the proper use of medications is just as important as prescribing the right medication. Using ineffective medication, taking too low a dose to save money, or stopping treatment early because of side effects can contribute to the spread of STDs and may cause antibiotic resistance. Programs that provide STD management need to be able to keep an uninterrupted supply of antibiotics on hand, or to correctly prescribe low-cost, effective medications that patients can afford.</p> <p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Compare the local cost and availability of recommended antibiotics. 2. Select effective, alternative drug treatment when necessary. 3. Explain what causes antibiotic resistance and how to prevent it. 4. Demonstrate how to counsel patients on proper use of medications, side effects, drug interactions, and dangers. 	<p>Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objectives using the prepared flipchart.

Specific Objective #1: Compare the local cost and availability of recommended antibiotics

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>National treatment guidelines for the management of STDs should have been discussed (if available) in the sessions on syndromic management. Are these drugs available in your worksites, pharmacies, hospitals, and markets, and from private practitioners? What must patients pay for them?</p> <p>Generic Medicines</p> <p>Most medications have two names—a generic or scientific name, and a brand name. The generic name is usually the same all over the world, but the brand name is given by the company that makes the medicine. If many companies make the same medicine, it may have many different brand names. <i>Trimethoprim sulfamethoxazole</i> is the generic name of a common antibiotic used to treat STDs as well as other kinds of infections. What is this drug called where you live? It is important to know the generic name of medicines you use. Generic drugs are often less costly than brand name medicines, as you have found out with our first exercise. In some places generics may be of poorer quality.</p>	<p>Group Discussion/Mystery Shopping Exercise (40 min.)</p> <p>Note: Participants should have completed the "Mystery Shopping Exercise" before today's session.</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present content. • On the previously prepared flipchart, write down the prices for each drug in the treatment regimen that each group has found. • Give a prize to the group that found the most effective regimen for the least money. • Ask Px what they learned from the "Mystery Shopping Exercise." • Compare and discuss the availability and prices of the formulations of each medicine, using the format of the reporting sheets for your discussion. • Discuss the following: <ul style="list-style-type: none"> ❓ Why do prices for the same drugs differ? ❓ What regimen was the least costly? ❓ How does cost compare to effectiveness for the drugs recommended in the handout? <div style="text-align: center;">  </div>

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<p> ? What are some strategies for helping patients choose the most effective and least costly treatments available? For example, would you do something differently if your patient could only afford to buy a drug of questionable effectiveness (say, co-trimoxazole to treat gonorrhoea rather than norfloxacin)? Would you stress a follow-up visit more strongly to make sure s/he is cured? </p> <p> ? If you were the patient, what would be your choice of drugs considering you have only the local equivalent of \$12 US? Would you buy only one drug, or would you buy part of each prescription, or would you decide not to treat yourself at all? </p> <p> ? What are locally important issues around generic and brand name drugs with Px? </p> <p>Optional:</p> <ul style="list-style-type: none"> • Use two examples the <i>International Drug Price Indicator Guide</i>¹ to compare the price of drugs purchased in bulk from non-profit vendors with local pharmacy prices. <div style="text-align: center;">  </div> <p> ¹ McFadyen, J.E., ed. 1999. <i>International Drug Price Indicator Guide</i>. n.p.: Management Sciences for Health. </p>

Specific Objective #2: Select effective, alternative drug treatment when necessary

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Alternative drugs are often needed when:</p> <ul style="list-style-type: none"> • The first line drug is too costly. • The first line drug is unavailable. • A woman is pregnant, breastfeeding, or too young. • There is a history of drug allergy. • There are intolerable drug side effects. • There is drug resistance. 	<p>Group Work (30 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Divide Px into 5 small groups. Assign one syndrome from the list below to each group and have them come up with three treatment options for the syndrome, using <i>Px Handouts 7.1A-H</i>. Allow 15 minutes. <ol style="list-style-type: none"> 1. Vaginal discharge, low risk 2. Vaginal discharge, high risk 3. Urethral discharge 4. Lower abdominal pain 5. Genital ulcers • When groups are finished, have each group present its choices and reasons for each choice to the large group . Allow 15 minutes.

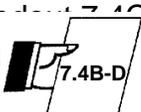
Specific Objective #3: Explain what causes antibiotic resistance and

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">(Time Required)</p>
<p>Definition: Antibiotic resistance is the ability of bacteria to adapt to changing environments in order to survive. With increased use of antibiotics over the 50 years since their discovery, weaker, susceptible strains of bacteria have been killed off. This has led to the selection of the strongest, most resistant strains. Such resistant strains are often very difficult to treat with more commonly used, low-cost antibiotics.</p> <p>There are many examples of resistance, such as multi-drug resistant tuberculosis (TB).</p> <p>Other bacteria, such as Chlamydia trachomatis, have remained extremely sensitive to drugs of the tetracycline family, even though this drug is often misused.</p> <p>The principle causes of antibiotic resistance are:</p> <ul style="list-style-type: none"> • Not completing the treatment regimen (i.e. stopping when feeling better, or sharing the medication). • Self-medication with too low a dose or the wrong medication, using drugs sold on the street. • Use of antibiotics when they are not needed (for example, to treat viral infections such as colds). • Misuse of antibiotics (using the wrong drug or the wrong dose). 	<p>Trainer Presentation/ Discussion (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the information in the content section. • Ask if anyone can give an example of drug resistance in STD control. One common example is penicillinase-producing gonorrhea (PPNG). Other examples are co-trimoxazole and GC, and fluoquinolones and GC (beginning). • Ask Px what are the principal causes of resistance. Discuss responses, making sure content is covered.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>How to Prevent Antibiotic Resistance in the Community, Country, and Region</p> <ul style="list-style-type: none"> • Use antibiotics appropriate for specific infections or syndromes. • Make sure you have prescribed the right drug for the right amount of time. • Always give clear instructions on how to take drugs and on the dangers of taking drugs incorrectly. Emphasize the need to take all of the drug, even if the patient is feeling better. Tell the patient not to save any of the drug or give it to someone else. • Be aware of changing resistance patterns by keeping in touch with the national STD control program. <p>Note: Providers usually do give the appropriate doses of antibiotics, but the problem with misuse lies with antibiotic sales in the community. Pharmacists or drug sellers often cut a treatment regimen to a fraction of what is needed in order to sell the drug at an affordable price.</p>	<p>Presentation (2 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute and present the prevention message and post it on the wall. <div style="text-align: center;">  </div>

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)

use of medicines, side effects, drug interactions, and dangers

CONTENT	Training/Learning Methods (Time Required)
<p>different ways: tablets or capsules that must be taken several times a day for a</p> <p>suppositories that are inserted into the vagina; injections; and combinations of all</p> <p>— actions that occur aside from the intended action of the drug. If patients</p> <p>medicine and are educated about the need for a medicine and its side effects, they will</p> <p>effects and be cured.</p> <p>Treating RTIs: What patients need to</p> <ul style="list-style-type: none"> • generic name; the common, locally available brand name; and probable • history of allergic reactions to any medicines and choose another • • • • • medicine. • Why FULL treatment is necessary. 	<p>Presentation/Demonstration/Return Demonstration (30 min.)</p> <p>The trainer should:</p> <p>Present content.</p> <p>Present the elements of patient</p> <div style="text-align: center;">  </div> <p>Note: Only patient education about here, which is just one part of what a patient needs to know. With practice, this minutes, allowing the patient time to ask questions and repeat back the instructions</p> <ul style="list-style-type: none"> • correct patient counseling on medications using the Har (Handout 7.4C). Px should follow the che (Handout 7.4B-D) (handout 7.4D) during the <div style="text-align: center;">  </div> <div style="text-align: center;">  </div> <p style="text-align: right;">role play</p>

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Encourage compliance.</p> <ul style="list-style-type: none"> • How to take the medication. <ul style="list-style-type: none"> – Give clear instructions. – Ask the patient to repeat the instructions back to you. – Ask if s/he has any questions. 	<p>again using different medications.</p> <p>❓ Following the role play, ask the provider how s/he felt giving this information.</p> <p><i>Possible responses: too much information, too complex, no problems.</i></p> <p>❓ Ask the patient how s/he felt being given all this information.</p> <p><i>Possible responses: helpful, too much, too little.</i></p> <ul style="list-style-type: none"> • Ask the Px for feedback: <ul style="list-style-type: none"> ❓ How does this exercise fit into your work situations? ❓ Do you normally give this kind of information to your patients? • Correct any problems or misinformation. <p>Note: Partner referral and treatment is necessary here, but this objective focuses on proper use of and patient education on medication.</p>

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)

Unit 7 Summary

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Summary</p> <ol style="list-style-type: none"> 1. Providers should be aware of local variability in availability and cost of RTI drugs. 2. Providers should ensure that patients get the lowest-cost and highest-quality drugs. 3. Providers should know how to prescribe or provide alternative drugs when necessary. 4. Knowledgeable prescribing and good patient education on medications prevent antibiotic resistance. 	<p>Presentation (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit summary. • Distribute Px Manual content for Unit 7.

UNIT 8: PATIENT COUNSELING AND EDUCATION

UNIT TRAINING OBJECTIVE:

Describe and demonstrate the general principles of counseling and interpersonal communication and apply them to STD prevention and management, including history taking, patient education, risk reduction, motivation for behavior change, and partner management.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Define key terms related to patient education.
2. Identify personal feelings, attitudes, and values and their impact on effective communication with patients.
3. Develop a plan for clinic-wide prevention of STDs.
4. Discuss the essentials of verbal and non-verbal communication skills.
5. List the steps involved in counseling.
6. Describe the barriers to good counseling.
7. Describe the goals and principles of effective patient education on STDs.
8. Demonstrate the principles of behavior change communication (BCC) to prevent STDs.
9. Identify activities that contribute to reducing risk.
10. Demonstrate how to teach partner negotiation skills.
11. Demonstrate good counseling skills in simulated role plays.

SIMULATED SKILL PRACTICE:

Role play

CLINICAL PRACTICUM OBJECTIVES:

Participants will be able to demonstrate good counseling and patient education skills in simulated patient encounters in the classroom.

TRAINING/LEARNING METHODOLOGY:

- Role play
- Sex vocabulary competition
- Values clarification exercise
- Short presentation
- Brainstorming
- Clinical practicum

MAJOR REFERENCES AND TRAINING MATERIALS:

- Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: A health guide for women*. Berkeley, California: Hesperian Foundation.
- Dallabetta, G.A., M. Laga, and P.R. Lamptey, eds. 1996. *Control of sexually transmitted diseases: A handbook for the design and management of programs*. Arlington, Virginia: AIDSCAP/Family Health International.
- Department of Health/HIV/AIDS Directorate. 1996. *Training manual for the management of a person with a sexually transmitted disease*. Pretoria, South Africa: Department of Health.
- Nepal Medical Association and Family Health International/AIDSCAP. 1996. *Case management of sexually transmitted diseases*. Arlington, Virginia: Family Health International/AIDSCAP.
- Solter, C. 1998. *Module 3: Counseling for family planning services*. Watertown, Massachusetts: Pathfinder International.
- World Health Organization (WHO). 1995. *STD case management workbook 3: History-taking and examination*. Geneva: WHO.
- World Health Organization (WHO). 1995. *STD case management workbook 5: Educating the patient*. Geneva: WHO.
- World Health Organization (WHO). 1995. *STD case management workbook 6: Partner management*. Geneva: WHO.
- Zimbabwe Aids Network and UNICEF. 1993. *Communicating about AIDS*. (Poster). Harare: Zimbabwe AIDS Network.

RESOURCE REQUIREMENTS:

- Newsprint
- Overhead projector
- Markers
- Tape
- Video with STD prevention messages
- VCR and monitor
- Condoms (male and female)

EVALUATION METHODS:

- Pre- and post-test
- Observations using standardized counseling and patient education checklists in simulated and real patient encounters

TIME REQUIRED: 7 hours 25 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

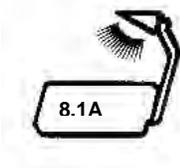
- Prepare the following as transparencies or on a flipchart:
 - 8.1A: Key Terms and Definitions
 - 8.2A: Survey of Sexual Attitudes
 - 8.4A: Terms Related to Verbal Communication
 - 8.5A: Guidelines for Counseling
 - 8.7A: Goals of Patient Education and Counseling
 - 8.9A: Picture Code: Laundry Day
- Copy the following Participant Handouts:
 - 8.1A: Matching Key Terms and Definitions
 - 8.2A: Sexual Word List (*4 copies only—one for each group*)
 - 8.5A: Role Play
 - 8.7A: Job Aid for Counseling STD Patients
 - 8.7B: Case Study
 - 8.8C: Role Play
 - 8.10A: Bargaining for Safer Sex
 - 8.11A: CBT Checklist for Counseling Role Play or Client Visits
 - 8.11B: Role Plays
- Write the unit objectives on a flipchart.
- Copy the Unit 8 content section (Px Manual) for distribution at the end of the unit.
- Obtain prizes for competition (S.O. #2).
- Prepare two signs, one with the word “agree” and the other with the word “disagree” (S.O. #2).
- Prepare flipchart with the following terms: "interpersonal communication", "verbal communication," and "nonverbal communication" (S.O. #4).
- Prepare slips of paper with a different feeling written on each (S.O. #4).
- Prepare a role play with another trainer showing a negative interaction between provider and patient, illustrating barriers to good counseling (S.O. #6).
- Prepare a flipchart with 3 columns labeled as follows: “motivation,” “barriers,” and “support” (S.O. #8).
- Prepare 4 pieces of newsprint with topics for group presentations (S.O. #9).
- Prepare pieces of paper with a safer sex message written on each (S.O. #10).

Introduction to Unit 8

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>Family planning and maternal child health providers are already skilled communicators; they talk about issues of sexuality and sexual health in their work every day. The way they talk about these issues with clients determines the quality of the interaction and, to a large degree, the quality of care the clients receive. Good communication of information on prevention, especially on behavior change, linked with effective treatment is key to the control of STDs. When clear communication is linked to effective treatment there can be additional benefits. Even when treatment is not available in an integrated setting, prevention information and condoms can be provided. These two should be the provider’s first integration priorities.</p> <p>This unit reviews general counseling skills and focuses on skills that relate specifically to STD prevention and management within the clinic. (Refer to <i>Pathfinder Module 3: Counseling</i> for more detailed information.)</p> <p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Define key terms related to patient education. 2. Identify personal feelings, attitudes, and values and their impact on effective communication with patients. 3. Develop a plan for clinic-wide prevention of STDs. 4. Discuss the essentials of verbal and non-verbal communication skills. 	<p>Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objectives using the prepared flipchart.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<ol style="list-style-type: none"> 5. List the steps involved in counseling. 6. Describe the barriers to good counseling. 7. Describe the goals and principles of effective patient education on STDs. 8. Demonstrate the principles of behavior change communication (BCC) to prevent STDs. 9. Identify activities that contribute to reducing risk. 10. Demonstrate how to teach partner negotiation skills. 11. Demonstrate good counseling skills in simulated role plays. 	

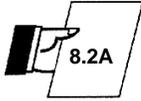
Specific Objective #1: Define key terms related to patient education

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>A number of different concepts and interpersonal skills overlap when providers communicate with patients, especially about private sexual matters.</p> <p>Definitions</p> <p>Counseling: Face-to-face, personal, confidential communication in which one person helps another to make decisions and then to act on them. Good counseling has two major elements: mutual trust between patient and provider and the giving and receiving of relevant, accurate, and complete information that enables the patient to make a decision. It requires conversational and listening skills.</p> <p>Patient education/health education: For STDs, giving relevant information based on public health needs. This includes information on infections, transmission, recommended treatment, prevention, risk reduction, behavior change, and partner referral. This information can be communicated one-on-one, in group settings in the clinic; and via posters, videos, and brochures. It should involve all possible staff. Patient education requires teaching and group facilitation skills.</p> <p>Interpersonal communication: The face-to-face process of giving and receiving information between two or more people. This involves both verbal and non-verbal communication.</p> <p>Verbal communication: The way we talk with patients, the words we use, and their meanings.</p>	<p>Group Exercise (10 min.)</p> <ul style="list-style-type: none"> Distribute the word matching exercise. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> Ask Px to match definitions to the correct terms. Allow 5 minutes. Using the transparency, present the correct answers, discuss the definitions, and answer any remaining questions. <div style="text-align: center;">  </div>

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Non-verbal communication: The way we behave with patients, including actions, behaviors, gestures, and facial expressions.</p> <p>Behavior change communication: The process of developing and providing simple messages based on proven information that suggests realistic ways to change risky behavior. This includes exploration of life situation and risk, consideration of options, and skill-building, practice, and support to implement and sustain the behavior change.</p> <p>Adult Education Principles</p> <p>Acknowledge that adults learn:</p> <ul style="list-style-type: none"> • 20% of what they hear. • 40% of what they hear and see. • 80% of what they do or discover for themselves. <p>Therefore, teaching patients to increase their awareness of STDs, risk reduction, behavior change, etc. must involve three things to be effective: action, feelings, and ideas. These correspond to the areas of skills, attitudes, and knowledge in this training.</p>	<ul style="list-style-type: none"> • Present content on adult education principles and answer any questions.

Specific Objective #2: Identify personal feelings, attitudes, and values and their impact on effective communication with patients

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>We all attach strong emotions, values, and attitudes to sex. Sometimes we are judgmental or disrespectful toward patients who do not share our views. This leads to a patient feeling attacked or judged, a situation that makes learning difficult, and to poor understanding and compliance with treatment.</p>	<p>Value Clarification Exercise (30 min.)</p> <p>The trainer should explain to Px:</p> <ul style="list-style-type: none"> • The goal of the following exercise is simply to help them examine their own opinions and beliefs about sexuality, gender roles, and STDs. There are no right or wrong points of view. • This is a learning exercise. One person should talk at a time, and everyone should hear each other out. <p>Instructions</p> <ul style="list-style-type: none"> • Display the transparency and put up the 2 prepared signs designating “agree” and “disagree” on opposite sides of the room. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Read aloud a statement from the list. • Px should decide whether they agree or disagree with the statement and move to the appropriate side of the room. • Ask one Px from each side of the room why s/he agrees or disagrees with the statement. • Repeat for several statements. • End the game by asking Px:

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Talking About Sex</p> <p>Most of us, including health care providers, respond emotionally to words that relate to the sexual organs and sexual activity. Such words often make us uncomfortable. This is communicated to patients who then feel even more uncomfortable bringing up their problems. Providers often use medical terms that patients do not understand to cover up their own embarrassment about sex.</p> <p>Be comfortable with the real words your patients use to communicate about sexual matters and use them yourself when appropriate in order to:</p> <ul style="list-style-type: none"> • Put patients at ease. • Make what you are saying understandable. • Make compliance with treatment and behavior change more likely. 	<ul style="list-style-type: none"> ❓ Did any of the responses surprise you? ❓ How did people respond to different statements? ❓ How did you feel about the responses of others? <p><i>Possible responses: defensive, judgmental, ambivalent, afraid to express opinion, angry, shocked.</i></p> <p>Group Work (40 min.)</p> <ul style="list-style-type: none"> • Divide Px into 4 small groups. Ask each group to select a reporter to present the group's findings. • Give each group a list of words for body parts, sex acts, STDs, and other terms referring to sex. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Ask the Px to write all of the terms—in any language that they have heard—for the words on the list. Explain that the goal is to see which group can create the longest list of words in 15 minutes. • Ask each group to assign a reporter. • After 15 min., ask the reporters to read the words on their groups' list. The group with the longest list is the winner. • Ask Px to consider:

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<ul style="list-style-type: none"> <p>? A young woman complains of “pain down there.” What words would you use from the lists to clarify her history?</p> <p>? A young man says he has sores on “his privates.” What words would you use to clarify?</p> <p>• Ask the Px to share their feelings about the exercise and about using these words. If time permits, discuss the following questions:</p> <ul style="list-style-type: none"> <p>? Which words should we use with patients and why?</p> <p>? Is it difficult to hear or say any of these words? If so, how do they make us feel?</p> <p>? Why do we laugh at them (if applicable)?</p> <p>? Why do people use particular words rather than others?</p>

Specific Objective #3: Develop a plan for clinic-wide prevention of STDs

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Opportunities for Patient Education</p> <p>Patient education does not happen only one-to-one. A friendly and supportive atmosphere clinic-wide promotes patient confidence and use of services. Important messages on prevention and treatment can be reinforced everywhere in the clinic.</p> <p>The attitudes of all clinic staff, from cleaning to administrative and laboratory personnel, may contribute significantly to the success of a STD prevention and management program. To foster positive and welcoming behavior towards patients with STDs, it may be helpful to sensitize all clinic staff so that they are comfortable giving out condoms, medications, and information on prevention and treatment. Positive, helpful staff behavior can be encouraged by:</p> <ul style="list-style-type: none"> • Holding staff training sessions on the importance of STD prevention and management. • Conducting values clarification exercises. • Staff participation in decision making around addition of new services. • Staff participation in the development of educational materials. <p>Prevention and quality of care can be promoted at various places around the clinic:</p> <p>Waiting room – health talks, posters, pamphlets, videos, condom demonstrations.</p>	<p>Brainstorming (15 min.)</p> <p>The trainer should ask for a volunteer to write Px responses on newsprint, and then:</p> <ul style="list-style-type: none"> ? Ask Px what prevention activities can happen in different parts of a clinic facility. Supplement their answers with information from the content section. ? Ask Px how they would go about changing attitudes and enlisting positive behavior from clinic staff toward STD patients.

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Registration desk – friendly clerk, confidential ways to identify patients’ complaints (such as choosing your problem from a list of pictures), brochures, condoms.</p> <p>Lab – posters, information about condoms, condoms to take.</p> <p>Exam area – friendly providers, written material, educational posters on the wall, condom demonstration by provider, pictorial list of where to get HIV testing and services.</p>	

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)

Specific Objective #4: Discuss the essentials of verbal and non-verbal communication skills

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Interpersonal Communication</p> <p>Interpersonal communication, the face-to-face process of giving and receiving information between two or more people, involves both verbal and non-verbal communication.</p> <p>Non-verbal Communication:</p> <ul style="list-style-type: none"> • Refers to actions, gestures, behaviors, and facial expressions that express how we feel in addition to speaking. • Is often complex and largely unconscious. • Often reveals the real feelings or messages being conveyed. • Can involve all of the senses. <p>Verbal Communication:</p> <ul style="list-style-type: none"> • Refers to words and their meanings. • Begins and ends with what we say and how we say it. • Is largely conscious and controlled by the speaker. 	<p>Discussion (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Using the prepared flipchart, ask Px to define the 3 terms. • Ask Px for examples of each. <p><i>Possible responses: providing privacy; establishing eye contact (as appropriate in the culture); how you are listening by leaning toward patient; nodding when s/he says something; not writing or doing other things during consultation; sitting or standing as patient does.</i></p> <ul style="list-style-type: none"> • Ask Px for examples of how negative emotions such as not paying attention, frowning, impatient tone of voice can be transmitted during counseling. <p>Exercise (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Hand out slips of paper with the name of a different feeling (such as defensiveness, anger, pride, fear, sadness, happiness, pain, impatience, disapproval, confusion) written on each. • Ask each Px to act out a feeling before the group. Px may use facial expressions and body language, but no words. <p><i>Note: there may be more Px than "feelings," in which case some of the feelings should be acted out twice.)</i></p>

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Other Verbal Communication Skills</p> <p>Facilitation: Encouraging, summarizing, and checking with the patient to be sure you understand her/his concerns.</p> <p>Reassurance: Showing your support.</p> <p>Direction: Guiding a client back to the reason for the visit.</p> <p>Empathy: A critical skill acknowledging feelings and showing you care.</p> <p>Partnership: Offering your commitment to help.</p> <p>Asking questions: Use open- and closed-ended questions to get the information you need.</p> <ul style="list-style-type: none"> • Open questions: Invite the patient to give a long answer. ("Tell me more about your back pain." "What else is troubling you?"). • Closed questions: Require only a "yes" or "no" or very short answer. ("Is your back painful?" "How old are you?"). 	<ul style="list-style-type: none"> • Ask the group to guess the emotion. • Ask Px which non-verbal cues or body language can be used to communicate understanding, support, or helpfulness. <p>Discussion (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to define the terms on the transparency and give examples of each, using the content. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Add any material not covered in the discussion. <p>Exercise (5 min.)</p> <ul style="list-style-type: none"> ❓ Ask Px to define open and closed questions ❓ Ask Px if they can tell which of these are open-ended questions: <ul style="list-style-type: none"> - Do you have abdominal pain? <i>(closed)</i> - Are you married? <i>(closed)</i> - What is troubling you? <i>(open)</i> - Is the discharge milky or clear? <i>(closed)</i> - What does the pain feel like? <i>(open)</i>

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
	<ul style="list-style-type: none"> - Tell me about your periods. <i>(open)</i> - Did you use a condom the last time you had sex? <i>(closed)</i> <p>❓ Ask Px to give advantages and disadvantages of each.</p> <p><i>Answers include: Can get more information from the patient's perspective with open-ended questions, can get a lot of information in a short time with closed-ended question. Reiterate that both are useful.</i></p> <ul style="list-style-type: none"> • Summarize S.O. #4 content.

Specific Objective #5: List the steps involved in counseling

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Guidelines for Counseling</p> <ul style="list-style-type: none"> • Welcome your patient warmly by name and introduce yourself. • Sit closely enough so that you can talk comfortably and privately. • Make eye contact and look at the patient as s/he speaks. • Use language that the patient understands. • Listen and take note of the patient's body language (posture, facial expression, looking away, etc.). Seek to understand feelings, experiences and points of view. • Be encouraging. (Nod or say, "Tell me more about that.") • Use open-ended questions. • Provide relevant information. • Try to identify the patient's real concerns. • Provide various options for the patient. • Respect the patient's choices. • Always verify that the client has understood what has been discussed by having the client repeat back the most important messages or instructions. 	<p>Presentation/Role Play (45 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the guidelines for counseling. • Distribute the role play. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Divide the group into pairs with one Px playing the provider and the other the patient. Allow 5 minutes for Px to prepare for their parts. • After 5 minutes, ask for 2 volunteers to present the role play to the whole group. • Time the interaction and stop after 5 minutes. Px should then switch roles. • After another 5 minutes, ask two other sets of volunteers to present the role play. • Have the group give feedback and discuss what worked well and what difficulties arose.

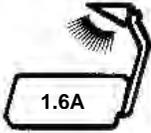
Specific Objective #6: Describe the barriers to good counseling

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>It is important to be aware of attitudes, behaviors, and other factors that could have a negative effect on the patient.</p> <ul style="list-style-type: none"> • Lack of privacy. • Not greeting or not looking at the patient. • Appearing to be distracted (for example, by looking at your watch or reading papers while s/he is talking). • Using a harsh tone of voice or making impatient or angry gestures. • Sitting while the patient stands or sitting far away from the patient. • Allowing interruptions during the consultation. • Being critical, judgmental, sarcastic, or rude. • Interrupting the patient. • Making the patient wait for a long time. • Not allowing enough time for the visit. 	<p>Presentation/Short Discussion (15 min.) The trainer should:</p> <ul style="list-style-type: none"> • Present the prepared role play showing a negative interaction between provider and patient. ❓ Ask Px to list all of the barriers they observed in the role play. Fill in any content not covered. ❓ Ask Px for ideas on how to deal with the factors of insufficient time and lack of privacy, noting the major effects of these barriers, which may be out of the providers' control. ❓ Ask Px for examples of attitudes and behaviors that could have a positive effect on the patient. <p><i>Possible responses: Greeting the patient warmly; being attentive; being non-judgmental; sitting or standing as the patient does; giving sufficient time to the patient.</i></p>

Specific Objective # 7: Describe the goals and principles of effective patient education on STDs

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Introduction</p> <p>A patient with a STD needs to understand what infection s/he has and how it is transmitted, to be encouraged to follow recommended treatment, to discuss risk and behavior change, and to refer partners for treatment. If a patient has come to the clinic with STD symptoms, this is an ideal time to communicate with her/him about these issues. If a patient has come for family planning and does not appear to be at risk for infection, it is a good time to offer information about STDs, such as how to prevent infection and how to recognize signs of infection. Information about condoms for dual protection against pregnancy and STDs should be given at every visit.</p> <p>Goals of Patient Education and Counseling on STDs</p> <ol style="list-style-type: none"> 1. Primary prevention, or preventing infection in uninfected patients. This is the most effective strategy to reduce the spread of STDs and can be easily integrated into all health care settings. 2. Curing the current infection. 3. Secondary prevention, which: <ul style="list-style-type: none"> – Prevents further transmission of that infection in the community – Prevents complications and re-infection in the patient 	<p>Trainer Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the introduction to the S.O. • Using the transparency, present the goals of patient education and counseling on STDs. <div style="text-align: center;">  <p>8.7A</p> </div>

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>The 4 Cs</p> <p>Providers can use the 4 Cs as a reminder of the key components of STD patient counseling.</p> <ol style="list-style-type: none"> 1. <u>Counseling</u> – empathize, ensure two-way communication, and discuss other 3 Cs with the patient. 2. <u>Compliance</u> – the patient should avoid self-medication, take the full course of medication, not share or keep the medication, and follow the provider’s instructions. 3. <u>Condoms</u> – teach that proper condom use is the only alternative to abstinence. Give condoms to your patient, and explain and demonstrate how to use condoms properly. 4. <u>Contact treatment</u> – encourage your patient to tell all of her/his sexual partners to seek medical attention. <p>What the Patient Needs to Know</p> <p>Prevention of STDs</p> <ul style="list-style-type: none"> • Using condoms if not in a monogamous relationship • Limiting the number of partners (ideally) to one • Alternatives to penetrative sex • Negotiating skills <p>Information About STDs</p> <ul style="list-style-type: none"> • How they are passed between people • Consequences of STDs • Links between STDs and HIV 	<p style="text-align: center;">Discussion/Small Group Work (35 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute the job aid for counseling STD patients. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Divide Px into the same 4 small groups. • Present the following case: A married woman has been diagnosed with cervicitis. • Ask groups to discuss how they would counsel her using the job aid, and to prepare a role play using the case.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>STD Symptoms</p> <ul style="list-style-type: none"> • What to look for and what symptoms mean <p>STD Treatment</p> <ul style="list-style-type: none"> • How to take medications • Signs that call for a return visit to the clinic • Importance of partner referral and treatment <p>Principles of Effective Patient Education</p> <ol style="list-style-type: none"> 1. Shows respect and concern for the safety of patients through body language, telling patients you are concerned, being attentive to and acknowledging patients' feelings, and taking more time with them. 2. Is patient-centered. Provides messages that are tailored for each individual –different messages for married women, adolescents, and sex workers. 3. Involves 3 kinds of learning: through ideas, actions, and feelings (cognitive, psycho-motor, and affective). 4. Uses multiple channels (eyes, ears and face-to-face/visual, auditory, interpersonal). Delivers messages via the eyes, ears, and face-to-face communication. 	<ul style="list-style-type: none"> • Display the pyramid and ask the groups to discuss how counseling can effect the pyramid.  <p><i>Answer: It enlarges the lowest bar.</i></p> <ul style="list-style-type: none"> • After 10 minutes, reconvene the large group and ask for each group to present its role play for 5 min. each. • Discuss the question about the pyramid. • Ask for feedback from the group, and add any content material not covered. <p>Case Study (30 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Review the principles of effective patient education. • Distribute the case study and ask for a volunteer to read it aloud to the group.  <ul style="list-style-type: none"> • Ask Px questions using the trainer's tool. 

Specific Objective #8: Demonstrate the principles of behavior change communication in preventing STDs

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Principles of Behavior Change for Prevention</p> <ul style="list-style-type: none"> • Give good information. Give patients clear and accurate information on risky behaviors, the dangers of STDs, and specific ways to protect themselves. Identify behaviors that put particular clients at risk. • People need motivation to change a behavior. People change behavior as a result of a personal experience or crisis. Meeting someone who has HIV/AIDS, hearing statistics about HIV/AIDS, hearing about a family member or friend who is infertile due to a STD, hearing about the children of someone who died of AIDS, or learning that a partner is HIV-positive are all experiences that might motivate someone to change. • Identify barriers to behavior change. What keeps someone from changing behavior? Is it personal views, lack of information, or social restraints such as the need to please a husband? • Establish goals for behavior change. Set up short- and long-term goals that patient and provider can agree upon. • Offer real skills. Teach negotiation skills for women, demonstrate how to use a condom, and conduct role-playing conversations. • Offer choices. Clients need to feel that they have choices and can make their own decisions. Offer substitute behaviors that are less risky. 	<p>Brainstorming/Discussion (15 min.)</p> <p>Referring to content as needed, the trainer should:</p> <ul style="list-style-type: none"> • Display the prepared flipchart with 3 vertical columns labeled “motivation,” “barriers,” and “support.” • Ask Px to think of a time when they tried to change certain behaviors. <ul style="list-style-type: none"> ? What methods did they try, what worked, and what did not? ? Were they successful? ? Why not? • Ask Px to think of behavior changes they have recently tried to make such as stopping smoking, exercising more, eating healthier food, etc. • Ask a volunteer to share the behavior, and then ask: <ul style="list-style-type: none"> ? How did you become aware the behavior was harmful? ? From what sources did you receive the information? ? What happened to get you started trying to change the behavior? ? How long was it between the time when you realized the behavior was harmful and when you actually started to change?

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<ul style="list-style-type: none"> • Plan for setbacks. Rehearse how the client can deal with a situation that temporarily worsens (for example, the husband becomes angry, or refuses to use condoms). 	<ul style="list-style-type: none"> • List the volunteer's responses in the column marked "motivation." • Ask the same volunteer the following questions: <ul style="list-style-type: none"> ? What things got in the way of your changing? ? What was the hardest thing for you to overcome in making the change? • List these responses in the column labeled "barriers." ? Ask the volunteer if there was anything that helped her/him make the change (i.e. friends, family, church, community, something s/he read, etc.). • List these responses in the column labeled "support." • Ask other volunteers to share their behavior changes and write their responses in the appropriate columns on the flipchart. • Ask Px why changing sexual behaviors is particularly difficult. <p><i>Possible responses should include: sex as fun and pleasure, which are important in people's lives; gender roles of women; social norms; lack of money and power; and fear of losing one's partner.</i></p>

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<p>Role Play/Discussion (35 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Refer Px to the case study (<i>PxH8.7B</i>) with the provider and B_____ and explain that the case study will provide the basis for the role play. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Divide Px into groups of 4. In each group, one person should play the provider, one should play the patient, and 2 should act as observers. • Distribute the handout containing the instructions for the role play, and review them with Px. • Allow the groups 10 minutes to prepare their role plays. • Reconvene the large group, and ask a group to volunteer to act out its role play. • Ask the larger group to critique the role play and discuss the experiences of the small groups for 10 minutes. The trainer should focus on/ask the following: <ul style="list-style-type: none"> ❓ What did you find useful about this exercise? ❓ What did you find difficult? ❓ What changes do you think B_____ will be able to make in the next week, the next month? ❓ What support will she need to make these changes?

Specific Objective #9: Identify activities that contribute to reducing risk

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Risky Behaviors</p> <p>We know that certain behaviors increase the risk of STD transmission. Most of these behaviors involve sexual activity and are called unsafe sex.</p> <p>What Is Safer Sex?</p> <p>Safer sex is sex with a partner who is uninfected or any sexual activity that reduces the risk of passing STDs and HIV from one person to another. Safer sex does not allow semen, vaginal fluid, or blood to enter the body through the vagina, anus, or an open sore or cut.</p> <p>Some Safer Sex Practices</p> <ul style="list-style-type: none"> • Mutually faithful relationship between two uninfected partners. • Increased sex between faithful partners to reduce “grazing.” • Reducing the number of sex partners. • Using a barrier such as a condom for all types of intercourse. • Non-penetrative sexual practices such as kissing, hugging, rubbing, and masturbating. • Avoiding sex when either partner has signs of a STD. • Abstinence. 	<p>Brainstorming/Short Presentation/ Case Study/Discussion (40 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Display picture code of a woman finding a condom in a pair of pants. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Ask Px: <ul style="list-style-type: none"> ? What do you see happening in this picture? ? Why is this happening? ? Does this happen in real life? ? What problems does this lead to? ? What solutions can this lead to? • Present content on risky behaviors (first paragraph in content only). • Divide Px into the same 4 small groups. • Assign each group one of the topics below, and give each group a piece of newsprint on which to prepare a presentation. <ul style="list-style-type: none"> – Group 1: Define safer sex. – Group 2: List safer sex practices. – Group 3: List practices that make sex risky. – Group 4: List safer sex messages

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Some practices that make sex risky:</p> <ul style="list-style-type: none"> • Unprotected vaginal sex if you don't know whether your partner is infected. • Sex with a partner who has signs of a STD. • Sex with a partner who has other partners. • Unprotected anal sex. • Unprotected oral sex. • Use of alcohol or drugs with sex. • Sex with an intravenous drug user. • Multiple partners. • Casual sex or sex with strangers. • Frequent change of partners. • Douching. • Use of vaginal drying agents. <p>Guidelines for Communicating With Patients</p> <p>Safer Sex Rules</p> <ul style="list-style-type: none"> • Use protection (condom or other barriers) every time you have sex unless you have sex with only one faithful partner who is uninfected. • Keep away from unsafe practices like “dry sex” that may break the skin—the vagina should be wet inside when you have intercourse. • Do not have sex in the anus, but if you 	<p style="text-align: center;">or rules to give to patients.</p> <ul style="list-style-type: none"> • After 10 minutes, ask a representative from each group to make the group’s presentation. • Ask Px for comments and present any material not covered.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>must, always use a condom with lubrication because the skin there can tear easily and allow HIV to pass.</p> <ul style="list-style-type: none"> • Try massage, rubbing, touching, dry kissing, hugging, or masturbation instead of intercourse. • Have oral sex with a male or female condom if this is acceptable to you. • DO NOT have sex when either partner has sores on the genitals or when there is a discharge from the penis. <p>How to Make Sex Safer</p> <p>Have sex that does not let semen into the vagina, mouth, anus, or an open sore. Safer sex can be real sex, and not just “eating a sweet with the wrapper on.” Couples can talk about sex together to learn to please each other. Bargain for safer sex. Safer sex can be more pleasurable for both partners because it is less likely to cause worry, discomfort, or disease. Instead of intercourse, try outercourse, which is having sex without putting the penis into the vagina.</p> <p><i>Male condoms are the most effective way to prevent transmission of all STDs (including HIV), during sexual intercourse.</i> If the man will not use condoms, the woman can use one of the other barrier methods that might help protect her. These methods include:</p> <ul style="list-style-type: none"> • the female condom • the diaphragm or cervical cap • spermicide cream, jelly, film, foam, or foaming tablets • vaginal sponge 	<p>Presentation/Discussion (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present content on how to make sex safer. • Ask Px: <ul style="list-style-type: none"> ? What is the most effective way to prevent STDs, including HIV, during intercourse? <p><i>Answer: condoms.</i></p> ? What other barrier methods might help protect against infection? <p><i>Answer: female condom, diaphragm, spermicide cream, jelly, foam or foaming tablets, vaginal sponge.</i></p> ? Do these prevent HIV? <p><i>Answer: They haven't been proven to.</i></p> ? What are the advantages and

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>These methods have been shown to be somewhat effective against bacterial STDs, but not HIV. Frequent use of spermicides, in fact, may increase the risk of becoming infected because it irritates the vaginal lining, which makes it easier for HIV, and probably STDs, to enter the body.</p> <p>No method works perfectly all the time to prevent HIV/AIDS. But if you use male condoms correctly every time you have sex, you will be 90% protected.</p>	<p style="text-align: center;">disadvantages of spermicides?</p> <p style="text-align: center;"><i>Answer: May protect against certain STDs, but may cause irritation and increase the risk of transmission.</i></p> <ul style="list-style-type: none"> • Add any content material not covered.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)

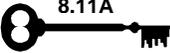
Specific Objective #10: Demonstrate how to teach partner negotiation skills

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Bargaining for Safer Sex</p> <p>Bargaining for safer sex is similar to bargaining for other things that we need. Thinking about how to bargain successfully in other areas will help. A way to begin is for someone to decide what s/he wants, and what s/he is willing to offer in return.</p> <p>Focus on Safety</p> <p>In bargaining for safer sex, the focus should be on safety, not lack of trust or blame or punishment. It is easier to reach agreement around safety because both people benefit from it.</p> <p>Use Other People as Examples</p> <p>Knowledge that others are practicing safer sex can make it easier to start.</p> <p>Ask For Help If You Need It</p> <p>Inviting another trusted person to help discuss safer sex with a partner may make it easier.</p>	<p>Role Play (25 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute the handout on bargaining for safer sex. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Divide the Px into pairs. Give each pair a piece of paper with one of the safer sex messages found below. Ask each pair to spend 10 minutes reading the handout and then creating a short role play that incorporates the safer sex message. <ol style="list-style-type: none"> 1. No intercourse today, I have a STD and must wait until it's cured. 2. I don't want to have sex at all with you because you go with too many women. 3. I don't want to get pregnant or get AIDS so no condom means no sex. 4. No condoms? Let's just play around. We can make each other come without having intercourse. 5. I want to try this female condom because I want us both to be safe. We could have HIV and not know it. 6. I don't want to have intercourse until my vagina feels wet because it's painful for me.

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<ul style="list-style-type: none"> • Reconvene the large group and ask for volunteer pairs to present their role plays. After several role plays, discuss the following questions: <ul style="list-style-type: none"> ❓ What did this feel like? ❓ Does practice improve negotiating skills?

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)

Specific Objective #11: Demonstrate good counseling skills in simulated role plays

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Counseling STD patients incorporates many skills, including interpersonal communication, patient education on prevention (risky behaviors, the 4 C's, bargaining for safer sex), assessment of and education about the disease itself (risk assessment, diagnosis, treatment and comfort measures), and partner referral and follow-up.</p>	<p>Role Play (30 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> Distribute the checklist. <div style="display: flex; justify-content: space-around; align-items: center; margin: 10px 0;">   </div> Divide Px into the same 4 groups and distribute the role plays. <div style="display: flex; justify-content: center; align-items: center; margin: 10px 0;">  </div> Instruct Px to take turns playing the counselor and the patient, while the other members of the group critique the practice, using the checklist. They have 15 min. for the exercise. Reconvene the large group, and ask for a pair of volunteers from two of the groups to do one of the role plays each. Ask Px for comments and add any content material not covered.

Unit 8 Summary

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Summary</p> <ol style="list-style-type: none"> 1. Providers should be aware of their attitudes, behaviors, and other factors that could have a negative effect on the patient and interfere with compliance and future prevention. 2. Being able to talk about sex comfortably with patients using non-medical language is very important. 3. Mastering principles and skills of counseling and patient education will serve the patient and help STD prevention efforts. 4. Changing sexual behavior can be very difficult, and understanding and using principles of behavior change with patients is key. 	<p>Presentation (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit summary and answer any questions. • Distribute Px Manual content for Unit 8.

UNIT 9: CONDOMS AND OTHER BARRIER METHODS

UNIT TRAINING OBJECTIVE:

Participants will be able to counsel clients on the importance of preventing pregnancy and STD, and demonstrate to clients the correct use of male and female condoms, as well as other available barrier methods.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Explain how male and female condoms work and their effectiveness for STD prevention and contraception (dual protection).
2. Demonstrate how to give instructions for the use of male and female condoms.
3. Explain dual protection and dual method use.
4. Discuss the possibilities for protection when a man refuses to use condoms.

SIMULATED SKILL PRACTICE:

Male and female condom demonstration.

CLINICAL PRACTICUM OBJECTIVES:

Trainees will successfully demonstrate the following:

- Counseling clients on male and female condom use.
- Instructing clients, including a demonstration, on how to properly use a condom.

TRAINING/LEARNING METHODOLOGY:

- Presentation
- Group discussion
- Skill practice

MAJOR REFERENCES AND TRAINING MATERIALS:

- Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: A health guide for women*. Berkeley, California: Hesperian Foundation.

- Dallabetta, G.A., M. Laga, and P.R. Lamptey, eds. 1996. *Control of sexually transmitted diseases: A handbook for the design and management of programs*. Arlington, Virginia: AIDSCAP/Family Health International.
- Department Of Health. HIV/AIDS Directorate. 1996. *Training manual for the management of a person with a sexually transmitted disease*. Pretoria, South Africa: Department of Health.
- Farrell, B. and D. Huber. 1998. *Module 9: Condoms and spermicides*. Watertown, Massachusetts: Pathfinder International.
- Feldblum, P. and C. Joanis. 1994. *Modern barrier methods*. Durham, North Carolina: Family Health International.
- Nepal Medical Association and Family Health International/AIDSCAP. 1996. *Case management of sexually transmitted diseases*. Arlington, Virginia: Family Health International/AIDSCAP.
- Solter, C. 1998. *Module 3: Counseling for family planning services*. Watertown, Massachusetts: Pathfinder International.
- World Health Organization (WHO). 1995. *STD case management workbook 3: History-taking and examination*. Geneva: WHO.
- World Health Organization (WHO). 1995. *STD case management workbook 5: Educating the patient*. Geneva: WHO.
- World Health Organization (WHO). 1995. *STD case management workbook 6: Partner management*. Geneva: WHO.
- Zimbabwe Aids Network and UNICEF. 1993. *Communicating about AIDS*. Poster. Harare: Zimbabwe AIDS Network.

RESOURCE REQUIREMENTS:

- Penis models
- Female pelvis models
- Spermicides
- Diaphragms
- Cervical caps
- Variety of male and female condoms
- Video on the Reality Female Condom. Order from The Female Health Company, 875 North Michigan Ave., Suite 3660, Chicago, IL 60611, 1-800-645-0844, website: www.femalehealth.com, or The Female Health Company, One Sovereign Park, Coronation Road, London NW10 7QP, +44-181-965-2813, e-mail: mitchellwarren@esi.com.

EVALUATION METHODS:

- Pre- and post-test
- Observation of demonstration using CBT skills assessment checklist
- Continuous assessment of objectives
- Participant reaction form (end of module)

TIME REQUIRED: 3 hours 20 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Send for female condom video—see references.
- Copy the following participant handouts:
 - 9.1A: Male and Female Condoms: Instructions for Use
 - 9.1B: Prevention Message
 - 9.2A: CBT Skills Assessment Checklist for Male Condoms
 - 9.2B: CBT Skills Assessment Checklist for Female Condoms
- Write the unit objectives on a flipchart.
- Prepare sheets of newsprint with 3 woman-controlled methods. (See S.O. #4 for details.)
- Copy the Unit 9 content section (Px Manual) for distribution at the end of the unit.

Introduction to Unit 9

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>With the urgency of the AIDS epidemic, reproductive health providers need to focus on the prevention of pregnancy and sexually transmitted disease. As FP programs integrate services, providers are more actively promoting condoms and teaching women condom use and negotiation. In various countries, community strategies like social marketing increased condom use tremendously. However, FP providers need to think of ways to reach men as well as women with condom messages. The male condom used <i>consistently</i> and correctly is still the most effective method for preventing STDs. The female condom also may be effective, although currently its cost remains too high for widespread use. Other barrier methods that could be used for disease protection such as the diaphragm and the cervical cap offer less protection than the male condom. Spermicides may increase the risk of transmission.</p> <p>Getting clients to think in terms of protection against disease and pregnancy is an example of the natural linking of STD control and family planning goals. This link has the potential to be an important first step in integration. Promotion of condom use with emergency contraceptive pills (ECP) as a backup may work well for young women or women in new relationships.</p>	<p>Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objectives using the prepared flipchart.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Explain how male and female condoms work and their effectiveness for STD prevention and contraception (dual protection). 2. Demonstrate how to give instructions for the use of male and female condoms. 3. Explain dual protection and dual method use. 4. Discuss the possibilities for protection when a man refuses to use condoms. 	

Specific Objective #1: Explain how male and female condoms work and their effectiveness for STD prevention and contraception (dual protection)

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>The Male Condom</p> <p>The male condom is a barrier method that prevents entry of sperm into the vagina. It is made of very thin latex rubber. (Some plastic condoms are now available.) Disease-causing organisms, including HIV, do not pass through intact latex or plastic condoms. Condoms made from lamb intestine are more expensive and can allow passage of HIV and other viruses. Therefore, they are not as effective as synthetic condoms. Condoms come in a variety of shapes, sizes, and colors; some are lubricated. (The lubrication sometimes contains a spermicide.)</p> <p>Effectiveness</p> <p>When used consistently and correctly with every act of intercourse, condoms can greatly reduce the risk of HIV infection. The rate of HIV infection is only 0-2% per year when condoms are used correctly. Inconsistent use results in 12-14% new HIV infections. However, using condoms only 50-75% of the time offers little protection against HIV infection.</p> <p>Although condoms protect against many STDs; genital herpes, genital warts, and pubic lice can be transmitted if someone comes into contact with infected skin surfaces not covered by the condom.</p> <p>The first year pregnancy rate among typical condom users is about 15%.</p> <p>Older couples who use condoms regularly and couples highly motivated to prevent</p>	<p>Presentation/Small Group Work (40 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Divide Px into 4 new small groups. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Using the material in <i>Px Handout 9.1A</i> and Px's own knowledge, ask the groups to spend 10 minutes discussing information on their topic and writing points on a flipchart for presentation. <ul style="list-style-type: none"> – Group 1: The male condom: what is it, mechanism of action – Group 2: The male condom: effectiveness – Group 3: The female condom: what is it, mechanism of action – Group 4: The female condom: effectiveness • Ask a representative of each group to present her/his topic to the large group (5 min. for each group). • Correct any errors and add any omitted material from the content. • ? Ask Px whether male and female condoms are available where they work. • Summarize key points.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>pregnancy tend to use condoms correctly and consistently and have fewer failures.</p> <p>Providers may give condom users ECPs as a backup for condom accidents. However, ECPs provide no protection from STDs. (Refer to Pathfinder <i>Module 5: Emergency Contraceptive Pills.</i>)</p> <p>The Female Condom</p> <p>The female condom is a polyurethane plastic pouch that covers the cervix, the vagina, and part of the external genitals. It is inserted into the vagina by the woman, and it can also be inserted by putting it on the man's penis.</p> <p>The female condom is sturdier (does not tear as easily) than male latex condoms and may last longer in storage. It has been shown to successfully prevent the transmission of trichomonas. However, its effectiveness against STDs is currently being studied. Although in the laboratory the female condom is a barrier to HIV, its potential to protect people against HIV is still being studied.</p> <p>The female condom provides some additional covering of the external genitals. As a result, it may offer more protection against genital ulcer disease and HPV, but this has not been proven.</p> <p>The female condom is becoming more widely available in developing countries at less costly prices, but it remains much more expensive than the male condom. New studies on washing and reusing it may bring the price down. Acceptability of the female condom so far has been mixed. Male partners like the fact that it is less</p>	

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>restricting. Some couples find the method awkward. The female condom, like the male condom, is sometimes negatively associated with sex workers.</p> <p>The female condom has the potential to increase sexual pleasure for both men and women. The device does not constrict the penis and the polyurethane transfers body heat. It also covers the introitus and can be used with oil-based lubricants, unlike latex male condoms. However, the device can also be less appealing, since it hangs out of the vagina and can be noisy, which some couples do not like. While promoted as a female-controlled method, men are aware of its presence and their cooperation is needed. The female condom can be difficult to insert, and care must be taken that the penis is not inserted into the vagina outside of the outer ring.</p> <p>Effectiveness</p> <p>The female condom has a somewhat higher pregnancy rate for typical use than the male condom. The annual pregnancy rate for typical use is about 21% for the female condom and 15% for the male condom. Other female barrier methods (diaphragm, sponge, and cervical cap) have typical use pregnancy rates of about 20% in the first year of use.</p> <p>The female condom is impervious to HIV and STDs, but semen spills can occur. Its effectiveness for STD prevention is still under study.¹</p>	<p>Presentation (2 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> Distribute and present the prevention message and post it on the wall.. 
<p>¹ Feldblum, P., and C. Joanis. 1994. <i>Modern barrier methods: Effective contraception and disease prevention</i>. n.p.: (Family Health International).</p>	

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)

Specific Objective #2: Demonstrate how to give instructions for the use of male and female condoms

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Promoting Condoms in Your Clinic</p> <p>Although many family planning providers have condoms to dispense or sell, promotion of condoms is often low in this setting. If a client’s primary goal is pregnancy prevention she may request a more reliable method of contraception than the condom, and providers are not accustomed to recommending two methods.</p> <p>Providers should:</p> <ul style="list-style-type: none"> • Take the time to promote and dispense condoms to every client. • Demonstrate condom use to male and female clients every time condoms are dispensed. • Make sure both male and female clients can demonstrate proper use. • Explain that the male condom can be a female-initiated method. • Make sure that women are given the skills to negotiate for and initiate condom use. <p>Incorrect use of condoms is a major reason for condom failure.</p>	<p>Presentation/Condom Demonstration/ Return Demonstration (1 hr 15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present content, emphasizing provider “shoulds.” • Distribute the <i>CBT Skills Assessment Checklist for Male Condoms</i>. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Demonstrate male condom use on a model following the checklist. <p>Note: For a review of the Demonstration/ Return Demonstration, refer to the “Notes to the Trainer” at the beginning of the module.</p> <ul style="list-style-type: none"> • Have one Px give a return demonstration while the others observe and make any necessary corrections. • Divide Px into pairs. Using the <i>Instructions for Use: Male and Female Condoms (Px Handout 9.1A)</i>, one Px should counsel the other, including a demonstration of proper condom use, and then they should trade roles. Px should use the <i>CBT Skills Checklist for Male Condoms</i> to evaluate each other’s performance. (15 min) • Show video on the female condom. • Repeat trainer demonstration and Px return demonstration for the female

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<p>condom. Have Px practice in the same pair using the <i>CBT Checklist for the Female Condom</i>. (15 min.)</p> <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <ul style="list-style-type: none"> • When the exercise is finished, ask a volunteer to demonstrate male condom use, including counseling, and another volunteer to demonstrate female condom use, including counseling. • Members of the group can ask questions of the demonstrators, who should respond appropriately. • Summarize content and exercise.

Specific Objective #3: Explain dual protection and dual method use

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Condom Use for Dual Protection</p> <p>Condoms are the only method that protects against both pregnancy and STDs, which makes aggressive condom promotion a very important strategy for protecting at-risk individuals and groups. Providers must develop skills to counter the many real and perceived patient complaints and myths about condom use to make it a viable method choice.</p> <p>Dual Method Use</p> <p>Women who face the possibility of unwanted pregnancy and STD need adequate protection against both. Strategies to encourage the simultaneous use of two methods need to be thought out with care. There is some evidence that women who are already using highly effective methods to prevent pregnancy are less likely to use a second method, even if there is STD risk. Many women remain unaware of their STD risk.</p> <p>When to Consider Dual Method Use</p> <ul style="list-style-type: none"> • When there is high risk of both unwanted pregnancy and STD. • When a couple cannot or will not use male or female condoms correctly all the time. <p>Benefits of Dual Method Use</p> <ul style="list-style-type: none"> • Possible increase in negotiation and communication skills for couples. 	<p>Presentation/Small Group Work (25 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Define the terms “dual protection” and “dual method use” from the content. • Divide Px into the same 4 groups, but distribute the first group among the other 3 to form 3 groups. • Assign each group to one of the topics below to discuss for 10 min. Record their lists on a flipchart. <ul style="list-style-type: none"> – Group 1: List as many reasons as possible for a woman/couple to consider dual method use. – Group 2: List as many benefits as you can of dual method use – Group 3: List as many challenges as possible to dual method use • In the larger group, ask each group to present its list for up to 3 min. • Ask Px for feedback and additions, and add any omitted material.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<ul style="list-style-type: none"> • Increased awareness of broader reproductive health needs of couple. • Increased protection for women and men. <p>Challenges to Dual Method Use</p> <ul style="list-style-type: none"> • Strategies and messages need to be developed. • Increased training of providers is needed. • It means increased cost to patients. 	

Specific Objective #4: Discuss the possibilities for protection when a man refuses to use condoms

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>What Can a Woman Do?</p> <p>Some women are not able to persuade their partners to use condoms. How can you help such women?</p> <ol style="list-style-type: none"> 1. Encourage a woman to use all means to persuade her partner to use condoms 100% of the time with any outside partners. Providers should reinforce the message that condom use with outside partners puts a married woman at lower risk. 2. If a woman thinks her partner is HIV+, encourage HIV testing (VCT) for him and her. 3. For a young woman or a woman in a new relationship, start with condoms or add them to another method. 4. For a woman who is at risk of STD who cannot convince her partner to use condoms, woman-initiated or controlled methods might be somewhat effective against STD, but have not proven to offer protection against HIV. <p>Woman-Controlled or Initiated Methods of Prevention of STDs and AIDS</p> <p>The female condom is a clear polyurethane (a soft plastic) pouch that is made to line the vagina and protect it from semen. Studies have shown it is effective in preventing trichomonas. Studies of its protective effect against other STDs and HIV are underway.</p>	<p>Trainer Presentation (45 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Pass around samples of all barrier methods for Px to examine during presentation. • Present content and answer any questions. • Ask Px to form the same 3 groups. • Give each group a piece of newsprint with one of the following strategies printed on it: <ol style="list-style-type: none"> 1. A woman relies on male condoms for STD protection. She is successful in negotiating condom use about 75% of the time. Explain why this provides only minimal protection. 2. A woman carries the female condom in case her partner refuses to use the male condom. However, she knows the female condom requires his cooperation. 3. A woman inserts her diaphragm before going out, and tries to get her partner to use the male condom, also. • Ask Px to discuss their strategy for 15 min. and report back to the large group on the following: <ul style="list-style-type: none"> ❓ How effective do you think this strategy is in preventing pregnancy?

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<p>A diaphragm is a latex cup used with spermicide that fits over the mouth of the uterus and is put in before sex. It can be used with or without spermicide. It is thought to be somewhat effective against gonorrhea and chlamydia.</p> <p>The cervical cap is a latex cup which is smaller than a diaphragm and fits snugly over the cervix. It can be used with or without spermicide. It is thought to be somewhat effective against gonorrhea and chlamydia, but no protection against HIV has been proven.</p> <p>Spermicides contain a chemical, usually Nonoxynol 9, which kills sperm and some organisms that cause STDs. It comes in the form of cream, jelly, foam, film, suppositories, or foaming tablets that are put in the vagina before sex. Spermicides may be somewhat effective against STD, but they have not been proven to offer protection against HIV. In fact, if used daily or more frequently, they may increase HIV transmission because they irritate the vaginal lining, which makes it easier for HIV, and possibly STDs, to enter the body.</p> <p>Spermicidal film and the vaginal sponge have not been shown to offer any protection against STDs or HIV at the present doses of the active ingredient, Nonoxyl 9.</p> <p>Research is underway to develop microbicides that can protect against STDs, including HIV. These will be applied in the vagina as a foam, film, cream, suppository, or gel, and will:</p> <ul style="list-style-type: none"> • kill microbes that cause STDs and HIV; 	<p>? How effective do you think this strategy is in preventing STDs or HIV?</p> <p>? How likely is a woman to use this strategy and be successful?</p> <p>? What are the advantages of the strategy?</p> <p>? What are the disadvantages of the strategy?</p> <ul style="list-style-type: none"> • Reconvene the large group. • Ask which of the strategies offers the woman the most protection and which might work best in Px's communities. • Summarize activity.

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)
<ul style="list-style-type: none">• create a barrier to block infection; and/or• prevent the organism from replication after infection has occurred.	

CONTENT (Knowledge/Attitudes/Skills)	Training/Learning Methods (Time Required)

Unit 9 Summary

<p style="text-align: center;">CONTENT (Knowledge/Attitudes/Skills)</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Summary</p> <ol style="list-style-type: none"> 1. Male condoms used consistently and correctly are still the most effective way to prevent STDs. 2. Correct and consistent condom use <i>with every act of intercourse</i> determines the effectiveness of condoms in prevention of pregnancy and HIV/STD. 3. The female condom may be effective, but presently its cost remains too high for general use. 4. Promote condom use with men when you see them for a STD or when they accompany their partners for family planning visits. 5. When men refuse to use condoms, women should have access to other barriers for protection. 	<p>Presentation (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit summary. • Distribute Px Manual content for Unit 9.

UNIT 10: HIV/AIDS

UNIT TRAINING OBJECTIVE:

To prepare Px for their roles in HIV prevention, counseling, and referral for voluntary counseling and testing and related services when needed.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Identify personal attitudes and beliefs about HIV/AIDS.
2. Define HIV and AIDS and explain how they are different.
3. Discuss how HIV infection affects men and women differently.
4. List the ways in which HIV is not and is spread.
5. List and discuss the elements of AIDS prevention for clients in the clinic and for the community.
6. Explain the process of voluntary counseling and testing (VCT) for HIV.
7. Recognize the major signs and symptoms of AIDS.
8. Demonstrate how to counsel HIV-infected women and women at risk for HIV about contraception and risks of pregnancy.

SIMULATED SKILL PRACTICE:

Role play

CLINICAL PRACTICUM OBJECTIVES:

AIDS prevention counseling with patients

TRAINING/LEARNING METHODOLOGY:

- Presentation
- Role play
- Case study
- Brainstorming in large group
- Small group work

MAJOR REFERENCES AND TRAINING MATERIALS:

- Burns A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: A health guide for women*. Berkeley, California: Hesperian Foundation.
- Center For Development and Population Activities (CEDPA). 1997. *Integrating STDs and AIDS services into family planning programs*. Training manual series Volume SD-1. Washington, DC: CEDPA.
- Evian, C. 1993. *Primary AIDS care: A practical guide for primary health care personnel in the clinical and supportive care of people with HIV/AIDS*. Johannesburg, South Africa: Jacana.
- Tietjen, L., W. Crown, and N. McIntosh. 1992. *Infection prevention for family planning service programs*. Baltimore: JHPIEGO.
- UNAIDS and World Health Organization (WHO). 1998. *Report on the global HIV/AIDS epidemic*. Geneva: n.p.
- World Bank. 1997. *Confronting AIDS: Public priorities in a global epidemic*. New York: Oxford University Press.
- World Health Organization (WHO) and Global Programme On AIDS (UNAIDS). n.d. *HIV prevention and care: Teaching modules for nurses and midwives*. Geneva: WHO.

RESOURCE REQUIREMENTS:

- Newsprint
- Marking pens
- Flip chart
- Condoms (male and female if available)

EVALUATION METHODS:

- Observation and assessment during group work, role plays, and presentations
- Participant reaction form
- Direct verbal feedback

TIME REQUIRED: 4 hours 40 minutes; with optional exercise, 5 hours 15 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare the following as transparencies or on a flipchart:
 - 10.1A: Beliefs and Attitudes About AIDS
- Make copies of the following participant handouts:
 - 10.3A: Special Problems of AIDS for Women
 - 10.3B: Special Problems of AIDS for Men
 - 10.6A: HIV Testing
 - 10.6B: The Window Period
 - 10.9A: Prevention Message
- Write the unit objectives on a flipchart.
- Copy the Unit 10 content section (Px Manual) for distribution at the end of the unit.

Introduction to Unit 10

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>It is largely the spread of AIDS that has given new attention and urgency to the prevention of STDs in developing countries. Although awareness and knowledge of HIV/AIDS have increased dramatically in the last decade, myths, fears, and stigma still hinder efforts at both prevention and care of HIV infection. What is the role of reproductive health programs and providers in preventing, counseling, and treating or referring for AIDS-related problems? As with other STDs, prevention of HIV transmission and prevention of pregnancy are overlapping areas. Exactly which AIDS-related prevention efforts and services are included in integrated reproductive health programs must be decided by the programs themselves, taking into account available resources and the needs of the communities being served. FP providers should, at the very least, have accurate, up-to-date information about HIV transmission and prevention, be able to recognize signs and symptoms of AIDS, and refer their clients when needed for counseling and testing or care. Providers will often be faced with the difficult situation of having to tell clients that they are HIV-positive.</p> <p>Providers should also be able to help clients who are infected or at risk of infection to make informed choices about pregnancy, methods of contraception, and dual protection. This unit provides an overview of the complex issues around HIV prevention and family planning. For a provider wishing to develop specific HIV/AIDS services, a more in-depth training is needed.</p>	<p>Trainer Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objectives using the prepared flipchart.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Identify personal attitudes and beliefs about HIV/AIDS. 2. Define HIV and AIDS and explain how they are different. 3. Discuss how HIV infection affects men and women differently. 4. List the ways in which HIV is not and is spread. 5. List and discuss the elements of AIDS prevention for clients in the clinic and for the community. 6. Explain the process of voluntary counseling and testing (VCT) for HIV. 7. Recognize the major signs and symptoms of AIDS. 8. Demonstrate how to counsel HIV-infected women and women at risk for HIV about contraception and risks of pregnancy. 	

Specific Objective #1: Identify personal attitudes and beliefs about HIV/AIDS

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Our Own Personal Beliefs About HIV/AIDS</p> <p>Identifying one’s own feelings about HIV/AIDS is a necessary step towards non-judgmental and compassionate treatment of those who are infected.</p> <p>People with HIV are all too often blamed, shunned, isolated, rejected, and stigmatized. This kind of discrimination severely affects people’s ability to live normal lives, even when they are not yet ill.</p> <p>If you are caring for people in your community with HIV or AIDS, by your example you are showing others that the AIDS virus is the enemy and not the people who are infected with it. Home-based care for people living with AIDS is an important part of the continuum of care for those who are infected and is a useful focus in educating the community about prevention as well as caring for each other. Your sympathy and compassion will go far in helping others to change their own attitudes and deal with the problem of AIDS together, as a community.</p>	<p>Discrimination Exercise (25 min.)¹</p> <p>Without any introduction of content, the trainer should:</p> <ul style="list-style-type: none"> • Choose a characteristic (for example, hairstyle, glasses, height, or age) that only a few Px have, and ask all Px with that characteristic to leave the group and go stand in the corner. Instruct the excluded group to stand without talking or moving in the corner. • Lead the rest of the group in an enjoyable activity such as a song or game. • After a few minutes invite the excluded group back and ask these Px to discuss how they felt about being excluded from the group. • Instruct the excluded Px to imagine that from now on, all people with the selected characteristic would be fired from their jobs, shunned by their families, and rejected by their communities. Ask them: <ul style="list-style-type: none"> ❓ How would you feel about this? ❓ What would you do? ❓ Would you try to hide the characteristic? ❓ If this were the community response to HIV infection, would you consider being tested?
<p>¹Adapted from Center for Development and Population Activities (CEDPA). 1997. <i>Integrating STDs and AIDS services into family planning programs</i>. Training manual series volume SD-1. Washington, DC: CEDPA.</p>	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Some Beliefs and Attitudes About AIDS</p> <ol style="list-style-type: none"> 1. HIV-infected women who find themselves pregnant should be allowed to have abortions. 2. HIV test results should always remain confidential. 3. If a man tests positive for HIV but refuses to tell his partner, she should be notified by the provider. 4. Sex workers are responsible for the spread of HIV. 5. People who are HIV-infected should stop having sexual relations. 6. HIV-infected women should be sterilized to prevent pregnancy. 7. HIV-infected people should be quarantined to protect all those who are not infected. 8. Health workers who are HIV-infected should not work directly with patients. 	<ul style="list-style-type: none"> • Summarize the exercise and add any content not covered. • Discuss how people with HIV/AIDS are treated in the Px's communities and what providers can do to change this. <p>Short Presentation/Discussion (25 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Display transparency. • Ask a different Px to read each statement in the content one by one. After each is read, have a 3- minute discussion. • Note that everyone is entitled to his or her opinion, but where opinions are stigmatizing or restrict the rights of others, they have harmful consequences.

CONTENT	Training/Learning Methods

Specific Objective #2: Define HIV and AIDS and explain how they are different

Knowledge/Attitudes/Skills	Training/Learning Methods
<p>What are HIV and AIDS?</p> <p>We defined these terms in Unit 1, but being able to define them in simple language for clients is an essential part of your work as a provider.</p> <p>AIDS (Acquired ImmunoDeficiency Syndrome) is a disease caused by a virus called HIV (Human Immunodeficiency Virus). AIDS is the disease, and HIV is the virus that causes the disease. People may be infected with HIV for many years without signs of illness, but once they become ill from the virus, we say they have AIDS. HIV causes illness by attacking the part of the body that usually defends it from infection: the <i>immune system</i>. When bacteria come into the body, a healthy immune system can usually fight them off, and you get well.</p> <p>If a person has AIDS, his or her immune system is weakened. People with AIDS can become very ill or die of illnesses that healthy people fight off, like diarrhea. HIV usually lives in the body for years <i>without</i> causing any visual or obvious illness. But HIV can be transmitted to others from the moment a person becomes infected, before AIDS and obvious illness develop.</p> <p>Sooner or later, as their immune systems weaken (the time is different for each person), people infected with HIV start to feel more tired than usual and to lose weight. They may suffer from common illnesses like diarrhea or coughs that do not go away with treatment. At this point they may have gone on to develop the disease AIDS. For some it takes 10 years</p>	<p>Presentation/Role Play (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the content, and then ask for questions and comments.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>or more to go from HIV infection to AIDS. For others it takes as little as 6 months.</p> <p>months of diagnosis with AIDS, but this can vary widely. Much can be done to</p> <p>AIDS, but at the present time there is no cure for AIDS itself.</p>	

Specific Objective #3: Discuss how HIV infection affects men and women differently

CONTENT	Training/Learning Methods (Time Required)
<p>The Epidemiology of AIDS</p> <p>We saw in Unit 1 that AIDS is spreading most quickly in parts of the world where people are poor and uneducated, and especially among young women. Other factors that affect the spread of AIDS are lack of work, famine, or war that force people to migrate away from their families to cities where traditions break down, and sex with new partners is common. In particular, poor and young women have less power to control their lives than men. In many countries, law, tradition, and economic dependence keep women from acquiring skills and information that could protect them.</p> <p>How HIV/AIDS Affects Women</p> <p>1. Women get HIV more easily than men do.</p> <p>Women are the receptive partners during sex. More HIV is present in semen than in a woman's vaginal fluids and when a man ejaculates inside her, the semen remains in contact with the vaginal wall for a long period of time. The vagina provides a large surface area of mucous membrane that absorbs the virus more easily than does a man's penis. Thus, men infected with HIV transmit it to women 2-5 times more easily than women infected with HIV transmit it to men.</p> <p>2. Women are blamed unfairly for the spread of AIDS.</p>	<p>Presentation/Small Group Work (35 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present "The Epidemiology of AIDS" in the content section on the left-hand side of the page. • Explain to Px that we will discuss how HIV/AIDS affects men and women differently. • Divide the Px into 2 groups with an equal mix of men and women, if possible. • Distribute handouts. <div style="text-align: center;">  </div> • Assign one group to discuss the special problems of HIV/AIDS for women, and the other to discuss the special problems of AIDS for men for 15 min. • One Px in each group should list problems on newsprint, and another should be prepared to present to the large group. • Px should use their own experience and knowledge, and may also refer to Px handout. • After 15 min. ask Px to return to the large group. One Px from each group should present the group's discussion points.

CONTENT	Training/Learning Methods
<p>Because of different standards of behavior blamed for spreading HIV, while their result, sex workers are often stigmatized.</p> <p>and are commonly treated poorly by women who have infected with HIV. Women with HIV may as a result of their HIV status.</p> <p>3. Many pregnant women are infected their babies.</p> <p>her baby during pregnancy, labor and</p> <p>Being pregnant and having HIV at the woman may worry that her baby might be childbirth can make her health worse. If extra care. The mother may have no this too could transmit HIV infection. A increased cost and stigma, and the risk of</p> <p>An HIV-positive woman should have ready counseling before she</p> <p>choices based on the real risks of</p>	<ul style="list-style-type: none"> • Fill in and correct misconceptions using • Summarize the activity.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>4. care for family members who are themselves.</p> <p>Caring for a loved one who is ill and dying of income for the family. Often there is no one to help bear this burden. Children, of school to care for sick adults. For the rest of their lives they will be affected by</p> <p>5. Women are infected at a younger age than men</p> <p>Young women and girls are less able to refuse unwanted and unprotected sex. tearing, bleeding, and infection.</p> <p>How HIV/AIDS Affects Men</p> <p>1. infected men are widespread.</p> <p>lose their jobs, their friends, and their social status.</p> <p>2. Most existing RH services don't have a strong component for men.</p> <p>Although there are some STD services for men, access to care is often difficult, and men's knowledge of their own reproductive systems is often limited. They may not seek comprehensive care for STDs, but might buy antibiotics on the street for urethritis, for instance, and not receive counseling on prevention or the necessity of treating their sexual partners.</p>	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>3. Social conditions affect men's</p> <p>Poor economic conditions, war, and environmental problems all play a part in</p> <p>Wherever there are large populations of single men—on plantations, in mines, or in and risky relationships.</p> <p>4.</p> <p>Men often feel they are expected to have sex on a regular basis or that multiple manhood. Young men are particularly vulnerable to the opinions of their peers, to protect themselves from infection.</p> <p>5.</p> <p>affects families and communities where HIV prevalence is high.</p> <p>otherwise be working and helping to care for their families has had a devastating countries, resulting in families with no means of support.</p> <p>Behaviors Necessary to Control HIV Transmission</p> <p>Men and women both need:</p> <ul style="list-style-type: none"> • To stick with one sex partner. • To insist their partners use condoms with any sexual encounters other than partners. 	<p>Discussion (15 min.)</p> <p>The trainer should:</p> <p>Lead a discussion about the behaviors and the broader social and cultural issues that need to be addressed to</p>

Knowledge/Attitudes/Skills	Training/Learning Methods
<ul style="list-style-type: none"> • these two behavior changes. <p>Women will be better able to promote from HIV when the following broader social and cultural issues are addressed:</p> <ul style="list-style-type: none"> • • support their families. • More power to make decisions at home and in their communities. <p>More legal rights—to own and inherit marry, and to divorce.</p> <p>Men need:</p> <p>Access to reproductive health programs</p> <ul style="list-style-type: none"> • appropriate no-risk or low-risk sexual behavior. <p>To support women being equal practices.</p> <ul style="list-style-type: none"> • Economic opportunities that allow them to live with and work near their families are more likely to engage in high-risk sexual behavior. 	

Specific Objective #4: List the ways in which HIV is not and is spread

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>HIV Transmission</p> <p>There are many myths about how HIV is transmitted. Part of the stigma associated with AIDS stems from people’s fears that everyday social contact with an infected person will result in becoming infected. Health workers are understandably concerned that their work will put them at risk of HIV infection. Although there are risks for providers and other staff in a health care setting, the risk of infection is often greater for patients than for providers when infection prevention guidelines are not followed carefully. Following infection prevention guidelines will prevent most health care related HIV transmission.</p> <p>How HIV/AIDS IS NOT Spread</p> <p>HIV can live outside the human body for no more than a few minutes. It cannot live on its own in the air or in water.</p> <p>One cannot give or get HIV in these ways:</p> <ul style="list-style-type: none"> • Touching, kissing or hugging someone with HIV or AIDS (unless there is blood in the saliva of the infected person) • Sharing food with someone with HIV or AIDS • Sharing a bed with someone with HIV or AIDS • Bites of mosquitoes, bedbugs, or other insects or animals • Caring for someone with AIDS if simple precautions are taken • Sharing clothes, towels, sheets, latrines, or toilets 	<p>Brainstorming/Presentation (30 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px what common myths they hear in their communities about HIV transmission and list them on newsprint. • Present the content on the left-hand side of the page. • Ask a volunteer to choose a myth from the list and role-play how they would counteract or dispel the myth. • Ask for other volunteers to do the same as time allows.

<p>HIV IS spread in these ways:</p> <ul style="list-style-type: none">• Unprotected sexual intercourse (85-90%)• Using an unclean needle or syringe or any other tool that pierces the skin that was recently used by an infected person• Through the blood of an infected mother to her unborn child• Through breastmilk of an infected mother to her baby• From transfusions of HIV-infected blood where the blood supply is not tested	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • Getting blood from an infected person into your body through an open wound or mucous membranes (for example, splashed into the eyes). <p>Note: <i>It is safe to live with someone who has AIDS and share his or her life if the person infected with HIV is careful with open sores, bloodstained clothing or sheets, toothbrushes, or razors.</i></p>	

Specific Objective #5: List and discuss the elements of AIDS prevention for clients in the clinic and for the community

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Prevention for Clients and in the Community</p> <p>For Clients: HIV prevention messages are very similar to STD prevention messages discussed elsewhere, with the exception that HIV (like hepatitis B) is blood-borne as well as sexually transmitted. The following are guidelines for clients who are at risk of giving or getting HIV.</p> <p>Clients can protect themselves from HIV by avoiding:</p> <ul style="list-style-type: none"> • Sex with more than one partner—the more partners, the greater the risk of infection. • Sex without protection (for example without condoms). • Blood transfusions with untested blood. • Injecting drugs with shared or unsterilized needles. • Traditional treatments or ceremonies that break the skin with instruments that have not been properly disinfected. • Sharing razors or toothbrushes. • Touching someone else’s blood or wound without protection. <p>Protecting a Client Whose Partner Has HIV</p> <p>It is very important for clients to protect themselves from the HIV or STD infection of another person, even if they are already HIV-infected. There is evidence that</p>	<p>Presentation/Small Group Work (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px what clients need to know to protect themselves, their partners, their families, and their communities from HIV infection. • List answers on newsprint • Ask Px for components of a strategy to reach the community about AIDS prevention. Give an example to get started. <p><i>Example: Bring AIDS education to bars, schools, religious meetings, military bases, work places, etc.</i></p> <ul style="list-style-type: none"> • Supplement answers from the content on the left-hand side of the page. • Emphasize the fact that 85-90% of HIV is sexually transmitted.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>people can become infected with more than one strain of HIV, and that this can make the disease more severe.</p> <p>Thus, infected clients should have safer sex even if both partners are HIV-infected. Also, STD infections can be more serious in those who are HIV-infected. Remind clients that there are other ways besides sex to show that you love someone. It is safe to hug, to hold someone in your arms, and to kiss if you have no cuts or sores in your mouth. You can also do the special things that your partner likes, whether they are sexual or not—listen to what s/he says, spend time together, and comfort and console each other.</p> <p>Community AIDS Prevention</p> <p>In many communities, 10% or more of the entire population is infected. Millions of children have been orphaned because both parents have died of AIDS. Clinics and hospital beds are increasingly taken up by people in the final stages of AIDS who are dying. The AIDS epidemic and its repercussions have stretched the resources of poor, extended families. All of this makes AIDS a community problem.</p> <p>What Can Be Done To Reach the Community About AIDS Prevention?</p> <p>Prevention of AIDS in the community follows the same principles as STD prevention, and efforts should address both STD/HIV/AIDS in most cases. (See Unit 3: Community Education and Prevention.) Elements of HIV prevention include linking care of HIV-infected people with prevention efforts and voluntary</p>	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>counseling and testing (VCT).</p> <ul style="list-style-type: none"> • Bring AIDS education to the community—to bars, schools, religious meetings, military bases, and work places. • Help educate clients, parents, and teachers on the facts about AIDS. • Help people become more comfortable talking about sex, and about AIDS. • Ensure access to correct information about AIDS. • Ensure access to health services including voluntary counseling and testing (VCT), and treatment and home-based care for people living with AIDS. • Link the care of people with AIDS to prevention efforts for their partners, families, friends, and community. • Help make condoms and other barrier methods easily available in the community. • Increase access to treatment for STDs in the community. • Train CBDs and other community health workers to carry AIDS education into the community. • Train peer educators to take the facts about AIDS to youth, to men, to sex workers, and to other high risk groups. 	<p>Optional Exercise (35 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to form 4 small groups. • Ask 2 groups to discuss AIDS prevention in the clinic. Px should list all AIDS prevention activities that take place in their clinics (such as health talks, posters, IEC materials, videos, meetings), and then answer the following questions: <p>? Who creates and gives these messages?</p>

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<p>❓ How could they be improved?</p> <ul style="list-style-type: none"> • Ask the other 2 groups to discuss AIDS prevention in their communities. Px should list all AIDS prevention activities that take place in their communities, and answer the following questions: <ul style="list-style-type: none"> ❓ How are these efforts linked with clinic efforts? ❓ Who creates and gives these messages? ❓ How could these messages be improved? • Each group should record answers on newsprint, and choose a spokesperson to briefly present them. • Allow 15 min. for group discussion and 15 min. for presentations. • Gently correct any items on the list that are incorrect or might cause harm. Add any items from the content that were not included in the presentations. • Summarize the exercise.

Specific Objective #6: Explain the process of voluntary counseling and testing (VCT) for HIV

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>In the early stage of HIV infection, the only way to know for certain if someone is infected is by performing the blood test that identifies HIV antibodies. If the test is positive, that person can seek treatment early on and can make sure that s/he does not infect anyone else. However, if a person is in the window period, antibodies may not yet be detectable.</p> <p>The Test For HIV</p> <p>Shortly after infection with HIV, the body starts to make antibodies to fight the virus. They usually appear in the blood 8–12 weeks after the virus enters the body, but in about 5% of people, antibodies can take as long as 6 months to appear. The time between when a person is infected with HIV and when the body makes detectable HIV antibodies is called the window period.</p> <p>A positive HIV test means there are antibodies to HIV and the person is infected with the virus. But a person can transmit the virus to others as soon as s/he becomes infected, even if s/he is in the window period, and even if s/he looks and feels completely healthy.</p> <p>A negative test can mean one of two things. Either:</p> <ul style="list-style-type: none"> • A person is not infected with HIV, or • A person is infected but has not yet made antibodies to HIV. 	<p>Brainstorming/Discussion/Presentation (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute the handout. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Ask Px: <ul style="list-style-type: none"> ❓ What do you see happening in the picture? ❓ Why is it happening? ❓ What problems does it lead to? ❓ What are the root causes of the problem? ❓ What can be done about it? • Be sure the discussion touches briefly on risky behavior of all those in the picture, the window period, and the need for awareness of risk and behavior change as responses to the last questions. • Distribute the handout. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Present the information on the window period using the content.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>A negative test does not mean someone will never become infected with HIV. Someone who practices unsafe behavior can become infected at any time.</p> <p>Remember that the HIV test is not a test for AIDS. It only shows that someone is infected with the HIV virus. AIDS is the later stage of HIV infection when a person becomes sick. Most people with HIV infection are healthy for most of the time they are infected with the virus.</p> <p>Because of the prejudice and discrimination that surround HIV/AIDS and the serious nature of the disease itself, a positive test result can cause a crisis that dramatically alters the course of a person's life. Pre- and post-test counseling is very important in making sure that clients understand their test results and are supported during what can be a very difficult time, if they are infected. Although in-depth training in these skills is beyond the scope of this module, this information may help providers to deal with patients where trained counselors are not readily available.</p> <p>If someone has tested negative for HIV but thinks s/he might be positive, s/he may need to be tested again in a few months. Where possible, testing to confirm a positive result should be done.</p> <p>Who Should Have the HIV Test?</p> <p>Changing unsafe behavior is usually more important than an HIV test. But increased awareness of risk of HIV may lead to a desire to be tested and to change behavior. A person may want to be tested if:</p>	<ul style="list-style-type: none"> • Ask a Px to explain “window period” in her/his own words. Check with the group to make sure the explanation is accurate and that everyone understands the concept. • Present the rest of the content and summarize the discussion. <p>Discussion (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px who they think should have the HIV Test. • Write their answers on a flipchart, and add and correct from the content.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<ul style="list-style-type: none"> • Her/his partner has had unsafe sex. • Her/his partner or their baby has symptoms that suggest AIDS. • S/he wants to marry or start a new relationship or have children. • She is pregnant and treatment is available to decrease the risk of transmission to the baby. <p>Definition of Voluntary Counseling and Testing (VCT)</p> <p>VCT means that a person trained in HIV counseling explains the test beforehand, gives the results, explains what they mean, and discusses options including safer sex and follow-up testing for those that are negative, and safer sex, treatment options, and referrals for those who are positive.</p> <p>Advice For Clients Who Are Thinking of Being Tested</p> <p>If you have a partner, usually it is best if you both take the test together. This way you can talk together about what you will do if one or both of you are positive. If you take the test without a partner, try to have someone who cares about you accompany you when you go for the test results.</p> <p>If you decide to have the HIV test, it should always be done:</p> <ul style="list-style-type: none"> • With your consent. • With counseling before you take the test. • With counseling after the results of the 	<ul style="list-style-type: none"> • Ask Px to define VCT. Supplement their answers if necessary. <p>Buzz Session (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to discuss the advantages and disadvantages of VCT with their neighbors for 5 min. • After 5 min., continue the discussion in the larger group, and list advantages and disadvantages on newsprint. • Divide Px into pairs again and ask each pair to discuss what advice they would give to clients who are thinking of being tested. Allow 5 minutes for discussion. • After 5 min., continue the discussion in a larger group.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>test.</p> <ul style="list-style-type: none"> • With privacy and confidentiality. No one should know the results but you and those whom you want to know. <p>Tests for HIV</p> <p>The two most common HIV antibody tests are the ELISA and the Western blot tests. The tests are done by taking a small amount of blood, usually in a clinic or hospital. Test results can take weeks to be available.</p> <p>The ELISA Test (enzyme-linked immunosorbent assay) is:</p> <ul style="list-style-type: none"> • The simpler and cheaper test. • A good screening test. • Very sensitive in detecting those who are positive. • Less specific in detecting those who are truly negative. This means that sometimes false positive or false negative results may occur. Ideally, a positive ELISA test should be confirmed by a Western blot test or a repeat ELISA test. <p>The Western blot test is:</p> <ul style="list-style-type: none"> • Highly specific. • More expensive than the ELISA. • Often not available in low-resource settings, in which case a second ELISA can be done to confirm the diagnosis. 	<p>Discussion (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask a few Px to describe HIV testing where they live and work, addressing the following questions: <ul style="list-style-type: none"> 🔍 Which tests are done? 🔍 What is the cost to the patient? 🔍 Is confidentiality strictly observed? 🔍 Is pre- and post-test counseling provided? • Ask Px if they have had to give HIV test results to patients and how they dealt with this. • Present information on tests for HIV. • Ask Px whether they would want to have voluntary counseling and testing available where they work, and whether that would be a good use of their resources, and why. • Summarize the specific objective.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Newer, rapid tests are available that can give accurate results in less than 10 minutes, without the use of a lab. A positive diagnosis can be confirmed by a second rapid test.</p>	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

Specific Objective #7: Recognize the major signs and symptoms of AIDS

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Recognizing the Signs and Symptoms of AIDS</p> <p>It is important for providers to recognize the signs and symptoms of AIDS in their clients so that they can counsel, refer, and advise on contraception, safer sex, pregnancy, and other issues related to reproductive health.</p> <ul style="list-style-type: none"> • The signs of AIDS vary from person to person. • They can also be different for women than for men. • Often they are the typical signs of other common illnesses, but are more severe and last longer. For example, the signs of tuberculosis (TB) and AIDS, are very similar. While many HIV-infected people also have TB, not all persons with TB have AIDS. The number varies from 18% to as much as 73% in Africa, and about 50% in Thailand. Since TB is treatable and highly infectious, anyone with signs of TB (cough, fever, weight loss) should be referred for TB testing, whether or not they decide to be tested for HIV. <p>WHO² has identified criteria for diagnosing AIDS, in the absence of a positive HIV test. None of these signs by themselves should be assumed to be evidence of HIV infection without antibody testing. However, if a combination of these 3 signs appears in a person with HIV and s/he gets sick more and more often, s/he may have AIDS.</p>	<p>Trainer Presentation/Discussion (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the information of recognizing the signs and symptoms of AIDS found in the content on the left-hand side of the page. • Ask Px what the major signs and symptoms of AIDS are and list them on newsprint. • Ask Px what the minor signs and symptoms of AIDS are and list on newsprint. • Ask Px how they would care for a patient who appears to have signs and symptoms of AIDS. • Emphasize that these conditions are not specific to AIDS and that they can often be treated with simple medications • Add to or clarify content.

²WHO, 1994, from CDC, *Family planning methods and practice: Africa*. DHHS, 1999.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Major Signs of AIDS</p> <ul style="list-style-type: none"> • Weight loss greater than or equal to 10% of body weight. • Chronic diarrhea for more than 1 month. • Prolonged fever that may come and go for more than 1 month. <p>Minor Signs of AIDS</p> <ul style="list-style-type: none"> • Cough that lasts for more than 1 month. • Swollen lymph nodes anywhere in the body. • Recurrent or persistent skin rashes of all kinds. • History of herpes zoster. • Chronic progressing or spreading herpes simplex infection. • Oral candidiasis (thrush). <p>The presence of at least two major signs and one minor sign is diagnostic of AIDS.</p> <p>A woman may also have these signs:</p> <ul style="list-style-type: none"> • Itching and white discharge in the vagina that keeps coming back, even with treatment (recurrent candida infection). • PID with tubo-ovarian abcess. • Lack of normal menses. • Problems during pregnancy and postpartum in advanced AIDS (nutritional problems, infections). 	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • Invasive cancer of the cervix. 	

Specific Objective #8: Demonstrate how to counsel HIV-infected women and women at risk for HIV about contraception and risks of pregnancy

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Many women who become infected with HIV or develop AIDS are young. They may not yet have had children. It is important that women who may be at risk of HIV or may be already infected are properly informed about the possibility of mother-to-child transmission so that they can make informed decisions about childbearing. Often a woman finds out she is infected with HIV during a pregnancy or soon after the birth of a baby. For a young woman with HIV or AIDS, there are difficult choices to make.</p> <p>Contraception for Women Who Are HIV-Infected</p> <p>Women with HIV infection can use most contraceptive methods, including condoms and other barriers, hormonal contraceptives, spermicides, and sterilization. Condoms are the only method, however, that provide dual protection against infection and pregnancy. IUDs are not recommended because they may increase the risk of pelvic inflammatory disease, increase bleeding, and increase the possibility of infection in an uninfected partner unless condoms are also used.</p> <p>Pregnant and Breastfeeding Women</p> <p>Women who are pregnant or breastfeeding may be at greater risk of HIV and other STDs because they are not thinking about protection from pregnancy. Becoming infected during pregnancy or while breastfeeding increases the chances that</p>	<p>Question and Answer (30 min.)</p> <p>The trainer should ask the following questions:</p> <p>Note to the Trainer: These questions concern issues that are controversial and may arouse strong emotions. Make sure Px understand that these are complex questions without easy answers, and that the role of a provider is to give accurate information and support people’s choices.</p> <ul style="list-style-type: none"> ❓ What advice would you give a pregnant or breastfeeding woman who you think might be at risk of HIV infection? ❓ What advice would you give to a woman who is trying to become pregnant and knows she is at risk of HIV infection from her husband? ❓ What advice would you give a young married woman who has no children, knows she is HIV infected, and is trying to become pregnant? ❓ What advice would you give a woman who is HIV-negative and wants to become pregnant, but whose partner has tested positive for HIV? ❓ What advice would you give to a woman who is 10 weeks pregnant and just found out she is HIV-positive? <p>The trainer should:</p> <ul style="list-style-type: none"> • Present any content not covered and answer any questions.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>HIV will be transmitted to the baby because just after infection there is more virus present. A pregnant woman may be at greater risk of infection because of the behavior of her partner, who may seek sex outside the relationship.</p> <p>Advice For a Woman Who Is Trying to Become Pregnant and Who May Be at Risk of HIV Infection</p> <p>If you are trying to become pregnant, you must have unprotected sex. There are some things you can do to reduce your risk of getting HIV.</p> <ul style="list-style-type: none"> • Learn your own and your partner's HIV status, (go for testing together), and, if negative, stay infection-free while trying to get pregnant. • Do not have sex when you have your monthly period or if you are bleeding. You are probably not fertile then. • Never have sex when there are signs of a STD in your partner or yourself. • Have unprotected sex only during the time of the month when you are most fertile. For the rest of the month, protect yourself with condoms or do not have sexual relations. <p>What if she is HIV negative and her partner is HIV positive and she wants to become pregnant? She is taking a big chance by having unprotected sex, but some women do this. Perhaps she can reduce her risk by following the advice above on protecting herself while trying to become pregnant. Make sure she understands the risk that both she and the baby may become infected.</p>	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Risks of Being Pregnant and HIV-Infected</p> <p>Many women with HIV still want to become pregnant. In many places women have no choice—either they have no way to prevent pregnancy or their partners want them to become pregnant. The risks to a pregnant woman’s health if she is HIV-infected are not clear. To date, research has not shown that pregnancy itself has negative effects on the health of a woman with HIV <i>if she has no symptoms</i>. However, women with symptoms of AIDS may experience increasing problems with opportunistic infections in pregnancy and postpartum. Women who are at risk of HIV infection, or known to be infected, should receive the following information on pregnancy and HIV, and should be referred for voluntary counseling and testing (VCT).</p> <ul style="list-style-type: none"> • Without preventive treatment, 1-out-of-3 to 1-out-of-4 babies born to HIV-positive mothers becomes infected. This can happen while the baby is in the uterus, during birth, or postpartum through breastfeeding. • Women with AIDS are more likely to have the following problems in pregnancy: <ul style="list-style-type: none"> – miscarriage. – fevers, infections, and worsening of their own health. – premature birth. – smaller babies who are more likely to have problems. – severe postpartum infections that do 	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>not respond well to treatment.</p> <p>If a woman is already pregnant and finds out she has HIV or AIDS, she may be thinking about having an abortion if this is legal. However, there should be no pressure on her from her provider or others to have an abortion.</p> <p>Good antenatal care is more important than ever for HIV-infected women.</p> <p>Antiviral drugs such as zidovudine (AZT) and nevirapine are becoming available in some countries. They reduce the risk of a mother passing HIV to her unborn baby.</p> <p>Good nutrition decreases the chance that an HIV-infected woman becomes sick or sicker. She should avoid anemia, which when present decreases response to zidovudine.</p>	<p>Presentation (2 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute and present the prevention message and post it on the wall.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

Unit 10 Summary

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Summary</p> <ul style="list-style-type: none"> • Negative attitudes about HIV/AIDS are a huge barrier to prevention in the clinic and the community. • AIDS is spreading most quickly where people are poor and uneducated, and especially among young women. • Men infected with HIV give it to women 2-5 times more easily than women infected with HIV give it to men. • 85-90% of HIV is transmitted through unprotected sexual intercourse. • HIV testing should <i>always</i> be voluntary, private, confidential, and supported with pre- and post-test counseling. 	<p>Presentation (5 min.)</p> <ul style="list-style-type: none"> • Present the unit summary. • Distribute Px Manual content for Unit 10.

UNIT 11: SCREENING AND USE OF THE LABORATORY

UNIT TRAINING OBJECTIVE:

Understand the limits and uses of laboratory testing for RTIs in low resource settings.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Define screening.
2. Explain the role of the laboratory in STD control.
3. Explain the limited usefulness of laboratory tests at the primary care level.
4. Describe laboratory services that are appropriate at the primary, regional, and national health care levels.
5. Develop and present a plan for antenatal syphilis screening in the participants' workplaces.

PRACTICUM OBJECTIVES:

None

TRAINING/LEARNING METHODOLOGY:

- Presentation
- Group discussion
- Simulated practice
- Role play
- Case study
- Demonstration

MAJOR REFERENCES AND TRAINING MATERIALS:

- Dallabetta, G.A., M. Laga, and P.R. Lamptey, eds. 1996. *Control of sexually transmitted diseases: A handbook for the design and management of programs*. Arlington, Virginia: AIDSCAP/Family Health International.

- Vargas T., E. Pinto, M.R. de Naranjo, A. Loaiza Galvan, R. Danielson, and K. Roy. 1998. *Partner participation in reproductive health: Client and provider perspectives in CEMOPLAF. English summary of final report and recommendations*. Quito, Ecuador: Centro Medico de Orientacion y Planificacion Familiar (CEMOPLAF).
- Williamson, N. November 1998. *Reaching men: OR summaries on rural Honduras*. Presented at the Population Council, Washington, DC.
- World Health Organization (WHO). 1995. *STD case management workbook 6: Partner management*. Geneva: WHO.

RESOURCE REQUIREMENTS:

- Newsprint
- Overhead projector and transparencies
- Large picture of male and female pelvic organs
- Rapid syphilis tests

EVALUATION METHODS:

- Pre- and post-test
- Verbal feedback from trainer
- Observation and assessment

TIME REQUIRED: 2 hours 5 min.; with optional lab visit, 2 hours 35 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Make copies of the following handouts:
 - 11.1A: Case Studies
 - 11.3A: Laboratory Tests
 - 11.5A: Syphilis Program Worksheet
- Write unit objectives on a flipchart.
- Copy the Unit 11 content section (Px Manual) for distribution at the end of the unit.
- Prepare a summary of local syphilis incidence and prevalence and a description of the national screening program, if any.
- Obtain samples of a rapid test for syphilis for demonstration and practice (S.O. #5).
- As an optional exercise, arrange to visit a lab with Px for an explanation and demonstration of RPR testing for syphilis.

Introduction to Unit 11

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>The objective of screening is the early detection of treatable disease in people who have no symptoms.</p> <p>A screening test ideally should be:</p> <ul style="list-style-type: none"> • Inexpensive. • Easy to administer. • Not cause the patient discomfort or harm. <p>Good example of screening that should be promoted: Testing all pregnant women for syphilis.</p> <p>Laboratory testing for RTIs can help:</p> <ul style="list-style-type: none"> • Diagnose patients with STD symptoms. • Detect STDs in patients who seek health care for other reasons. • Screen groups of people who are at risk but are not seeking health care. <p>Many laboratory tests that are used in developing countries are costly, cause delays in diagnosis and treatment, and are <i>not</i> helpful.</p> <p>However, laboratory tests do play a key role in public health decision making. These tests give valuable information on prevalence and incidence of specific STDs, and enable us to follow trends and to monitor the success of STD programs including syndromic management.</p>	<p>Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objectives using the prepared flipchart.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>At the peripheral, primary health care level, much can be done to manage STDs without the use of any laboratory, saving time, money, and scarce resources.</p> <p>No simple laboratory tests exist to help diagnose or screen for gonorrhoea or chlamydia in women.</p> <p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Define screening. 2. Explain the role of the laboratory in STD control. 3. Explain the limited usefulness of laboratory tests at the primary care level. 4. Describe laboratory services that are appropriate at the primary, regional, and national health care levels. 5. Develop and present a plan for antenatal syphilis screening in the participants' workplaces. 	

Specific Objective #1: Define screening

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Screening</p> <p>Screening is the early detection of disease in a population of people at risk. The first step in screening is to identify those at risk. Once people at risk of STD are identified, strategies can be developed for screening, further testing, treatment, or prevention. For example, cervical cancer is a disease that is most common in women over 35 years of age, so a screening test to detect signs of early cervical cancer will detect more cases if it is directed at women over 35. Treatment must be available for the disease being screened for.</p> <p>Antenatal screening for syphilis for all pregnant women is the most cost-effective STD screening currently available and should be implemented. It is one of the 10 most cost-effective interventions to decrease infant morbidity and mortality.</p> <p>VCT for HIV is an effective screening tool that can decrease transmission in at-risk populations.</p> <p>Screening by Taking a Careful History and Assessing Risk</p> <p>Assessment of risk is a tool used to decide which patients need further examination and testing or treatment. Research on simple and inexpensive screening tests for other STDs, especially those causing cervicitis is urgently needed. However, until such tests are available, providers should be creative about how they use limited resources for those who they think are at highest risk.</p>	<p>Case Study/Discussion (30 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the information on screening found in the content section and lead a short discussion on the following questions: <ul style="list-style-type: none"> 🗨️ What kinds of screenings are available or might make sense in a family planning setting? <p><i>Possible responses: Pap smears or other screening for cervical cancer, urine tests, breast exams, and other?</i></p> 🗨️ How can partners be involved in syphilis screening? <p><i>Possible responses: Emphasize partner’s participation in ANC activities; increase community and particularly male awareness of syphilis, its effects on the newborn, and the need for prevention and treatment; develop partner referral strategies for women who are screened.</i></p> <ul style="list-style-type: none"> • Distribute the case studies and ask a Px to read the first one. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Ask the group: <ul style="list-style-type: none"> 🗨️ What would you do for N___? <p><i>Possible response: Because her husband has been gone for an extended period, and she described STD symptoms, you</i></p>

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Screening by Conducting a Physical Examination</p> <p>Doing speculum exams on all women who present for the first visits for FP (as well as women who present with STD symptoms) can also be considered screening. While this requires trained providers and other resources, it may be cost-effective if STD rates are known to be high among your female population. Examination of the vagina and cervix will not rule out disease but can aid in syndromic diagnosis of STD and can detect early changes indicative of cervical cancer.</p> <p>Obstacles to screening:</p> <ul style="list-style-type: none"> • Lack of resources in general. • Lack of national screening policies (for syphilis, cervical cancer, etc.). • Lack of accurate, inexpensive screening tests. • Lack of trained personnel including providers, laboratory technicians. • Lack of infrastructure such as lack of water and power, poor transport and referral services, and long waits for lab results. 	<p><i>decide she is at risk. You decide to do an examination, including bimanual pelvic and speculum examinations, and a test for syphilis, give her information on STD risk, and treat or refer her as needed.</i></p> <p>❓ What are your other options?</p> <p>❓ What if you simply treated her for some STDs?</p> <ul style="list-style-type: none"> • Ask a Px to read the second case study and ask the group the following questions: <ul style="list-style-type: none"> ❓ What would you do for K___? <p><i>Possible response: If she has no complaints, only counsel her and give her condoms.</i></p> <p>❓ Would you test for syphilis?</p> <p><i>Possible response: No, because she is low-risk and not pregnant.</i></p> <p>❓ What would you do with a client who is known to be a sex worker who comes for family planning and has no symptoms of STD?</p> <p><i>Possible responses: Further examination and tests could be done, or if they are not available or are too expensive or unreliable, you could decide to treat her presumptively for the most common STDs in your region.</i></p> <p>❓ In each of the above cases, how would your use of risk assessment for the purpose of screening affect your advice on family planning methods?</p>

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<p>  How would you decide whom to examine when resources are limited? Who should get first priority? </p> <p> <i>Possible responses: Women who want an IUD, women with vague symptoms, women you perceive to be at high risk but for whom partner notification will be difficult so the diagnosis needs to be more sure.</i> </p> <p>  What do you see as the major obstacles to screening for RTIs and what kinds of screening might you be able to use or develop in your setting? </p>

Specific Objective #2: Explain the role of the laboratory in STD control

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Laboratory Testing Can Be Useful In:</p> <ul style="list-style-type: none"> • Screening and detection of disease in those without symptoms who seek health care for other reasons. • Screening groups of people who may be at risk for a STD but have no symptoms. • Testing a sample of the population to see what percentage is infected (prevalence) and how many new infections are occurring in a certain time period (incidence). • Conducting simple studies to check on the accuracy of syndromic management (validation). • Testing for drug resistance. • Sentinel surveillance. • Making an accurate etiologic diagnosis for patients who present with STD symptoms. • However, most labs in resource-poor settings have little or no capacity to test for gonorrhea, chlamydia, herpes and other STDs. Even when they do such tests, the accuracy of diagnosis has proven to be poor. 	<p>Discussion (25 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the information about how the laboratory can help in STD control found in the content section. <p>🔍 Ask Px for an example of each point.</p> <p><i>Some examples may be: #1. Gonorrhea culture of a woman's cervical discharge; #2. Syphilis screening in all pregnant women who come to antenatal clinics; #3. HIV testing of all foreigners entering the country¹; #4. HIV testing of pregnant women to determine the state of the epidemic; #5. Taking samples for accurate STD testing (for example with polymerase chain reaction, PCR testing) to see how well the syndromic diagnosis matches the laboratory diagnosis (validation); #6. Looking for resistant strains of gonorrhea; #7. By doing anonymous HIV testing in certain populations in selected areas of the country, we can track the HIV epidemic.</i></p>
<p>¹HIV testing of all foreigners entering a country is generally NOT considered a useful HIV control measure.</p>	

Specific Objective #3: Explain the limited usefulness of laboratory tests at the primary care level

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>The Limited Usefulness of Laboratory Tests</p> <p>Unfortunately, many simple laboratory tests used in developing countries are costly, cause delays in diagnosis and treatment, and are <i>not</i> helpful.</p> <p>As we have seen earlier, except in the case of vaginal discharge, syndromic management works well when symptoms are present. In the FP clinic, if a woman has vaginal discharge we would like to be sure that we aren't missing a STD with possible serious consequences, or that we aren't causing problems by telling a woman she has a STD when she does not. There are laboratory tests that can differentiate one from the other, but these are still too expensive for most developing countries. Carefully following the flowcharts for vaginal discharge will help find and treat cases of gonorrhea and chlamydia in the absence of affordable lab capability.</p>	<p>Discussion (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute and go over the chart on laboratory tests, discussing each test separately. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Ask Px which of these tests is offered in their facilities. • Discuss the usefulness of the tests. • Summarize the objective by discussing the information found in the content section.

Specific Objective #4: Describe laboratory services that are appropriate at the primary, regional, and national health care levels

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Primary health care level (peripheral): At PHC centers, and MCH and FP clinics, it is possible, though not easy, to offer microscopic examination of fresh and stained samples of urethral and cervical discharges, and to offer wet mounts for examination of vaginal discharge. It is possible to take cervical samples such as Pap smears and send them to more sophisticated laboratories for reading. RPR testing for syphilis can easily be done at the peripheral level.</p> <p>Regional health care level: Laboratories are usually larger than at the PHC level and may have more skilled workers and a more reliable infrastructure. They may be able to do gonorrhea cultures, confirmatory tests for syphilis, HIV antibody testing and, if there is a cytotechnician, read Pap (cervical) smears.</p> <p>National health care level: These laboratories are usually located in a capital city or university teaching hospital and can have the highest level of services.²</p>	<p>Question and Answer (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the material on appropriate services at each health care level from the content section. ? Ask Px which, if any, laboratory services are offered at their facility and whether these services function well and are useful. ? Ask Px which services do not function well and what the problems are. ? Ask Px what methods are used to ensure quality control.
<p>²Adapted from Dallabetta, G.A., M. Laga, and P.R. Lamptey, eds. 1996. Control of sexually transmitted diseases: A handbook for the design and management of programs. Arlington, Virginia: AIDSCAP/ Family Health International. 229-252.</p>	

Specific Objective #5: Develop and present a plan for antenatal syphilis screening in the participants’ workplaces

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>The Case for Syphilis Screening</p> <ul style="list-style-type: none"> • Syphilis is a disease that, in its early stages, is largely asymptomatic. • The effects of untreated syphilis on adults include increased transmission of HIV if genital ulcers are present, and in later stages, include a variety of serious health problems sometimes resulting in death. • Syphilis passed in pregnancy to the fetus results in adverse outcomes (stillbirth, spontaneous abortion and premature birth) in up to 8% of pregnancies in Africa.³ • Inexpensive blood tests exist to screen for syphilis so one can obtain results and treat on the spot. • No simple and inexpensive screening tests for other STDs in women exist, but they are badly needed. <p>Rapid Screening Tests</p> <p>Rapid screening tests that can be used without a lab for syphilis and HIV are presently available. Rapid tests for gonorrhea, chlamydia, and hepatitis B are under study. Some are more cost-effective than others, but all allow the patient to be informed within minutes and treated on the spot.</p>	<p>Discussion and Workplan (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> ❓ Ask Px what they know about signs and symptoms of syphilis, the natural history of the disease, transmission to the fetus in pregnancy, and effects of congenital syphilis. (See Unit 5: Physical Exam for RTIs.) • Present statistics on local incidence and prevalence of syphilis. ❓ Ask Px if syphilis screening is done where they work, and if so, to describe any existing screening program, along with its successes and problems. • Present and describe the national syphilis screening program including percentage of all pregnant women screened yearly. • Present any existing cost data. <p>Demonstration and Practice (10 min.)</p> <p>The trainer should demonstrate the rapid test for syphilis. (Px volunteers may allow other Px to practice on them.)</p> <p>Optional (30 min.)</p> <p>Take Px to lab for an explanation and demonstration of RPR testing for syphilis.</p>
<p>³ Holmes, K.K., P.F. Sparling, P.-A. Mardh, S.M. Lemon, W.E. Stamm, P. Piot, and J.N. Wasserheit, eds. 1999. <i>Sexually transmitted diseases</i>. 3rd ed. New York: McGraw-Hill, 1999.</p>	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<p>Homework</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to sketch out a syphilis screening program for their workplace using the handout, and turn it in the next day. <div style="text-align: center;">  </div> <p>Note to the trainer: <i>These sketches must be read, commented on, and handed back to Px before the end of the course.</i></p>

Unit 11 Summary

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Summary</p> <ol style="list-style-type: none"> 1. Screening is the early detection of disease in a particular population of people at risk. 2. Screening and treatment of pregnant women for syphilis is cost effective and should be widely implemented. 3. No simple, low-cost screening test exists for gonorrhea or chlamydia in women. 4. Laboratory tests have very limited usefulness in the diagnosis of STDs in most low resource settings. 5. Laboratory testing at the national or regional level plays a key role in public health decision making. 	<p>Summary (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit summary. • Distribute Px Manual content for Unit 11.

UNIT 12: REACHING MEN

UNIT TRAINING OBJECTIVE:

To prepare participants to develop strategies for reaching men in the FP setting in order to prevent and treat STDs.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Discuss how reaching men can improve the reproductive health of men, women, and their children.
2. Develop strategies for involving men in STD awareness, prevention, treatment, and partner referral.
3. Explain the principles and importance of partner management in effective treatment of STDs as well as in breaking the cycle of STD transmission.
4. Discuss the challenges of incorporating STD services for men as part of integration.

SIMULATED SKILL PRACTICE:

Counseling and role play

CLINICAL PRACTICUM OBJECTIVES:

Partner management with patients

TRAINING/LEARNING METHODOLOGY:

- Trainer presentation
- Case study
- Role play
- Brainstorming

MAJOR REFERENCES AND TRAINING MATERIALS:

- Vargas T., E. Pinto, M.R. de Naranjo, A. Loaiza Galvan, R. Danielson, and K. Roy. 1998. *Partner participation in reproductive health: Client and provider perspectives in CEMOPLAF*. English summary of final report and recommendations. Quito, Ecuador: Centro Medico de Orientacion y Planificacion Familiar (CEMOPLAF).

- WILLIAMSON, N. 1998. *Reaching men: OR summaries on rural Honduras*. Presented at the Population Council, Washington, DC. n.d.
- WORLD HEALTH ORGANIZATION (WHO). 1995. *STD case management workbook 5: Educating the patient*. Geneva: WHO.

RESOURCE REQUIREMENTS:

- Newsprint
- Tape
- Markers
- Overhead projector

EVALUATION METHODS:

- Pre- and post-test
- Verbal feedback
- Continuous assessment of unit objectives
- Participant reaction form (end of module)

TIME REQUIRED: 2 hours 15 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Make copies of the following handouts:
 - 12.2A: Case Study
 - 12.3A: Role Play (2 copies only)
- Write unit objectives on a flipchart.
- Copy the Unit 12 content section (Px Manual) for distribution at the end of the unit.
- Prepare 3 sheets of newsprint with the headings: “awareness,” “prevention,” and “treatment” (one heading per sheet) (S.O. #2).

Introduction to Unit 12

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>Often men are the bridging group who acquire infection from and transmit STDs to high-risk partners such as sex workers, and who then carry it home to their regular partners. In this way, STDs spread even to women who have only one partner. Reaching men with prevention messages and condoms and treating their STDs early and correctly are very effective ways to prevent the spread of STDs in their regular partners. A key strategy is getting men with STDs to refer or bring their regular partners for treatment, thus reaching the many women who may appear to be low risk and have no symptoms.</p> <p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Discuss how reaching men can improve the reproductive health of men, women, and their children. 2. Develop strategies for involving men in STD awareness, prevention, treatment, and partner referral. 3. Explain the principles and importance of partner management in effective treatment of STDs as well as in breaking the cycle of STD transmission. 4. Discuss the challenges of incorporating STD services for men as part of integration. 	<p>Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objectives using the prepared flipchart.

Specific Objective #1: Discuss how reaching men can improve the reproductive health of men, women, and their children

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>Men may have access to services for STD treatment through STD clinics, PHCs, and pharmacies, but they are often even less informed than women about basic issues of sexual health and disease prevention. It is clear from new research that men are eager for more information about their own reproductive health and that of their partners. Men and women alike suffer from the fear of shame and embarrassment attached to seeking treatment for STD and need sensitive treatment from providers.</p> <p>Why should FP/RTI services include men?</p> <ul style="list-style-type: none"> • To increase access to information for male partners. • To give men the opportunity to support their partners. • To increase effectiveness of partner referral for STD treatment. • To increase partner communication skills. • To increase the use of condoms with partners outside of the primary relationship. • To increase the use of condoms inside the primary relationship if either partner is infected or has unprotected sex outside of it. 	<p>Presentation/Group Work (35 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the introduction to S.O. #1. • Ask Px to form 4 new groups. • Ask them to discuss and list all possible reasons why FP/RTI services should include men (15 min.). • Ask each group to present and discuss its lists. • Discuss the answers and supplement them with the content.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<ul style="list-style-type: none"> • To help men play a role in the prevention, recognition, and treatment of other RTIs such as postpartum and postabortion infections. • To break the cycle of infection in their partners and newborns. • To give men the opportunity for more confidential treatment. • To encourage men to share sexual responsibility with their partners. • To increase men's support of family planning. • To challenge social norms that are harmful to women. 	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

Specific Objective #2: Develop strategies for involving men in STD awareness, prevention, treatment, and partner referral

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Ways to Involve Men in Awareness, Prevention, and Treatment</p> <p>There are many ways to involve men in the awareness, prevention, and treatment of STDs. The following are only a few examples:</p> <ul style="list-style-type: none"> • Public information campaign on STDs directed to men receiving early treatment and informing their partners of the need for treatment. • Condom promotion for men with casual partners in addition to primary partners if not practicing safer sex outside of the primary relationships. • Posters in local bars where men gather that address STDs and the need for men to protect their families. • Drug treatment packets with information on STDs for female partners. • Partner referral cards for a man to give to his primary partner. • Linking FP/MCH/RTI services with STD services for partner referral. • Public information campaign on syphilis and HIV that addresses how men can protect both their wives and newborns by decreasing the number of casual partners and using condoms. • Advertising ANC services that promote male partnership in pregnancy and birth. 	<p>Case Studies/Discussion (30 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute the case study. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Combine Px's 4 groups into 2. • Ask each group to choose a spokesperson. • Ask the groups to discuss the following questions. (Allow 20 minutes.) <ul style="list-style-type: none"> ❓ How could J___ have gotten information on STDs? ❓ What methods would be effective to teach him about safer sex? ❓ What role could his workplace assume in STD prevention and treatment? ❓ What could community leaders (male) do to prevent infection in men? • Ask the groups to also think of ways in which the male partner could have been or could be involved in awareness, prevention, or treatment, including within the clinic and the community. • Ask the spokesperson from each group to present her/his ideas to the whole group.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • Trained peer educators in the workplace. 	<ul style="list-style-type: none"> • On the 3 sheets of newsprint prepared earlier, list the male involvement strategies from the presentations and post on the wall. • Present any content material not covered. • Remind Px of the following: <ol style="list-style-type: none"> 1. Very few models of providing care to men exist now—they need to be invented by people like you. 2. We need to create a “sexual health literacy” in both men and women so there is common ground for communication between partners and between clients and providers. • Summarize the exercise.

Specific Objective #3: Explain the principles and importance of partner management in effective treatment of STDs as well as in breaking the cycle of STD transmission

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Partner Management</p> <p>Definition: Partner management is education and treatment of the patient's sexual partner or partners and is a key part of STD management. Although partners can be male or female, in the RH setting women are most often the patient, and we need to find effective ways to deal with male partners. Partner management breaks the cycle of STD transmission, including prevention of re-infection of the patient. According to WHO, partner management includes:</p> <ul style="list-style-type: none"> • Treatment for all of a patient's partners. • Providing the same STD treatment to both patient and all partners. • Treating partners whether or not they have symptoms. <p>Principles of Partner Management</p> <ul style="list-style-type: none"> • If a patient has more than one sexual partner, any of these partners could be the source of infection. • There is no value in trying to identify the source of infection. All partners could be infected and should be treated. • For practical purposes, assume the time period of infection is two months. • Partner management must be confidential and voluntary. 	<p>Trainer Presentation/Role Play/Discussion (25 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the information from the content section. • Distribute the role play. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Ask for 2 Px volunteers to act out the role play. • Allow them 5 minutes to prepare and ask them to describe the clinician and F___ to the group before beginning the role play. • Following the role play, ask Px the following questions: <ul style="list-style-type: none"> ❓ How would you discuss partner management with F___? ❓ What information could you give her to help motivate her partner to change his behavior? ❓ What strategies can you offer F___ to help her give this information to her partner? ❓ What skills can you offer her? • Ask a volunteer to briefly summarize the principles and options for partner management.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • No one should be forced to say or do anything s/he is unwilling to do. For some patients, partner notification can be damaging or even dangerous, resulting in blame and domestic violence. <p>Options for Partner Management</p> <ul style="list-style-type: none"> • The patient can contact the partner directly and explain about STD infection and the need for treatment. • The patient can ask the partner to go to the clinic to receive information and treatment, or give the partner a “partner referral card” asking her/him to attend the clinic. • The patient can ask someone else to talk to the partner. 	<ul style="list-style-type: none"> • Add any content not covered in the discussion.

Specific Objective #4: Discuss the challenges of incorporating STD services for men as part of integration

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>The Challenge of Reaching Men</p> <p>There are many reasons why it is difficult to reach men:</p> <ul style="list-style-type: none"> • Men may not feel comfortable using services mainly used by women. • Men may feel shame or embarrassment about seeking information or treatment for STDs. • There is a lack of confidentiality for women if their partners are with them. • Treating men may take time and resources away from women. • Treating men requires new skills from providers. • Treating men may require different facilities and more male providers. 	<p>Group Work/Discussion (30 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Divide the group into pairs, representing couples. • Ask one person in each pair to write down and discuss one barrier to reaching men that s/he has encountered or identified, and the other person to identify one success. • Allow 10 minutes for the couples to identify their barriers and successes. • Reconvene the group and ask the couples to present the barriers and successes they identified. • Write these on a flipchart. • Add any additional barriers from the content section. • Have the Px list 3–5 ways they might approach each of the barriers. • Explain that treating men may require different facilities and more male providers. • Ask Px to discuss their clinic situations: what services are provided; what barriers exist to providing services to men; and what successes they have already achieved in addressing men (e.g., involving men in FP decisions, increasing communication between couples, etc.). • Summarize exercise

Unit 12 Summary

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Summary</p> <ol style="list-style-type: none"> 1. We need to reach men with prevention messages and condoms. 2. Treating men’s STDs early and correctly is an effective way to prevent the spread of STDs to their regular partners. 3. Getting men to bring their partners for treatment is one of the most effective ways to reach asymptomatic women. 4. More strategies are needed to involve men in STD awareness, prevention, treatment, and partner referral. 	<p>Presentation (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit summary. • Distribute Px Manual content for Unit 12.

UNIT 13: REACHING YOUTH

UNIT TRAINING OBJECTIVE:

To prepare participants to develop strategies for reaching youth in the RH setting in order to prevent and treat STDs.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Understand the magnitude of STDs among youth.
2. List barriers that prevent youth from obtaining information and services related to STDs.
3. Develop strategies for involving youth in STD prevention, treatment, and outreach.
4. Generate new ideas for youth-friendly activities for the communities served by participants' work sites.

SIMULATED SKILL PRACTICE:

None

CLINICAL PRACTICUM OBJECTIVES:

None

TRAINING/LEARNING METHODOLOGY:

- Presentation
- Discussion
- Brainstorming

MAJOR REFERENCES AND TRAINING MATERIALS:

- Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: A health guide for women*. Berkeley, California: Hesperian Foundation.
- ISLAM, Q.M. 1996. STDs: The burden and the challenge. *AIDSCaptions* 3(1): 4-7.
- Senderowitz, J. 1997. *Health facility programs on reproductive health for young adults*. Washington, DC: FOCUS.

- UNAIDS and World Health Organization (WHO). 1998. *Report on the global HIV/AIDS epidemic*. Geneva: n.p.
- United Nations Children’s Fund (UNICEF).1997. *Youth health—for a change: A UNICEF notebook on programming for young people’s health and development*. 1997 edition. New York: UNICEF.

RESOURCE REQUIREMENTS:

- Newsprint
- Markers
- Overhead projector
- Tape

EVALUATION METHODS:

- Pre-and post-test
- Continuous assessment of unit objectives
- Participant evaluation form (end of module)

TIME REQUIRED: 2 hours 45 minutes; with optional exercise, 3 hours 30 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare the following as participant handouts:
 - 13.4A: Strategy for Youth Services
- Have *Transparency 1.4A: STD Patients: Age and Sex* on hand for S.O. #1.
- Write the unit objectives on a flipchart.
- Copy the Unit 13 content section (Px Manual) for distribution at the end of the unit.
- Obtain a prize for the “Youth at Risk” competition. The prize may be male or female condoms, a T-shirt, or a key ring from local social marketing NGO.
- Prepare small pieces of paper with items from the list of barriers to information and services for youth found in S.O. #2.
- Arrange to have Px youth strategies typed up after the exercise (S.O. #3) for distribution to all Px.

Introduction to Unit 13

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Unit Introduction</p> <p>Many RH programs do not offer services to adolescent or unmarried women. In some countries, laws prohibit family planning for women under age 18 or for those who are unmarried. At the same time pregnancy, abortion, and STD rates in young women are high, accounting for a large part of maternal morbidity and mortality.</p> <p>Young women are particularly vulnerable to STDs since they are less likely to have access to health services and to recognize symptoms. Health services for adolescent boys are also extremely limited.</p> <p>Lack of education about sexual health for both boys and girls leaves them ill-equipped to make important choices to protect themselves against unwanted sex, pregnancy, and STDs. The AIDS epidemic gives a new urgency to STD prevention and is also an opportunity to protect new generations from the devastating effects of AIDS by making information and services available.</p> <p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Understand the magnitude of STDs among youth. 2. List barriers that prevent youth from obtaining information and services related to STDs. 3. Develop strategies for involving youth in STD prevention, treatment, and outreach. 4. Generate new ideas for youth-friendly activities for the communities served by participants' work sites. 	<p>Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objectives using the prepared flipchart.

Specific Objective #1: Understand the magnitude of STDs among youth

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Introduction</p> <p>Protection against infection and pregnancy involve many of the same strategies and services.</p> <p>Young men can be involved in both family planning and RTI prevention if their need for information and treatment is addressed.</p> <p>Youth at Risk</p> <ul style="list-style-type: none"> • An estimated 1 in 20 youths contracts STDs each year and one-third of all STDs occur among 13–20-year-olds (110 million STDs/year). • In many African countries, up to 20% of all births are to women 15–19 years old. • 40–70% of women have become pregnant or mothers by the end of their teens in many African countries. • In many Latin American countries, 35% of women hospitalized for septic abortion are under age 20. • In many countries maternal deaths are 2–3 times greater in women 15–19 years old than in women 20–24 years old. <p>These statistics document the extent of unprotected sexual activity among youth, and the clear need to protect young women against both STDs and pregnancy. Because young women already come for care because of pregnancy and abortion, we may have the opportunity to educate,</p>	<p>Trainer Presentation/Discussion (45 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Display and discuss transparency on age and s  its. <ul style="list-style-type: none"> • Present the introduction to S.O. #1. • Present “Youth at Risk” from the content. • Ask Px to form 4 new small groups. • Ask each group to discuss and report back on the following questions (15 min. small group and 20 min. large group presentations): <ul style="list-style-type: none"> ❓ How do you see youth affected by STDs in your region or work setting? ❓ Do you have educational materials and services directed at youth? ❓ Are there laws, regulations, or community norms that prevent you from serving youth? ❓ How does the need to prevent pregnancy and to prevent STDs overlap in adolescents? • Back in the larger group, a representative from each group should present the results of the group's

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>sexual experiences with older men.</p> <ul style="list-style-type: none"> • Youth lack accurate knowledge about the body, sexuality, sexual health, and STDs. • There is a lack of political will to educate youth: no health/sexuality education, poor communication between youth and elders, lack of materials directed at youth. • Youth lack control over their sexuality and are subject to early marriage, forced sex, and poverty. • There is a lack of laws to prevent early marriage. • Changing partners is more common among youth than among older men or women who may be in stable relationships. 	<p>information from the content section.</p>

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

Specific Objective #2: List the barriers that prevent youth from obtaining information and services related to STDs

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Barriers to Information and Services for Youth</p> <ul style="list-style-type: none"> • Lack of services: little access to family planning or services for treatment or prevention of STDs • Lack of access to condoms • Provider, parent, teacher, and community attitudes about youth and sexuality • False belief that young people are not sexually active, and that information will increase sexual activity • Lack of messages targeted to youth • Lack of providers trained to deal with youth 	<p>Small Group Work/Discussion (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to form pairs. • Pass out 1–2 previously prepared slips of paper with the following messages on them to each pair. <ol style="list-style-type: none"> 3. No access to FP services. 4. No access to STD services. 5. No access to condoms. 6. Poor provider attitudes about youth and sexuality. 7. Poor teacher attitudes about youth and sexuality. 8. Poor parent attitudes about youth and sexuality. 9. Poor community attitudes about youth and sexuality. 10. Belief that youth aren't sexually active. 11. Belief that information on STDs and sexuality increase sexual activity. 12. Lack of health/STD messages targeting youth. 13. Lack of providers trained to deal with youth. • Ask Px to discuss their barrier/s and a realistic way to challenge the barrier (solution) with their partner for 5 min.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	<ul style="list-style-type: none">• In large group, ask each pair to quickly present in one minute the barrier and a solution.• Add information from the content section as needed and summarize the discussion.

Specific Objective #3: Develop strategies for involving youth in STD prevention, treatment, and outreach

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Strategies for Youth</p> <p>Prevention</p> <ul style="list-style-type: none"> • There is evidence that prevention works especially well with young people. • Prevention works best when provided along with health care. • Sexual habits in youth are not yet developed or rigid. • Youth may be more willing to adopt safer behavior earlier in life. • Boys who use condoms the first time they have sex are much more likely to be consistent condom users thereafter. <p>Behavior Goals for Youth</p> <p>Young people should have information about and be encouraged to:</p> <ul style="list-style-type: none"> • Delay onset of sexual activity. Abstain from vaginal and anal intercourse until married or in a stable relationship. • Learn how to use condoms. Both boys and girls should practice using condoms before becoming sexually active. • Use condoms. These may be discontinued when a stable relationship evolves or pregnancy is desired, if both partners know they are disease-free. • Limit the number of partners. Stick 	<p>Trainer Presentation/Group Work (45 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Discuss prevention as a strategy, using information from the content section. •  Ask Px what behavior messages we should give to encourage reduced risk of STDs in youth. • Write answers on flipchart and supplement from the content section. • Divide Px into 3 groups and assign each group one of the following topics: prevention, outreach, clinical services. • Ask each group to design a strategy for youth that falls under one of these categories, or to describe a program that they know which is successful. Make sure the strategy addresses ways to make services “youth friendly.” • Give them newsprint and ask them to write an outline of their strategy and prepare to present it. • After 20 minutes, someone from each group should present strategy to the large group. • Ask for any additions to the presented strategies and add as needed from the Content section. <p>Note to the trainer: Make sure that all strategies are typed after the session so that they can be distributed to all Px later on.</p>

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>with one partner.</p> <ul style="list-style-type: none"> • Avoid high-risk partners. For example in Africa, girls should avoid older men and “sugar daddies,” and boys should avoid sex workers and older women. • Recognize symptoms of STDs. If burning with urination and/or discharge from the penis, or there are genital sores, young men and their partners should not have sex, but both should come to the clinic for treatment. <p>Treatment</p> <p>Reasons to provide clinic services for youth include:</p> <ul style="list-style-type: none"> • High STD rates among youth. • STD diagnosis and treatment are not available outside a clinic. • Few contraceptive options are available to young women or men outside the clinic setting. • Young women already come for care because of pregnancy and abortion. • Prevention can be offered alongside care. <p>Strategies to Attract Youth to Clinic Services</p> <ul style="list-style-type: none"> • Make services friendly towards youth. • Providers who want to work with youth, have special training, and are non-judgmental. 	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<ul style="list-style-type: none"> • Convenient and confidential services. • Special hours (after school, evenings, weekends, drop-ins). • Comfortable for young men and young couples. • Private exam and consultation rooms. • Array of contraceptive choices. • Emphasize barrier methods with emergency contraceptive pills (ECPs) for backup against pregnancy. • Emphasis on communication skills for young people. <p>Outreach</p> <ul style="list-style-type: none"> • School-based education programs. • Peer education programs. • Target out-of-school youth. • Target married youth. • Word-of-mouth about where to find clinic services. • Use entertainment to gather youth and disseminate health messages (concerts, movies, theatre, etc.) and encourage clinic attendance. • Organize or link with sports programs. 	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

Specific Objective #4: Generate new ideas for youth-friendly activities for the communities served by participants' worksites

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Lessons Learned From Youth Programs</p> <p>We have learned some lessons from those who have started successful programs that target youth.</p> <ul style="list-style-type: none"> • Do needs assessment. • Involve communities. • Talk to community leaders. • Involve youth from the beginning. Ask them about their needs. • Involve parents from the beginning if possible, although this can be tricky. • Train peer educators. • Target messages and ways of reaching specific groups, such as in-school or out-of-school youth, married or unmarried youth. 	<p>Homework/Individual Exercise (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Distribute the instructions for the proposal. <div data-bbox="1089 653 1230 751" style="text-align: center;">  </div> <ul style="list-style-type: none"> • Instruct Px as follows: In this individual exercise, each participant should develop a one-page strategy proposal to start or improve services for youth for your worksite. The strategy should include elements of prevention, treatment, and outreach tailored to your work situation. It should be as realistic as possible—for example, if the community is not ready to accept offering services to young adults, concentrate on prevention, increasing awareness of STDs, and possibly condom distribution. • Select 3 proposals the following day and ask Px to present them briefly to the group. • Fill in any content material not covered in the discussion. <p>Optional Exercise (40 min.)</p> <p>If expanded emphasis on youth is desired, do this homework in class as a small group exercise, and discuss in class.</p>

Unit 13 Summary

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Unit Summary</p> <ol style="list-style-type: none"> 1. One-third of all STDs occur among 13-20 year-olds. 2. Young women are particularly vulnerable to STDs since they are less likely to have access to health services or to recognize symptoms. 3. Lack of education about sexual health for both boys and girls leaves them ill equipped to protect themselves against unwanted sex, pregnancy, and STDs. 4. A false belief that young people are not sexually active is a barrier to youth services. 5. Youth need services that are friendly and tailored to their special needs. 	<p>Presentation (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit summary. • Distribute Px Manual content for Unit 13.

UNIT 14: REACHING SEX WORKERS

UNIT TRAINING OBJECTIVE:

Develop and discuss strategies to prevent and treat STDs among sex workers within a FP setting.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Define the term “sex worker” and identify the range of women who trade sex.
2. Explain the role of sex workers in the STD/HIV/AIDS epidemic.
3. Identify ways to make services attractive, accessible, confidential, and non-stigmatizing for women at high risk for STDs.
4. Identify treatment strategies to care for sex workers in the clinical setting.
5. Demonstrate how to counsel sex workers on safer sex and negotiating condom use.
6. Identify community strategies to improve the health of sex workers.

SIMULATED SKILL PRACTICE:

None

CLINICAL PRACTICUM OBJECTIVES:

None

TRAINING/LEARNING METHODOLOGY:

- Case study
- Role play
- Discussion

MAJOR REFERENCES AND TRAINING MATERIALS:

- Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: A health guide for women*. Berkeley, California: Hesperian Foundation.

- Ghee, A., D. Helitzer, H. Allen, and M. Lurie. 1997. *The manual for targeted intervention research on sexually transmitted illnesses for the setting of commercial sex*. Arlington, Virginia: AIDSCAP/Family Health International.
- World Bank. 1997. *Confronting AIDS: Public priorities in a global epidemic*. New York: Oxford University Press.
- Family Health International, AIDSTECH. n.d. *AIDS prevention with CSWs: A manual*. Research Triangle Park: Family Health International.

RESOURCE REQUIREMENTS:

- Markers
- Pens
- Flipchart

EVALUATION METHODS:

- Pre- and post-test
- Verbal feedback on discussion and presentations
- Continuous assessment of unit objectives
- Participant reaction form (end of training)

TIME REQUIRED: 3 hours 30 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare the following as transparencies or on a flipchart:
 - 14.2A: Infections Averted per Year by Raising Condom Use
 - 14.3A: At the Clinic
- Prepare the following participant handouts:
 - 14.1A: Case Study
 - 14.3A: Action Plan
- Write the unit objectives on a flipchart.
- Copy the Unit 14 content section (Px Manual) for distribution at the end of the unit.
- Retrieve copies of flowcharts #4 and #5 (Px Handouts 6.2D-E) (S.O. #4).
- Prepare simulation of a clinic visit (2 trainers) (S.O. #5).

Introduction to Unit 14

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Introduction</p> <p>Preventing transmission of STDs among people who have the highest number of partners is the single most effective strategy to reduce the number of new infections within the general population. Women who exchange sex for money, services, or favors on a regular basis are exposed to and can transmit infections at a higher rate than others in the population.</p> <p>Like all sexually active women of reproductive age, these women have RH needs and may come to a FP clinic for services. Providers need skills to help them recognize women at high risk, to welcome them non-judgmentally, and to treat them with the same care as their other clients. Because of their high potential to transmit infections to others, sex workers need effective treatment whenever and wherever they present for care, as well as knowledge and skills to promote condom use with their regular partners and customers. Health workers have a public health role to play in advocating for a policy of 100% condom use for all sex workers and their customers, and in working with the community to make this a reality.</p> <p>Unit Objectives</p> <ol style="list-style-type: none"> 1. Define the term “sex worker” and identify the range of women who trade sex. 2. Explain the role of sex workers in the STD/HIV/AIDS epidemic. 	<p>Presentation (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the unit introduction. • Present the unit objectives using the prepared flipchart.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<ol style="list-style-type: none"> 3. Identify ways to make services attractive, accessible, confidential, and non-stigmatizing for women at high risk for STDs. 4. Identify treatment strategies to care for sex workers in the clinical setting. 5. Demonstrate how to counsel sex workers on safer sex and negotiating condom use. 6. Identify community strategies to improve the health of sex workers. 	

Specific Objective #1: Define the term “sex worker” and identify the range of women who trade sex

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Sex Workers</p> <p>A sex worker can be categorized as anyone who sells sex for money or favors. Many people stereotype sex workers as immoral women who work in brothels and wear suggestive clothing, but women who sell or trade sex are a diverse group. A sex worker may be a young girl or a woman with six children. She may work in a bar or out of her home. She may not categorize herself as a sex worker.</p> <p>Most sex workers are forced into selling sex because they desperately need money. A sex worker may sell sex because she needs money to feed herself or her children. She may be a widow or a divorced woman with no means of support. Or she may need money to pay off debts or to buy drugs. Sex work may provide a higher income than any other work available to an unskilled woman, thus allowing her more time to spend with her family or go to school.</p> <p>What all sex workers have in common is that their work puts them at high risk for STDs. As health workers, it is important to be able to identify these women at risk and give them the care they need in a non-judgmental and compassionate way.</p>	<p>Name Game (10 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to list all the names they can think of for the term “sex worker.” • Write each word on the flipchart. • Discuss the judgments and assumptions associated with each name. <p>Case Study/Discussion (20 min.)</p> <ul style="list-style-type: none"> • Distribute the case study. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Ask for a volunteer to read the story out loud to the group. • Discuss the following: <ul style="list-style-type: none"> ❓ Does N___ fit your definition of a prostitute? Why or why not? ❓ What other choices were available to N___? ❓ What information or services did she need to avoid being infected with HIV? ❓ Why would a woman sell or trade sex? • Supplement answers from the content section. Make sure all content is covered.

Specific Objective #2: Explain the role of sex workers in the STD/HIV/AIDS epidemic

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Sex Workers and STDs</p> <p>Not everyone in the population has the same probability of becoming infected with STDs or transmitting them to others. Sex workers along with intravenous drug users have the highest rates of transmission of HIV. The reasons for the high rates of infection and transmission for sex workers include their high number of sexual contacts, as well as co-factors such as the presence of other STDs, concurrent substance abuse and/or poor health status, and lack of access to health services.</p> <p>In some communities, as many as 9 out of 10 sex workers are infected with HIV. Providing services to sex workers and enabling them to adopt safer behavior can have the greatest impact on slowing STD transmission in the larger community.</p> <p>The Nairobi Experience</p> <p>A highly successful program in Nairobi, Kenya provided free condoms and STD treatment to 500 sex workers, 80% of whom were already infected with HIV. The women had an average of 4 partners per day. Following the interventions, condom use rose from 10 to 80 percent. It was calculated that 10,200 new HIV infections were averted per year. One-third of the prevented cases were expected among clients of the sex workers and two-thirds among the clients' other partners, including their wives.</p>	<p>Trainer Presentation/Discussion (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present content information on “Sex Workers and STDs.” • Show “Infections Averted per Year by Raising Condom Use...” and discuss it. <div data-bbox="1079 779 1230 911" style="text-align: center;">  </div> <ul style="list-style-type: none"> • Describe “The Nairobi Experience” found in the content section. • Discuss the following: <ul style="list-style-type: none"> ❓ Why do sex workers have such high rates of transmission? <p><i>Response: Because they have so many sex partners.</i></p> <ul style="list-style-type: none"> ❓ Why is reaching sex workers important to the health of the general community? <p><i>Response: If STDs are reduced in this population then the chances that sex workers will transmit a STD to their clients, who in turn will transmit a STD to their wives/girlfriends is also reduced. This leads to an overall reduction of STDs in the community.</i></p> <ul style="list-style-type: none"> ❓ What are the obstacles to reaching this at-risk population?

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>In contrast, if condom use had been raised to 80% among 500 men chosen at random from the same community in which the sex workers worked, of which 10% were infected with HIV, and the average man had four partners per year, the intervention would have prevented only 88 new HIV infections per year among the men's partners.¹</p>	<p><i>Response: They are stigmatized, illegal in many places, few services exist, lack of money.</i></p> <ul style="list-style-type: none"> • Summarize the S.O.

¹World Bank. 1997. *Confronting AIDS: Public priorities in a global epidemic*. New York: Oxford University Press.

Specific Objective #3: Identify ways to make services attractive, accessible, confidential, and non-stigmatizing for women at high risk for STDs

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Barriers to Services</p> <p>Though women who trade sex are often at the highest risk for STDs, these women are often the least likely to seek out services. In addition to the barriers to care that affect all women, sex workers often find that services:</p> <ul style="list-style-type: none"> • May be highly stigmatized. The “VD (venereal disease) clinic” providers may judge her harshly as immoral and may treat her badly. • May be located far away. She may need to access services frequently. • Lack confidentiality. Fear that others will know she has a STD may prevent her from seeking care, even if she is very ill. • Are costly. This may make frequent visits or treatment prohibitive. <p>Possible solutions</p> <p>Integration of STD services into the facility where a sex worker comes for family planning may solve some of the problems of stigmatization, cost, and accessibility.</p> <p>Taking services to communities or workplaces of sex workers is another strategy that is working in some countries. In Nigeria and the Republic of South Africa, sex workers and health workers together have organized health services within the brothels and hotels where sex workers work. The Lesedi Project in South Africa has a mobile clinic that visits</p>	<p>Question and Answer (40 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to form the same 3 groups. • Display the transparency. <div data-bbox="1079 745 1230 882" style="text-align: center;">  </div> <ul style="list-style-type: none"> • Ask the groups to discuss the following questions for presentation to the large group. Allow 20 min. for the small group discussion. <ul style="list-style-type: none"> ❓ What do you see happening in the picture? ❓ Why is it happening? ❓ How many of the women in this picture are sex workers? ❓ How do you think the sex worker feels? ❓ What problems does it lead to? ❓ What are the root causes of the problem? ❓ What can be done about it? • The groups should then discuss how they might address these problems. For example, how would they: <ul style="list-style-type: none"> – Make services more attractive to sex workers?

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>neighborhoods where sex workers work.</p>	<ul style="list-style-type: none"> - Improve access for sex workers? - Assure confidentiality? - Decrease the stigma of seeking services? <ul style="list-style-type: none"> • Reconvene the larger group. • One Px from each group should present his/her answers to the larger group. Allow 15 minutes in total. • Trainer should summarize what has been said at the end of the discussion using any content which has not been presented. <p>Homework:</p> <p>Ask Px to write an action plan (300-500 words) incorporating at least two of the above changes into their workplace, including why they chose what they did.</p>

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)



Specific Objective #4: Identify treatment strategies to care for sex workers in the clinical setting

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Providing Care for Sex Workers</p> <p>You can make a big difference in the life of a sex worker by helping her get the care she needs and prevent transmission of STDs to the wider population.</p> <ul style="list-style-type: none"> • Give the same respectful care to sex workers as you give to others. • Always treat a sex worker as high risk. • Learn which medications provide the most up-to-date, effective, and affordable treatment, make sure to keep a supply available. • Find a regular and adequate supply of free or cheap condoms. • Link up with organizations doing social marketing of condoms to make them available at clinics, shops, bars, cafes, and from outreach workers. <p>Presumptive Treatment</p> <p>Sex workers who are not able to demand condom use may benefit from regular treatment with effective drugs, whether they have symptoms or not.</p> <p>Periodic presumptive treatment (the provider presumes that the sex worker has been exposed to infection because of her work and inability to use condoms with every customer) has been shown to be effective in a South African mining community where large numbers of male migrant workers live apart from their</p>	<p>Discussion (20 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to look at <i>Px Handouts 6.2D</i> and <i>6.2E</i> (flowcharts for vaginal discharge). • Review treatment strategies for high-risk patients from Unit 6, including the flowchart and treatment guidelines. • Ask Px the following questions and have a volunteer record answers on a flipchart: <ul style="list-style-type: none"> ❓ What are the disadvantages of such strategies? ❓ Which medications are available in your communities? ❓ How might you help sex workers in the community get the care they need? • Discuss presumptive treatment, using information from the content section.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>families in single-sex hostels. Monthly presumptive treatment, prevention education, and condoms were provided to women at high risk around the mines. After 9 months, rates of all STDs declined among women using the services and condom use with clients increased. Among the miners, prevalence of urethral discharge was decreased by one-third, and genital ulcers fell by almost 80%. In the 1960s in the Philippines, weekly screening and treatment was provided to sex workers for 4 months, after which gonorrhea prevalence fell in the sex workers from 12% to 4%, and the incidence of new infections among the military (their population of casual partners) was cut in half.</p> <p>The advantage of presumptive treatment is that high-risk individuals who may not have symptoms are treated.</p> <p>While such a strategy can have a significant effect on STDs both in sex workers and their partners, it cannot stand on its own. Community interventions which emphasize prevention, condom use in men, and the use of improved STD services should also be part of an integrated strategy.</p>	

Specific Objective #5: Demonstrate how to counsel sex workers on safer sex and negotiating condom use

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Counseling</p> <p>Women at high risk for STDs may not know how to protect themselves or how to negotiate for safer sex. Do not assume that because a woman engages in sex work that she knows everything she needs to know. You may be the only person she meets who can give her the information she needs. The following are suggestions for talking about ways to decrease her risk.</p> <p>To make sex safer she should:</p> <ul style="list-style-type: none"> • Use a new latex condom with each sex act, whether vaginal, anal, or oral, by far the most effective and practical way to protect herself. • Offer hand sex (manual masturbation) or fantasy if a client will not use condoms. • Use a female condom. <p>Warning!</p> <p>Use of spermicides by sex workers and other high-risk groups has been found to increase their rate of infection with HIV. This is presumably because frequent use of spermicides irritates the vaginal lining, allowing the virus to enter the body more easily and probably allowing other STDs to enter as well. There is no other method that offers high protection against all STDs other than the condom.</p>	<p>Discussion/Role Play Demonstration (30 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Discuss counseling sex workers on safer sex and negotiating condom use. • Two trainers should simulate a clinic visit between a health worker and woman who reveals that she is a sex worker. The health worker should ask the patient about her current sexual practices and explain ways to make her practices safer. The role play should focus on a demonstration of how to ask explicit questions and how to give advice without sounding embarrassed, judgmental, or imposing. Give advice from the content section on how to make sex safer. • Ask Px to take notes on the strengths and weaknesses of the role-play and give feedback when it is over. • Ask Px to turn to their neighbors and practice giving one piece of the advice found in the role play, such as providing a customer with hand stimulation of the penis. Allow 5 min. and then reconvene the larger group. • Ask a few of the Px who gave advice and a few who received advice to comment.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>A sex worker should never do the following:</p> <ul style="list-style-type: none"> • Douche with any substance using a douche bag or any device to push liquid into the vagina. This can push bacteria into the upper genital tract and cause infection. Douching washes out the normal secretions of the vagina and increases STD risk. • Wash the genitals with bleach or other harsh chemicals. This can cause drying or ulceration and increase the possibility of STD transmission. • Put drying agents or herbs into the vagina. <p>Refer to the section on safer sex in Unit 8 for more information.</p> <p>Negotiating Condom Use</p> <ul style="list-style-type: none"> • In order to get a man to use condoms, he must believe that it is in his own interest. • Explain to him that condoms can: <ul style="list-style-type: none"> – Protect him as well as you from disease. – Make him less likely to pass on a STD to his wife or other women. – Make his pleasure last longer. • Assure him that sex will still be good for him. • If you practice oral sex, learn how to put condoms on with your mouth. 	

Specific Objective #6: Identify community strategies to improve the health of sex workers

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>By helping sex workers decrease their risk of STDs, the entire community benefits. The following strategies have been shown to reduce STDs in sex workers.</p> <p>Peer Education Programs</p> <p>Peer education programs train sex workers to provide outreach, teaching other sex workers about safer sex, condom negotiation, family planning, and recognition and treatment of STDs. Peer educators can help other sex workers learn how to choose customers and how to handle clients' unwanted demands.</p> <p>Laws That Promote 100% Condom Use</p> <p>In Thailand, the Ministry of Health requires all sex workers to use condoms. If they do not, the brothel can be shut down or charged a fine. This law resulted in an increase in condom use from 14% to 90% in three years. Such laws help sex workers insist on condom use.</p> <p>Literacy and Job Skills Programs</p> <p>Such programs help sex workers improve their lives. When a sex worker has other skills she can leave sex work or at least earn some money doing other jobs. She then has more control over who she has sex with and greater ability to demand condom use.</p>	<p>Group Work (1 hour)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Divide Px into 3 groups. One person in each group should be the recorder. Ask the groups to: <ol style="list-style-type: none"> 1. Discuss the situation of sex workers in their own communities. 2. Share information about any successful outreach programs that target high-risk women. 3. Discuss strategies to reduce STDs in sex workers that might be appropriate and feasible in their own communities. 4. Choose 3 priority interventions and develop a strategy for the implementation of each. • After 30 minutes, reconvene the group and ask the recorder from each group to present findings. • Summarize key points

Unit 14 Summary

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Unit Summary</p> <ol style="list-style-type: none"> 1. A sex worker can be anyone who sells or trades sex for money or favors. 2. All sex workers are at high risk for STDs because they have multiple partners. 3. Providing high quality health care services, especially for STDs, can have the greatest impact on STD transmission in a community. 4. Women at highest risk of STD are often the least likely to seek out health services. 5. Providers need to treat high-risk women with the utmost courtesy and care, and offer them effective treatment at their first visit. 6. Community strategies to improve the health of sex workers will also improve the health of the whole community. 	<p>Presentation (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present unit summary. • Distribute Px Manual content for Unit 14.

UNIT 15: CLINICAL PRACTICUM

PRACTICUM OBJECTIVES

During the clinical practicum, trainees will demonstrate the following:

- Counseling.
- History taking and risk assessment.
- Physical examination, including general (brief), abdominal, visual inspection of external genitalia, speculum and bimanual for women, and exam of male genitalia.
- Diagnosis and treatment using syndromic management.
- Condom demonstration and patient education—individual and group.
- Proper infection prevention practices.

CLASSROOM PRACTICE

Prior to the clinical practicum, each Px is expected to demonstrate competence, based on standardized checklists, with some degree of proficiency in performing the skills outlined above on an anatomic model. In the case of counseling skills, history taking and risk assessment, condom demonstration and education for prevention, Px should demonstrate competence through participation in role play.

PURPOSE OF THE CLINICAL PRACTICUM

- Provide an opportunity for the trainees to receive direct feedback on their performance
- Give trainees the opportunity to discuss problems encountered in the performance of clinical skills
- Provide an opportunity to evaluate and ensure competence in the trainees' performance of clinical skills

To ensure appropriate application of learning from the classroom setting to clinical practice, clinical practicum sessions are an essential part of this training. For consistency in observing clients' rights, all Px should be completely familiar with *Client's Rights During Clinical Training* so that they are respected at all times during the practicum.

LENGTH OF THE PRACTICUM

The practicum should be at least 3 days with ideally some time spent by each Px in a high-risk, high volume setting, for example a STD referral center. Each Px should see as many patients as possible, both male and female. They should demonstrate proficiency in all skills, as well as good provider-client interaction and communication. Some trainees may need more practice than others to become proficient; therefore, it is important to individualize the practicum sessions in order to allow as much practice as each trainee requires.

THE CLINICAL EXPERIENCE

Arrange clinical practice as existing clinic schedules and patient caseloads make possible. If available, Px should follow their national guidelines for syndromic management and include the “4 Cs.” The ideal clinical practicum site is a high volume setting that offers participants frequent repetition of skills. It is also useful to vary Px’s experiences by placing them, for some of the time, in a family planning setting if possible. To further enhance the experience, aim to have the smallest number of trainees possible at each session. If possible, several rooms should be available for the Px, some for exams and others for counseling, so that several Px can be actively practicing their skills at the same time. Other Px can be observing or giving condom demonstrations and/or health prevention talks to patients in the waiting areas. The goal is to frequently repeat skills while being observed by trainers and other Px for maximum feedback; and to diagnose and treat STDs in a setting similar to where Px will be practicing, which for many will be FP/MCH settings. Each Px should see as wide a variety of cases as possible.

The trainer should demonstrate a patient encounter from the greeting to the counseling, the examination, the diagnosis by syndrome, and the prescribed treatment, including comfort measures. Counseling should include prevention for every patient. Each Px must practice each step as well.

The trainer needs to observe each Px closely and may need to intervene if there is any question that the patient is not receiving good care.

In order to maximize experiences, Px should hold group conferences at the end of each clinical practice session. Each Px can use the case study format to present the details of her/his cases back to the group. If the clinical setting is not busy during a practicum visit and if circumstances allow, use clinical practice time to review cases and discuss Px’s questions.

The Trainer: The clinical trainer should be present in the examination room for at least each Px’s first few patient encounters. Ideally, Px should be observed and evaluated during clinical skills practice by the course trainer. At the very least, the trainee should be observed by an experienced provider who has been trained as a clinical trainer. For each clinical site, a provider or providers should also be identified and committed to

providing advice on protocols and second opinions, and receiving referrals of cases beyond the scope of the training. All diagnoses and treatment plans must be reviewed with a clinical trainer before the patient is discharged.

Qualification: The number of patients each trainee will need to see will depend on her/his previous training and experience. There is no ideal number. When anatomical models and role play have been used extensively for skills acquisition, most Px will be judged competent after only a few cases with clients. Proficiency most likely requires additional practice. Both the Px and the clinical trainer determine when the Px is proficient enough to perform clinical skills without supervision. The satisfactory performance of clinical skills should be evaluated by the clinical trainer using the competency-based training (CBT) skills checklists. The trainer will observe and rate each step of the skill or activity. The participant must attain a satisfactory rating on each skill or activity to be evaluated as competent.

RESOURCES NEEDED FOR PRACTICUM EXPERIENCE

Depending on the number of participants and the number of clinical sites, other trainers/preceptors may have to be identified. These may be drawn from the sites themselves. These trainers need to be thoroughly informed of the skills part of the curriculum to fill their roles as observers, trainers, and evaluators.

The sites may not have all or any of the materials needed for the practicum. This should be known well in advance so that the trainers and participants can bring materials with them.

1. National guidelines for syndromic management of STDs, if available
2. Water and soap for handwashing
3. Clean gloves
4. HLD or sterile specula
5. Decontamination solution and buckets for used specula
6. Lubrication or water for speculum insertion
7. Signed prescriptions for participants
8. Light source/torch (flashlight)
9. Cloth drapes (or use patient's clothing)
10. Pens or pencils and paper for history taking and presentation of cases later
11. Patient encounter forms/records

APPENDIX

TRAINING GUIDE

INFECTION PREVENTION IN STD MANAGEMENT

UNIT TRAINING OBJECTIVE:

Describe and demonstrate the principles and procedures of infection prevention in the management of STDs, including use of protective barriers, hand washing, waste disposal, cleaning, and processing instruments for reuse.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Demonstrate infection prevention procedures for the provider
2. Demonstrate how to process instruments for reuse

SIMULATED SKILL PRACTICE:

Return demonstration

CLINICAL PRACTICUM OBJECTIVES:

Participants will be able to demonstrate good understanding of infection prevention principles and procedures through class discussion and return demonstration, and during the clinical practicum.

TRAINING/LEARNING METHODOLOGY:

- Discussion
- Video
- Demonstration of practices and procedures
- Clinical practicum

MAJOR REFERENCES AND TRAINING MATERIALS:

- Solter, Cathy. 1997. *Module 2: Infection prevention*. Watertown, MA: Pathfinder International.
- Tietjen, L., W. Crown, and N. McIntosh. 1992. *Infection prevention for family planning service programs*. n.p.: JHPIEGO.

RESOURCE REQUIREMENTS:

- Newsprint
- Marking Pens
- Flipchart
- Video and video player. Infection Prevention for Family Planning Service Providers. JHPIEGO
- Sterile or HLD gloves

Optional:

- Soap, antiseptic soap solution, soft brush, and water for handwashing.
- Mask, goggles, gown, apron, and other barriers.
- Chlorine for decontamination, plastic or enamel pails or basins, measuring cup, cleaning brush, utility gloves, instruments, HLD container, pickup forceps and dry container, storage container with tightly fitting lid, metal pot for boiling, sterile drape, gluteraldehyde, formaldehyde, and other common, locally available solutions for HLD and sterilization.

EVALUATION METHODS:

- Observation during return demonstration
- Observation during clinical practicum

TIME REQUIRED: 3 hours 25 minutes; with optional exercise, 3 hours 50 minutes

WORK FOR TRAINERS TO DO IN ADVANCE

- Obtain video, Infection Prevention for Family Planning Service Providers, JHPIEGO, and video player and monitor.
- Gather materials for infection prevention demonstration/return-demonstration.
- Copy the following participants handouts:
 - IP1A: Recommended Dilutions of Chlorine-releasing Compounds
 - IP1B: Recommended Dilutions of Sodium Hypochlorite (Bleach)
 - IP1C: Formulas for Preparing Dilute Chlorine Solution
 - IP2: High-level Disinfection (HLD) for Instruments
 - IP3: Prevention Message

Specific Objective #1: Demonstrate infection prevention procedures for the provider

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Infection Prevention</p> <p>Infection prevention is vitally important to prevent disease transmission in the clinical setting and minimize risk to patients, health care workers, and the community. When working with RTI patients, in a clinical setting, the biggest risk to the patient is from infection from poorly processed instruments or from a provider who is not using good infection prevention practices.</p> <p>(See Pathfinder's <i>Module 2: Infection Prevention</i> for more information.)</p> <p>In this section, participants will be introduced to infection prevention procedures, including protective barriers, the use of sterile gloves, antiseptics, safe waste disposal, and the correct processing of equipment.</p> <p>Who is at risk of acquiring an infection in a health care facility?</p> <p>Clients may become infected through:</p> <ul style="list-style-type: none"> • Contaminated equipment that is not processed correctly (needles, speculum, etc.). • Providers' unwashed hands or contaminated gloves. <p>Staff (both service providers and housekeeping personnel) may become infected through:</p> <ul style="list-style-type: none"> • Contaminated equipment that is not processed correctly. 	<p>Trainer Presentation/Discussion (15 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask the following questions: <ul style="list-style-type: none"> ❓ What are some of the general infection prevention problems you see in your clinics? ❓ Who is at risk of acquiring an infection from any health care facility and how might the infection be acquired? • Using the content section on the left hand side of the page, describe how infections may be transmitted to clients, staff and the community. • Explain what protective barriers are. • Discuss the use of protective barriers to prevent the transmission of infection.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • Splashes of blood or other bodily fluids. • When the provider’s broken skin (chapped, cut, rash, or fungal infection) is exposed to infection. This can happen while cleaning a procedure room, caring for a client or working with contaminated equipment. • Not using the “no hands” method for needle recapping, or not disposing of sharps in appropriate containers. • Not wearing protective barriers such as gloves, goggles, masks, etc. <p>The Community may be infected through:</p> <ul style="list-style-type: none"> • The improper disposal of medical waste such as sharps and contaminated dressings which can be found by children. • An infected staff member bringing the infection home to family or community. <p>Protective Barriers</p> <p>Placing a physical, mechanical, or chemical “barrier” between microorganisms (such as bacteria, viruses, or endospores) and an individual is an effective way of preventing the transmission of infection. Protective barriers include:</p> <ul style="list-style-type: none"> • Handwashing. • Use of mechanical barriers such as gloves, eye protection, or gowns. 	<p>Discussion/Demonstration (30 min.)</p> <ul style="list-style-type: none"> • Discuss handwashing. Ask why it is important and who needs to do it. • Ask how staff can be encouraged to wash their hands at appropriate times in a busy clinic. • Ask how hands can be dried in a busy clinic or between each procedure (air drying, alcohol swabs, personal towels). • Ask one Px who feels very competent to demonstrate proper handwashing technique following the steps in the “How to Wash” content column. • Demonstrate how to prepare a glycerin and alcohol solution. • Discuss the difference between surgical scrub and routine handwashing. <p>Video (10 min.)</p> <ul style="list-style-type: none"> • Show the introduction and the first 3 Training Demonstration Segments (TDS) of the videotape <i>Infection Prevention for Family Planning Service Providers</i>. • Review and summarize the video by asking the following questions: <ul style="list-style-type: none"> ❓ How long should normal handwashing take? ❓ How long should surgical hand scrub take? ❓ Is running water available in your facility? Can you do proper

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<ul style="list-style-type: none"> • Use of chemical barriers such as antiseptics for cleaning wounds or skin prior to surgery. • Safe waste disposal. • Decontamination and correct processing of instruments and linen. • Protection from sharp instruments. • Ensuring that cleaning supplies are available in exam room, i.e. soap, clean towels, and water. <p>Handwashing</p> <p>(See Specific Objectives 5 and 6 in Module 2 for more information and details.)</p> <ul style="list-style-type: none"> • Handwashing is the single most important step in preventing infection, because we touch surfaces with our hands and then touch our face—eyes, nose, mouth—carrying microorganisms into the body. <p>When to Wash</p> <ul style="list-style-type: none"> • Before putting on gloves • Immediately after removing gloves • After any possible contamination <p>How to Wash</p> <p>Providers should not wear nail polish and should remove all jewelry. Jewelry and nail polish offer protection to microorganisms and can even carry microorganisms.</p>	<p>handwashing if there is no running water? How?</p> <p>❓ Do you reuse gloves in your facility? How do you process them? How many times can you reuse them?</p>

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • Turn on the water from the tap. Avoid splashes. • If there is no running water, use a dipper to pour water on the hands at the beginning and when rinsing. • Position the hands and wrists downward as you wet them so that the water flows down and away from the elbows. • Soap the hands. • Hold the bar with two fingers on the edges, and rinse it before placing it back in the soap dish. • Avoid touching the sink or soap dish, as they are probably contaminated. • Wash hands for 10–15 seconds. • Use a soft brush or thick stick to clean nails at the beginning and end of the clinic session, and any time that they become dirty during the session. • Point hands down when rinsing them with running water so that water does not go on the arms. • Air dry hands or dry them with an unused, dry portion of a clean cotton towel. This towel should not be used by others. • Hold the towel or a paper towel over the faucet to protect your clean hands from touching the faucet. 	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>If Clean Water Is Not Available:</p> <p>Clean hands with isopropyl or ethyl alcohol 70%. Keep a covered container of alcohol swabs ready for use. Alcohol makes the skin dry, but lotion can be applied at the end of the session. Do not use lotion after every cleaning of the hands with alcohol because it is contaminated with microorganisms.</p> <p>A non-irritating alcohol solution can be made by adding either glycerin, propyl glycol, or Sorbitol® to the alcohol (2ml in 100ml 60-90% alcohol solution).</p> <p>Use of Mechanical Barriers</p> <p>Wear gowns, aprons, goggles, and gloves whenever providing patient care that involves blood or body fluids, and whenever handling bloody items, such as instruments, sheets, etc.</p> <p>Gloves</p> <p>Use high-level disinfected exam gloves (or surgical gloves) for patient exams and MVA procedure.</p> <p>Make sure gloves have no holes or cracks. Wash hands and change gloves between patient contacts and after pelvic or rectal exams.</p> <p>Use clean, heavy utility gloves when cleaning instruments, equipment, tables, and rooms.</p> <p>When putting on sterile gloves, be careful not to touch the outer glove surface.</p>	<p>Optional Exercise/Demonstration (30 min.)</p> <p>The trainer may:</p> <ul style="list-style-type: none"> • Demonstrate the use of masks, aprons, goggles, and other barriers. Discuss and use items which are locally available. • Demonstrate putting on and taking off gloves and proper glove use for procedures and instrument processing.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>When rolling gloves off, keep your hands above your waist to prevent contamination from microorganisms moving down your arms and to keep microorganisms or body fluids on the gloves from touching another part of your arms or body.</p> <p>Note: After using gloves during a pelvic (bimanual) exam, the provider cannot use the same gloves to touch sterile instruments. Remove the gloves, wash hands, and put on another pair. If using reusable gloves, put the gloves in a decontamination solution.</p> <p>Protection From Sharp Instruments</p> <p>Injuries from sharp instruments are the most common way that HIV and HBV are transmitted in health care situations.</p> <p>To protect from needlesticks and other injuries:</p> <ul style="list-style-type: none"> • Keep handling of sharp instruments to a minimum (pass these on a tray). • Always have puncture-proof container for sharps within reach. • If you must recap a needle, use the "no hand" method. <p>If you do get a needlestick or other injury:</p> <ul style="list-style-type: none"> • Remove gloves and wash wound immediately with soap and water. Treat needle stick injuries according to local protocol, and inform clinic or hospital management that an injury has occurred. 	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>If blood or body fluids splash in eyes:</p> <ul style="list-style-type: none"> Wash eyes thoroughly with clean water or saline solution. Treat according to local protocol, and inform management. <p>Waste Disposal</p> <p>Waste materials generated at a facility may be either contaminated or non-contaminated. Non-contaminated waste does not pose any risk of injury or infection. It is the same kind of waste generated at home. It includes paper, trash, boxes, bottles, plastic containers, or trash from the kitchen.</p> <p>Contaminated waste is waste that could injure or infect staff. It may be medical waste generated from the clinical procedures done in the facility. It may include blood, pus, urine, feces or other body fluids. It may be on objects such as needles, bandages, laboratory supplies, or supplies used during surgery or to do procedures in a patient's room. Contaminated waste also includes items that might cause injury, such as used needles or scalpel blades. It may be chemical waste that is poisonous or potentially toxic such as cleaning products, drugs, or radioactive material</p> <p>Disposing of Sharp Objects (Needles, Razors, and Scalpel Blades)</p> <ul style="list-style-type: none"> Dispose of all sharps in a puncture-resistant container such as a heavy plastic or glass container. 	<p>Discussion (15 min.):</p> <ul style="list-style-type: none"> Lead a discussion on the difference between non-contaminated waste and contaminated waste. Ask Px what happens to needles immediately after use in their facility. Discuss containers that can be used for needle disposal. Ask Px if they know where the waste generated in the hospital or clinic goes after it leaves the facility or how it is disposed of. Ask Px to discuss the current procedures used in sorting, handling, and disposing of trash. If possible, go with Px to see areas in and around the facility where waste is disposed of. Discuss the proper disposal of sharp objects, liquid contaminated waste, solid waste, and disposing of used chemical containers.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • If possible, fill the container partially full with a 0.5% chlorine solution. This solution will rapidly kill HBV and HIV. • Keep the containers near areas where procedures are conducted so staff doesn't have to go far to dispose of needles or blades. • Be sure the containers are labeled. • When the container is $\frac{3}{4}$ full, close it securely and dispose of it. • Always wear heavy gloves when disposing of waste. • If the hospital has a large incinerator, the sharps may be burned. If there is no incinerator, dispose of the sharps by burying them. • Wash hands after handling the sharps container. <p>Disposal of Contaminated Liquid Waste</p> <ul style="list-style-type: none"> • Always wear heavy gloves when handling or transporting liquid waste. • When transporting liquid waste, cover it to avoid splashing. • Carefully pour the waste down a utility sink, toilet, or sluice. Avoid splashing. • After pouring out waste, carefully rinse toilet or sink with water. • If a container is to be used again, such as a specimen bottle, decontaminate it with 0.5% chlorine before cleaning it. • Wash your hands after disposing of contaminated liquid waste. 	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Disposal of Solid Waste</p> <ol style="list-style-type: none"> 3. Wear heavy gloves when handling or transporting solid waste. 4. Dispose of solid waste in a washable container with a tightly fitting cover. 5. Keep enough containers accessible so staff always has them available to throw away solid waste. 6. Collect containers on a regular basis and transport them to the incinerator. 7. Wash hands after handling waste. <p>Disposing of Used Chemical Containers</p> <ol style="list-style-type: none"> 1. Wearing heavy gloves, rinse the glass containers thoroughly with water and wash them with detergent. Dry and reuse. 2. For plastic containers that were used to store toxic substances like Cidex, rinse them 3 times and dispose of them by burying. Never reuse these containers. <p>Adapted from: Tietjen L, W. Crown, N. McIntosh. 1992. <i>Infection prevention for family planning service programs</i>. n.p.: JHPIEGO.</p> <p>Cleaning Room and Exam Table: When and How to Clean the Procedure Room</p> <p>Total cleaning of the procedure room should be done at the end of each day. Total cleaning is not necessary between each case. However, between each client or procedure, certain decontamination procedures should be followed.</p>	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Cleaning Between Each Client or Procedure</p> <ul style="list-style-type: none"> • Always wear heavy utility gloves when cleaning the operating room or procedure room. • Using a 0.5% chlorine solution, decontaminate instruments, examination tables, trolleys, or Mayo stands, countertops, lamp handles, and anything which might be potentially contaminated. • Clean up any blood or body fluid spills with 0.5% chlorine solution. For large spills, flood the area with 0.5% chlorine solution. Mop up solution, and then mop as usual with a disinfectant cleaning solution. • Clean any visibly soiled areas of the floor with a mop soaked in a disinfectant cleaning solution. • Remove any contaminated gowns or linen, transporting them in a leak-proof bag or a clean linen bundle with contaminated linen on the inside. • Remove the contents of the decontamination bucket after 10 minutes and clean the equipment. If the solution is heavily contaminated, mix a fresh solution. <p>Total Cleaning Done at the End of the Day</p> <ul style="list-style-type: none"> • Remove the decontamination bucket and decontaminated equipment for cleaning. • Remove any contaminated waste, and 	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>burn or bury it as soon as possible.</p> <ul style="list-style-type: none"> • Wipe down all surfaces with a disinfectant cleaning solution. • Clean floors with a mop dampened with a disinfectant cleaning solution. Never dry mop or sweep. 	<p>Discussion (10 min.)</p> <p>Discuss when and how to clean the procedure room using the steps found in the content section. Note the difference between the cleaning done between each client and procedure and the total cleaning done at the end of each day.</p> <ul style="list-style-type: none"> • Ask Px who does this cleaning in their facility and whether any training has been given to personnel doing the cleaning. • Ask if the personnel doing the cleaning are supervised to be sure they are practicing the correct procedures.

Specific Objective #2: Demonstrate how to process instruments for reuse

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Procedures for Reuse of Instruments</p> <p>This section of the module will outline the procedures for reuse of instruments. These procedures need to be followed closely to protect health workers and their patients from the spread of infection.</p> <p>Many microorganisms (such as the HBV virus) can live in dry blood. Local or general infections can be caused by bacteria, fungi, or parasites. HIV and hepatitis are caused by viruses. Tetanus and gangrene are caused by bacterial endospore.</p> <p>If instruments are not properly cleaned and disinfected, blood in the crevices of syringes, tenacula, etc. can dry and flake off on a patient or onto a health worker the next time the instruments are used.</p> <p>Instruments must be processed safely in order to protect doctors, nurses, housekeeping staff, and patients from infection.</p> <p>Safe processing of instruments does not require expensive, high-tech equipment.</p> <p>The 4 Steps in Processing Instruments</p> <ol style="list-style-type: none"> 1. Decontamination 2. Cleaning with detergent and water 3. High-Level Disinfection (HLD) or sterilization 4. Safe storage and reassembly of instruments 	<p>Video, Discussion, and Demonstration (2 hours)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Discuss the purpose of safe instrument processing, including definitions of the 4 steps in processing instruments. • Show the remaining portions of the JHPIEGO video on Infection Prevention for Family Planning Programs. • If there is no video available, demonstrate the 4 steps in instrument processing. • If time permits, show all segments and include some of the discussion questions found in the booklet that accompanies the video. • Demonstrate decontamination, cleaning, and if possible, high level disinfection and chemical sterilization. Ask Px to return the demonstration. • Lead a discussion on changes in current local protocols required to institute the guidelines for instrument reuse. Consider the availability of supplies, obstacles to be overcome, possible solutions to shortages, etc. • Review the appropriate instructions and dilutions for preparing a chlorine solution for decontamination. Refer to the handout <i>Recommended Dilutions of</i> <div style="text-align: center;">  </div>

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Decontamination makes soiled objects safer to touch. It kills HBV and HIV.</p> <p>Cleaning removes up to 80% of the microbes on the equipment.</p> <p>High-level disinfection destroys all bacteria, viruses, fungi, parasites, and some endospores (up to 95% of microbes).</p> <p>Sterilization destroys all microorganisms, including all endospores.</p> <p>Proper storage of HLD or sterile instruments is essential to prevent recontamination. HLD or sterile instruments must be stored safely in a HLD container or sterile container with a tight-fitting cover.</p> <p>Steps Involved in Processing Instruments, Gloves, and Other Items</p> <p>Step 1: Decontamination</p> <p>Decontamination is the first step in handling used (soiled) instruments and gloves. Instruments contaminated with body fluids, especially blood, from one client must be decontaminated before being cleaned and high-level disinfected or sterilized. These include uterine sounds, tenacula, specula, etc. Decontamination is done to protect personnel who must handle the instruments.</p> <p>Supplies needed for decontamination include water, a plastic or enamel pail, and chlorine.</p>	<ul style="list-style-type: none"> • <i>Chlorine-Releasing Compounds and Recommended Dilutions of Sodium Hypochlorite</i> to determine the type of chlorine available in the country and the concentration required. • Distribute the procedures for high-level disinfection and sterilization of equipment.  <ul style="list-style-type: none"> • Process this specific objective by exploring with Px which procedures are feasible and appropriate in the Px's site. • Answer any questions Px may have. • Review with Px the objectives and content of the session.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Procedures for Decontamination</p> <ul style="list-style-type: none"> • Wear protective gloves. (Keep a separate set of gloves for decontamination.) • Submerge all instruments, in a 0.5% chlorine bleach solution for 10 minutes. To prevent metal corrosion (rust), do not submerge for more than 20 minutes. • This step should be performed immediately after a procedure. Use a plastic container for this, and keep it next to the treatment table. • Reusable needles and syringes should be filled with 0.5% chlorine solution. Draw in and expel the solution several times. The syringe and needle should be soaked in solution for 10 minutes. • Disposable needles should be placed in puncture-resistant containers. These can be made of quart or liter size plastic or glass containers. Label these containers clearly and keep them close to the examining table. A 0.5% chlorine solution may be put in the container. Chlorine both decontaminates needles and eventually rusts them, making them unusable and no longer dangerous. • Remove the reusable item(s), rinse them immediately with cool water to prevent rust, and clean following the steps outlined below. • When removing items from the decontamination solution, use gloves or a strainer bag to avoid contact with skin. 	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • Change the solution at least once a day or more often if it looks dirty or cloudy. <p>Step 2: Cleaning</p> <ul style="list-style-type: none"> • Always wear heavy rubber or plastic utility gloves during cleaning. <p>Washing Equipment</p> <ul style="list-style-type: none"> • Instruments should be cleaned with a brush in soapy water. Pay special attention to instruments with teeth, joints or screws, where organic matter can collect. <p>Rinsing and Drying Equipment</p> <ul style="list-style-type: none"> • After washing, rinse equipment thoroughly with clean water. • Dry by air or with a clean towel. <p><i>Depending on the available means of infection control at your clinic, perform the following high level disinfection or sterilization routines.</i></p> <p>Step 3: HLD/Sterilization</p> <p>All clean, dry instruments should be either high level disinfected or sterilized.</p> <p>High-Level Disinfection (HLD)</p> <p>High-level disinfection destroys all microorganisms except for some endospores. Objects that have undergone HLD are safe to touch broken skin or intact mucous membrane.</p>	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>HLD by Boiling</p> <ul style="list-style-type: none"> • Fill a large pot $\frac{3}{4}$ full of clean water and put it on a stove or fire. • Place equipment in boiling water. Bring to boil again. Boil for 20 minutes. • Remove the equipment with HLD forceps. Tip the instruments so the water drains out. Air dry on disinfected surface <p>Chemical High-Level Disinfection</p> <ul style="list-style-type: none"> • Follow instructions to mix 0.1% solution of chlorine or 2% glutaraldehyde (Cidex). • Submerge clean, dry items in a non-metal container for 20 minutes. Remove with HLD forceps, and rinse with boiled water. • Let the instruments air dry on HLD surface. • Change solution at least every day. <p>Important Things to Remember:</p> <ul style="list-style-type: none"> • Tap water should never be used for rinsing because it is contaminated. • HLD items must be rinsed in boiled water to remove the residue left by the chemical disinfectant. • Never store instruments in solutions such as Savlon, alcohol, iodine, or boiled water because the liquids easily become contaminated. 	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<ul style="list-style-type: none"> • Low-level disinfectants or antiseptics such as Phenol, Savlon, or Hibitane, will not kill microbes on instruments and must <u>not</u> be used for disinfection. <p>Storage of High-Level Disinfected Equipment</p> <ul style="list-style-type: none"> • Store HLD instruments in a dry HLD container with a tight fitting lid for up to one week. • Storage of instruments should be carefully designed to protect their disinfection. Store equipment off the floor in enclosed shelves away from dust and moisture. • A HLD container can be prepared by boiling the container for 20 min. or soaking the container in 0.5% chlorine solution for 20 min., and rinsing thoroughly with boiled water. <p>Removing Instruments from Storage</p> <ul style="list-style-type: none"> • Keep instruments in small quantities in each container. • Use HLD forceps to remove instruments. <p>Sterilizing Instruments</p> <p>Chemical Sterilization</p> <ul style="list-style-type: none"> • Whenever using chemical sterilization, make sure items are completely submerged and that the solution fills the inside of instruments. 	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • Once timing has begun do not add or remove any items until the time is up. • Instruments may be sterilized using either 2% glutaraldehyde (Cidex) or formaldehyde 8%. <p>Using 2% Glutaraldehyde (Cidex)</p> <ul style="list-style-type: none"> • Glutaraldehyde works best at warm temperatures. Follow manufacturer's instructions for mixing. • Soak the instruments for 10 hours, remove with sterile forceps, rinse with sterile water, and air dry. • The glutaraldehyde solution lasts up to 14 days. • Note: Glutaraldehyde is irritating to skin, eyes and respiratory tract. Wear gloves, limit your exposure time and keep the area well ventilated. <p>Using 8% Formaldehyde</p> <ul style="list-style-type: none"> • Never dilute formaldehyde with chlorinated water. This will produce a highly toxic gas. • Soak the instruments in 8% formaldehyde for 24 hours for sterilization, remove with sterile forceps, rinse with sterile water, and air dry the cannulae. • Formaldehyde solution will last 14 days after activated. • Note: Formaldehyde produces toxic vapors and is potentially cancer-causing. It must be used only in well-ventilated areas while wearing gloves. Limit exposure time. 	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Important Points to Remember</p> <ul style="list-style-type: none"> • Items must be rinsed in sterile water following sterilization to remove the residue that chemical sterilants leave on instruments. This residue is toxic to skin and tissues. <p>Heat Sterilization</p> <p>Either an autoclave (steam under pressure) or an oven (dry heat) is necessary for heat sterilization.</p> <p><i>Procedures for Operating an Autoclave or Pressure Cooker</i></p> <ul style="list-style-type: none"> • Decontaminate, clean, and dry the instruments to be sterilized. • Disassemble the items as much as possible for best steam penetration. • Wrap needles and sharp edges in gauze to prevent dulling them. • Strictly follow the directions supplied by the manufacturer for operation of the autoclave or pressure cooker. • Loosely wrap instruments in a double layer of muslin or newsprint to allow steam to penetrate. Don't tie the instruments tightly together with rubber bands or by other means. • Arrange the packs so air can circulate and steam can penetrate all surfaces. • Heat water until steam escapes from the pressure valve only, and then turn down the heat enough to keep steam coming out of the pressure valve only. Don't allow it to boil dry. 	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • The temperature should be at 121°C (250°F); the pressure should be at 106 kPa or 15 lbs/in²; sterilize wrapped objects for 30 minutes or unwrapped objects for 20 minutes. • After turning off the heat source, wait 20—30 minutes until the pressure gauge reads zero. • Open the lid and let the packs dry completely (about 30 minutes) before removing. (Damp packs act like a wick to draw in bacteria, viruses, and fungi.) • Remove packs and store on sterile trays padded with paper or linen. • Packs may be stored up to one week if kept dry. They may be stored up to a month if sealed in a plastic bag (date the bag). Unwrapped objects must be used the same day. <p>Storage of Sterile Equipment</p> <ul style="list-style-type: none"> • Store dry sterile equipment in a sterile container with a tight fitting lid. As long as the container is not contaminated, the instruments will remain sterile for up to 7 days. Reprocess the equipment after 7 days if not used. <p>Removing Instruments from Storage</p> <ul style="list-style-type: none"> • Keep instruments in small quantities in each container. • Use only sterile forceps to remove sterile equipment. Remove the cannula by the non-aperture end. 	

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<ul style="list-style-type: none"> • Avoid touching the rest of the cannula. • Forceps used to pick up sterile cannula must be sterilized daily and stored dry in a sterile forceps jar. • Storage containers, forceps, and the forceps jar may be sterilized by dry heat, steam heat, or by chemical sterilization 	

Unit Summary

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Summary</p> <ol style="list-style-type: none"> 1. Infection prevention is vitally important to in preventing disease transmission to clients, staff, and the community. 2. Handwashing is the single most important element of infection prevention in the clinical setting. Other barriers must be used appropriately 3. Improper cleaning of procedure rooms, unsafe disposal of sharps and syringes, and improper waste disposal can put clients, staff, and the community at risk. 4. Proper instrument processing for re-use consists of correct time, strength of solution, and handling for decontamination, cleaning, HLD, and sterilization. 	<p>Presentation (5 min.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Present the prevention message and post it on the wall. <div style="text-align: center;">  </div> <ul style="list-style-type: none"> • Present the unit summary. • Distribute Px Manual content for Infection Prevention unit.



IP1A: Recommended Dilutions of Chlorine-Releasing Compounds

Available chlorine required	Dirty condition (e.g., blood spills, soiled equipment), or dilution made with contaminated water	Clean condition (e.g., cleaned medical equipment)
	0.5% (5g/litre, 5000 ppm)	0.1% (1 g/litre, 1000 ppm)
Sodium hypochlorite solution	see table on previous page	20 ml/litre, if starting with 5% available chlorine
Calcium hypochlorite (70% available chlorine)	7.0 g/litre	1.4 g/litre
NaDCC (60% available chlorine)	8.5 g/litre	1.7 g/litre
NaDCC-based tablets (1.5 g of available chlorine per tablet)	4 tablets/litre	1 tablet/litre
Chloramine (25% available chlorine)	20 g/litre*	20 g/litre*

* Chloramine releases chlorine at a slower rate than do hypochlorites. Therefore, a higher available chlorine concentration is required of chloramine solutions for the same effectiveness. On the other hand, chloramine solutions are not inactivated by biological materials (e.g., protein and blood) to the same extent as hypochlorites. Therefore, a concentration of 20 g/litre (0.5% available chlorine) is recommended for both clean and dirty conditions.

Source: World Health Organization. 1989. *Guidelines on sterilization and disinfection methods effective against human immunodeficiency virus (HIV)*. 2nd edition. WHO AIDS Series 2. Geneva.



IP1B: Recommended Dilutions of Sodium Hypochlorite (Bleach)

Dilution is necessary when using a pre-made bleach solution because bleach sold by commercial brands is more concentrated than 0.5%. The following chart shows how to obtain **0.5%** solution from pre-made solutions.

Brand of Bleach (Country)	Percent Available Chlorine	Dilution Necessary to Achieve 0.1% Concentration (for high level disinfection of cannulae)	Dilution Necessary to Achieve 0.5% Concentration (for decontamination, blood spills, soiled equipment)
JIK (Africa), Robin bleach (Nepal), Ajax (Jamaica)	3.5%	1 part bleach to 34 parts water, or 30 ml bleach to 1 liter water	1 part bleach to 6 parts water, or 160 ml bleach to 1 liter water
Household bleach, Clorox (USA, Canada), ACE (Turkey), Jif, Red & White (Haiti), Odex, (Jordan), Eau de Javel (France, Viet Nam) (15° chlorum**), Clorox (Peru)	5%	1 part bleach to 49 parts water, or 20 ml bleach to 1 liter water	1 part bleach to 9 parts water, or 110 ml bleach to 1 liter water
Blanqueador, cloro (Mexico), Hypex (Jordan)	6%	1 part bleach to 59 parts water, or 17 ml bleach to 1 liter water	1 part bleach to 11 parts water, or 90 ml bleach to 1 liter water
Lavandina (Bolivia)	8%	1 part bleach to 79 parts water, or 13 ml bleach to 1 liter water	1 part bleach to 15 parts water, or 70 ml bleach to 1 liter water
Chloros (UK), Liguria (Peru)	10%	1 part bleach to 99 parts water, or 10 ml bleach to 1 liter water	1 part bleach to 19 parts water, or 50 ml bleach to 1 liter water
Extrait de Javel (France) (48° chlorum**), Chloros (UK)	15%	1 part bleach to 149 parts water, or 7 ml bleach to 1 liter water	1 part bleach to 29 parts water, or 30 ml bleach to 1 liter water

** In some countries, the concentration of sodium hypochlorite is expressed in chlorometric degrees (° chlorum); 1° chlorum is approximately equivalent to 0.3% available chlorine.

Source: Tietjen, L., W. Cronin, and N. McIntosh. 1992. *Infection prevention for family planning service programs*. Baltimore: JHPIEGO.



IP1C: Formulas for Preparing Dilute Chlorine Solution

Using Liquid Bleach

Chlorine in liquid bleach comes in different concentrations. You can use any concentration to make a 0.5% dilute chlorine solution using the following formula:

% chlorine in liquid bleach
 _____ - 1 = Total parts of water for each part bleach

% chlorine desired

Example: To make a 0.5% chlorine solution from 3.5% bleach.

3.5% chlorine bleach
 _____ - 1 = [7] - 1 = 6 parts bleach to 1 part water

0.5% chlorine desired

Therefore: Add 1 part bleach to 6 parts water to make a 0.5% chlorine solution.

Using Bleach Powder (such as calcium hypochlorite 35%)

Using bleach powder, calculate the ratio of bleach to water by using the following formula:

% chlorine desired
 _____ x 1,000 = Number of grams of powder for each liter of
 water

% chlorine in bleach powder

Example: To make a 0.5% chlorine solution from calcium hypochlorite powder containing 35% active chlorine.

0.5% chlorine desired
 _____ x 1,000 = 0.0143 x 1,000 = 14.3

35% chlorine in bleach powder

Note: When using bleach powder the solution often looks cloudy and the smell is not as strong as it is when liquid bleach is used.



IP2: High-level Disinfection (HLD) of Instruments

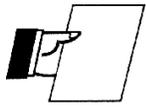
High-Level Disinfection (HLD) of Instruments							
Equipment	Disinfecting Agent	Advantages	Disadvantages	Solution Strength	Minimum Time Required for Disinfection	Steps	Precautions
Metal Instruments	Boiling water	Easily available; will provide HLD up to 5,500 meters (18,000ft.)		N/A	20 minutes at rolling boil	Fill large (at least 25 cm/10" diameter) pot ¾ full with clean water; deposit instruments; cover pot; bring to boil again; boil for 20 minutes; remove items gently with HLD forceps; air dry on a HLD tray or in a HLD container.	Remove instruments immediately after boiling. Do not leave instruments in water or they will rust.
Metal Instruments	Glutaraldehyde (2-4%)	Not easily inactivated by organic materials	Skin, eye, respiratory irritant	Use full strength - never dilute; follow manufacturers' instructions for mixing	20 minutes	Submerge items completely, making sure solution fills the interior, soak; remove with HLD forceps; rinse with boiling water, air dry on a HLD tray or in a HLD container.	Discard solution (7 to 28 days) after mixing or sooner if cloudy (follow manufacturers instructions).
Non-metal Instruments or equipment	Chlorine (0.1%)	Fast-acting, very effective against HBV and HIV	Corrosive to metal	Dilute to 0.1% for clean equipment using boiled water; 0.5% if tap water used	20 minutes	Submerge items completely in a non-metal container, making sure solution fills cannula interior; soak; remove with HLD forceps; rinse with boiled water; air dry on a HLD tray or in a HLD container.	Change solution daily or sooner if cloudy.
Non-metal Instruments or Equipment	Hydrogen Peroxide (6%)	Not easily inactivated by organic materials	Corrosive to copper, aluminum, zinc and brass; inactivated by prolonged exposure to heat (over 30°C) or light	Mix 1 part 30% hydrogen peroxide with 4 parts boiling water to make 6% solution	30 minutes	Submerge items completely in a non-metal container, making sure solution fills cannula interior; soak; remove with HLD forceps; rinse with boiled water; air dry on a HLD tray or in a HLD container.	Store hydrogen peroxide in opaque container away from light and heat. Change solution daily or sooner if cloudy.

High-Level Disinfection (HLD) of Instruments

Equipment	Disinfecting Agent	Advantages	Disadvantages	Solution Strength	Minimum Time Required for Disinfection	Steps	Precautions
Metal Plastic or Rubber	Formal- dehyde (8%)	Not easily inactivated by organic materials	Vapors toxic; skin, eye, respiratory irritant	Dilute 1 part commercial formaldehyde (35-40%) with 4 parts boiled water to make 8% solution	20 minutes	Submerge items completely, making sure solution fills the interior, soak; remove with HLD forceps; rinse with boiling water, air dry on a HLD tray or in a HLD container.	Use only in well-ventilated area. Do not dilute with chlorinated water - this produces toxic gas. Discard solution after 14 days or sooner if cloudy.

Sterilization of Instruments

Equipment	Sterilizing Agent	Advantages	Disadvantages	Solution	Minimum Time Required for Sterilization	Steps	Precautions
Metal Plastic or Rubber	Glutaral- dehyde 2-4% (Cidex)	not easily inactivated by organic materials	Sterilization slower below 25°C (77°F); skin, eye, respiratory irritant	full strength never dilute; follow manufac- turer's instructions for mixing	10 hours	Submerge instruments completely, make sure solution fills cannulae interior; soak; remove with sterile forceps; rinse with sterile water; air dry	Use only in well-ventilated areas; discard according to manufacturers instructions or sooner if solution is cloudy
Metal Plastic or Rubber	Formal- dehyde (8%)	not easily inactivated by organic materials	vapors toxic; skin, eye, respiratory irritant	dilute 1 part commercial formaldehyde (35-40%) with 4 parts bottled water to make 8% solution	24 hours	Submerge instruments completely, make sure solution fills the interior; soak; remove with sterile forceps; rinse with sterile water; air dry	Use only in well-ventilated areas; do not dilute with chlorinated water — this produces toxic gas; discard 14 days after mixing or sooner if solution is cloudy



IP3: Prevention Message

Prevention Message

Never rely on the knowledge that one of your patients has had a recent negative HIV test to protect yourself from infection.

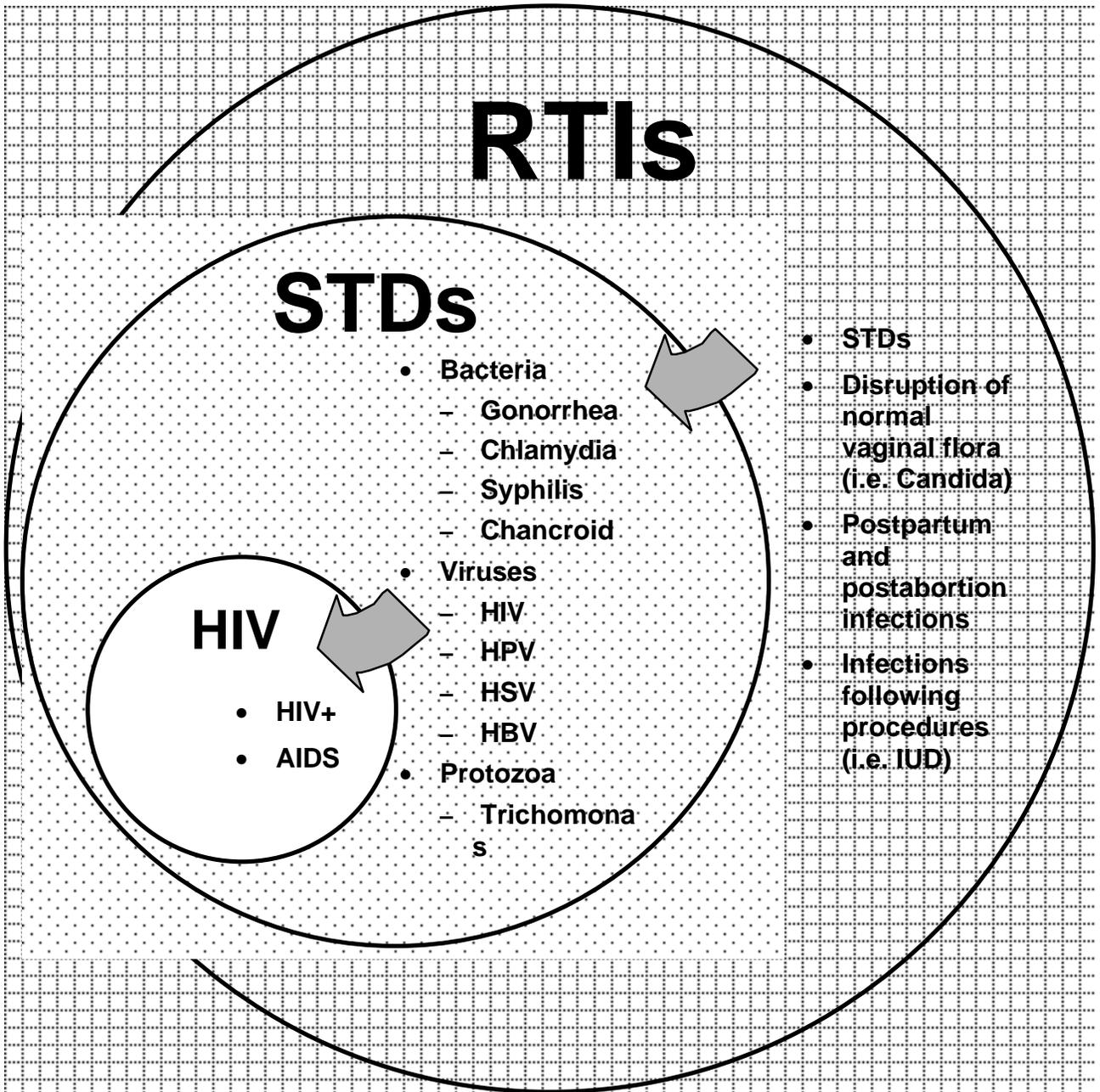
He or she could be in the window period or have become infected after the test was done.

Only universal precautions will protect you from infection in the workplace.

TRANSPARENCIES



1.1A: RTIs, STDs, and HIV





1.2A: Acute and Long-term Consequences of STDs

STDs causing genital discharge syndrome (urethritis, cervicitis)

Disease (etiologic agent)	Acute Disease	Complications	Effect on Pregnancy/Newborn
Gonorrhea <i>Neisseria gonorrhoeae</i>	urethritis, cervicitis, pelvic inflammatory disease (PID), epididymitis	infertility, ectopic pregnancy, chronic pelvic pain, urethral stricture, death	prematurity, septic abortion, ophthalmia neonatorum, postpartum endometritis
Chlamydial infection <i>Chlamydia trachomatis</i>	urethritis, cervicitis, PID, epididymitis	infertility, ectopic pregnancy, chronic pelvic pain, death	ophthalmia neonatorum, neonatal pneumonia, postpartum endometritis
Trichomoniasis <i>Trichomonas vaginalis</i>	vaginitis, urethritis	none known	postpartum endometritis, neonatal infection (infrequent)
Bacterial vaginosis overgrowth of anaerobic bacteria in the vagina	vaginal discharge, PID	infertility, ectopic pregnancy, chronic pelvic pain, death	prematurity, postpartum endometritis
Vulvovaginal candidiasis <i>Candida albicans</i>	vaginitis	none known	neonatal thrush



1.2A: Acute and Long-term Consequences of STDs continued

STDs causing genital ulcer syndrome

Disease (etiologic agent)	Acute Disease	Complications	Effect on Pregnancy/Newborn
Syphilis <i>Treponema pallidum</i>	genital ulcer, secondary syphilis	neurosyphilis, cardiovascular syphilis, gummata	spontaneous abortion, still birth, congenital syphilis
Chancroid <i>Hemophilus ducreyi</i>	genital ulcer	none known	none known
Herpes Herpes simplex virus(HSV)	genital ulcer	asptic meningitis, transverse myelitis	neonatal HSV, prematurity



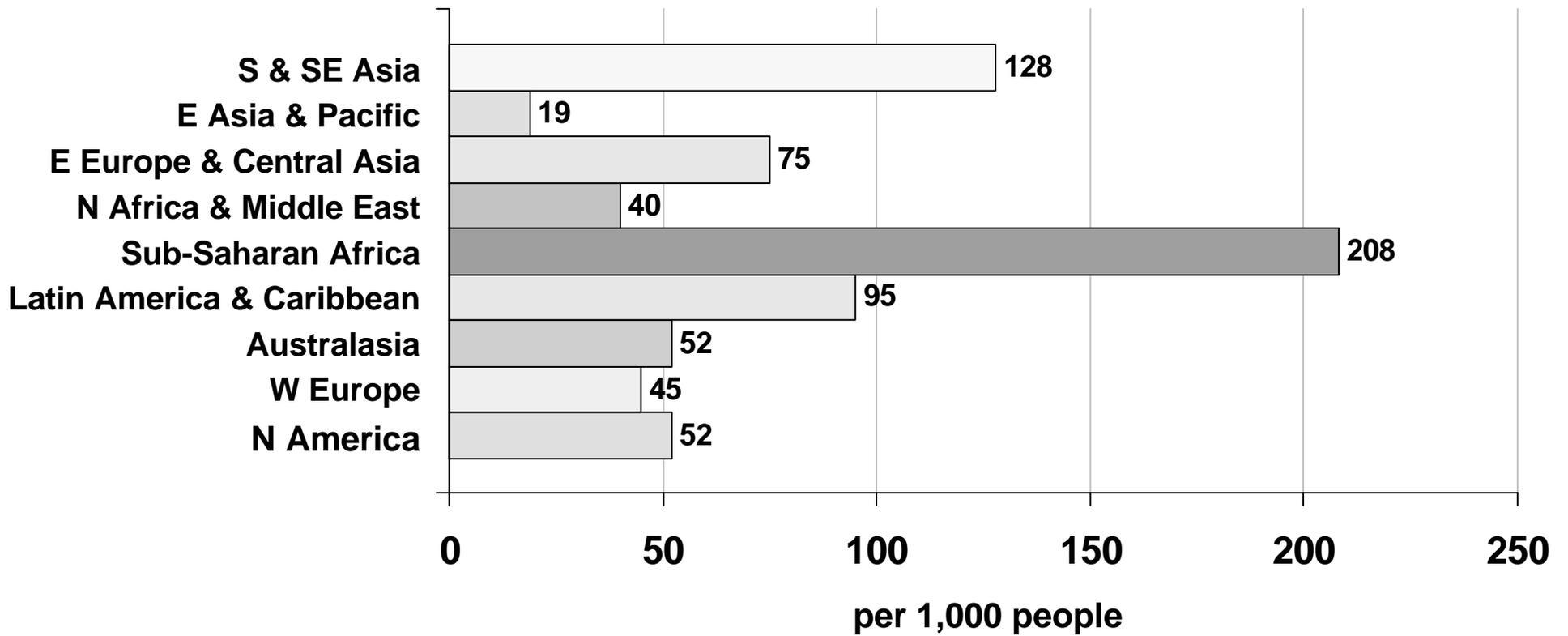
1.2A: Acute and Long-term Consequences of STDs continued

Other STDS

Disease (etiologic agent)	Acute Disease	Complications	Effect on Pregnancy/Newborn
Genital warts/cancer Human papilloma virus (HPV)	genital warts	genital cancer	congenital transmission possible
Hepatitis B Hepatitis B virus (HBV)	acute hepatitis	chronic hepatitis, cirrhosis, liver cancer	perinatal HBV
HIV/AIDS Human immunodeficiency virus (HIV)	acute infection	AIDS	perinatal HIV



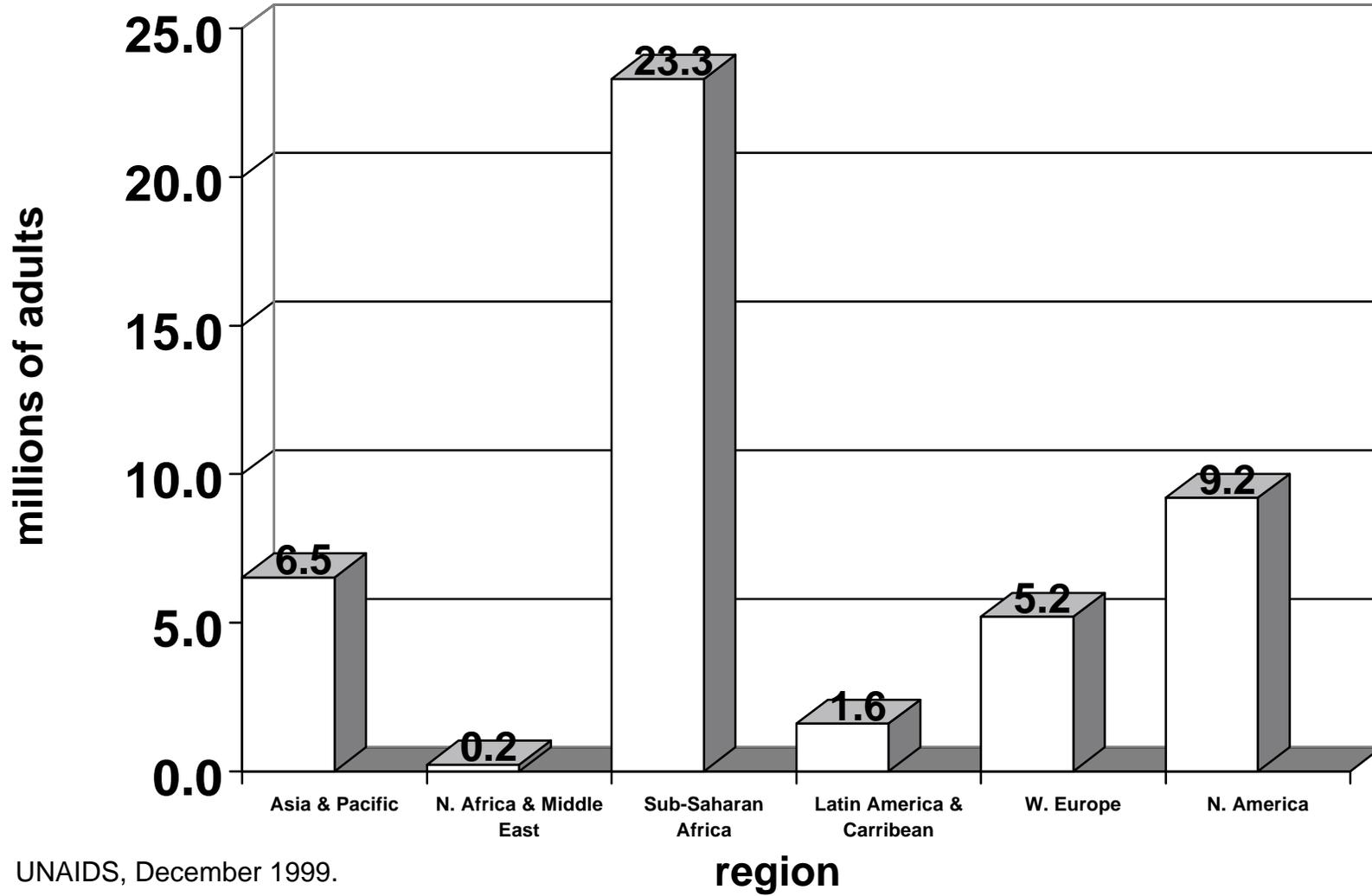
1.3A: Regional Prevalence of Curable STDs



Source: WHO/GPA, 1995.



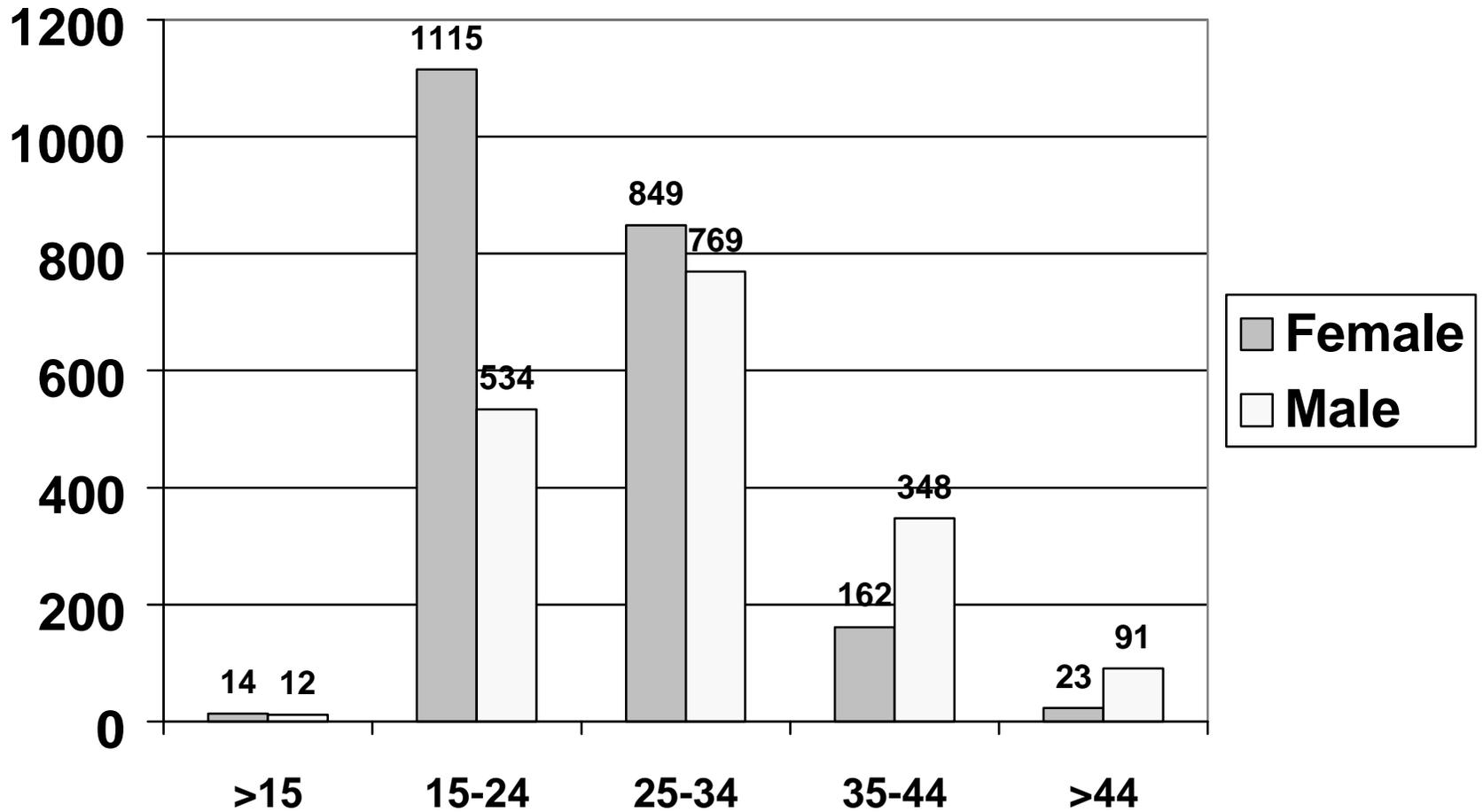
1.3B: Adults with HIV/AIDS by Region



Source: UNAIDS, December 1999.



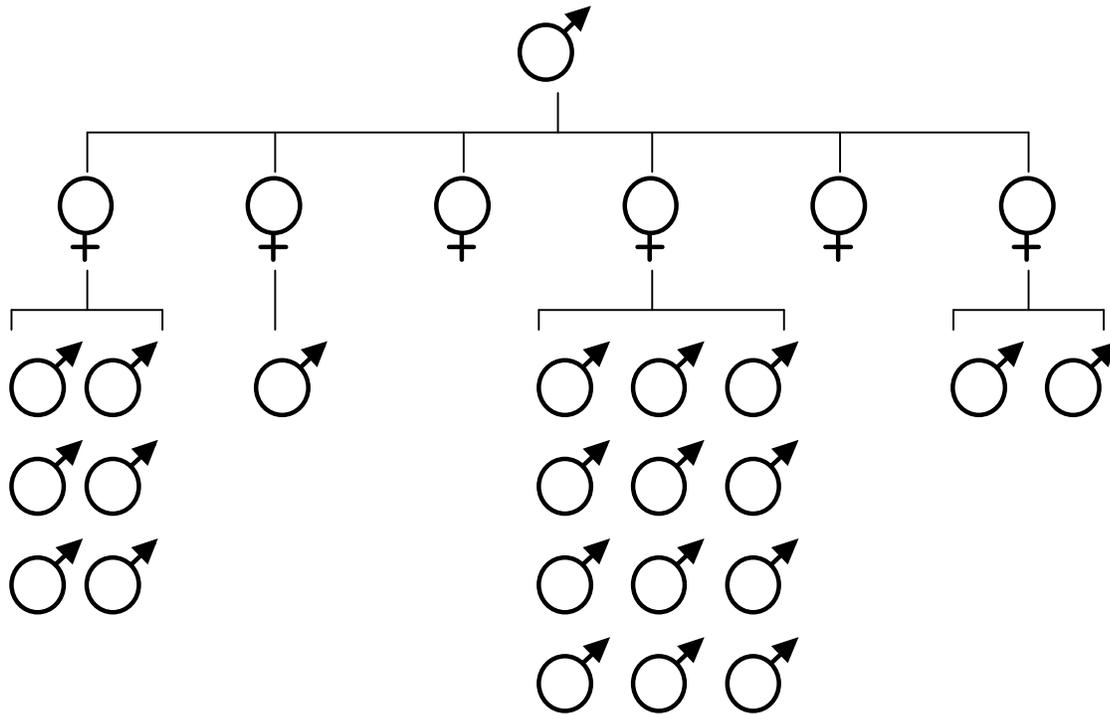
1.4A: STD Patients: Age and Sex



Source: FPPS/FHI 1997

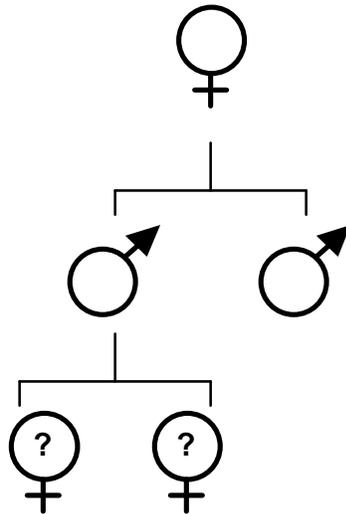


1.5A: Case Study Diagrams



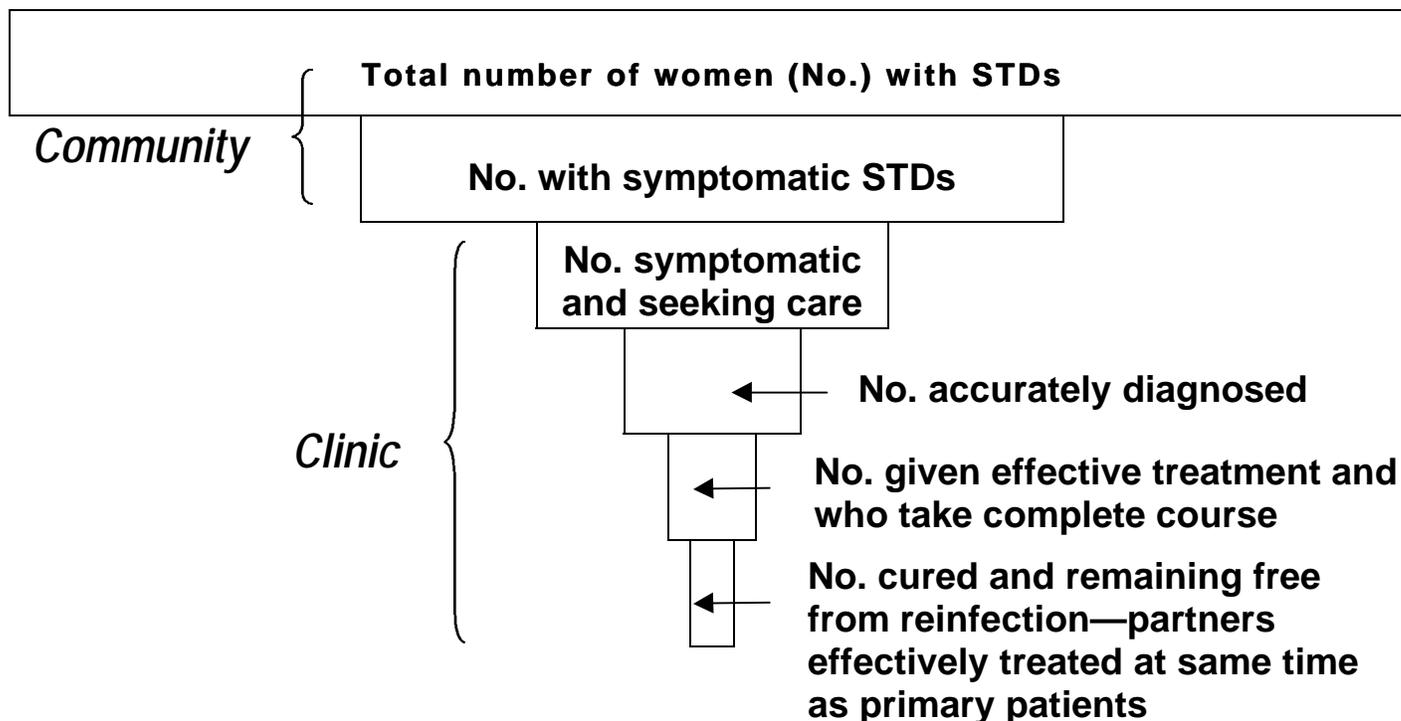


1.5A: Case Study Diagrams continued





1.6A: Total STDs are Reduced Very Little by Classic Clinical Diagnosis and Treatment



Pathfinder International, October 1999

Illustration modified from one designed by Piot and Fransen, cited by Grosskurth et al. in Mayaud, P., Ka-Gina, G., and Grosskurth, H., *STD case management in prevention and management of sexually transmitted diseases in Eastern and Southern Africa: current approaches and future directions*, NARESA monograph 3, published by the Network of AIDS Research of Eastern and Southern Africa, 1994, and adapted in Adler M. et al. *Sexual health and health care: sexually transmitted infections: guidelines for prevention and treatment*, published by DIFD, 1998. The original model came from a women-only sample.



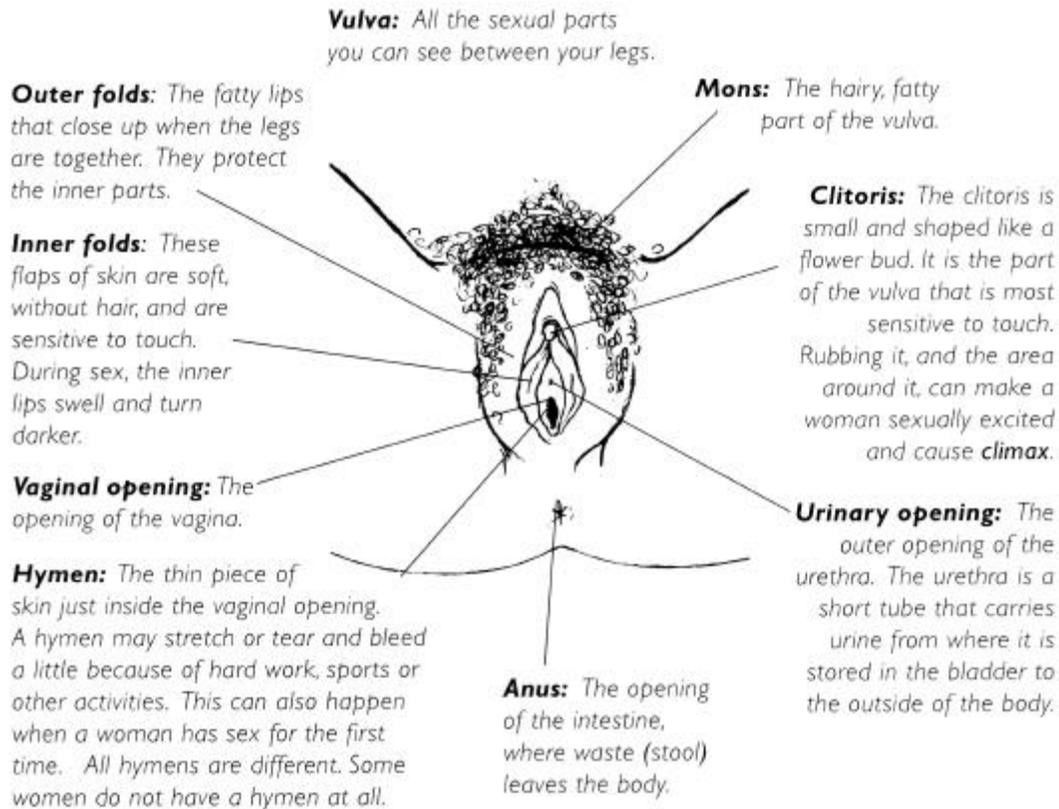
4.1A: The Goals of Taking a History

1. To efficiently collect essential information needed to make an accurate diagnosis and provide treatment.
2. To establish the patient's risk of getting or transmitting a STD.
3. To find out about partners who may have been infected.



5.2A: Female External Anatomy

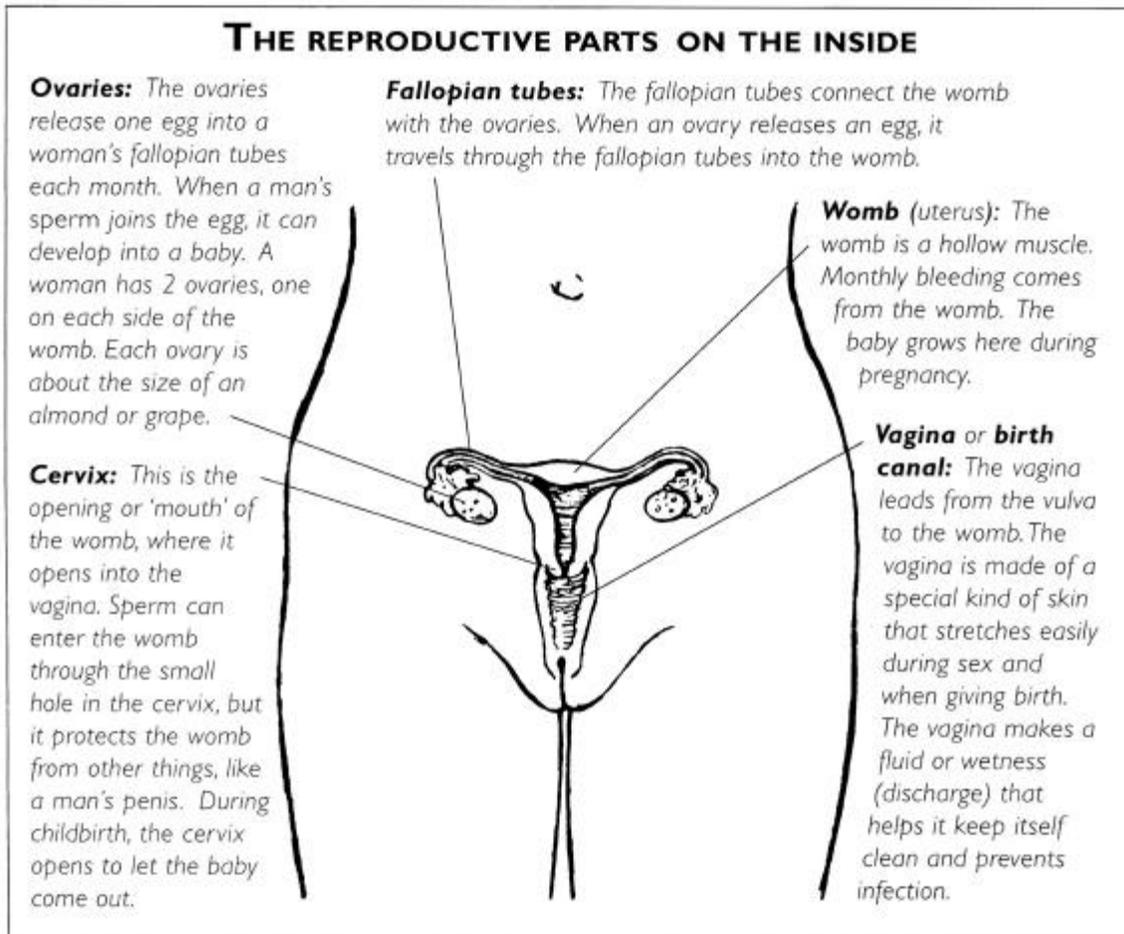
THE REPRODUCTIVE PARTS ON THE OUTSIDE



Source: Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: A health guide for women*. Berkeley, California: Hesperian Foundation. p. 44.



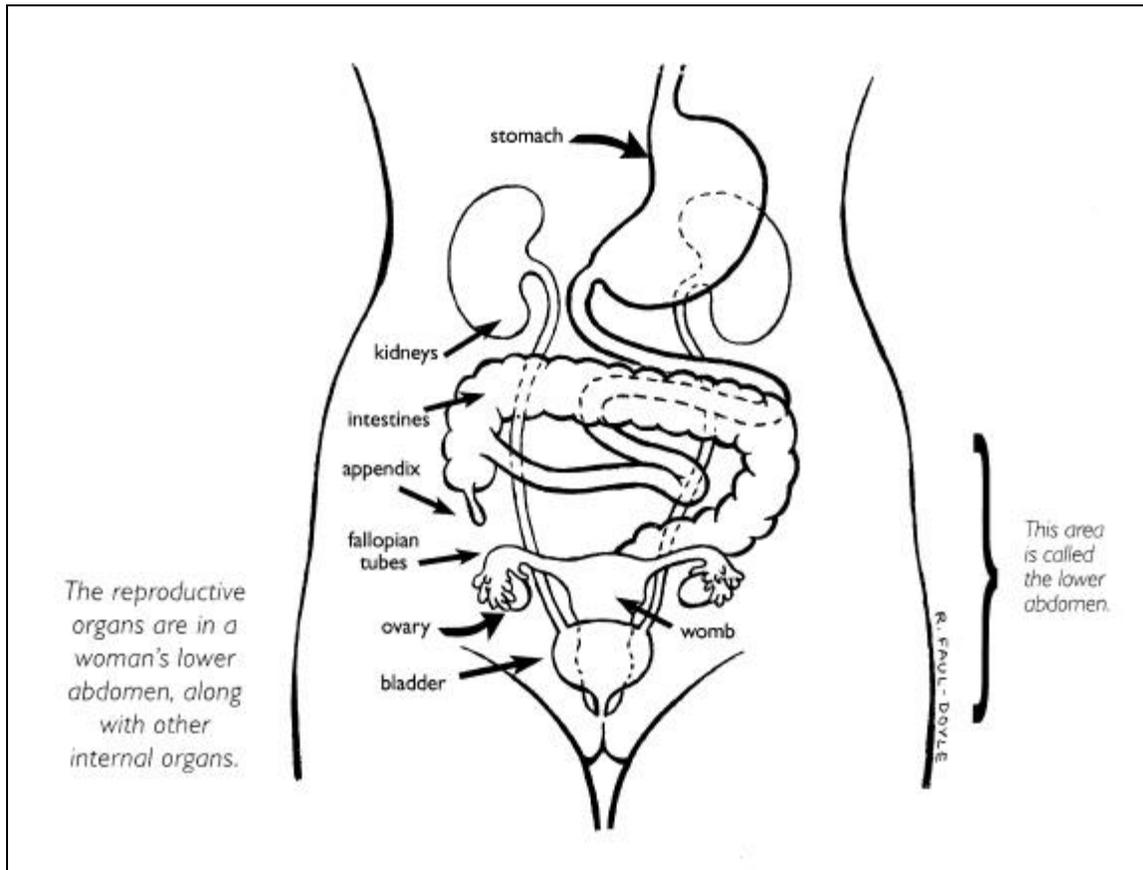
5.2B: Female Internal Anatomy



Source: Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: A health guide for women*. Berkeley, California: Hesperian Foundation. p. 45.



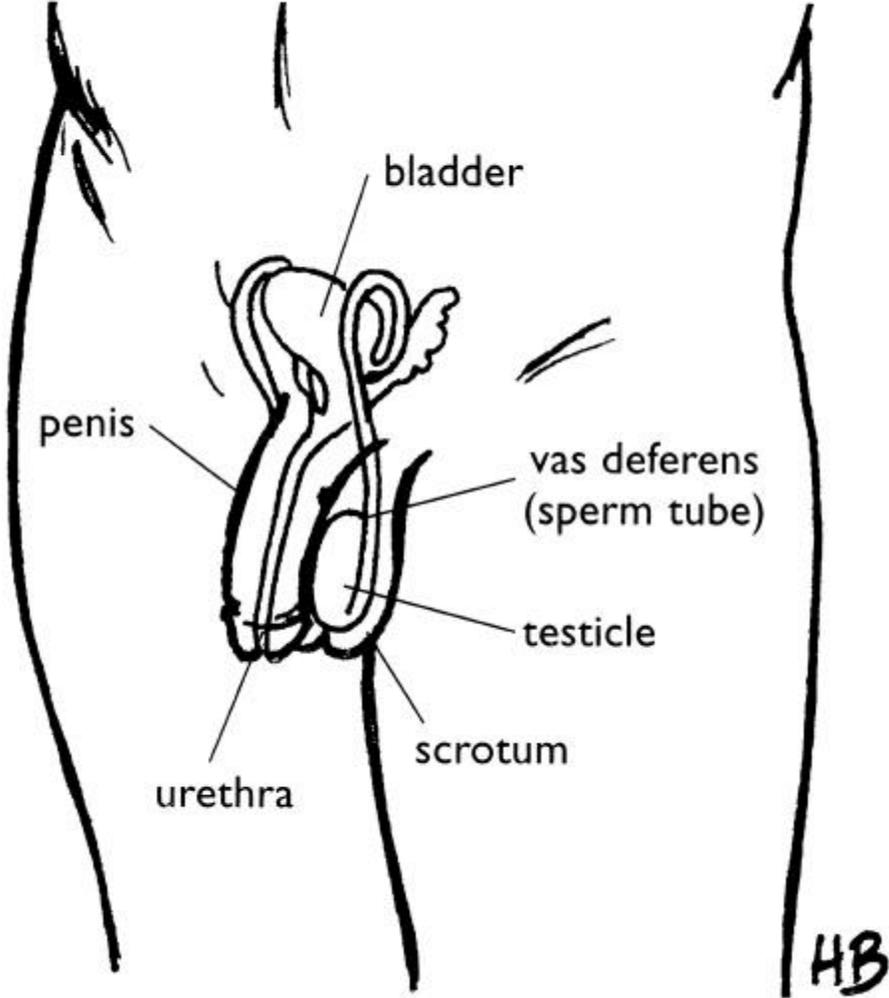
5.2C: Female Organs of the Abdomen and Pelvis



Source: Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: A health guide for women*. Berkeley, California: Hesperian Foundation. p. 353



5.2D: Male Reproductive Organs



A.A., R. Lovich, J. Maxwell, and K. . 1997.
guide for women. Berkeley, California:



5.5A: Reassuring Patients About an Examination

- Ensure privacy and confidentiality
- Explain reasons for the examination and what the patient should expect.
- Emphasize that the examination will be brief and that you will be gentle.
- If the provider is not the same sex as the patient, have a medical coworker present or friend of the patient who is the same sex.

Remember—you cannot force a person to be examined.



6.1A: Define STD Management

STD case management means:

- Correctly diagnosing and treating symptomatic patients.
- Providing patient education and partner management.
- Preventing reinfection and transmission to others.



6.1B The Three Approaches to STD Management

Etiologic—diagnosis is based on the results of laboratory tests

Clinical—diagnosis is based on patient’s history, signs, and symptoms

Syndromic—diagnosis and treatment are based on groups of symptoms rather than on specific STDs



7.4A: What Patients Need to Know About Their Treatment

Prevention of STDs

- Using condoms if not in a monogamous relationship
- Limiting the number of partners (ideally) to one
- Alternatives to penetrative sex
- Negotiating skills

Information About STDs

- How they are passed between people
- Consequences of STDs
- Links between STDs and HIV

STD Symptoms

- What to look for and what symptoms mean

STD Treatment

- How to take medications
- Signs that call for a return visit to the clinic
- Importance of partner referral and treatment



8.1A: Key Terms and Definitions

interpersonal communication: The face-to-face process of giving and receiving information between two or more people. This involves both verbal and non-verbal communication

counseling: Face-to-face, personal, confidential communication in which one person helps another to make decisions and then to act on them. Good counseling has two major elements: mutual trust between client and provider and the giving and receiving of relevant, accurate and complete information. It requires conversational and listening skills.

verbal communication: The way we talk with clients, the words we use and their meanings.

non-verbal communication: The way we behave with clients, including gestures and facial expressions.

behavior change communication: The process of developing simple messages based on proven information to suggest realistic ways that people can change risky behavior.

patient education/health education: Giving relevant information on RTIs designed according to public health needs. This includes information on infections, transmission, recommended treatment, prevention, risk reduction, behavior change, and partner referral. This can be done one-on-one, in group settings in the clinic, via posters, videos, brochures, and involving all possible staff. It requires teaching and group facilitation skills.



8.2A: Survey of Sexual Attitudes

- A woman who carries a condom with her is prepared to have sex and is therefore loose and immoral.
- Homosexuality is a sickness that is unnatural.
- Prostitutes provide a useful social service.
- STDs are more common among poor, illiterate people.
- A child should be given sex education at school.
- Parents should allow their daughters as much sexual freedom as they allow their sons.
- Marital infidelity is equally acceptable or unacceptable for both sexes.
- Abortion should be legal and safe to protect women with unplanned pregnancy.
- It is not unusual for people to be in love with more than one person at a time.
- Most people who get STDs have more than one partner.
- STD treatment should be available for adolescent men and women.
- Women with HIV infection should not have children.
- A women should not have sexual intercourse before marriage.
- Masturbation should be discouraged.
- Sex workers deserve to be treated respectfully like any other client.



8.4A: Terms Related to Verbal Communication

Facilitation: Encouraging, summarizing, and checking with the patient to be sure you understand his or her concerns.

Reassurance: Showing your support.

Direction: Guiding a client back to the point of the visit.

Empathy: A critical skill acknowledging feelings and showing you care.

Partnership: Offering your commitment to help.

Asking questions: Use open- and closed- ended questions to get the information you need.

- **Open questions:** Invite the patient to give a longer answer. (Tell me more about your back pain. What else is troubling you?).
- **Closed questions:** Require only a “yes” or “no” or very short answer. (Is your back painful? How old are you?).



8.5A: Guidelines for Counseling

- Welcome your client warmly by name and introduce yourself.
- Sit closely enough so that you can talk comfortably and privately.
- Make eye contact and look at the client as she speaks.
- Use language that the client understands.
- Listen, taking note of the client's body language (posture, facial expression, looking away, etc.) and seeking to understand feelings, experiences and points of view.
- Be encouraging. (Nod or say, "Tell me more about that.")
- Use open-ended questions.
- Provide relevant information.
- Try to identify the client's real concerns.
- Provide various options for the client.
- Respect the client's choice.



8.7A: Goals of Patient Education and Counseling on STDs

- Primary prevention, or preventing infection in uninfected patients. This is the most effective strategy to reduce the spread of STDs and can be easily integrated into all health care settings.

- Curing the current infection.

- Secondary prevention, which:
 - Prevents further transmission of that infection in the community
 - Prevents complications and re-infection in the patient



8.9A: Picture Code: Laundry Day



ZIMBABWE AIDS NETWORK. and UNICEF. 1993. Communicating About AIDS. Poster. Harare: n.p.



14.3A: At the Clinic



Source: Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. *Where women have no doctor: A health guide for women*. Berkeley, California: Hesperian Foundation. p. 344

TRAINER'S TOOLS



0.0C & 15.0A: Pre- and Post-test Answer Key

Participant Name _____

Instructions. Circle correct answers in Sections A, B, and C. Follow specific directions for each section. There is a total of 50 points.

Section A. Circle one letter only.

1. In women, the signs and symptoms of STDs are often:

- a. More easily recognized than in men.
- b. **Less reliable indicators of disease than in men.**
- c. Less likely to become serious than they are in men.
- d. More likely to affect older women.

2. Which of the following contributes to the rapid spread of HIV?

- a. Lack of sufficient laboratory facilities for diagnosis.
- b. Poor hygiene.
- c. Lack of effective drugs.
- d. **High risk sexual behavior.**

3. A woman with 2 children has HIV and wants to get pregnant. What is the best action to take?

- a. Tell her it is not a very good idea because the baby is unlikely to live very long.
- b. Tell her you think it is a bad idea, but she has to make her own decision.
- c. Tell her to discuss it with her husband and then decide.
- d. **Give her all the information she needs and support her in her own decision.**

4. Which of the following questions may help you assess a person's risk of getting or giving a STD?

- a. Does your partner live away from home?
- b. Are you over 30 years old?
- c. Do you know anyone with AIDS?
- d. Have you had a new sexual partner in the past 3 months?
- e. Have you ever had a STD?
- f. B, c and e.
- g. **A, d, and e.**



0.0C: Pre- and Post-test Answer Key continued

5. **The following are all good ways to prevent STDs in married, monogamous women except:**
 - a. Make sure that STD services are available to their husbands.
 - b. **Outlaw prostitution.**
 - c. Promote widespread condom use.
 - d. Give women the skills to negotiate safer sex.

6. **When a patient complains of symptoms of a STD, the following examination is ideal:**
 - a. A general physical examination.
 - b. A genital examination.
 - c. **Both general physical and genital examinations.**
 - d. Neither is necessary when using a syndromic approach for STD management.

7. **Examination for urethral discharge in men should be done:**
 - a. With the patient lying down.
 - b. Asking the patient to urinate before the examination.
 - c. **By asking the patient to milk the penis if you don't see any discharge.**
 - d. By asking the patient to wipe off his penis before you examine him.

8. **The main causes of urethral discharge are:**
 - a. Syphilis and gonorrhea.
 - b. Herpes simplex and chancroid.
 - c. **Gonorrhea and chlamydia.**
 - d. Chlamydia and syphilis.

9. **The new approach to syndromic management of vaginal discharge excludes which of the following?**
 - a. Treat vaginal discharge as an infection of the vagina.
 - b. If the patient complains of vaginal discharge and she is at high risk for a STD, treat her for cervicitis and vaginitis.
 - c. **If the patient complains of vaginal discharge, treat for all possible infections of the vagina and cervix.**
 - d. Use every method you have to make a better, more specific diagnosis of STD.



0.0C: Pre- and Post-test Answer Key continued

- 10. A woman has cervical mucopus and lower abdominal pain with no rebound tenderness or guarding. Which of the following is correct?**
- She should be referred immediately to a surgeon.
 - She should be treated for PID.**
 - Trichomonas vaginalis is probably the causative organism.
 - She is unlikely to have complications unless she is pregnant.
- 11. Genital ulcer disease is important because:**
- It is a major cause of infertility.
 - It may facilitate the spread of HIV.**
 - It often causes impotence in men.
 - It is usually associated with another RTI.
- 12. The practice of treating for 2 different types of genital ulcer disease (chancroid and syphilis) at the same time is:**
- Bad because an individual is rarely infected with 2 different pathogens.
 - Wasteful because a good clinical examination will almost always lead to a specific diagnosis.
 - Necessary because it is difficult to predict clinically the cause of most genital ulcers.**
 - Dangerous because of drug interactions.
- 13. A person infected with chancroid will often have:**
- Genital ulcers which come and go spontaneously over many months.
 - Genital ulcers which progress, causing extensive tissue damage if not treated.**
 - A genital ulcer that lasts one or 2 weeks and then resolves completely on its own.
 - Multiple, painful vesicles filled with clear fluid.
- 14. Which of the following laboratory tests is most useful for STD control in developing countries?**
- Screening tests for syphilis such as RPR and VDRL.
 - Gram stain for gonorrhea.
 - Urine LED (leukocyte esterase dipstick) for white blood cells.
 - Gonorrhea culture.



0.0C: Pre- and Post-test Answer Key continued

15. A young female sex worker comes to you with vaginal discharge. She says she has had several STDs in the past. Which of the following is the most appropriate action to take?
- Find out what she knows about STDs.
 - Tell her to find other work.
 - Warn her that she might have AIDS.
 - Avoid topics that might embarrass her.

Section B. Circle the two correct answers to each question.

16. Why are STDs, excluding HIV, regarded as a public health priority?
- Because unless they are treated promptly, they are incurable.
 - Because they have severe health consequences.**
 - Because treating them promptly can help HIV from spreading.**
17. Which of the following consequences may result if STDs are not treated?
- Men may develop prostatic carcinoma.
 - Women may develop breast cancer.
 - Women may become infertile**
 - Men may become infertile.**
18. A negative test for HIV can mean:
- A person is not infected with HIV.**
 - A person is infected but has not yet made antibodies.**
 - The person has already made antibodies to HIV.
 - The person cannot possibly be HIV infected.
19. Which are signs of AIDS?
- Gradual weight gain.
 - Constipation.
 - Generalized swelling of the lymph nodes.**
 - A fungal infection.**
20. Which of the following are open-ended questions?
- Tell me about your symptoms.
 - Is the discharge milky or clear?
 - Did you use a condom the last time you had sex?
 - What does the pain feel like?**



0.0C: Pre- and Post-test Answer Key continued

21. **The 2 main elements of STD control are:**
- Case management.**
 - Legalizing prostitution.
 - Prevention.**
 - Providing laboratory diagnosis at all clinics.
22. **Women are more vulnerable to HIV infection than men are because:**
- Pregnancy and breast feeding lower a woman's resistance to HIV.
 - Women are smaller, so they have fewer white blood cells to fight infection.
 - Women are often anemic.
 - Semen stays in contact with the vaginal wall for a long time.**
 - Women have less power to negotiate safer sex.**
23. **The disadvantages of syndromic management include which of the following?**
- There is a potential for the over-use of antibiotics.**
 - Patients must wait for treatment.
 - It avoids the wrong treatment since all possible RTIs causing signs and symptoms are treated at once.
 - It doesn't work well for vaginal discharge.**
24. **Syndromic management of vaginal discharge has which of the following problems?**
- Many women with vaginal discharge might have a cervical infection.
 - Many women with cervicitis do not have a vaginal discharge.**
 - The cervix is not easily accessible for examination.**
 - Most women with vaginal discharge have a STD that needs to be treated.
25. **A young woman who has come to see you with a vaginal discharge is at high risk for a STD. Before prescribing medication for her, what is most important for you to know?**
- How many partners she has.
 - Whether she can afford the medication.**
 - Whether she is pregnant or breastfeeding.**
 - When her last menstrual period was.



0.0C: Pre- and Post-test Answer Key continued

26. Education about sexual health for girls and boys:

- a. **Helps prevent unwanted pregnancy.**
- b. **Delays the age of onset of sexual activity.**
- c. Encourages early sexual activity.
- d. Increases unsafe abortion.

Section C. Place an X before all correct answers

HIV is spread by which of the following?

- Using an unclean needle or syringe.**
- Using an unclean speculum.**
- Kissing someone with AIDS.
- Through mosquitoes and/or bedbugs.
- Through breastfeeding.**
- From a pregnant mother to her unborn infant.**
- By sharing latrines or toilets.
- Drinking from the same cup as someone with AIDS.
- Getting blood from an infected person in an open wound.**
- Being stuck with a needle used on a person infected with AIDS.**
- From a blood transfusion if the blood was not tested.**
- Taking care of a person who has AIDS.
- Sharing towels or sheets.

Section D. Circle T (true) or F (false).

- T **F** Women who are monogamous may need a contraceptive, but not protection from STDs.
- T **F** Condoms are the only barrier method proven highly effective against STD transmission and pregnancy prevention.
- T **F** More men are infected with HIV than women.
- T **F** Cervical cancer can be prevented by screening women for herpes.
- T **F** The most common causes of vaginal discharge are not sexually transmitted.
- T **F** Using spermicide can prevent HIV transmission.

1.0A: Data Collection Tool

It is helpful to supplement the information in Unit 1 with whatever local data is available to make the training more relevant for participants. Data on HIV/AIDS is often easier to obtain than data on STDs, but don't be discouraged, because whatever you find will be of interest.

Where to Find Information

1. Your national AIDS control program
2. A UNAIDS representative
3. The UNAIDS website (www.unaids.org/hivaidsinfo).
4. Local researchers who could be funded through a university
5. Health
6. NGOs working in HIV prevention
7. World Health Organization (WHO)
8. The Ministry of Teaching Health
9. Teaching hospitals
10. Other research projects

Information to Look For

GROUP	YEAR				
	1999	1998	1997	1996	1995
HIV/AIDS					
• Number of adults and children living with AIDS					
– Children 0-14					
– Women 15-49					
– Men 15-49					
• Adult rate of HIV infection					
• Number of adults and children who died of AIDS					
• Number of adults and children who died of AIDS					
• Number of orphans					

GROUP	YEAR				
	1999	1998	1997	1996	1995
• HIV seroprevalence in selected populations					
– pregnant women					
– sex workers					
– military					
– injecting drug users					
– men having sex with men					
– blood donors					
STDs					
• Incidence (new infections) and prevalence (total infections at a certain point in time of curable STDs(
– syphilis					
– gonorrhoea					
– chlamydia					
– trichomonas					
• Proportion of men age 15-49 who reported urethritis in the last year					
• Proportion of women age 15-24 attending antenatal clinics who have tested positive for syphilis					
• Other relevant national data					



1.5A: Case Studies Answer Key

Scenario 1. A truck driver was away from home for many days last month. He had sex with 6 women during the month. One woman was his wife, who has no other sexual partner. Four were women working in bars along the road, and the sixth was a sex worker he met in the capital city.

Question and Answer

1. Of this man's partners, which are the most vulnerable to getting a STD?

Answer: *They are all vulnerable to infection if he is infected, but those women with more partners have a greater risk of infection from other sources as well.*

2. The man is found to have gonorrhea and is treated. The health worker advises him to bring all his partners to the clinic for treatment. Which of the women would he be most likely to bring?

Answer: *Studies show that the majority of partners referred by men are wives or regular partners, so those at highest risk are not treated.*

3. In terms of reducing the spread of gonorrhea in the community, which of these people would be most important to treat?

Answer: *Those at highest risk.*

4. Which of the people described above would be most likely to use your clinic?

5. If you saw this man, how many of his partners would you be able to reach by traditional partner notification?

Be sure to include discussion of prevention and raising awareness of STDs outside the clinic.



1.5A: Case Studies Answer Key continued

Scenario 2. A young woman has a steady boyfriend. Until recently, she had not had sex with anyone else for 2 years. Last week she saw an old boyfriend who had returned to town. Today, at her routine family planning visit, she has a purulent cervical discharge on speculum exam and a lot of pain on lower abdominal and bimanual examinations. You treat her for pelvic inflammatory disease and advise her to arrange for her partners to be treated.

1. Compare this situation with the previous one. How many new infections are possible in each case?

Answer: *Number of possible new infections are: scenario 1: 27; scenario 2: 3.*

2. In which scenario would strategies such as partner notification be more effective?

Answer: *If it worked, notifying all the truck driver's partners would be the most effective. However, since they are casual partners, they would be hard to find and notify.*

3. What other strategies might be effective in limiting STD spread in these situations?

Answer: *Prevention strategies such as 100% condom use in roadside bars, easy access to effective treatment along the road, condom use with regular partners.*

4. Compare this situation with the previous one. How many new infections are possible in each case?

Answer: *Number of possible new infections are: scenario 1: 27; scenario 2: 3.*

5. In which scenario would strategies such as partner notification be more effective?

Answer: *If it worked, notifying all the truck driver's partners would be the most effective. However, since they are casual partners, they would be hard to find and notify.*

6. What other strategies might be effective in limiting STD spread in these situations?

Answer: *Prevention strategies such as 100% condom use in roadside bars, easy access to effective treatment along the road, condom use with regular partners.*



4.2A: Instructions for Competency Based Training (CBT) Skills Assessment Checklists

Date of Assessment _____ Dates of Training _____

Place of Assessment: _____ Clinic Classroom _____

Name of Clinic Site _____

Name of the Service Provider Name of the Assessor _____

These assessment tools contains the detailed steps that a service provider should follow in in the prevention and management of RTIs. They may be used during training to monitor the progress of the trainee as s/he acquires the new skills, and they may be used during the clinical phase of training to determine whether the trainee has reached a level of competence in performing the skills. They may also be used by the trainer or supervisor when following up or monitoring the trainee. The trainee should receive a copy of the assessment checklist so that s/he may know what is expected of her/him.

Instructions for the Assessor

1. Always explain to the client what you are and what you are doing before beginning the assessment. Ask for the client's permission to observe.
2. Begin the assessment when the trainee greets the client.
3. Use the following rating scale:
 - 2= Needs improvement
 - 1=Needs improvement
 - N/O = Not observed
4. Continue assessing the trainee throughout the time s/he is with the client, using the rating scale.
5. Observe only and fill in the form using the rating numbers. Do not interfere unless the trainee misses a critical step or compromises the safety of the client.
6. Write specific comments when a task is not performed according to standards.
7. Use the same copy for several observations.
8. When you have completed the observation, review the results with the trainee. Do this in private, away from the client or other trainees.

4.2B: Competency Based Training (CBT) Skills Assessment Checklist for History Taking

Date of Assessment _____ Dates of Training _____

Place of Assessment: _____ Clinic Classroom _____

Name of Clinic Site _____

Name of the Service Provider Name of the Assessor _____

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
General				
• Greets the patient				
• Provides the patient with privacy				
• Establishes eye contact				
• Is attentive during the visit				
• Sits if the patient sits, stands if s/he stands				
• Empathizes with the patient during the visit				
• Listens actively to the patient during the visit				
• Poses questions clearly				
General Information Questions				
• Asks the patient's age				
• Asks if s/he has any children and how many				
• Asks if s/he is employed and at what job				
• Asks if s/he is single, married or widowed				
• Asks when her last normal menstrual period was				
• Asks if s/he uses a contraceptive method and which one				
Present Illness				
• Asks why she has come for a visit				
• Asks what symptoms she has				
• Asks when symptoms began and their duration				
Medical History				
• Asks if she has ever had a STD in the past				

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
• Asks which STD and how it was diagnosed and treated				
• Asks if her/his problem was cured				
• Asks if any tests were done and about the results				
• Asks if s/he has had any other illness				
• Asks how they were treated, and if they were cured				
For Vaginal Discharge				
• Asks if there is pain when she passes urine				
• Asks if she is passing urine more than usual				
• Asks if there is itching and burning of the genital area				
• Asks about the color of the discharge				
• Asks if she experiences pain with intercourse				
• Asks if her partner has symptoms of STD such as discharge from the penis or sores on the penis				
• Asks if she has vaginal bleeding				
For Abdominal Pain				
• Asks if she missed a period or if a period were late				
• Asks if she is experiencing vaginal bleeding or discharge				
• Asks if she had recently given birth or had an abortion				
• Asks if her menses are painful or irregular				
• Asks if her partner has symptoms of STD such as discharge from the penis or sores on the penis				
• Asks if she experiences pain with intercourse				
For Genital Ulcer				
• Asks if ulcers are painful				
• Asks if ulcers are recurrent				
For Urethral Discharge				
• Asks if he experiences burning on urination				
Medications				
• Asks if s/he is taking any medications				
• Asks which medications and for what reason				

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
<ul style="list-style-type: none"> Asks if s/he has any medication allergies 				
<ul style="list-style-type: none"> Asks if she is pregnant 				
Sexual History				
<ul style="list-style-type: none"> Asks age of first intercourse 				
<ul style="list-style-type: none"> Asks if s/he is currently sexually active (has a partner/s with whom s/he has intercourse) 				
<ul style="list-style-type: none"> Asks if s/he has had a new partner in the past 3 months 				
<ul style="list-style-type: none"> Asks if s/he uses condoms and if so, are they used with every act of intercourse 				
<ul style="list-style-type: none"> Ask if s/he practices any sexual behaviors which might put him or her at risk 				
Risk Assessment				
<ul style="list-style-type: none"> Asks risk assessment questions as appropriate: <ul style="list-style-type: none"> Partner is a migrant worker Partner in the military She has other partners She works as a maid She works as a bar girl She is a street child She is a sex worker Her partner has other partners Her partner has a STD Her partner has AIDS He has many or casual partners He works as a truck driver He is a migrant worker He has a STD His partner has a STD He frequents bars often and drinks 				
<ul style="list-style-type: none"> Asks if patient has sex with more than one partner 				



5.4A: Guide to Color Transparencies

- TXP 1** Male urethritis caused by gonorrhea. Note profuse, purulent discharge and meatal redness.
- TXP 2** Male urethritis caused by chlamydia. Note the scant, almost clear urethral discharge.
- TXP 3** Primary peri-anal syphilitic chancre in homosexual man. Note that chancre can be very subtle.
- TXP 4** Chancroid ulcer of the fourchette in a female. Note that labia had to be spread to see it.
- TXP 5** Primary syphilitic chancre of the cervix.
- TXP 6** Chancroid ulcer involving the foreskin with “kissing” lesion of the penile shaft. Note the border that is healing over in one portion while continuing to advance in another. The ulcer is superficial and covered with purulent exudate.
- TXP 7** Penile chancre in primary syphilis. Classic lesions show rolled, hardened and fibrous edges with clean ulcer base.
- TXP 8** Mild primary genital herpes (HSV) infection with small blisters and pustules with surrounding redness, together with an earlier lesion that is crusted and healed. Note that primary herpes infection is more often severe, but important to recognize ulcers over a range of severity.
- TXP 9** Secondary syphilitic rash of palms and soles. The rash can extend over the back, abdomen, arms and legs.
- TXP 10** Primary genital herpes of the vulva.
- TXP 11** Extensive penile condylomata acuminata.
- TXP 12** Cervical-vaginal candida. Note the white curd-like, clumped exudate characteristic of candida.
- TXP 13** Profuse, prurulent vaginal discharge due to trichomonas. Note the typical bubbles, and yellowish color viewed on a white swab.
- TXP 14** Mucoprurulent cervicitis caused by chlamydia before and after treatment.
- TXP 15** Neonatal gonococcal conjunctivitis. Note profuse, purulent exudate.
- TXP 16** Oral thrush (candida) in a patient with HIV.

5.6A: Competency-Based Training (CBT) Skills Assessment Checklist for Physical Examination for STDs

Date of Assessment _____ Dates of Training _____

Place of Assessment: _____ Clinic Classroom _____

Name of Clinic Site _____

Name of the Service Provider Name of the Assessor _____

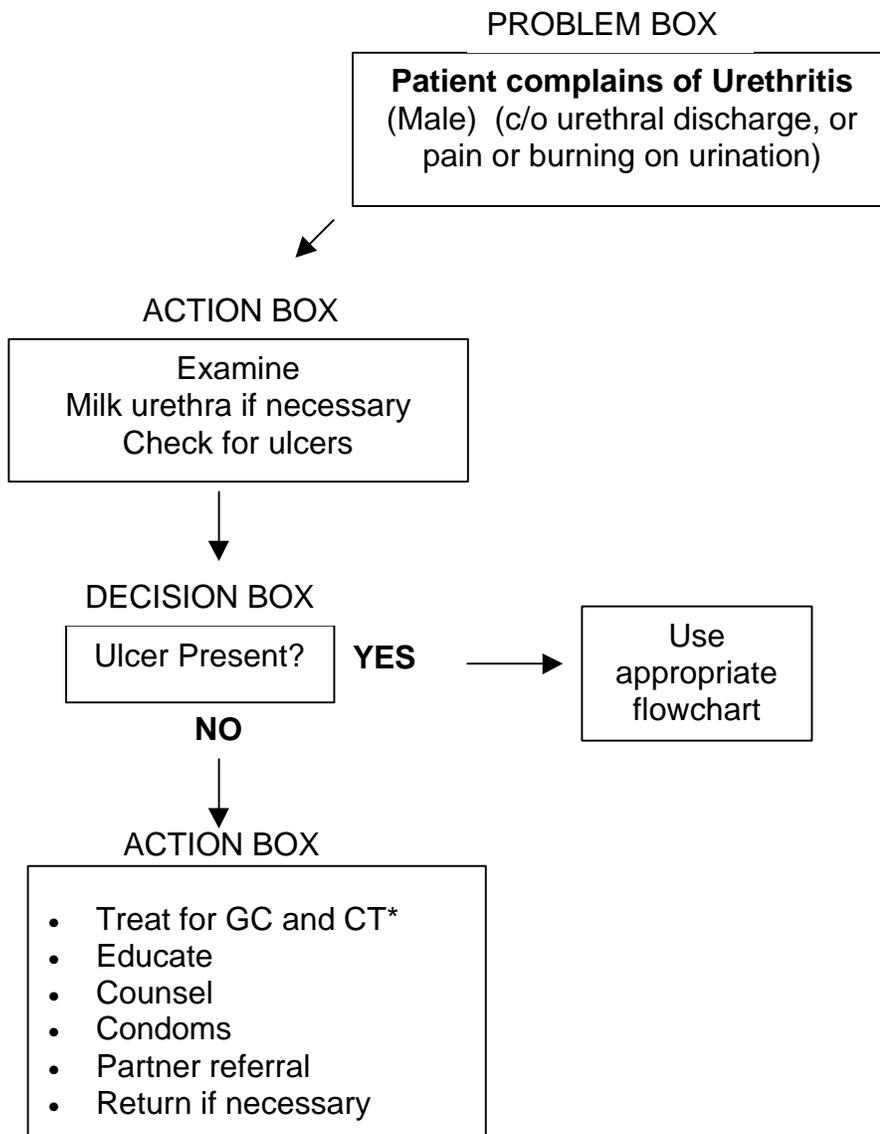
TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
Prepares the Room for Physical Examination				
<ul style="list-style-type: none"> Ensures privacy 				
<ul style="list-style-type: none"> Ensures availability of a light, exam table, speculum (if available). 				
Reassures the Patient				
<ul style="list-style-type: none"> Ensures privacy and confidentiality. 				
<ul style="list-style-type: none"> Explains reasons for the examination. 				
<ul style="list-style-type: none"> Emphasizes that the examination will be brief and gentle. 				
<ul style="list-style-type: none"> Has a friend or co-worker present if provider and patient are not the same sex. 				
General Examination of Males and Females				
<ul style="list-style-type: none"> Tells the patient what s/he is going to do as s/he does each step of the examination. 				
<ul style="list-style-type: none"> Observes general appearance to determine if the patient: <ul style="list-style-type: none"> Looks ill. Walks with difficulty because of pain or weakness. Looks thin, wasted, pale, flushed, or feverish. Is coughing. Has detectable signs of HIV/AIDS (weight loss, thin wasted appearance, generalized swelling of lymph nodes, thrush, fever, chronic cough, chronic diarrhea, shingles, and other rashes). 				
<ul style="list-style-type: none"> Asks the patient to open his/her mouth and looks for mouth ulcers or signs of thrush. 				

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
Abdominal Examination for Women				
<ul style="list-style-type: none"> Washes his/her hands before the examination. 				
<ul style="list-style-type: none"> Asks the patient to empty the bladder before beginning the exam. 				
<ul style="list-style-type: none"> Tells the patient what s/he is going to do as s/he does each step of the examination. 				
<ul style="list-style-type: none"> Asks patient to undress or pulls dress up to see the abdomen. 				
<ul style="list-style-type: none"> Asks her to lie flat on her back with knees bent and feet close to her buttocks. 				
<ul style="list-style-type: none"> Asks her to relax her buttocks. 				
<ul style="list-style-type: none"> Listens for bowel sounds. 				
<ul style="list-style-type: none"> Asks patient to point to where it hurts most. 				
<ul style="list-style-type: none"> Presses gently while moving around the abdomen. 				
<ul style="list-style-type: none"> Checks for rebound pain. 				
Female Genital Exam				
<ul style="list-style-type: none"> Asks the patient to empty her bladder before beginning the exam. 				
<ul style="list-style-type: none"> Tells the patient what s/he is going to do as s/he does each step of the examination. 				
<ul style="list-style-type: none"> Asks patient to remove clothing from the waist down. 				
<ul style="list-style-type: none"> Asks her to lie on the table on her back. 				
<ul style="list-style-type: none"> Covers parts of the patient's body not being examined. 				
<ul style="list-style-type: none"> Asks the patient to bend her knees, put her feet next to her buttocks, and let her legs fall apart. 				
<ul style="list-style-type: none"> Puts a clean glove on hand used for vaginal exam or on both hands. 				
<ul style="list-style-type: none"> Points light source towards the vagina. 				
<ul style="list-style-type: none"> Examines labia majora and minora, clitoris, urethra, vaginal opening, anal area, and inner thighs for sores, abscesses, warts, vesicles, and rashes. 				
<ul style="list-style-type: none"> Palpates the inguinal region (groin) and looks for swollen lymph nodes. 				
<ul style="list-style-type: none"> Decontaminates used gloves and speculum in 0.5% chlorine solution for 10 min. 				

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
Bi-manual Pelvic Examination				
<ul style="list-style-type: none"> Tells the patient what s/he is going to do as s/he does each step of the examination. 				
<ul style="list-style-type: none"> Puts the index finger of his/her gloved hand into the vagina while pushing gently downward. 				
<ul style="list-style-type: none"> Inserts the middle finger also as the patient relaxes and turns the palm of his/her hand up. 				
<ul style="list-style-type: none"> Feels the cervix and moves it gently. 				
<ul style="list-style-type: none"> Places his/her outside hand on the patient's lower abdomen and pushes down gently towards his/her inside hand. 				
<ul style="list-style-type: none"> Feels the uterus for size and shape. 				
<ul style="list-style-type: none"> Feels the ovaries and fallopian tubes on each side for size and tenderness. 				
<ul style="list-style-type: none"> Gently removes the gloved hand. 				
<ul style="list-style-type: none"> Decontaminates used gloves and equipment in 0.5% chlorine solution for 10 min. 				
Examining a Male Patient				
<ul style="list-style-type: none"> Washes his/her hands before the examination. 				
<ul style="list-style-type: none"> Tells the patient what s/he is going to do as s/he does each step of the examination. 				
<ul style="list-style-type: none"> Asks the patient to stand up and lower his pants down to his knees. 				
<ul style="list-style-type: none"> Palpates the inguinal region (groin) looking for enlarged lymph nodes and buboes. 				
<ul style="list-style-type: none"> Palpates the scrotum, feeling for the testis, epididymis, and spermatic cord on each side. 				
<ul style="list-style-type: none"> Examines the penis, noting any rashes or sores. 				
<ul style="list-style-type: none"> Asks the patient to pull back the foreskin if present and looks at the glans penis and urethral meatus. 				
<ul style="list-style-type: none"> Asks the patient to milk the urethra if s/he does not see any obvious discharge. 				
<ul style="list-style-type: none"> Asks the patient to turn his back towards him/her and bend over while he spreads his buttocks slightly. 				
<ul style="list-style-type: none"> Looks at the anus for the presence of ulcers, warts, rashes, or discharge. 				
<ul style="list-style-type: none"> Washes his/her hands following the examination. 				
<ul style="list-style-type: none"> Records findings, including the presence or absence of ulcers, buboes, genital warts, and urethral discharge, noting color and amount. 				

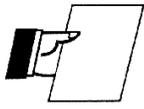


6.2A: Flowchart #1: Urethritis Syndrome

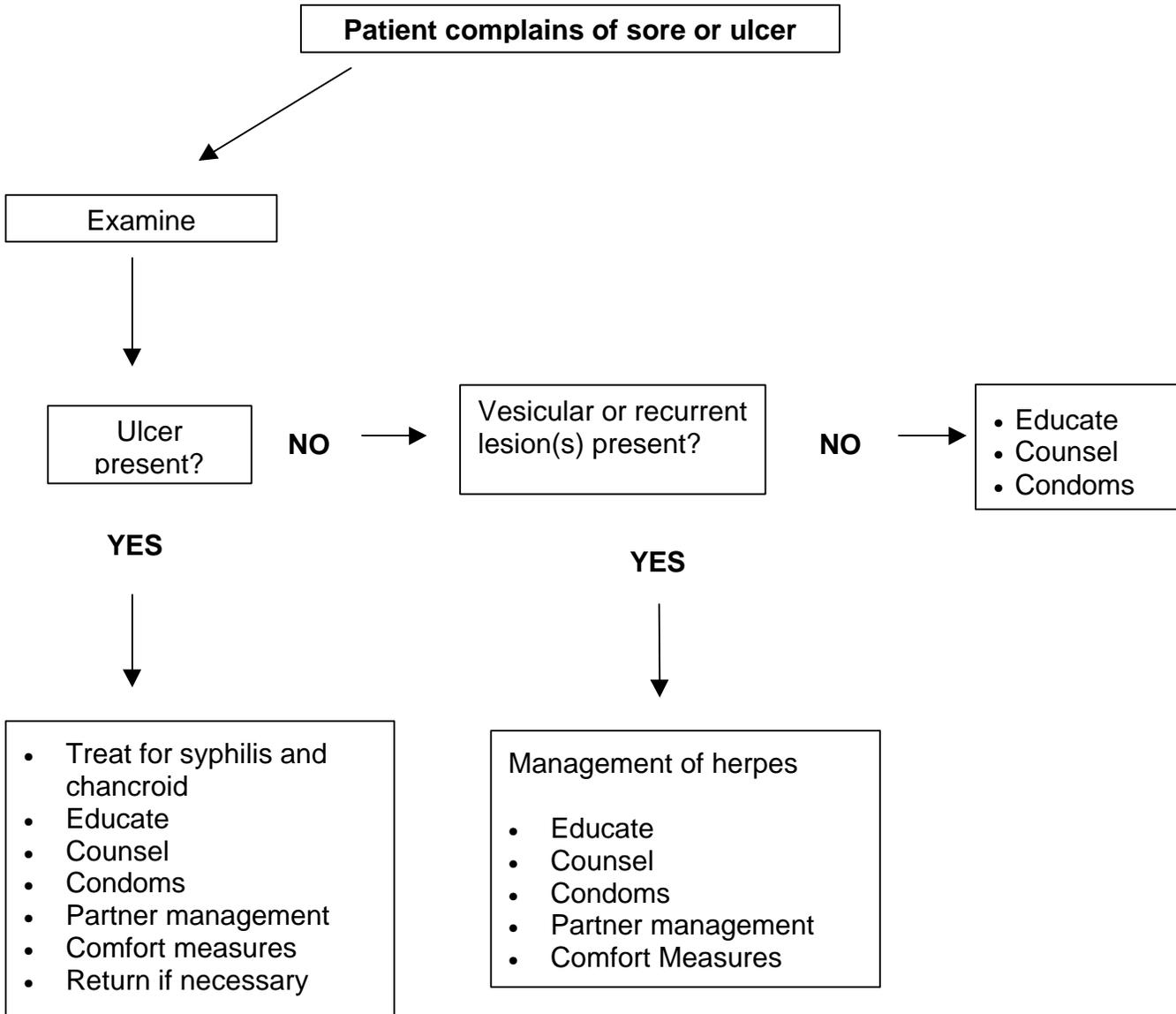


If a man has urinated in the past few hours, there may be no discharge visible. If he complains of discharge or burning, he should be treated anyway.

* GC = gonorrhea
CT = chlamydia trachomatis

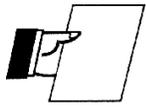


6.2B: Flowchart #2: Genital Ulcer Syndrome

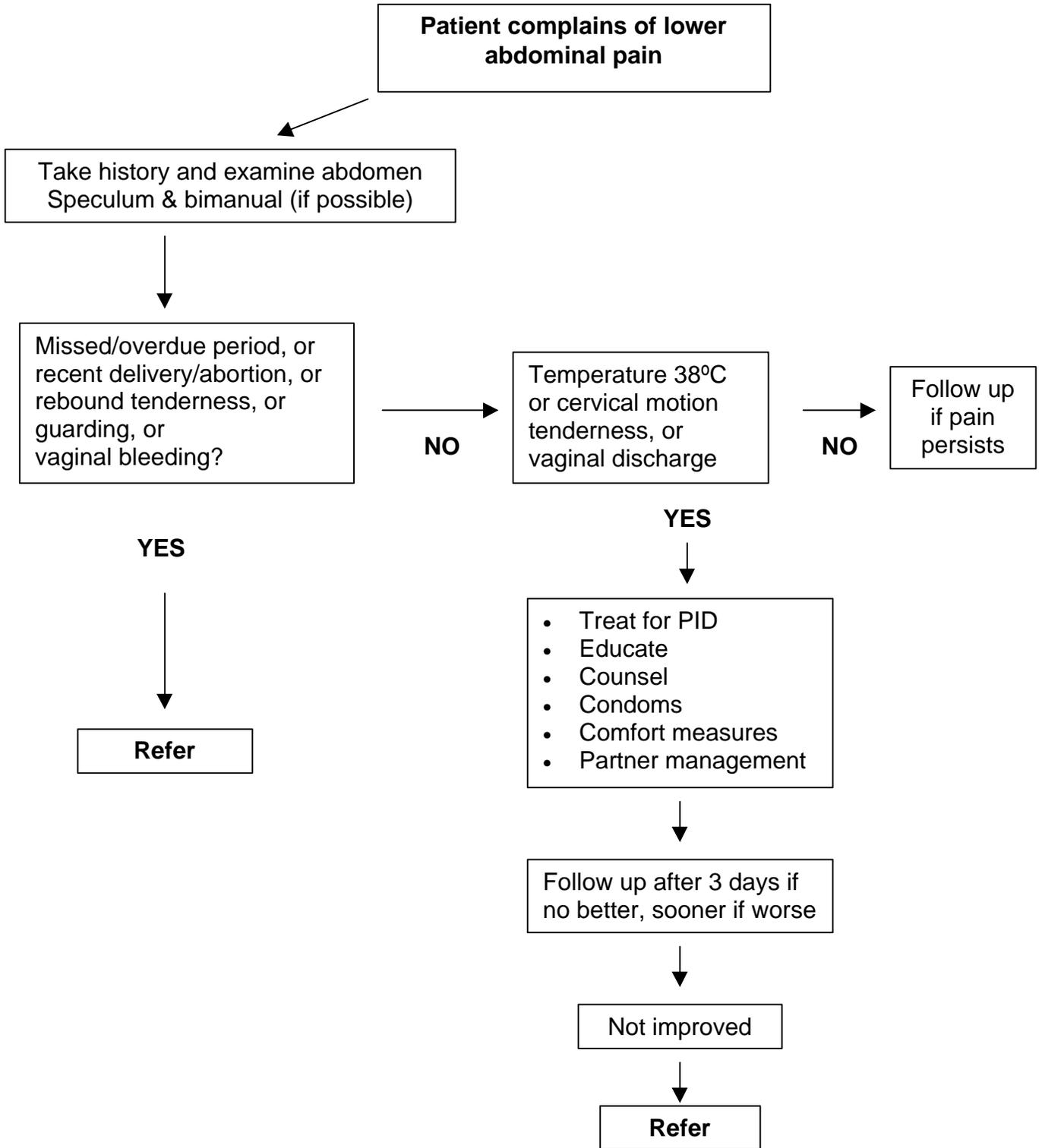


In men look at external genitalia, including the inner surface of the foreskin and the parts normally covered by the foreskin.

In women, examine the skin of the external genitalia: ask the patient to separate the labia so that you can look at the mucous surfaces for ulcers.

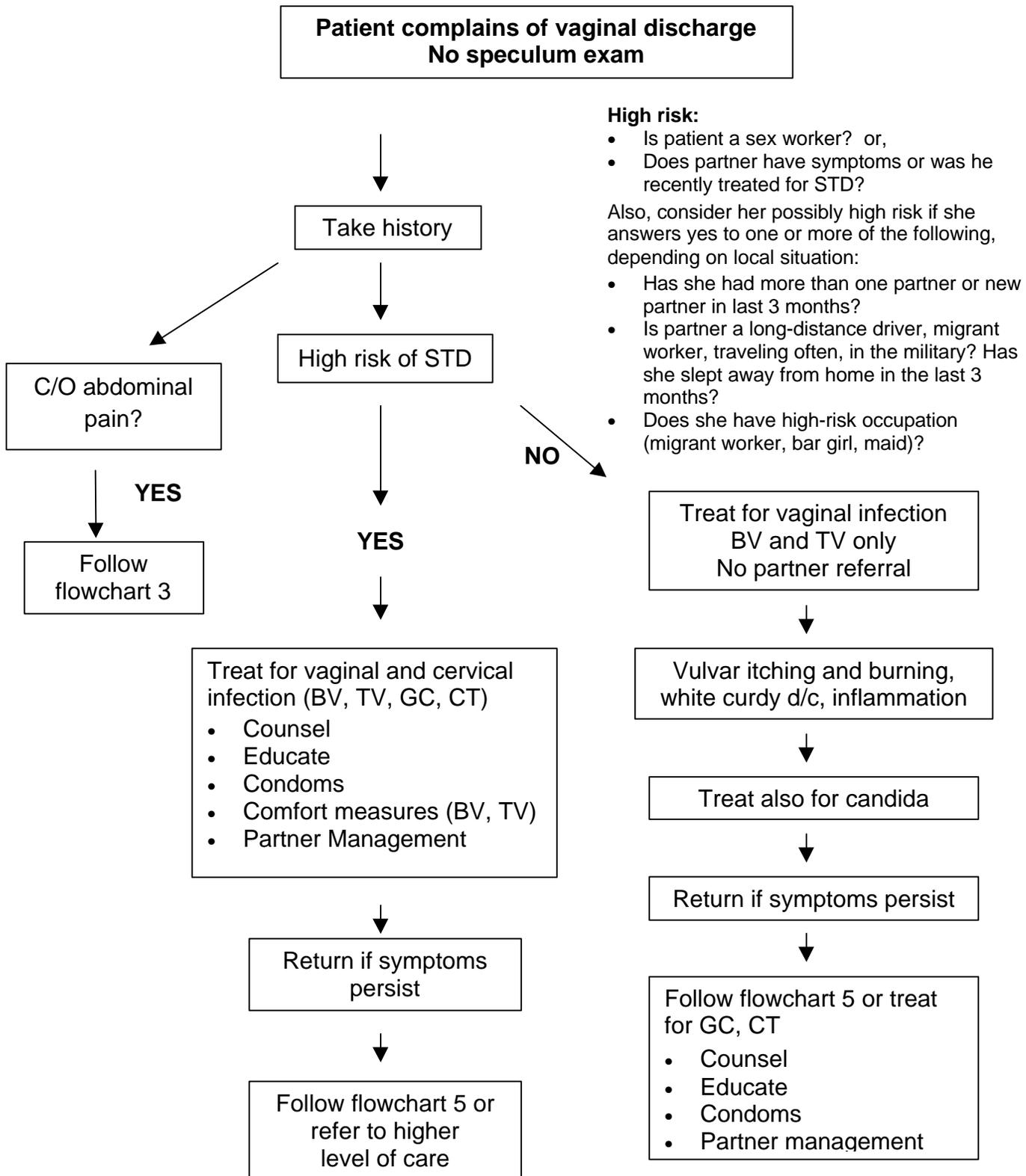


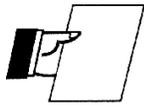
6.2C: Flowchart #3: Lower Abdominal Pain



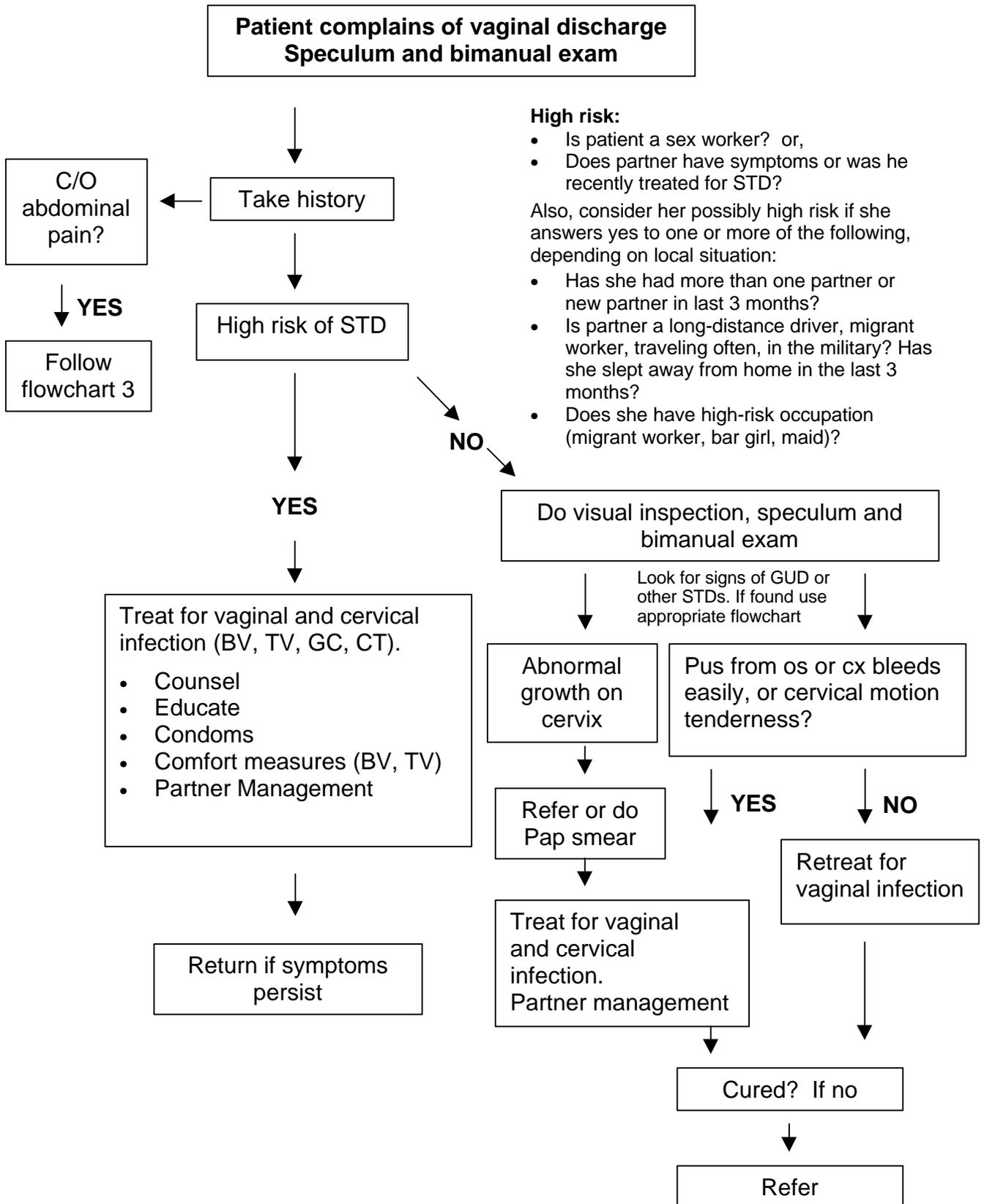


6.2D: Flowchart #4: Vaginal Discharge Syndrome





6.2E: Flowchart #5: Vaginal Discharge Syndrome



6.5A: Case Studies Answer Guide

Instructions:

For each case, answer the questions:

🗑️ What is your diagnosis?

🗑️ What is the correct management?

1. A 30-year-old woman complains of a white discharge, itching and burning in her private parts. She is married and her husband lives with her.

Answer:

- *Flow chart – vaginal discharge*
- *Diagnosis – vaginal discharge*
- *Treatment – for vaginal discharge, low risk*
- *Counsel, educate, condoms, comfort measures, partner management*
- *Special points – assess her risk carefully*

2. A 25-year-old married woman has had lower abdominal pain for 2 weeks which is getting worse. Her husband was recently home to visit from the city where he works. She uses Ocs for contraception. She just finished a normal menstrual period but did not note more than the usual cramping. On examination you note a normal vagina, and the cervix is red and bleeds easily. She has a non-pregnant uterus and positive cervical motion tenderness. The uterus and adnexae are very tender to palpation. She has a low grade fever.

Answer:

- *Flow chart – Lower abdominal pain*
- *Diagnosis – Lower abdominal pain, probably PID*
- *Treatment – Antibiotics*
- *Counsel, Educate, Condoms, Comfort measures, Partner Management*
- *Special points: What would you emphasize? Education about risk, how to talk to her husband or get him in for treatment, rest and no sex until cured, and, very important, condoms for dual protection.*



6.5A: Case Studies Answer Guide continued

3. A 20-year-old woman complains of a watery discharge “down below.” It has been there for two weeks and getting worse. It smells bad. She does not know if her partner has a discharge or not because she has not seen him for two weeks.

Answer:

- *Flow chart – vaginal discharge*
- *Diagnosis – vaginal discharge – could be at risk of STD*
- *Treatment – probably treat for STD (gonorrhea and chlamydia) and for vaginal discharge*
- *Counsel, Educate, Condoms, Comfort measures, Partner management*

4. A 19-year-old soldier was taken by his friends to a brothel two weeks ago; he developed a thin watery discharge a few days later. He was treated at your clinic one week ago, but he still has burning on urination and discharge.

Answer:

- *Flow chart – urethritis*
- *Diagnosis – urethritis*
- *Treatment – antibiotics for urethral discharge (treat for gonorrhea and chlamydia)*
- *Counsel, Educate, Condoms, Comfort measures, Partner management*
- *Special points – second line treatment, compliance, risk awareness, condoms. Probably will not bring in partner who is a sex worker.*

5. A 35-year-old widowed woman works in a roadside bar and occasionally has casual partners. She complains of burning and discharge for two days. She had a new partner one week ago.

Answer:

- *Flow chart – vaginal discharge*
- *Diagnosis – vaginal discharge high risk for STDs*
- *Treatment – vaginal discharge high risk and for vaginitis*
- *Counsel, Educate, Condoms, Comfort measures, Partner management*
- *Special points – awareness of risk, help with condom negotiation*



6.5A: Case Studies Answer Guide continued

6. A 40-year-old married woman was treated for vaginal discharge 8 days ago at your clinic. She still has a discharge and her husband is returning home tomorrow from the city where he works and she would like to be cured.

Answer:

- *Flow chart – vaginal discharge*
- *Diagnosis – vaginal discharge, probably low risk*
- *Treatment – vaginal discharge low risk (vaginitis)*
- *Counsel, educate, condoms, comfort measures, partner management*
- *Special points – risk assessment important – does she have other partners?*

7. A 19-year-old school girl complains of lower abdominal pain and light bleeding with intercourse. She has one boyfriend considerably older than she is. She sometimes uses pills to prevent pregnancy after sexual intercourse. Her last normal period was 3 weeks ago. On exam you discover some yellow discharge from her cervix, cervical motion tenderness and a swelling in her right side.

Answer:

- *Flow chart – lower abdominal pain*
- *Diagnosis – lower abdominal pain, probably PID*
- *Treatment – antibiotics*
- *Counsel, Educate, Condoms, Comfort measures, Partner management*
- *Special points: Education about risk, dual protection, treatment of partner. Needs protection from pregnancy, how to use contraception.*

8. A 50-year-old businessman has a thick yellow discharge from his penis for 3 days and urination is very painful. He wants to go home to the village to see his wife, whom he has not seen for 3 months, and would like to be rid of this problem.

Answer:

- *Flow chart – urethritis*
- *Diagnosis – urethritis*
- *Treatment – antibiotics for urethral discharge (to treat gonorrhea and chlamydia)*
- *Counsel, Educate, condoms, Comfort measures, Partner management*
- *Special points – emphasize partner management, especially communication, condoms*



6.5A: Case Studies Answer Guide continued

9. A 20-year-old sex worker has developed a painful sore in her genital area. She tries to get all of her clients to use condoms, but is not always successful. On exam you notice 4 shallow gray ulcers with irregular borders on her vulva and labia majora.

Answer:

- *Flow chart – genital ulcers*
- *Diagnosis – genital ulcers, could be chancroid*
- *Treatment – antibiotics for genital ulcers*
- *Counsel, Educate, Condoms, Comfort measures, Partner management*
- *Special points – emphasis on condom negotiations skills*

10. A 30-year-old married truck driver noticed burning on urination 2 days ago. He is taking some tablets which he bought in the market, and they seemed to help at first, but today the pain is so bad that he cannot pass urine.

Answer:

- *Flow chart – urethritis*
- *Diagnosis – urethritis, partially or incorrectly treated*
- *Treatment – antibiotics for urethral discharge (treat for gonorrhea and chlamydia)*
- *Counsel, Educate, Condoms, Comfort measures, Partner management*
- *Special points—education about how to take medications and why to finish, awareness of risk, condoms*

11. A 30-year-old healthy appearing complains of a painful sore on her vagina. Her husband is her only partner. She has a fever and cannot pass urine because of the pain. On examination you find many small blisters filled with fluid on the labia majora and minora, and some small ulcers.

Answer:

- *Flow chart – genital ulcers*
- *Diagnosis – genital ulcers, probably HSV*
- *Treatment – no treatment, comfort measures, possibly acyclovir, but very costly*
- *Counsel, Educate, Condoms, Comfort measures, Partner management*
- *Special points – don't have sex with sores because it is both highly contagious and painful. Problems if this is a first time infection and late in pregnancy. Review local guidelines on syphilis testing and treatment of other causes of genital ulcers.*



6.5A: Case Studies Answer Guide continued

12. A 35-year-old farmer noticed a sore on his penis 3 days ago. It is not painful but he has had contact with a bar girl recently in another town, and is concerned that he might have gotten AIDS.

Answer:

- *Flow chart – genital ulcers*
- *Diagnosis – genital ulcers, possibly syphilis*
- *Treatment – antibiotics for genital ulcers including syphilis*
- *Counsel, Educate, Condoms, Comfort measures, Partner management*
- *Special points – risk awareness*

13. A 42-year-old woman complains of occasional severe lower abdominal pain, nausea, lightheadedness and spotting for the last month. She has had an IUD for 3 years without problems. Her husband visited from his job in a neighboring country 3 months ago. You note that she appears generally uncomfortable and ill. Her entire lower abdomen is tender. On speculum examination you do not see an IUD string. And her cervix is bluish. She has cervical motion tenderness and extreme pain on her left side.

Answer:

- *Flow chart – lower abdominal pain*
- *Diagnosis - rule out acute abdomen from ectopic pregnancy*
- *Treatment – refer immediately*
- *Counsel, Educate, Condoms, Comfort measures, Partner management*
- *Special points – always need to rule out an acute surgical emergency*



7.4D: Competency-Based Training (CBT) Skills Assessment Checklist for Counseling Patients on the Use of Medications

Participant's Name: _____

Clinical Site: _____

Clinical Trainer's Name: _____

Date of Assessment: _____ Dates of Training: _____

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
• Tells patient what the medication is.				
• Tells the patient the generic name and common locally available brand name.				
• Tells the patient what the probable cost will be.				
• Asks if the patient can afford the cost.				
• Asks about drug allergy to this medication.				
• Asks about allergic reactions to any other medicines.				
• Chooses another medication if allergic.				
• Describes the most common side effects of the medication.				
• Gives the warning signs of an allergic reaction.				
• Gives clear instructions on how to take the medication using Px Handout 7.5B.				
• Explains why full treatment is necessary.				
• Encourages compliance.				
• Tells patient that the medication should not be shared with partner—the partner needs full treatment with his/her own medicine.				
• Asks the patient to repeat back instructions.				
• Explains comfort measures, if any.				
• Asks the patient if s/he has any questions.				

8.7A: Case Study Answer Guide

Case History

B___, recently married, came to the clinic today because she had pain with intercourse the night before and noted a sore outside her vagina this morning. She walked 10 km. to get to the clinic and waited 2 hours before being seen for 5 minutes by the nurse who seemed stern and in a hurry. The nurse diagnosed an STD and told **B___** she must have an injection, use condoms and bring her husband in for treatment. or she would get another infection and be unable to bear children. **B___** was too stunned to respond when the nurse asked hurriedly if she had any questions, and as she walked home she felt increasingly worried and confused. **B___** didn't want to tell her husband anything for fear that he would accuse her of playing around, although she wondered if her husband still went with other women even though they were now married. She worried that bringing up the subject might make him angry.

Questions:

1. What did the nurse do correctly for **B___**?

Response: She made a diagnosis and offered treatment on the spot, and she counseled briefly about consequences of STDs and the need for partner treatment.

2. What did she omit or do badly?

*Response: She didn't show concern, allow discussion, deal with **B___**'s emotions, offer help on how to talk to her partner, or allow her to practice what she might say to him.*

3. How the nurse could employ the following elements of effective patient education to better help **B___**?

- a. Showing respect and concern for the safety of patients. (Ask for examples of how the nurse could show respect and concern to **B___**.)

Possible responses: body language, telling her she's concerned, being attentive to and acknowledging her feelings, and taking more time with her.

- b. Patient-centered education, meaning messages that fit each individual—different messages for married women, adolescents, and commercial sex workers.

*Since **B___** is married she is unlikely to refuse her husband sex and may need help negotiating safer sex with him.*

 **8.7A: Case Study Answer Guide continued**

- c. Adult education principles.

B___'s feelings need to be acknowledged, and she needs room to express her fears. Then she can accept information on treatment, and risk reduction and even be ready to learn and practice some negotiation skills.

- d. Using multiple channels, such as one-to-one counseling and teaching of accurate information with access to written materials for reinforcement.

The nurse could counsel one-to-one, provide information, give written materials, and refer to posters.

8.11A: Competency-Based Training (CBT) Skills Assessment Checklist for STD Counseling

Date of Assessment _____ Dates of Training _____

Place of Assessment: Clinic _____ Classroom _____

Name of Clinic Site _____

Name of the Service Provider _____

Name of the Assessor _____

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
Non-verbal Communication				
1. Sits close enough to talk comfortably and privately.				
2. Friendly, welcoming, smiling.				
3. Makes eye contact as culturally appropriate.				
4. Is attentive.				
Verbal Communication				
5. Uses language the client can understand.				
6. Tries to identify the client's real concerns.				
7. Is non-judgmental concerning sexual behavior or life style.				
8. Asks open ended questions.				
9. Talks comfortably and accurately about sexual matters pertaining to risk, treatment, and behavior.				
10. Listens to client closely.				
11. Answers client's questions.				
12. Provides relevant information on:				
– Risk				
– Prevention				
– Diagnosis				
– Treatment (including how to take medicine, side effects, cost, allergy)				

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
– Partner referral				
– Condom use and negotiation				
– Follow-up if needed				
– Referral if needed				
• Counsels client about the need for appropriate treatment if necessary.				
• Helps client to reach an informed decision about treatment, partner notification, or referral.				
• Asks if anything is not understood.				
• Dispenses medications or prescription if required.				
• Asks that any instructions be repeated.				

9.2A: Competency-Based Training (CBT) Skills Assessment Checklist for Male Condoms

Date of Assessment _____ Dates of Training _____

Place of Assessment: Clinic _____ Classroom _____

Name of Clinic Site _____

Name of the Service Provider _____

Name of the Assessor _____

ACTIVITY/TASK	CASES			COMMENTS
	1	2	3	
1. Provides basic facts about condoms:				
– How they work and their effectiveness				
– Stresses that consistent and correct use with every act of intercourse is the key to effectiveness				
– Explains their ability to prevent both pregnancy and STD				
– Asks if client/partner has any allergies to latex				
– Tells where to obtain them and the cost				
2. Ask if client has any questions and responds to them				
3. Provides very specific instruction on how to correctly use and when to use condoms:				
– Package must be torn open carefully				
– Use during every act of intercourse				
– Use with spermicide whenever possible				
– Do not "test" condoms by blowing up or unrolling				
– Put on when penis is erect				
– Put on before penis is near/introduced into vagina				
4. Demonstrates how to correctly put on condom by using a model, banana, or two fingers:				
– Cautions client not to unroll condom before putting it on				

ACTIVITY/TASK	CASES			COMMENTS
	1	2	3	
– Shows how to place rim of condom on penis and how to unroll up to the base of penis				
– Instructs how to leave 1/2 inch space at tip of condom for semen, which must not be filled with air or the condom may burst				
– Shows how to expel air by pinching tip of condom as it is put on				
– Cautions about tearing accidentally with fingernails/rings				
5. Counsels client what to do if condom breaks or slips off during intercourse:				
– See doctor/clinic where woman can be assessed for emergency contraception				
– Request emergency contraceptive pills within 72 hours (the earlier the better) of unprotected intercourse or condom breakage				
6. Has client demonstrate and practice putting on condom using the model/banana/fingers. Corrects any technique errors.				
7. Counsels client on how to remove penis from vagina with condom intact and with no spillage of semen:				
– Hold on to rim of condom when withdrawing				
– Be careful not to let semen spill into vagina when penis is flaccid				
8. Discusses use of lubricants and what not to use:				
– Do NOT use: – petroleum-based products (vaseline) – mineral, vegetable, or cooking oil – baby-oil – margarine or butter				
– Use a water-based lubricant if one is needed				
9. Advises client to dispose of condoms by burning, burying, or throwing in the latrine and to not flush down the toilet				
10. Provider repeats major condom messages to client:				

ACTIVITY/TASK	CASES			COMMENTS
	1	2	3	
– Be sure to have a condom before you need one				
– Use a condom with every act of intercourse				
– Do not use a condom more than once				
– Do not rely on condom if package is damaged, torn, outdated, dry, brittle, or sticky.				
11. Provides client with at least a three-month supply (about 30–40 condoms).				
12. Reassures client s/he should return at any time for advice, more condoms or when s/he wants to use another method.				



9.2B: Competency-Based Training (CBT) Skills Assessment Checklist for Female Condoms

Date of Assessment _____ Dates of Training _____

Place of Assessment: Clinic _____ Classroom _____

Name of Clinic Site _____

Name of the Service Provider _____

Name of the Assessor _____

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
1. Provides basic facts about female condoms (FC):				
– How they work and their effectiveness				
– Their ability to prevent both pregnancy and STD				
– That women can initiate their use				
– Where to obtain them and their cost				
– Safety and effectiveness of re-usability has not been determined				
2. Asks if any questions and responds to them				
3. Provides general instructions on when and how to use the FC:				
– The FC can be inserted anytime from 8 hours before to immediately before intercourse				
– Neither insertion nor removal requires an erect penis				
– Cautions that the outer ring may move from side to side or the sheath may slip up and down inside the vagina during intercourse, but this does not reduce protection				
– Explains that there is little protection if the outer ring is pushed into the vagina, or the penis is underneath or beside the sheath, rather than inside the sheath				
– Explains that any kind of lubricant can be used with the female condom				

TASK/ACTIVITY	CASES			COMMENTS
	1	2	3	
<ul style="list-style-type: none"> - Tells not to use the male condom with the female condom as it may cause too much friction and result in one or the other slipping or tearing 				
4. Provides instructions on how to insert, remove, and dispose of the FC:				
<ul style="list-style-type: none"> - The packet must be carefully torn open 				
<ul style="list-style-type: none"> - Find the inner ring, which is at the closed end of the condom 				
<ul style="list-style-type: none"> - Squeeze together the inner ring with your fingers and put it in your vagina 				
<ul style="list-style-type: none"> - Put the inner ring in the vagina 				
<ul style="list-style-type: none"> - Push the inner ring up into your vagina with your finger. The outer ring stays outside the vagina. 				
<ul style="list-style-type: none"> - When you have intercourse, guide the penis through the outer ring, making sure it goes inside the sheath. 				
<ul style="list-style-type: none"> - Another way to insert the FC is to put it over the erect penis so that the end of the penis is touching the inner ring, and insert the penis with the sheath into the vagina. 				
<ul style="list-style-type: none"> - Remove the female condom immediately after sex, before you stand up. Squeeze and twist the outer ring to keep the man's sperm inside the pouch. 				
<ul style="list-style-type: none"> - Pull the pouch out gently, 				
<ul style="list-style-type: none"> - Burn or bury it—do not flush it down the toilet. 				
5. Counsels client on what to do if female condom breaks or slips off during intercourse:				
<ul style="list-style-type: none"> - Go to clinic where you can be assessed for emergency contraception. 				
<ul style="list-style-type: none"> - Request emergency contraceptive pills within 72 hours (the earlier the better) of unprotected intercourse or breakage of condom. 				
6. Asks client to repeat back instructions and practice with a female condom. Corrects any errors in technique.				

ACRONYMS
&
GLOSSARY

List of Acronyms and Abbreviations

AIDS	acquired immune deficiency syndrome
AIDSCAP	AIDS Control and Prevention Project
ANC	antenatal care
BCC	behavior change communication
BV	bacterial vaginosis
CBD	community-based delivery
FP	family planning
GUD	genital ulcer disease
HBV	hepatitis B virus
HIV	human immunodeficiency virus
HPV	human papilloma virus
HSV	herpes simplex virus
ICPD	International Conference on Population and Development
LAP	lower abdominal pain
MCH	maternal and child health
MOH	ministry of health
NGO	non-governmental organization
PE	physical examination
PHC	primary health care
PID	pelvic inflammatory disease
PPNG	penicillinase-producing <i>Neisseria gonorrhoea</i>
PPV	positive predictive value
Px	participant(s)
RH	reproductive health
RTI	reproductive tract infection
SMVD	syndromic management of vaginal discharge
STD	sexually transmitted disease
STI	sexually transmitted infection
TCA	trichloroacetic acid
TV	<i>Trichomonas vaginalis</i>
VCT	voluntary counseling and testing

Glossary

adnexae Consists of fallopian tubes and ovaries together on either side.

AIDS Acquired Immunodeficiency Sndrome AIDS is the stage of HIV infection that develops some years after a person is infected with HIV.

anus The opening of the rectum below the perineum.

Bartholin's ducts Openings of two small glands (the greater vestibular glands) on either side of the vaginal introitus which secrete a clear mucoid substance during sexual activity.

bladder The hollow muscular organ that holds urine located between the uterus and the public bone.

case finding: Finding an STD in a woman who has come to you for other reasons and has an asymptomatic infection.

case management means correctly diagnosing and treating symptomatic patients and providing patient education and partner management to cure the patient; and prevent reinfection and transmission to others.

cervical os The opening of the cervix, which is round and virtually closed in nulliparas, but may be wider and more variously shaped in women who have given birth.

cervix The neck of the uterus, its lower portion, part of which protrudes into the vagina and is at the junction of the uterus and the vagina. It is firm like the tip of the nose. It is covered with columnar epithelium until maturity, at which point this tissue begins to recede into the interior of the cervical canal and squamous epithelium predominates.

clinical approach to STD management Provider makes a diagnosis (or educated guess about which organism is causing infection) based on the patient's history, signs, and symptoms.

clitoral hood The overlying skin of the clitoris, which is analagous to the male foreskin.

clitoris A small organ just above the urethral orifice, which is well supplied with nerve endings to promote sensation and pleasure during intercourse. It contains erectile tissue and is analagous to the male posterior penis.

closed questions Questions that require only a "yes" or "no" or very short answer. (E.g., Is your back painful? How old are you?).

dual method use In this training we use the term "dual method use" to mean the use of two methods of contraception, usually one that is highly effective at pregnancy prevention along with an effective barrier to STD transmission, usually condoms.

dual protection In this training we use the term "dual protection" to mean use of condoms to prevent both STDs and pregnancy.

epididymus A highly coiled tube that lies on top of each testis. Nearly mature sperm move into the epididymis where they mature and gain ability to swim. They are stored there until ejaculation when semen passes out of the urethral opening in the penis..

etioloical approach to STD management A diagnosis is based on the results of laboratory tests that can identify the specific organism causing the infection.

fallopian tubes Paired, narrow, soft, muscular tunnels of about 5 inches (10 cm.) in length , beginning in the uterine wall and continuing on to the isthmus, the main portion, and ending with the ampulla, the wide, fringed open end near the ovary. Their function is to search for the egg when it is released from the ovary and guide it from the mouth of the tube and into the uterus.

flow chart A flow chart is like a map (or a decision tree) that goes carefully through the decisions and actions needed to make a diagnosis of the patient's condition, to treat it, and to prevent future infection.

foreskin A loose tube of skin covering the glans and protecting it. In some cultures this covering is removed. This is called circumcision.

glans penis The head or tip of the penis. It is highly sensitive and can be a source of sexual pleasure. It is analogous to the female clitoris. The urethral opening, or meatus, is at the tip of the glans.

HIV Human Immunodeficiency Virus The sexually transmitted disease that causes AIDS.

incidence The number of new cases of disease occurring (usually each year).

inguinal region The groin area where the top of the leg joins the body, through which pass a number of internal structures including the lymph drainage system for the external genitalia . Lymph nodes can be palpated in the groin.

integration The addition of services to prevent and manage RTIs into an already existing family planning program.

interpersonal communication The face to face process of giving and receiving information between two people. This involves both verbal and non-verbal communication.

labia majora The outer, heavier lips of the vagina which are analagous to the scrotum in the male.

labia minora The smaller, inner lips of the vagina which are hairless, smooth and pigmented.

mons pubis The fatty area covering the pubic bone above the introitus, which is covered with pubic hair at puberty.

non-verbal communication The way we behave with clients, including gestures, facial expressions and behaviors.

open questions These are questions that Invite the patient to give a longer answer (Tell me more about your back pain, what else is troubling you?).

ovaries Paired glands of 2.5-5 cm. in length with the dual function of egg production and female hormone production. They are located in the pelvis at the ends of the fallopian tubes, a little below the rim of the pelvis.

perineum An area of skin which is part of the external genitalia between the vaginal opening and the anus.

positive predictive value (PPV) or simply predictive value, is the proportion of people who really have disease when they have a positive test.

prevalence (the percentage of those in your population who actually have the disease in question—you only know this if prevalence studies have been done). (usually expressed as percent). E.g. “10% prevalence of chlamydia among pregnant women” “10% of pregnant women have chlamydia”

prevention means using community education and other strategies to prevent infection from occurring, including messages to raise awareness about RTIs and the harm they cause, reduce the number of sex partners, use barrier methods, and have safer sex.

reproductive health The International Conference on Population and Development (ICPD) in Cairo defined reproductive health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system.”

risk assessment is a term used to describe a process of confidentially asking patient particular questions to determine his or her chance of getting or giving a STD.

RTIs The term RTI, or **reproductive tract infection**, refers to any infection of the reproductive tract. In women, this includes infections of the outer genitals, vagina, cervix, uterus, tubes, and ovaries. In men, RTIs involve the penis, testes, scrotum, and prostate. RTIs include STDs but also include infections that are not sexually transmitted such as infection after childbirth, abortion, or IUD insertion.

scrotum A loose sac that hangs directly under the penis and contains the male internal reproductive organs and protects them.

seminal vesicles Two small organs located beneath the bladder where the sperm combines with a fluid called seminal fluid that gives the sperm more room to move and provides it nourishment. The sperm passes through the prostate and Cowper’s glands which each add more fluid, into the urethra and out of the body through the urethral opening of the glans penis.

sensitivity of a flow chart, or a diagnostic test is the proportion of people who test positive who really have the disease.

shaft The largest part of the penis, shaped like a tube, connecting at one end with the body and the other with the glans.

Skene's ducts Openings of two smaller glands (the lesser vestibular glands) on either side and just below the urethral opening.

specificity of a flow chart, or diagnostic test is the proportion of people who test negative, who really do not have the disease.

STDs (or sexually transmitted diseases) are infections caused by germs such as bacteria, viruses, or protozoa that are passed from one person to another through sexual contact.

STIs (or sexually transmitted infections) a term sometimes used to indicate that infections do not always result in a disease.

syndromic approach to STD management The patient is diagnosed and treated based on groups of symptoms, or syndromes, rather than for specific STDs.

testes Two ball-shaped glands inside the scrotum which produce sperm, the reproductive cells of men.

urethral meatus A small opening at the tip of the penis through which urine and semen

pass from the man's body.

urethral opening A small opening just above the vaginal orifice and below the clitoris from where urine is excreted.

uterus A pear-shaped, thick-walled, muscular organ in the pelvis between the bladder and rectum, about half the size of the patient's fist. It is divided into two main portions, the body, or corpus above, and the smaller cervix, below.

vagina The vagina itself is a muscular canal which begins at the hymen and ends at the opening of the uterus and serves as the birth canal. It is lined with mucus membrane and has many rugae, that is, deep and expandable ridges.

vaginal orifice or **introitus** The outermost area of the vagina, bordered on the outside by the labia minora, the clitoris and the perineum. The inside border is the hymen, a thin membrane which may or may not be present depending on age, parity, coitus and other factors.

vas deferens A long, thin tube that connects the epididymis to the seminal vesicles on the way out of the body.

verbal communication The way we talk with clients, the words we use, and their meanings.

vulva The name given to the external female reproductive organs, consisting of the mons pubis, the labia majora, the labia minora, the clitoris and the ducts of the glands that open into the outer vagina (Skene's and Bartholin's ducts).

window period: Shortly after infection with HIV the body starts to make *antibodies* to fight the virus. They usually appear in the blood 8-12 weeks after the virus enters the body, but it can take as long as 6 months for antibodies to appear. The time between when a person is infected with HIV and when the body makes antibodies against it is called the "window period."