STANDARD OPERATING PROCEDURES FOR STI CLINICS

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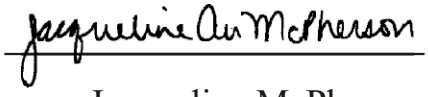
FOREWORD

The first Sexually Transmitted Infections (STI) Standard Operating Procedure (SOP) manual was developed by Family Health International/Nepal (FHI/Nepal) in 2003 with financial support from the United States Agency for International Development (USAID). This is the second revision and is compatible with the National Guidelines on Sexually Transmitted Infection Case Management, 2006.

This STI SOP manual was developed for use by FHI/Nepal's implementing agencies, which provide STI services through their Integrated Health Services (IHS) sites. This SOP is meant to assist IHS sites establish and implement high quality STI services.

Early diagnosis and treatment of STIs is an effective strategy to prevent the transmission of HIV, as the presence of certain STIs can increase the risk of HIV transmission. Therefore it is essential to provide quality STI services, especially to most at risk populations including female sex workers and their clients, injecting drug users, men who have sex with men, and migrant workers and their partners. IHS sites provide diagnosis and treatment of STI infections for most at risk populations as well as health education for effective management of STIs.

FHI/Nepal would like to express its sincere appreciation to all contributors to this manual. We hope that this SOP will be useful to ensure high quality STI services in Nepal.



Jacqueline McPherson
Country Director
Family Health International/Nepal

CONTENTS

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARD	Ano-rectal discharge
ARV	Anti-retroviral
AZT	Zidovudine
BID	Twice daily
DIC	Drop-in-Center
EIA	Enzyme-linked Immunoassay
GUD	Genital Ulcer Disease
HBsAg	Hepatitis B surface antigen
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HCW	Health care worker
HIV	Human Immuno-deficiency Virus
Hpf	High power field
HPV	Human papillomavirus
HSV	Herpes simplex virus
IDU	Injecting drug user
IEC	Information, Education, Communication
IM	Intramuscular
IU	International Unit
LAP	Lower Abdominal Pain
MSM	Men who have Sex with Men
MARP	Most-at-risk population
NGO	Non-government organization
PE	Peer Educator
PEP	Post Exposure Prophylaxis
PID	Pelvic Inflammatory Disease
QID	Four times a day
RPR	Rapid Plasma Reagin
RTI	Reproductive Tract Infection
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TID	Thrice in a Day
TPPA	Treponema pallidum Particle Agglutination test
TPHA	Treponema pallidum Hemagglutination test
UD	Urethral Discharge
VDRL	Venereal Disease Research Laboratory
VCT	Voluntary Counseling and HIV testing
WBC	White Blood Cell
3TC	Lamivudine

Introduction

These Standard Operating Procedures for STI clinics have been developed to improve the overall quality of STI service delivery including the accurate diagnosis and management of sexually transmitted infections (STIs) through the FHI-run STI service delivery facilities in Nepal and thereby to prevent the transmission of STIs as well as HIV in the community.

This SOP manual is expected to guide the clinic managers and the clinical team as a reference to facilitate the day-to-day management of STI clinics and also to guide the clinical staff who directly participate in STI patient management, including doctors, nurses, counselors and educators.

Key Activities of an STI clinic:

- Establish strong linkages with the agencies working on awareness raising and behavioral change interventions through their outreach activities and targeted mostly to the most-at-risk populations (MARPs)
- Promote prevention activities, such as promoting correct and consistent use of male condoms (and female condoms where available) and other safer sexual practices
- Provide effective services including immediate diagnosis and clinical management, for patients with STI symptoms (Enhanced Syndromic Management)
- Perform regular (monthly) health check-ups (history taking and physical examination) of FSWs and treat them presumptively for gonorrhea and chlamydia infection even if they are asymptomatic at their first visit and repeat such treatment if the client has not come for STI screening for three months
- Screen and provide effective STI services to the partners/clients of STI patients and other high-risk populations through effective contact tracing programs
- Follow the standard (national) recording and reporting system of STI data to contribute to the national surveillance system for STIs in Nepal
- Develop an on-going monitoring system from within and outside the agency to maintain and improve the quality of its services
- Establish referral links with other service delivery agencies for the relevant services that are not provided from the STI clinic (family planning and other reproductive health services)
- Be well equipped, adequately staffed, easily accessible and user-friendly

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

STI 1: Clinic Set-up and Operation

(To be ensured by STI clinic management team)

Community Involvement and Coordination with Outreach Services

i. Promote the effective participation of the local community (including the targeted populations wherever feasible) in the clinic operations and management.

ii. Develop strong communication links with the community through the community leaders for increasing their involvement in the clinic activities

iii. Preferably employ the clinic staff, the outreach educators and peer educators from within the targeted community.

iv. Work harmoniously and collaborate closely to ensure that the targeted community has a sound understanding of the program.

v. Clinic staff should explore the community perceptions about the clinic activities, their satisfaction and effectiveness of outreach and peer education in a timely manner to maintain the attendance and effectiveness of the clinic.

vi. Establish close collaboration and communication between clinic staff and outreach staff to help identify and address problems between the clinic and the community.

vii. Organize regular meetings between project clinical staff, outreach educators, and peer educators to discuss and coordinate the ongoing clinic activities. User-friendly Environment

a. Make the STI Clinic Acceptable to MARPs and Promote Trust within them:

- Respectful attitude of staff
- Convenient location and clinic opening hours
- Anonymity and confidentiality of clients' information
- Right to refuse services by MARPs
- Standardized services

b. Ensure Confidentiality of Clients' Information:

- Confidentiality should be ensured at all times and must be continually reinforced
- Clinics should have a confidentiality policy that is enforced and communicated to the patients and the community.
- Clients should be informed about how their medical information is handled
- A unique identity number should be assigned to each client as his/her identifying information to ensure them the freedom of anonymity.
- All staff should receive orientation in the confidentiality policies of the clinic and be strictly followed.
- Procedures and systems (such as setting up a complaint register) should be in place for patients who feel their confidentiality has been breached.

c. Ensure Accessibility:

- To improve access and attendance of the target populations, clinics should remain open during times when the target population can conveniently access services.

- The clinic should be located at the site accessible and convenient to its users
- Outreach Educators/Peer Educators (OREs/PEs) should counsel the clients and give them the most convenient appointment date and time to attend the clinic.

d. Ensure Right of Clients to Refuse Services

- Patients have the right to refuse services
- Patients will not be coerced into attending the clinic or receiving treatment.
- The clinic staff will however, explain their clinical status, consequences and the available services to the clients

Clinic Structure

(Responsibility of implementing agency)

Ideally, each STI clinic* should have at least the following rooms:

- Waiting and Registration room
- Consultation and Examination Room
- Laboratory room and
- Counseling Room

(However, some mobile STI clinics may not have these facilities)*

The clinic structure should have the following qualities:

- Consulting, counseling and laboratory rooms should ensure both auditory and visual privacy
- All rooms should be clean and have adequate lighting and ventilation.
- The Laboratory should be separate but adjacent to the consultation/examination & counseling room.
- Rooms should be properly furnished and maintained to ensure a comfortable, safe and hygienic environment
- STI clinic must have clean and safe toilets preferably separate for male and female

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Date Adopted: September 2007

Reviewed by:

Name	Signature	Date
Graham Neilsen		**September 24, 2007**
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STI 2: Clinic Staff and Training

Staff and their job responsibilities

(Responsibility of the clinic management authority)

An STI clinic should at least have the following staff to perform the desired functions:

Table I. Showing lists of essential staff in a STI clinic and their main responsibilities

S. No.	Position	Major Responsibilities
1	Medical Doctor	History-taking in sexual and reproductive health, clinical examination and patient management, including STI counseling and education
2	Health Assistant (If provision made in Sub- agreement)	History-taking in sexual and reproductive health, clinical examination and patient management, including STI counseling and education
3	Staff Nurse	Assist/Accompany medical doctor/ health assistant in consultation and examination Prepare the clients for examination
4	VCT Counselor	Counseling for HIV testing
5	Lab. Technician	Laboratory-based diagnostic testing for STIs
6	Adm. Assistant	Clinic administration, patient registration, record-keeping and reporting management of clinic supplies
7	Clinic Helper	Maintenance of clinic standards and proper disposal of clinic wastes

Note: Clinic management authority should develop Terms of Reference (and should attach with the appointment letter) for each staff and orient them on their respective job responsibilities.

Staff Training and Skills Development

Role of implementing agency:

- Clinic staff should be selected based on their optimum qualification and training to perform their assigned tasks
- Standard National STI Case Management Training is the necessary requirement for the clinical staff (Medical Doctor, Health Assistant, and Staff Nurse) providing services at the STI clinics. It is the responsibility of the implementing agencies to ensure proper training of the clinical staff)
- Clinic staff should be skilled, polite, friendly and have a non-judgmental attitude towards the target populations
- Staff should get clear orientation from Program Coordinator/Manager and understand the rules and norms of clinic functioning before the start of clinic operations
- The clinic management should develop and implement a plan for on-going technical support (supportive monitoring) and supervision of their staff from the Program Coordinator and hired consultants

Clinicians should be:

- Able to perform all the basic clinical procedures (e.g., speculum, bimanual and proctoscopic examinations, and specimen collection) that are necessary to diagnose and manage STI patients
- Able to provide basic life support in case of anaphylactic reaction and coordinate to the referral channels whenever needed
- Able to orient/train rest of the clinical team as and when needed

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Reviewed by:

Name	Signature	Date
Graham Neilsen		**September 24, 2007**

STI 3: Clinic Equipments

Responsibility of Clinic Management Authority

The clinic should have and maintain all the basic essential equipment in a good working condition by:

- Properly cleaning, wiping/dusting daily with clean cloth
- Covering when not in use with protective coverings

Suggested Lists of Minimum Clinic Equipment and Supply

a. General Medical Equipment:

1. Sphygmomanometer
2. Stethoscope
3. Thermometer
4. Adult height and weighing scales
5. Tongue depressor
6. Medicine cabinet
7. Torch

b. Equipment for Examination:

8. Screens for privacy
9. Examination couch Ideally with steps and “cut-away” recess for speculum examination
10. Examining chair (preferably with wheels)
11. Sheets for examination couch
12. Pillow for examination couch
13. Drapes or clean towels
14. Torch with fresh batteries and backup supply of batteries
15. Examination light (preferably gooseneck lamp halogen bulb)
16. Kelly pad or other waterproof sheeting
17. Hand mirror

c. Instruments and Sterilization:

18. Sterilizer (Electric Autoclave)
19. Scissors
20. Instrument tray with cover
21. Movable instrument holder
22. Cotton ball holder
23. Vaginal specula of various sizes
24. Speculum holder
25. Proctoscopes/anoscopes of various sizes
26. Ovum forceps
27. Generator or Inverter

d. Laboratory Equipments and Supplies (refer to Annex II)

For other medical consumables refer to Annex II.

e. Hand Washing Facilities

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Reviewed by:

Name	Signature	Date
Graham Neilsen		**September 24, 2007**

STI 4: Clinic Management

Patient Registration at STI Clinic:

STI patients will be registered in the STI clinic from the following sources:

- Patient counseled and brought by outreach workers
- Patient counseled and brought by community mobilizers
- Patient referred from other health facilities/agencies
- Patient traced and referred as partners of STI
- Self-referral
- Others

a. First Time Registration (for all new patients):

Each new patient attending the STI clinic will be registered by the receptionist in a new register file and should record the demographic profiles of the patient that includes: Name or pseudonym (if desired), Age, Sex, Address, Occupation and mode of referral to the clinic (as above). The receptionist should provide an ID card with an ID number (a unique identifier), to each patient to facilitate the record keeping and patient's identification in the subsequent visits

b. Registration on Subsequent Visits:

On subsequent visits, the client will report either for scheduled appointments or will come for emergent needs. After verifying the unique identifier number through the client's registration card, the receptionist will update the necessary information on the registration form including the date and purpose of visit and sends her/him to the respective service provider

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Reviewed by:

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STI 5: Steps of STI Case Management

- Sexual and reproductive health history-taking;
- Physical examination including external ano-genital examination, a speculum and bimanual examination of the genital tract for all female patients and rectal examination (including anoscopy, if indicated) for patients practicing receptive anal sex or with ano-rectal symptoms
- Specimens collection for the following tests, where on-site laboratory services are available:
  - Basic microscopy (Gram stain for cervical specimens and wet-mount slide preparation for vaginal specimens)
  - Whiff test
  - Syphilis serology, on-site quantitative RPR and TPHA/TPPA for all positive syphilis serology
- Provision of referral for the laboratory services should be made if such facility does not exist within the clinic
- Appropriate and immediate treatment and counseling of every patient emphasizing the "four C's" (condom demonstration and provision, counseling, contact tracing and compliance/adherence with treatment)
- Follow-up care
- Contact tracing and partner treatment
- Referral network for services not available at the clinic (e.g., family planning services other than condom promotion, pregnancy test, HBsAg, ART, CD4 count, referral for higher management of STIs etc.)

> *Note: Whiff test is positive when the clinician detects the fishy (amine) smell that emerges on adding 1-2 drops of 10% freshly prepared potassium hydroxide solution to the smear made of vaginal secretion and is indicative of bacterial vaginosis*

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Graham Neilsen		**September 24, 2007**

STI 6: History Taking

Performed by the clinician (Medical Doctor/ Health Assistant or Nurse)

General Rules:

- Help the patient feel at ease.
- Be tactful, tolerant and non-judgmental.
- Provide auditory and visual privacy.
- Assure confidentiality.
- Use simple terms that the patient understands.
- Ask the least sensitive questions first.

The Information a Clinician needs to Collect Includes:

- General personal details
- Present illness
- Medical history
- Obstetric & menstrual (in female) and contraceptive history
- Sexual history

When taking a sexual history, reassure the patient that the information is being obtained only to help in treating him or her and will be kept confidential and is routinely asked of all patients. Properly taken sexual history forms the basis for risk assessment and treatment of STI. A good way to start off the questions regarding sexual behavior is by saying:

"I would now like to ask you some very personal questions. Please try to answer the questions as best you can. The answers to the questions will help me plan your treatment."

Risk assessment of the female clients is done by answering following questions with Yes or No. These questions are included in female health record form.

For High Risk Women (e.g., FSWs and partners of patients with STIs including HIV infection)

From history and/or BCI referral: Is patient high-risk woman? ☐ Yes ☐ No

Has she been seen in the clinic in last three months? ☐ Yes ☐ No

Did she use a condom with her last client? ☐ Yes ☐ No

Does she use condoms consistently? ☐ Yes ☐ No

Yes to the first question or no to any of the remaining three is the indication for the presumptive treatment of cervicitis.

For Low Risk women

BEHAVIORAL FACTORS

Sexual intercourse with partner with urethral discharge in the last 3 months? ☐ Yes ☐ No

Aged 25 years or less? ☐ Yes ☐ No

Has had multiple partners in the last one month? ☐ Yes ☐ No

'Thinks' that a partner has other sexual partners? ☐ Yes ☐ No

In last 3 months, had sexual intercourse with partner within one week of their return from travel?

☐ Yes ☐ No

CLINICAL FACTORS

Abdominal tenderness? ☐ Yes ☐ No

Cervical bleeding on touch? ☐ Yes ☐ No

Non-clear endocervical discharge (i.e. mucopus, pus)? ☐ Yes ☐ No

Cervical excitation (pain or discomfort on moving the cervix during bimanual examination)? ☐ Yes ☐ No

One behavioral factor 'Yes' + One clinical factor 'Yes' is the indication for cervicitis treatment

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Graham Neilsen		**September 24, 2007**
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STI 7: Clinical Examination

Role of the Nurse

- Put the patient at ease by talking about informal topics
- Explain the steps and importance of procedures will be done
- Take pulse, temperature and blood pressure

Role of the Clinician (Medical Doctor / Health Assistant)

- Take informed consent for the examination, explaining about the procedure.
- (If the clinician is male and the client is a female, ensure that a female health care worker is also present during the examination)
- Ask the female patient to void her bladder if she hasn't done so within the past one hour (males should NOT empty their bladder prior to examination since this will remove any evidence of urethral discharge).
- Wash hands before conducting the examination.
- Cover parts of the body not being examined.
- Perform the examination gently and carefully maintaining a confident and professional demeanor

General Examination

- Examine the mouth with the help of a tongue depressor and examination light for sores, pharyngeal inflammation, and growths including warts, ulcers and candidiasis.
- Palpate the neck, the axillae, supraclavicular, submandibular and epitrochlear areas for enlarged lymph nodes.
- Look for rashes, swellings and sores on the chest, back and abdomen.
- Inspect the patient's hands, forearms and inside the elbow. Note any rashes, nail changes or “needle track” marks.
- Palpate the abdomen, feeling for areas of tenderness and for swellings. Check particularly for tenderness deep in the pelvis.
- Auscultate lungs if the patient looks unwell.

Examination of Female Clients

a. External Ano-genital Examination

- Explain and take consent from the patient to perform the procedure
- Wear gloves for the examination.
- Ask the patient to bend her knees and separate her legs (in lithotomy position)
- Inspect pubic hair for signs of ectoparasite infestations.
- Palpate for any inguinal lymph nodes or rashes.
- Inspect the labia and then retract them to inspect the urethral meatus, clitoris, introitus, perineum and perianal areas. Note any discharge, ulcers, warts or growths.

b. Speculum examination

- Wear gloves to carry out a speculum and bimanual examination.
- Ask the patient to lie on the examination couch with her legs bent at the knees and her feet and knees

separated (lithotomy position)

- Remember to explain each step of the procedure as you carry it out.
- Use a sterile Cusco bivalve speculum of appropriate size.
- Use water-based lubricant or clean warm water to wet the speculum
- Separate the labia. Place your left index finger in the opening of the vagina and apply gentle downward pressure while instructing the woman to relax her vaginal muscles. With your right hand, slowly insert the speculum with the blades rotated at a 45 degree angle to avoid causing painful contact with sensitive anterior structures. Insert the speculum on a slightly downward slope. Rotate the speculum to the horizontal position when it is about halfway in.
- Open the speculum blades slowly and look for the cervix. If it is not visible, withdraw the speculum slightly and redirect it at a different angle. Move the speculum gently and slowly until the cervix is clearly visible. Lock the speculum in the open position and adjust the light source.
- Inspect the cervix; it should look pink, round and smooth. Small yellowish cysts, redness around the os and clear odourless mucoid discharge are normal findings. If the cervix is not visible due to the presence of discharge, wipe the exocervix with a swab or cotton wool
- Cervical infection is suspected when there is yellow muco-pus discharge or friability when touching the cervix with a swab.
- As you remove the speculum, turn it gently to inspect the walls of the vagina for ulcers or discharge. If discharge is present, note the type (homogenous, thin, thick/curd-like, frothy), colour (white, grey, green/yellow) and amount (scant, moderate, profuse).
- Take specimens for laboratory tests while the speculum is inside the vagina and while inspecting the vagina and cervix directly. Procedures for taking specimens are outlined below.

> *Note: A correctly performed speculum examination should not be painful. If a patient has extensive genital ulcerations, it may not be possible to carry out a speculum examination until it heals after proper treatment*

c. Specimen Collection

Follow the steps below for specimen collection. Specimens should be collected while the speculum is inside the vagina. The procedure is as follows:

- Take one swab from the vaginal secretions or discharge from the posterior fornix of vagina. Make a smear of this on two microscope slides: one for KOH preparation and the other for saline preparation.
- Wipe the cervix with a swab or cotton wool. Insert a clean swab into the cervix, roll it around inside the cervix for 30 seconds and then remove it and make a smear on a glass slide for Gram stain.
- After the examinations is over, counsel and offer HIV Counseling Testing and if agreed, fix an appointment for VCT and send the client (and collected specimens) to the laboratory to collect blood for syphilis and HIV tests (as applicable).

d. Bimanual Examination

- Lubricate (with water-based lubricant) the gloved index and middle fingers of your examining hand. Insert them into the vaginal opening.
- Locate the cervix and gently move it side to side (cervical excitation test) while watching the

expression on the woman's face. Pain on cervical motion suggests infection.

- Place your other hand on the lower abdomen while your fingers are still in the vagina. Check the size of the uterus while palpating it between your hands. A soft, large uterus may indicate pregnancy. A hard or lumpy uterus may be due to fibroids or other growths. A painful uterus may indicate it is infected.
- Move your upper hand to the right lower quadrant of the abdomen and your intravaginal hand to the right fornix. Any severely painful area or lump larger than an almond-Desi Badam (to rule out ovary) may indicate infection or other emergency. If there is a painful lump and missed menstruation this may indicate an ectopic pregnancy (a surgical emergency).

> *Note: Any patient with history or physical findings of lower abdominal pain or tenderness should undergo bimanual examination to check for the presence of cervical motion tenderness (cervical excitation test), which is clinically diagnostic of cervicitis and/or PID.*

e. Proctoscopic/anoscopic Examination for Males, Females and Transgenders

(For indication, and steps refer to proctoscopic/anoscopic examination in male)

Examination of Male Clients

(Steps of general examination are same as female clients)

Steps of Anogenital Examination

Ensure that, the patient should not have passed urine at least one hour prior to examination

- Explain and take consent from the patient to perform the procedure
- Wear gloves for the examination.
- Ask the patient to lie down on an examination table with trousers and underpants lowered to the knees.
- Palpate for any inguinal lymph nodes or rashes.
- Inspect pubic hair for signs of ectoparasite infestations.
- Palpate the contents of scrotum for lumps and tenderness. This is achieved by gently cradling each testicle in one hand while feeling for the epididymis with the fingers of the same hand. With the other hand, gently roll the vas deferens to detect any lumps. (Repeating the scrotal examination with the patient standing allows for better detection of conditions such as hernias and varicoceles)
- Inspect the skin along the length of the penis from base to the tip.
- Retract the foreskin (if present) and inspect the urethral meatus by parting the tip bilaterally. Note any discharge, ulcers, warts, rashes or lumps. Ask the client to milk the urethra if no discharge is seen on first inspection.
- Ask the patient to turn onto the left side and to bend his both knees and flex the hips to 45 degrees. Ask the patient to place his right hand on his right buttock and draw it upwards to give full exposure of the perianal area. Inspect the buttocks, perineum and perianal area. Note any lumps, ulcers, fissures, rashes, excoriations, scars or discharge.

Digital and Proctoscopic/anoscopic Examination

Indications:

- If there are ano-rectal signs or symptoms
- As a routine examination for patients who give a history of receptive anal sex

Steps:

- Arrange a bright light source to inspect the rectal walls.
- Remember to explain the patient each step of the procedure as you carry it out.
- Ask the patient to lie in a left lateral position with knees bent and hip flexed
- **Perform digital examination** using a lubricated and gloved right index finger
  a. Place the pad of your finger over the anus and ask the patient to bear down.
  b. As the sphincter relaxes, insert your finger into the anal canal, in the direction of the umbilicus asking the patient to relax the muscles by bearing down effort
  c. Palpate the prostate and lower rectum and feel for the presence of masses or lumps beneath or any opening (fissure-in-ano) of the rectal mucosa, location of painful areas and size and contour of the prostate gland.
  d. Rotate your hand to palpate all walls of the rectum.
  e. Withdraw your finger slowly after returning your hand to neutral position and check it for the colour of the stool and any abnormal findings
- **Perform Anoscopic/proctoscopic Examination**

  Before putting anoscope, points to remember:

  a. The examiner should change gloves between the digital rectal examination and anoscopy
  b. The examiner should be sure that the proctoscope/anoscope has been properly sterilized before using it.
  c. Before inserting, warm the proctoscope/anoscope with water and apply water-based lubricating jelly to both the perianal area and the tip of the proctoscope/anoscope

Steps:

- Rest the proctoscope/anoscope at the anal verge until the sphincter relaxes, then insert it slowly applying gentle constant pressure.
- Allow the proctoscope/anoscope to follow the line of least resistance rather than pushing it. Generally aim towards the navel. Elevation and relaxation of the buttocks aids insertion, as does asking the patient to "bear down" as if opening the bowels.
- Remove the introducer once the proctoscope/anoscope has reached its limit. With the aid of the examination light observe the colour and texture of the rectal mucosa and the presence and characteristics of discharge, ulceration, bleeding, or lesions.
- While the proctoscope/anoscope is inside the rectum, take a swab of the rectal mucosa and make a smear on a glass slide for Gram stain.
- Slowly remove the proctoscope/anoscope, checking for hemorrhoids and/or other lesions on withdrawal.

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Reviewed by:

Name	Signature	Date
Graham Neilsen		September 24, 2007

STI 8: Syndromic Diagnosis and Management of STIs

Introduction:

Diagnosis of STIs in STI clinics is made mostly on the basis of the history and the physical examination based on finding the common symptoms and signs grouped according to those that are predictive of the presence of sexually transmitted infection. Diagnosed based on such groups of symptoms is called "syndromic diagnosis". The diagnosis is however supported by basic laboratory tests wherever available but this does not necessarily imply etiological diagnosis. For example, Gram stain of urethral discharge allows for confirmation of urethral inflammation (by showing the presence of pus cells), or can suggest gonococcal infection (by showing Gram-negative intracellular diplococci) but is unable to show the definitive cause of the discharge or exclude others. Additional tests would be required to do that (e.g., gonococcal culture and chlamydial antigen detection). In FHI supported sites diagnosis of the STI syndromes is supported by some laboratory tests , hence it is referred as enhance syndromic approach. Table below showsthe common STI syndromes.

Table: STI Syndromes probable causes and their drug treatment

STI Syndromes:	**Probable Causes**	**Common Drug Treatment***
Genital Ulcer Disease	Syphilis, Herpes Simplex Virus, chancroid	Benzathine Penicillin + Acyclovir Azithromycin or Ciprofloxacin
Urethral Discharge	Gonococcal and/or chlamydial urethritis	Cefixime + Azithromycin
Inguinal Bubo	Lymphogranuloma venereum and chancroid	Azithromycin or Ciprofloxacin + Doxycycline or Erythromycin
Scrotal Swelling	Gonococcal and chlamydial epididymo-orchitis	Cefixime + Azithromycin
Vaginal Discharge	Cervical origin: gonococcal and chlamydial cervicitis Vaginal origin: trichomoniasis, bacterial vaginosis, candidiasis	Cefixime + Azithromycin Metronidazole + Fluconazole
Lower Abdominal Pain	Gonococcal, chlamydial and/or anerobic bacterial endometritis, salpingitis or oophoritis	Cefixime + Azithromycin + Metronidazole
Neonatal Conjunctivitis (ophthalmia neonatorum)	Gonococcal and chlamydial conjunctivitis	Inj. Ceftriaxone, erythromycin + Local Eye Care

*** The drug schedule should comply with the national STI case management guidelines**

Essential Components of Syndromic Management:

- Diagnosis and treatment based on syndromes
- Education on risk reduction and STI counseling
- Condom promotion

- Partner notification and treatment
- Follow up

Prepared by: FHI

Date Adopted: September 2007

Reviewed by:

Name	Signature	Date
Graham Neilsen		**September 24, 2007**

STI 9: Standard Treatments, Education & Ethical Considerations

Standard Treatments (Enhanced Syndromic Approach)

Use the appropriate Flow-chart to treat the STI patient with STI Syndromes

See Annex IV for Flow-charts

- As stated above, treatment recommendations should be consistent with national STI case management guidelines.
- The treatment should be standardized, and be adapted based on the local epidemiological and antimicrobial sensitivity information.
- Flowcharts that describe the standardized approach to be used in the clinic should be displayed in each room where treatments are prescribed to patients (Annex IV Flow charts)
- All treatments, procedures, testing and counseling for the patient should be performed to the highest professional and ethical standards, within the limitations of the service.
- The staff should ensure, above all, that they do no harm to the patient. In all aspects, the basic human rights of each patient must be respected and given the utmost importance.

Guidelines for Treatment

- Treat all RPR reactive client with Injection Benzathine penicillin, follow RPR test flow chart. Failure to provide effective treatment for single RPR reactive client from MARP adversely effect population at large.
- For female Clients:
  - Take vaginal smear and do the whiff test for the detection of bacterial vaginosis
  - Prepare wet mount from vaginal smear for the detection of Trichomonas vaginalis
  - Collect endocervical swab for microscopy send for gram stain. Treat for gram negative intracellular diplococci and /or PML > 25cell/cumm.
  - Follow annex III , guidelines on management of STI for treatment

Education on Risk Reduction and Condom Provision

In every instance, the contact of STI patients with the health facility should be utilized to promote safer sexual behavior and to educate patients on how to minimize or eliminate the risk of acquiring or transmitting STI/HIV infection to others. They should be taught how to correctly use condoms. Condoms must be made available in all health facilities treating patients with STIs free of charge.

Counseling, Partner Notification and Follow-Up

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

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Name	Signature	Date
Graham Neilsen		September 24, 2007

STI 10: Targeted STI Clinics

General Consideration for all MARPs

- During the visits of MARPs at STI clinic, staff should carefully take a history (being non-judgmental and ensuring full privacy and confidentiality) and perform an examination (including, genital, anal and oral examination).
- Anoscopic/proctoscopic examination should be offered as a routine screening procedure & performed if there are anal symptoms or a history suggestive of anal sex.
- If there are signs of STI infection, treatment should be given according to the National STI Case Management guideline flowchart (Annex IV Flow Chart for FSWs and MSM/MSWs) along with the serologic screening for syphilis in the first visit and repeated every three months.
- All STI clients (or those visiting to STI clinics) should be offered screening for syphilis in the first visit and repeated in every three months; offered HIV testing according to the risk.

Screening and Treatment of Asymptomatic Infections for Female Sex Workers (FSWs)

- Monthly history taking, physical examination and syndromic or enhanced syndromic management
- Serologic screening for syphilis in every three months and HIV as required according to risk.
- Presumptive treatment for gonococcal and chlamydial infections when indicated. Because of the high prevalence of asymptomatic infections and high rate of re-infection, presumptive treatment for gonococcal and chlamydial infections is recommended even if there is no evidence of infection:
  - If the client is visiting the clinic for the first time;
  - If the time lapse is three months or more since the last STI screening visit.

  Rationale for presumptive treatment of STIs in asymptomatic MARPs is that:

  i. MARPs are frequently exposed to STIs considering their inconsistent condom use and have high prevalence and incidence of gonococcal and chlamydial infections.

  ii. STIs such as cervical and rectal gonococcal and chlamydial infections are asymptomatic in the majority of those infected.

Subsequent and Follow-Up Visits:

- After their first visit, FSWs should be encouraged to attend the clinic for monthly routine check-ups (fixing appointment date for next visit).
- All FSW on the monthly visit are provided physical examination and the laboratory tests as needed. Treatment is provided on the basis of syndrome or on the basis of laboratory tests.
- More frequent visits are encouraged if new STI symptoms appear or the previous symptoms get worse.
- Monthly follow-up visits for routine examination and counseling should be promoted to all FSWs.
- Outreach/Peer educators should remind them about their clinic appointment date and help them keep their appointments.
- FSWs should be counseled by peer/outreach educators and clinic staff at every opportunity (in the clinic and in the community) on the importance of use of condoms reinforcing the message:

  "One of the best ways to protect oneself from HIV and STIs and to prevent unwanted pregnancy is to use condoms consistently and correctly at each sexual act. Antibiotics dispensed at the clinic are effective only for the few curable STIs and are not effective against most of the other STIs (viral) including HIV.

Abstinence, reduction of partner numbers, non-penetrative sexual practices and fidelity with a faithful uninfected partner are also effective ways to reduce the risk of STIs including HIV."

STI Clinic Service for Non-Sex Workers (Including IDUs, Clients of Sex Workers and Migrant Workers) with Symptoms of STIs

STI clinics should also provide enhanced syndromic management to all clients with symptomatic STIs according to the National STI Case Management Guidelines and offer screening with syphilis and HIV serology and clients should be treated accordingly.

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STI 11: Medications and Commodity Security

- All STI clinics should maintain an adequate stock of the essential drugs required to treat STIs (as per standard treatment protocol) at all times.
- Stocks of these medications should be maintained in the clinic at such a level so as to ensure a continuous and adequate supply without stock-out situations (minimum three month's stock).
- All medications and clinic consumables should be stored in a safe and secure location and should be used before their expiration date (should be stored and used on "first-to-expire: first-tobe-used" basis).
- Drug and consumables should be stored in a lockable cupboard with working stock kept in the treatment area.
- Drug records should preferably be kept on the Inventory Control Cards that should be updated daily and include information on:
  - Product name/description
  - Stock on hand/beginning stock balance
  - Receipts
  - Issues
  - Losses/adjustments
  - Closing/ending balance
  - Transaction reference (e.g., issue voucher number or name of supplier or recipient)
  - Special storage conditions
  - Item codes
  - Expiry dates

The drug stock should be tallied daily from the patients' medical sheet (record of drug dispensed) and the internal stock

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STI 12: Drug Supply Chain Management

- Drugs should be supplied at a regular basis to ensure a minimum three-month stock of each item within the clinic at all times.
- Maintaining drug stock: The following procedure should be used to maintain the drug stock:
  - ❍ Count and record the number of units of each product received.
  - ❍ Record the date and quantity received on a stock card.
  - ❍ Check for damaged or expired stock and return it to the supplier if needed
  - ❍ Check and ensure that the expiry date is visibly marked on every package or unit.
  - ❍ Check for any special conditions for storage. (Follow the manufacturer's recommended storage conditions for all products).
- The following terms relate to temperature and storage of medical supplies:
  - ❍ **Keep cool** means: Store between 8°C and 15°C.
  - ❍ **Store at room temperature** means: Store between 15°C and 30°C.
  - ❍ Arrange products in the storage area so that the first to expire is the first out
  - ❍ Maintain an expiry chart

Table: Essential drugs and their indications in STIs

Essential STI Drugs	Primary Indication	Alternative STI Drugs
Acyclovir 200 mg tablets	Genital herpes (HSV-2)	Acyclovir 400 mg tablets
Azithromycin 500 mg, or 1 gram tablets	GUD (chancroid), urethral discharge, cervicitis (chlamydia)	
Injection Benzathine penicillin 2.4 million IU	GUD (primary syphilis), Reactive syphilis test (latent syphilis)	
Gamma benzene hexachloride 1% lotion or cream or Benzyl benzoate 25% lotion	Scabies, pubic lice	
Cefixime 200/400 mg tablets	Urethral discharge, cervicitis (gonorrhea)	Injection Ceftriaxone 250 mg
Clotrimazole 500 mg vaginal pessaries or Fluconazole 150 mg oral tablets	Vaginal candidiasis (fluconozole is also recommended treatment for oral and esophageal candidiasis)	Clotrimazole 100 mg vaginal pessaries
Doxycycline 100 mg tablets	Alternative treatment for chlamydial infection or syphilis	
Erythromycin 250 mg or 500 mg tablets	Alternative treatment for chlamydial infection or syphilis (pregnant women)	
Metronidazole 400 mg tablets	Bacterial vaginosis, trichomoniasis	Tinidazole 500 mg tablets (optional)
Podophyllin tincture 25%	Genital warts *(Condylomata acuminata)*	Trichloroacetic acid 80 to 90%

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STI 13: Other Supplies and Consumables

All other supplies and consumables for patient examination and treatment and for cleaning, disinfecting and sterilizing should be recorded in an inventory database and included in the drug and supplies management system to ensure adequate stock at all times (Annex II, List of Supplies and Consumables)

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STI 14: Prevention and Management of Allergic Reactions

Since the recommended and most effective treatment for syphilis is benzathine penicillin, all patients who present with genital ulcer disease (after excluding clinical genital herpes) and/or positive syphilis serology should be treated with Benzathine penicillin unless it is clear that the patient is allergic to it. Severe allergic reactions to penicillin are rare but sometimes can be fatal so every clinic and clinician should be aware of the issues and be able to manage it properly. This SOP recommends following steps for the management of penicillin allergy.

1. **Prevention of Possible Allergy:** Get the proper history related to any allergic reaction with penicillin in the past. Usually clients remember such incidents either related with oral drugs or injections. If he or she reports reactions such as rash, difficulty in breathing or swollen lips, tongue or face after penicillin use, penicillin should be avoided. Look for alternative drugs in the SOP/guideline.
2. **Readiness:** All STI sites using penicillin should be equipped with the following essential drugs and equipment to manage anaphylaxis.
   a) Aqueous adrenaline (epinephrine) 1:1000 dilution, for injection;
   b) Antihistamines (injection and oral) e.g., chlorpheniramine and diphenhydramine
   c) Hydrocortisone injection
   d) IV drip set with IV canula
   e) AMBU bag for ventilation
   f) Oropharyngeal airway
   g) Oxygen supply
3. **Special Care:** Symptoms of anaphylaxis generally begin within 5-60 minutes of injection; keep the client for observation at least for this period of time after injection.
4. **Recognize the Allergic Reactions:** Common signs of symptoms of penicillin allergy include rash, hives, itchy eyes, swollen lips, tongue or face.

   The most serious allergic reaction is anaphylaxis which can produce symptoms throughout body:
   a) **Skin:** itching, flushing, urticaria (hives) and swelling
   b) **Eyes:** itching, tears and swelling of the tissues around eyes
   c) **Nose and Mouth:** sneezing, runny nose, nasal congestion, itching of the mouth
   d) **Lung and Throat:** difficulty breathing, wheezing (noisy breathing), increased airway secretions, swelling of the throat or tongue, hoarseness, sounds of labored breathing and a sensation of choking
   e) **Heart:** very rapid heart beat, arrhythmia(an irregular heart beat), low blood pressure and cardiac arrest (cessation of hearts pumping action resulting no heart beat or pulse)
   f) **Digestive System:** nausea, vomiting, abdominal cramps, bloating and diarrhea
   g) **Nervous System:** dizziness, weakness, fainting, and a sense of impending disaster.

Most common symptoms of anaphylaxis are urticaria and angiedema (swelling of tissues under the skin), which occur in nearly 90 percent of people who have anaphylaxis. These symptoms usually starts after a period of generalized itching, flushing and some times a growing sense of impending doom.

Anaphylactic shock (extremely low blood pressure) occurs in 30 percent of the people who have a reaction. Low blood pressure can cause lightheadedness, dizziness, tunnel vision and loss of consciousness.

5. **Management of Allergic Reactions:**

Management of simple allergic reactions: Antihistamines oral or injections.

Management of Anaphylaxis

- Place client in recumbent position and elevate lower extremities, do not attempt to put in the bed or raise promptly from the floor where the client may have fallen.
- Clear the airway and keep an oro-pharyngeal airway device
- Administer oxygen, usually 8 to 10 L per minute; lower concentrations may be appropriate for patients with chronic obstructive pulmonary disease
- Administer an antihistamine such as chlorpheniramine or diphenhydramine (Avil or Benadryl), for adults: 25 to 50 mg parenterally.
- If anaphylaxis is caused by an injection, administer aqueous epinephrine (adrenaline), 1:1,000 0.15 to 0.3 mL, into injection site to inhibit further absorption of the injected substance.
- Inject epinephrine (adrenaline) 1:1000 at 0.01 mL per kg, (in an adult) up to a maximum of 0.2 to 0.5 mL by SC or IM route (if necessary, repeat every 15 minutes, up to two doses). Caution: Injecting adrenaline in the wrong place can be dangerous. So, always inject adrenaline either subcutaneously or into the muscle of the side of the thigh and nowhere else.
- Monitor vital signs frequently (every two to five minutes) and stay with the patient.
- If no pulse or heart beats are felt, start CPR immediately.
- Give hydrocortisone, 5 mg per kg, or approximately 200 mg intravenously to reduce the risk of recurring or protracted anaphylaxis can be repeated every six hours, as required.

Cardio Pulmonary Resuscitation (CPR)

- Call for help.
- Confirm the cardiac arrest check for pulse or heart beat
- Where possible, avoid moving the person. If their position prevents you from completing any of the following steps, move them gently into a better position.
- If after ten seconds there are no signs of circulation or you are at all unsure, start chest compressions.
- Ensure the casualty is on their back on a firm, flat surface.
- Locate the bottom of the breastbone, moving clothing aside if necessary.
- Place two fingers on the lower end of the breastbone. Place the heel of the other hand beside the fingers, higher up the breastbone.
- Keeping the heel of the second hand over the breastbone, place the first hand on top.
- Ensure only the heel of the lower hand is touching the person's chest.
- Lean over the patient and, with the arms straight, compress the chest about 4-5 cm (approx 1/3 of the depth) and then release the pressure.
- Repeat this until a total of 15 compressions has been completed.
- Re-open the airway and give two rescue breaths. Continue resuscitation alternating 15 chests compressions with 2 rescue breaths.
- Do not routinely re-check the casualty, continue until help arrives and takes over from you or until you are too exhausted to continue.

Four Reasons to Stop CPR:

- Patient is revived.
- You are relieved by another trained individual.
- Become exhausted.
- Doctor is present and pronounces death.

Transfer Patient to Hospital

- Transfer immediately for continued emergency management. All patients with anaphylaxis should be monitored preferably in a hospital setup for the possibility of recurrent symptoms after initial resolution.
- An observation period of two to six hours after mild episodes, and 24 hours after more severe episodes, seems prudent.
- The clinician should accompany the patient to the hospital to ensure immediate care on arrival.
- Extra doses of adrenaline should be transported with the patient in case the patient has a relapse before reaching the hospital. Stay with the patient until care is directly transferred to person on duty.

> *Note: Text of this SOP is adopted from National Training Manual on Management of Sexually Transmitted Infections, NCASC,2006.*

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STI 15: Post-Exposure Prophylaxis (PEP)

This SOP deals with the post exposure prophylaxis of HIV related to the occupational exposure of the health personnel working in the facilities supported by FHI. Universal precautions for infection control are must for all IA. Follow STI 18 for the purpose

Any injury with the infected instrument or any exposure to the bodily fluid with possible HIV infections during the care of the client or handling waste material is considered as an occupational exposure.

All the staff of the IHS should be made aware of the management of such exposure using the flow chart provided at Annex IV of this SOP.

It is mandatory to keep the PEP flow chart in laboratory and STI clinic with proper orientation to the staff.

IA should make the provision for providing pre exposure prophylaxis of Hepatitis B through the vaccination of the concerned staff (laboratory staff, clinic staff and those involved with the disposal of sharp and infected materials).

PEP is provided to staff members when infection control measures fail and staffs are considered to be at high risk of infection with HIV. The most common injury is the needle stick injury.

The Injured Staff

1. Should not panic.
2. Should wash the site with running water and mild soap.
3. Should not squeeze the wound.
4. Should not apply any antiseptic and spirit to the wound.
5. Immediately inform the in charge of the clinic.
6. Follow the instructions provided by the doctor/clinician and the clinic in charge as stated below.

The Clinic Incharge:

1. Arrange for the HIV testing of the source person and injured staff following the standard procedure of the HIV counseling and testing.
2. Ask the doctor/ clinician for the risk assessment. Arrange for PEP drugs according to the instruction of the clinician preferably within 2 hours
3. Provide all doses of PEP drugs kept in the starter pack (five or three days pack) to the injured staff .
4. Call focal person at FHI country office, send the occupational exposure form filled by the doctor/clinician and get the supply of total 28 days pack of the PEP drugs
5. Refill the starter pack, keep for the future use. Provide remaining doses to the injured staff to complete the course of 28 days.

The Doctor or Clinician will:

1. Do the risk assessment following the flow chart at Annex
2. Prescribe PEP drugs if indicated (if the source has the positive status and the injured staff has the negative status)
3. Fill up the occupational exposure form (see annex) and provide to the clinic in charge

The Counselor will:

1. Do the counseling of the source and injured person following the standard HIV counseling and testing SOP
2. Counseling session can be shortened to meet the goal to start PEP earliest as possible (preferably within 2 hours)

   Drugs for PEP for HIV should be available in the clinic at all times and checked for shelf life and expiry dates on a regular basis. These include:

   - Zidovudine (AZT) 300 mg; and
   - Lamivudine (3TC) 150 mg; and
   - Indinavir 400 mg or,
   - Zidovudine 300 mg and Lamivudine 150 mg may also be provided as a combination tablet.
   - Lopinavir/ Ritonavir (200/50mg)

   Keep the stock of the PEP drugs following the instruction of FHI CO. Drugs for PEP may change according to the availability or change in national or international guidelines. FHI CO will provide the update information.

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STI 16: Referrals

Patients whose health problems cannot be addressed or managed appropriately by the services available at the STI clinic should be referred to a higher-level service, such as a local hospital or specialty care and should be non-discriminatory, non-judgmental and confidential.

Services for referrals include STI specialist care, general medical care, family planning, obstetrics/gynecological care (such as prevention of cervical cancer), VCT and legal services and follow-up on the emergency care management.

Referral networks should be established as an integral part of establishing a STI clinic explicitly depending on anticipated needs. Clinics should compile a list of recommended providers for referrals that includes names, addresses, telephone numbers and operating hours. It should refer the client with a referral card and keep the record of the referred clients.

For each referral, the following steps should be taken:

1. Fill out IHS referral slip with:
   - Reason for referral;
   - Where referred;
   - Follow-up information; and
   - Patient feedback.
2. Keep the copy of referral slip in the personal file.
3. OREs should accompany patient (without any coercion), whenever possible.
4. Request patient to come back after the referral or request feedback from the referral service provider.

A tracking system should be in place for referrals to allow managers to monitor the effectiveness and efficiency of the system, from initiation of the referral to receiving the referral report.

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STI 17: Laboratory Services

The laboratory should have the following procedures in place:

1. All diagnostic tests performed by a qualified laboratory technician/assistant;
2. Written SOPs in place for diagnostic testing and infection control; (follow STI-18, STI-20 and Annex V)
3. Daily maintenance of records;
4. Routine internal quality control mechanism;
5. External quality assessment schemes or willingness to cooperate with external assessment; and
6. Results of tests available on a timely basis

Laboratory Tests

Diagnostic tests available in all STI clinics

The following simple laboratory diagnostic tests can be performed on-site at an STI clinic. Test results should be made available immediately (within one hour) to make diagnoses and provide treatment on site to the patient in a single visit.

1. **Wet-mount slide preparations for microscopy:** For detection of motile trichomonads and clue cells.
2. **KOH** slide preparation for:
   - "Whiff test" to detect amines indicative of bacterial vaginosis (performed by examining clinician)
   - Detection of candidal spores and pseudohyphae.
3. **Gram stain** of urethral specimens from males and cervical specimens from females for polymorphonuclear leucocytes (PMNLs) and Gram-negative intracellular diplococci. Gram stain of rectal swabs for the same should be performed whenever indicated.
4. **Syphilis serology** should be performed on-site using quantitative RPR tests.
   Samples showing RPR reactive results should be confirmed by TPPA test (Confirmatory test for Syphilis).

Other Laboratory Tests

1. **Pregnancy testing** should be provided whenever demanded and test kits are available.
2. **HIV testing** should be provided to the STI client on-site through the VCT, following national VCT guidelines/ FHI /Nepal SOP of HIV testing and counseling.

External Quality Assurance:

Collect, preserve and send the samples to the reference laboratory according to the instructions provided by the ASHA project

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STI 18: Infection Control

Universal Precautions

All staff - including clinical, housekeeping and any other staff who could possibly come in direct physical contact with bodily fluids, waste, linen or spills should be well aware of and trained on universal precautions. The sterile medical practices with universal precautions used in the clinic should be explained clearly and thoroughly to patients so that they have confidence that the clinic services are safe.

1. Proper hand washing.

Wash hands for 15-30 seconds with soap and running water and air dry or dry with paper or clean towel.

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

2. Gloves should be worn to prevent contact with bodily fluids when

- Examining mucous membranes or non-intact skin (for example, genital examination);
- Drawing blood (phlebotomy), fingersticks/heelsticks or establishing intravenous access
- Handling soiled instruments, equipment or linen
- Disposing of contaminated medical waste (cotton, gauze or dressings, serum & blood).

Note: Health staff should change gloves between patients and between procedures on the same patient.

Two types of gloves should be made available:

- Examination gloves for wearing when coming in contact with body fluids or mucous membranes.
- Heavy duty utility gloves for use when cleaning equipment or handling hospital waste.
- Dispose gloves after decontaminating with 0.5% bleach at least for 10 minutes.

3. Safe handling and disposal of needles and sharps

- Use only new, sterile, disposable needles and syringes.
- Needles and syringes are for single use only, do not re-use.
- Do not bend, break or recap needles.
- After collection of blood, **DO NOT RECAP THE NEEDLE** but *hold the base of the needle with forceps and pull it off and place the needle in the destroyer using the forceps.* Take precautions not to injure yourself.
- Place needles and sharp objects in puncture-proof containers (either specially manufactured or other puncture-proof buckets or containers with lids), whether needle destroyers have been used or not.
- Place containers within easy reach in all areas where needles are used.
- Seal and remove containers when they are three-quarters full.
- Decontaminate the container by putting it into a solution of 0.5% bleach at least for 30 minutes before disposing of it.
- Containers should be disposed off by incineration.

4. Cleaning, disinfecting and sterilizing surfaces and equipment

As part of universal precautions for infection control, *all instruments and equipment should be disinfected and sterilized prior to use*.

- **SOAK** all washable equipment in disinfectant prior to cleaning (10 minutes in 0.5% bleach).
- **WASH** equipment with soap and water prior to sterilization or disinfection.
- **STERILIZE** medical equipment and instruments (e.g. specula, ovum forceps, and kidney basins) by autoclave.
- **DISINFECT** objects and equipment that are not sterilized by autoclave (e.g. surgical scissors, laser tips) by soaking in 0.5% bleach solution for 30 minutes and rinsing with sterile water.
- **CLEAN SURFACES** such as floors, walls, tables and counter tops with a disinfectant cleansing solution. Use heavy-duty or utility gloves when cleaning.
- **CLEAN SPILLS** with proper disinfecting solutions. Wear heavy duty or utility gloves.

Table showing level of risk and the decontamination process needed for the equipments

Level of risk	Items	Decontamination method
1. High	Instruments which penetrate the skin/body (e.g. needles, surgical instruments)	a. Sterilization b. Single use of disposable needles and syringes
2. Moderate	Instruments which come into contact with mucous membranes or non-intact skin (e.g. speculums, ovum forceps, kidney basins)	a. Sterilization b. Boiling c. Chemical disinfection
3. Low	Equipment which come into contact with intact skin	a. Thorough washing

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STI 19: House-keeping

At the start of each day, the helper should:

- Clean examination tables, trolleys, lamps and other office furniture with a damp cloth to remove dust.
- Use a damp mop to remove excess dust from the floors.

Between patients if there is a risk of contamination,

- Clean with a disinfectant cleaning solution examination tables, counters, lamps, blood pressure cuffs and other patient care equipment and surfaces that are at a risk of contamination.
- Clean floors, ceiling and/or walls with disinfectant solution if there is evidence of soiling.

At the end of each day,

- Use a disinfectant solution to clean all counters, tables, sinks, lights, door handles, walls, blood pressure cuffs and other patient care equipment and floors.
- For facilities with toilets/commodes, clean the seat and other areas with warm water and neutral detergent using cleaning cloth or sponge and then wipe them dry. Then use a disinfectant solution, such as 1-2% sodium hypochlorite and dry again.
- Ceilings should be cleaned regularly in patient care areas using a mop or other appropriate instrument dampened with a disinfectant solution.

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STI 20: Waste Management

Proper waste management is the final step in infection control. Hazardous waste must be disposed of in a safe manner that eliminates any possibility of infecting the clinic staff or community members.

> *Note: Waste disposal does not end at the clinic door. All hazardous waste should be decontaminated prior to disposal. STI clinics should properly dispose of hazardous waste.*

Potentially infectious or toxic waste includes the following:

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

Heavy duty gloves should be used by anyone transporting waste to the site of disposal. Waste should be segregated in to color-coded bags and handled as follows:

Table showing methods of disposal of different types of wastes

Type of Waste (defined below)	**Color of Bag**	**Means of Disposal**
Sharps	Blue (puncture proof)	Decontaminate with bleach or autoclave. Transport to waste treatment facility for incineration and burial OR if unavailable, dispose in burial pit or sanitary landfill.
Infectious solids (non-sharps)	Yellow	Decontaminate with bleach or autoclave Shredded gloves. Transport to waste treatment facility for incineration and burial OR if unavailable, dispose in burial pit or sanitary landfill.
Infectious waste (blood and body fluids)	Red	Decontaminate with bleach or autoclave. Transport to waste treatment facility for incineration and burial OR if unavailable, dispose in burial pit or sanitary landfill.
Pharmaceutical	Black	Solid - municipal landfill or burial pit Liquid - municipal sewer
General (non-medical)		Same as domestic waste

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

Infectious solid waste (non-sharps): Waste contaminated with blood and other body fluids, including gloves, cotton, dressings, linen, disposable IV sets, catheters, etc. Also infectious laboratory wastes such as waste from laboratory tests and other items that were in contact with the specimens such as gloves.

Infectious waste: Blood and body fluids.

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

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

Disposal of Hazardous Waste

Hazardous waste must be disposed safely, in a manner that eliminates any possibility of infecting clinic staff or community members.

Potentially infectious or toxic waste includes the following:

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

Proper waste management begins in the clinic with safe handling of waste and continues until its safe final disposal. STI clinics should dispose of hazardous waste through arrangements with either a recognized medical waste disposal service or by:

Burn and bury: Pit burning is a low-cost, but relatively ineffective, means of waste disposal. A fence should surround the pit to prevent children, animals, and others from coming into contact with the waste. The pit should be located to avoid walking paths (high-traffic areas). The fire, usually started with a petroleum-based fuel and allowed to burn, should be supervised by designated staff and located downwind of the facility and residential areas. The low-temperature fire emits pollutants, and the ash and remaining material should be covered with 10-15 cm of dirt.

Prepared by: FHI

Date Adopted: September 2007

Reviewed by:

Name	Signature	Date
Graham Neilsen		**September 24, 2007**

STI 21: Health Education and Counseling

Health education and counseling are the most essential tools for prevention and management of STIs and should be offered to all patients who receive treatment for STIs, including patients treated for asymptomatic STIs following the "four C's" (**C**ondom demonstration and promotion, ensuring **C**ompliance with treatment, **C**ounseling / education on STI and **C**ontact treatment/partner management).

Education During Treatment of STI Patients

1. Need for regular check-ups
2. Taking the full course of treatment will cure most STIs
3. Avoid sex during treatment period and until the symptoms get resolved to prevent spread of STIs to the sex partner
4. Help your sexual partner(s) to get treatment.
5. Stay uninfected with use of condoms appropriately and consistently
6. Reduce risk of acquiring new infection by having just one sex partner
7. Protect yourself against HIV seek counseling to see if you should be tested for HIV
8. Assess the need for contraception for you or your partner/s
9. If you or your partner is pregnant, report to the antenatal clinic as soon as possible to protect both the mother and the baby.

Condom Demonstrations and Distribution

Condoms and water-based lubricants should be given directly (if available) to each STI patient at the time of counseling. In addition, clinic staff should also explain and demonstrate the correct use of lubricants and condoms with the help of a penis model (wooden dildo).

Information, Education and Communication Materials

Appropriate and "informative information, education and communication (IEC) materials" should always be available in the clinic, particularly, at the time of counseling and outreach activities. IEC materials should be very simple, easily understandable and translated into local languages, if required.

HIV Counseling and Offer for Testing

- All patients being treated for STIs should also be counseled to help them reduce their risks for HIV and other STIs and unintended pregnancy and should be given information that allows him or her to decide voluntarily for HIV testing explaining both the potential benefits and the adverse psychological impacts of knowing their HIV status.
- Each STI clinic should have its own VCT center or develop formal referral linkages with a local VCT center that is accessible to patients.

- Each STI clinic should have a trained VCT counselor who can provide post-test counseling if a patient prefers to have on-going supportive counseling at the STI clinic or drop-in center.
- The patient's decision to disclose their HIV status is his/her own decision and it should be respected.

Prepared by: FHI

Date Adopted: September 2007

Reviewed by:

Name	**Signature**	**Date**
Graham Neilsen		**September 24, 2007**

STI 22: Monitoring/Evaluation and Supportive Supervision

STI clinics should address the beneficiary community in a community-friendly way. To ensure that the program addresses the community's needs appropriately; members of the community must be included and share responsibility for monitoring and evaluating the STI clinics and their activities. Monitoring should be the joint responsibility of clinic staff and their peers.

Monitoring

Monitoring is the regular, methodical process of collecting information (data) to determine the progress and achievements of a program.

To support clinic-based monitoring, individual clinics should collect data according to variables specified in the Project Indicator Form (PIF) in Annex VII, to ensure effective service delivery and sufficient coverage at the community level.

Evaluation

Evaluation involves analyzing and assessing a project (or program), or part of a project, to determine its quality and progress toward achieving project goals. Evaluation helps project participants self-evaluate and subsequently improve their own practices and the overall project. Quality assessment indicators will be developed to evaluate the coverage and quality of STI clinical services in the ASHA intervention areas.

The quality assurance team from the Technical Unit of FHI Nepal (which may also include an external consultant) will conduct site assessments on a six-monthly basis. New sites or sites requiring additional support will be monitored as needed. The ASHA Laboratory Specialist will coordinate with the quality assurance team regularly and be responsible for overall quality assurance.

Supportive Supervision

Ideally, all STI clinics should be visited by a qualified clinical supervisor/coordinator on monthly basis and by an external consultant on a quarterly basis. However, the frequency of the visits can be made less frequent as the staff develop their capacity and improve their skills. The clinical supervisor/coordinator appointed by the project should assess all major elements of clinic function at regular (preferably monthly) intervals. At a minimum, the clinic should be assessed for compliance with the minimum standards as specified in this document, including:

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

Supervision and technical support should be carried out using checklists based on the "Supervision and Monitoring Tool" (QA/QI Check list).

Prepared by: FHI

Date Adopted: September 2007

Reviewed by:

Name	**Signature**	**Date**
Graham Neilsen		**September 24, 2007**

STI 23: Documentation and Reporting

Documentation

Clinical history, examination findings, laboratory findings and treatment prescribed for each patient should be recorded on the standardized forms (Annex Example of Recording Format) for monitoring and evaluation purposes. The reports should be regularly sent to the district health office, NCASC and to the donor agency. No data with individual identification of the client should be shared.

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

Apart from the standard reporting form, typical reporting records that should be maintained by each STI clinic include:

- Patient Register (Ledger Book) (Annex VIII)
- Laboratory Register; and (Annex IX)
- Weekly/Monthly Summary Report (PIF) (Annex X)

Clinic staff who are also the members of the community should be trained, guided and monitored on a long-term basis to build their capacity to handle the reporting records listed above and update the following recording forms:

- Medicine Distribution Register for Individual Patients;
- Daily Stock Register;
- Monthly Monitoring Sheet; and
- Monthly Report Register of Peer & Client Outreach Workers
- Commodity Monthly Reporting Form (Annex XI)
- Commodity Expiry Tracking Chart (Annex XII)
- STI OI Drug Dispensing Record (Annex XIII)
- Stock Book (Annex XIV)

Prepared by: FHI

Date Adopted: September 2007

Reviewed by:

Name	Signature	Date
Graham Neilsen		**September 24, 2007**
_____	_____	_____
_____	_____	_____
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2. Guidelines for Treatment of Sexually Transmitted Diseases. Centers for Disease Control and Prevention. 2002. MMWR 2002;51(No. RR-6). MMWR ,
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6. European STD Guidelines, vol.12, supl. 3, 2001
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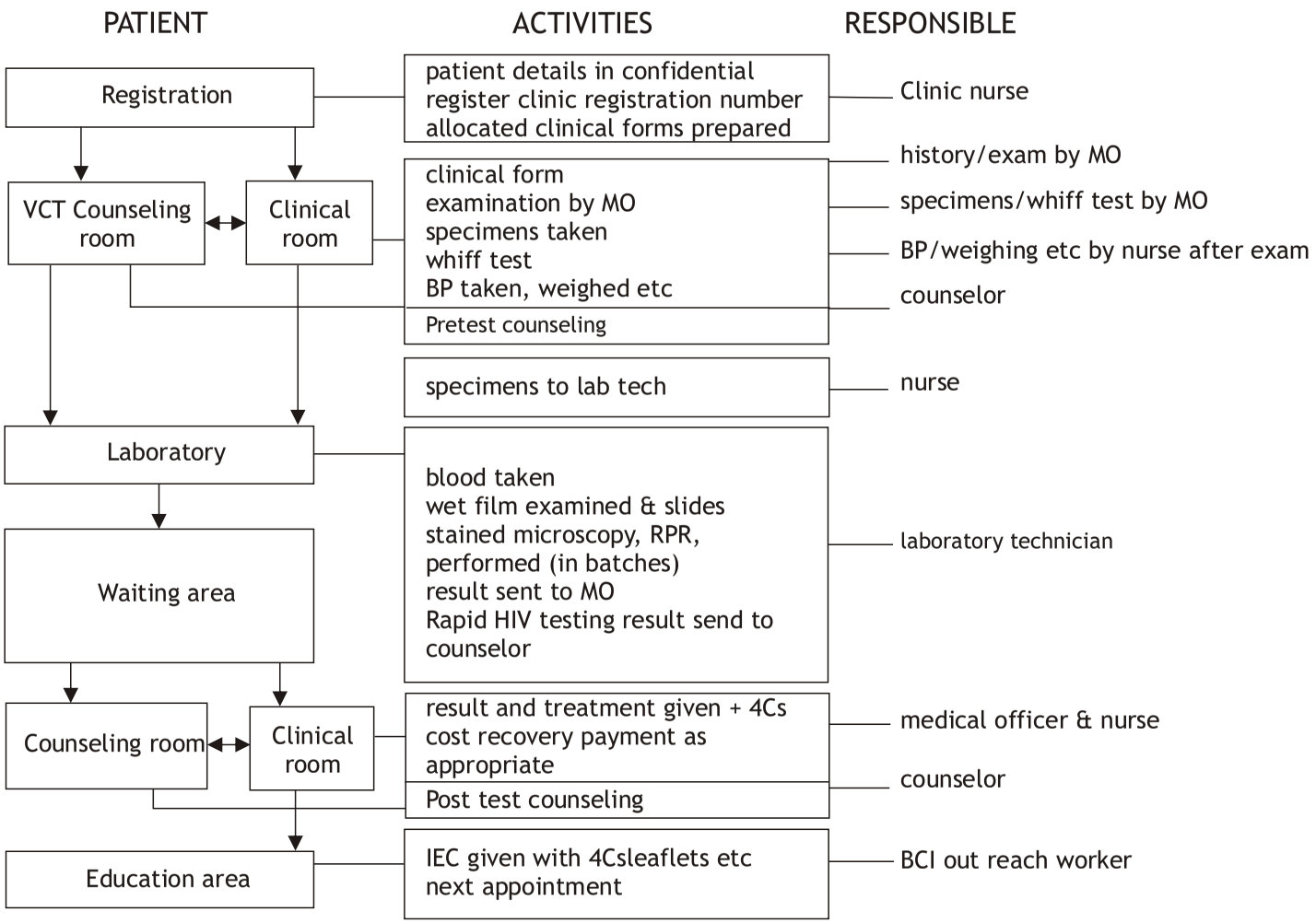
9. National STI Case Management Guidelines, NCASC, Ministry of Health and Population, Govt. of Nepal, 2006
10. Avahan STI Services, Clinic Operational Guidelines and Standards (COGS), Family Health International (FHI) and World Health Organization (WHO), November 2006

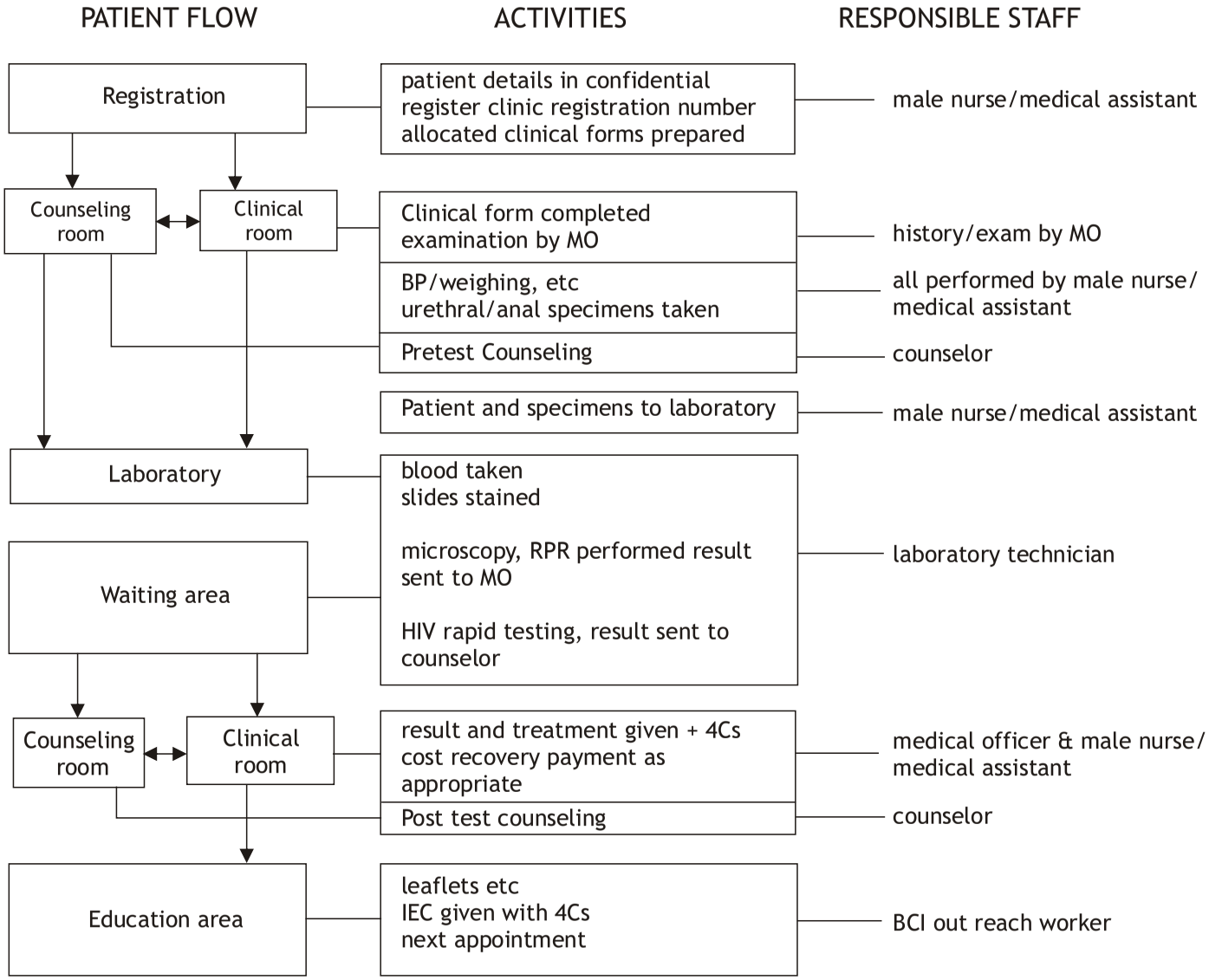
Annex I: Operational Flow Charts for STI Clinics

OPERATIONAL FLOW CHART FOR DIC FEMALE PATIENT



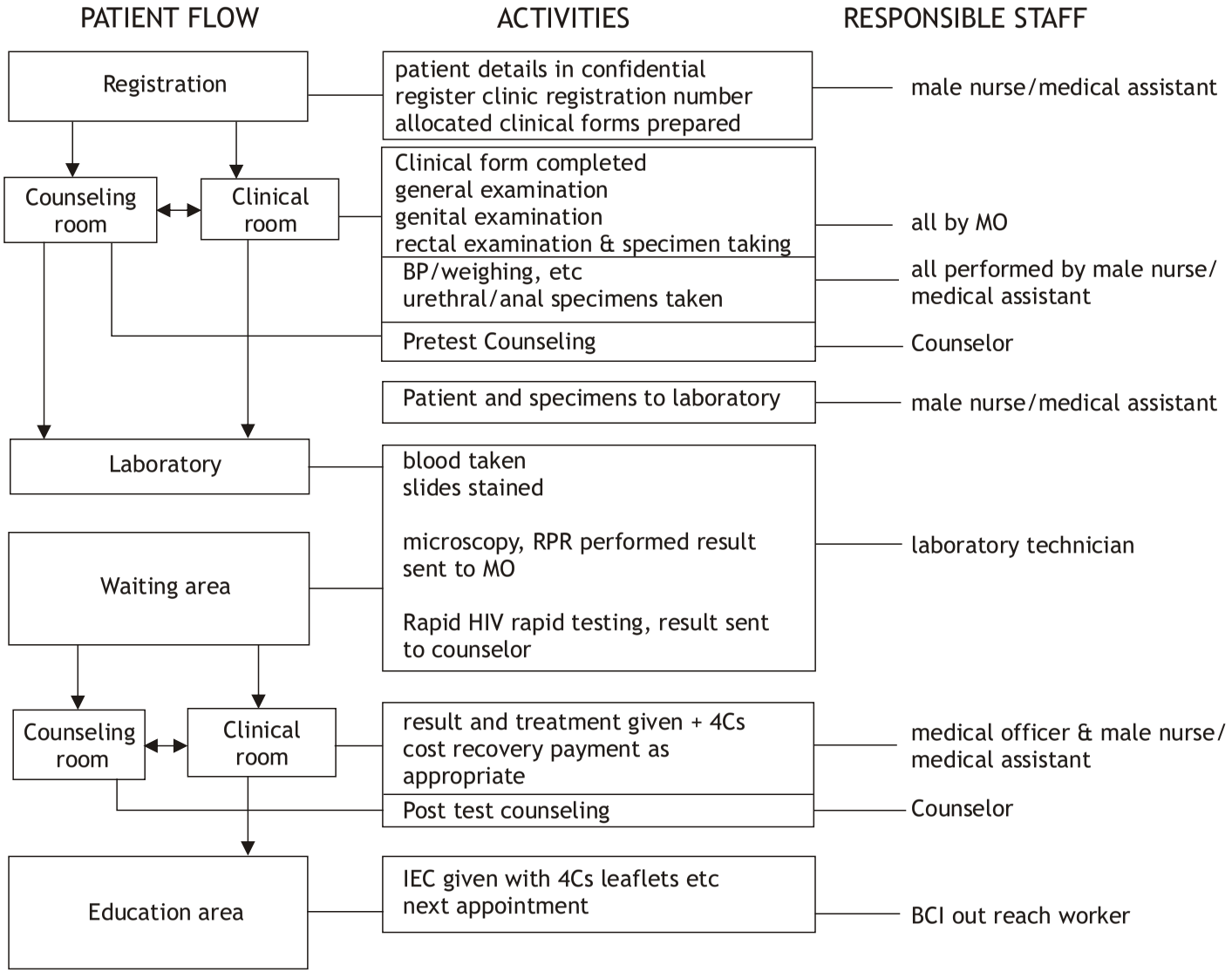
Note: VCT part should be used if apprpriate

OPERATIONAL FLOW CHART FOR DIC
MALE HETEROSEXUAL ATTENDER



Note: VCT part should be used if apprpriate

OPERATIONAL FLOW CHART FOR DIC MSM



Note: VCT part should be used if apprpriate

Annex II: Suggested Minimum Lists of Equipment in a STI Clinic

General

1. Access to a male and female toilet
2. Fans, heaters as needed
3. Separate rooms for consultation and counseling with auditory and visual privacy
4. Sink with running water for washing hands, cleaning equipment, etc.
5. Power supply (electricity, generator or battery operated lights)
6. Waste basket in all rooms
7. Mops, brooms, and other equipment to clean the clinic

Waiting and Registration Room

1. Clinic record system - Including data summary sheets for attendance and surveillance purposes
2. Filing cabinet - Lockable
3. Desks
4. Chairs
5. Telephone
6. Chairs for waiting room

Optional (Funds and Staff Permitting):

1. Computer
2. Printer
3. Modem
4. Fax
5. Potted plants for waiting room

Consultation and Examination Room

For examination:

1. Screens for privacy
2. Examination couch - Ideally with steps and "cut-away" recess for speculum examination
3. Examining chair (preferably with wheels)
4. Sheets for examination couch
5. Pillow for examination couch
6. Drapes or clean towels
7. Torch with fresh batteries and backup supply of batteries
8. Gooseneck lamp - halogen bulb preferred
9. Kelly pad or other waterproof sheeting
10. Hand mirror

General Medical:

1. Sphygmomanometer
2. Stethoscope
3. Thermometer
4. Adult weighing scales
5. Tongue Depressor
6. Medicine cabinet

Instruments and Sterilization:

1. Sterilizer or access to sterilization facilities
2. Scissors
3. Instrument tray with cover
4. Movable instrument holder
5. Cotton ball holder
6. Cotton tip holder
7. Vaginal specula of various sizes
8. Speculum holder
9. Proctoscopes/anoscopes of various sizes
10. Ovum forceps
11. Uterine forceps

Medical Supplies - Consumables

1. Needles and syringes - disposable
2. Cotton wool
3. Gauze pads (2x2 and 4x4)
4. Examination gloves, latex
5. Sterile cotton-tipped applicators Small (sterile individually wrapped and non-sterile), large (for cleaning the cervix)
6. Microscope slides and cover slips
7. Water-soluble lubricant for clinical examination
8. Disposable tissues
9. Tongue depressors, disposable
10. 10% potassium hydroxide solution
11. Physiological saline solution
12. Disinfectant (sodium hypochlorite)
13. 70% isopropyl alcohol
14. Distilled water
15. Male latex condoms
16. Male polyurethane condoms (if available, for patients allergic to latex)
17. Female condoms (if available)

18. Water-based lubricant for clinical use and for distribution
19. Demonstrators for male condom use (e.g., wooden dildos)
20. Sharps disposal containers

Pharmaceuticals for Management of STIs, PEP, and Anaphylactic Reaction

1. Supply of drugs as listed under Sections
2. Secure system for storing drugs appropriately
3. Stock management system
4. Record system

Laboratory

General:

1. Binocular microscope
2. Spare bulbs for microscope
3. Spare fuses for microscope
4. Waste basket suitable for laboratory
5. Refrigerator

Equipment, Reagents and Consumables for Specific Tests:

Microscopy for urethral, vaginal and cervical swabs

1. Alcohol lamp
2. Staining rack
3. Glass slides, frosted end
4. Cover slip (22x22mm)
5. Cotton-tipped swabs (sterile and non-sterile)
6. Gram stain kit
7. Potassium hydroxide 10% solution
8. Sterile distilled water
9. Normal saline solution

Syphilis RPR

1. Rotator
2. Centrifuge
3. RPR kit and controls
4. RPR cards
5. Micropipette (200 µL, 1000 µL, adjustable volume)
6. Yellow pipette tips
7. Test tubes (12x75mm)

Annex III: Guidelines on Management of STIs

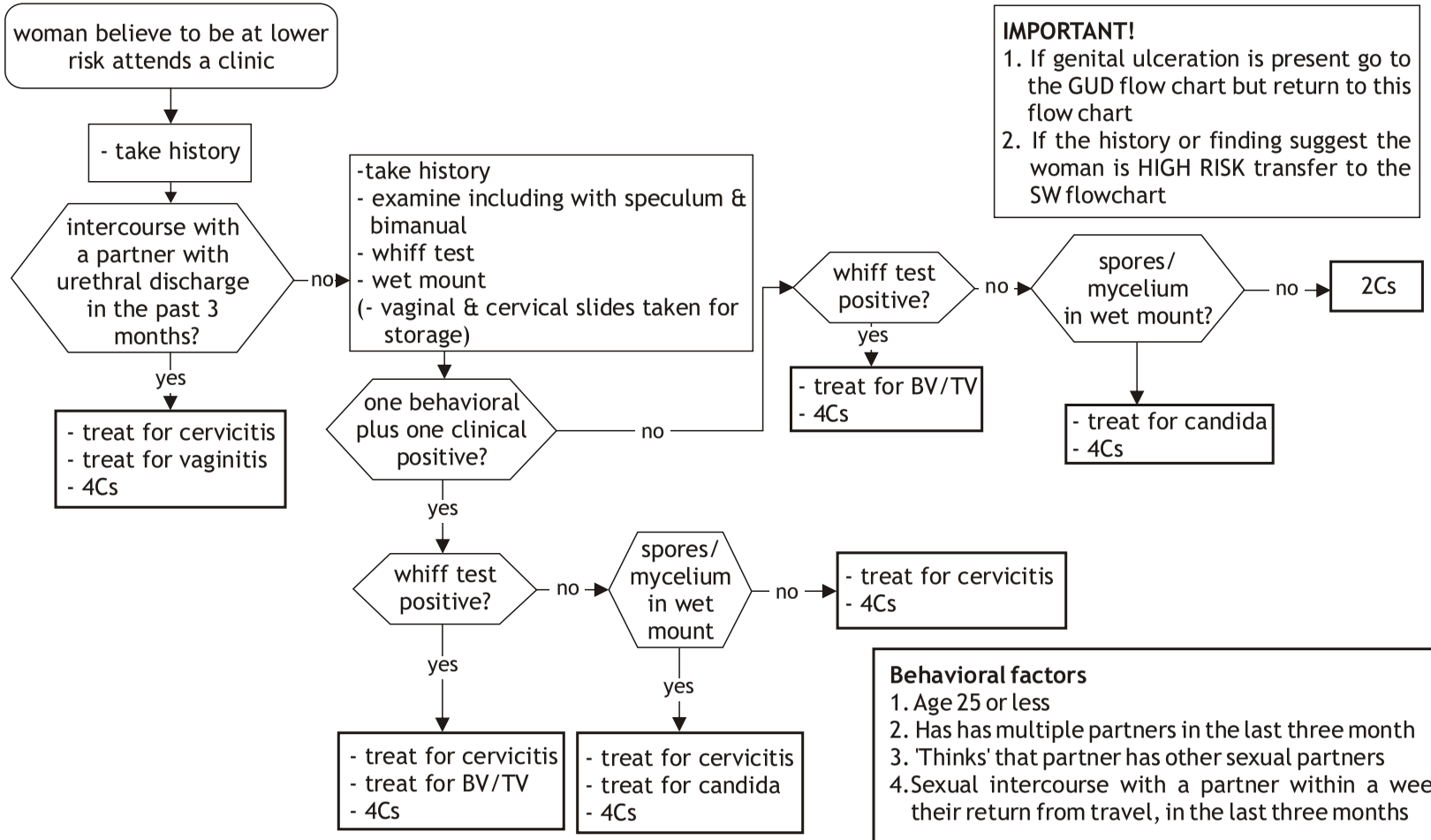
DISEASE		TREATMENT
Cervicitis	Uncomplicated ano-genital infection including Pregnant women.	Azithromycin1G single oral dose PLUS Tab Cefixime 400mg single oral dose **OR** Ceftriaxone 250mg single dose by I/M injection
	Disseminated infection	Refer to dermato-venereologist
Urethral Discharge	Uncomplicated urethritis in male	Azithromycin1G single oral dose PLUS Tab Cefixime 400mg single oral dose **OR** Ceftriaxone 250mg single dose by I/M injection
Trichomoniasis or Bacterial vaginosis	In non-pregnant women	Metronidazole, 400 mg orally, three times daily for 7 days **OR** Tinidazole 2 G as a single oral dose
Candidiasis	In non-pregnant women	Fluconazole 150 mg as a single oral dose **OR** Clotrimazole pessary 100 mg intravaginally, daily for 6 days
	In non-pregnant women	Clotrimazole 100 mg vaginal pessary 6 days.
Genital herpes	*First clinical episode*	Acyclovir 200 mg five times daily for 5 days
	If severe or complicated	Refer to Dermato-venereologist
	Recurrence	Acyclovir 200 mg five times daily for 5 days
	If severe or complicated	Refer to Dermato-venereologist
	Frequent recurrences >6/year	Refer to Dermato-venereologist

Syphilis (Non-penicillin allergic patients including in pregnancy)	Primary, secondary or early latent syphilis (<2 years duration)	Benzathine penicillin 2.4 IU by deep I/M injection (1.2 IU in each buttock)
	Late latent syphilis (>2 years duration or of unknown duration)	Benzathine penicillin 2.4 IU by I/M injection weekly for three weeks
	Cardiovascular or neurosyphilis	Refer to Dermato-venereologist before treating
Syphilis (penicillin allergic patients) & non-pregnant women	Primary, secondary or early latent syphilis (<2 years duration)	Doxycycline 100 mg twice daily for 15 days
	Late latent syphilis (>2 years duration or of unknown duration)	Doxycycline 100 mg twice daily for 30 days
Syphilis (penicillin allergic patients) in pregnant women	Primary, secondary or early latent syphilis (<2 years duration)	Erythromycin 500 mg four times daily for 15 days
	>2 years duration or of unknown duration & any late syphilis	Erythromycin 500 mg four times daily for 30 days (& refer to dermato-venereologist for further evaluation and treatment)

Lower Abdominal Pain		Ceftriaxone 250mg single dose by I/M injection Plus Doxycycline 100 mg twice daily for 14 days Plus Tab Metronidazole 400mg three times daily for 14 days
Suspected Chancroid		Refer to dermato - venereologist for diagnosis and treatment
Other conditions	Candidal balanitis	Clotrimazole cream (Note: exclude glycosuria & be aware of diabetic tendency)
	Genital warts	Podophyllin 1025% in tincture of benzoin compound Concentrated trichloracetic acid (80-90%) for recalcitrant warts. Intrameatal warts should be referred.
	Scabies	GAMMA-BENZENE HEXACHLORIDE, 1% lotion/cream applied to all areas of the body from neck down and washed off on the following day
	Pediculosis pubis	GAMMA-BENZENE HEXACHLORIDE, 1% lotion/cream applied to all hairy areas of the body excluding the scalp and washed off after 8 hours.

Annex IV: Flow Charts for Case Management

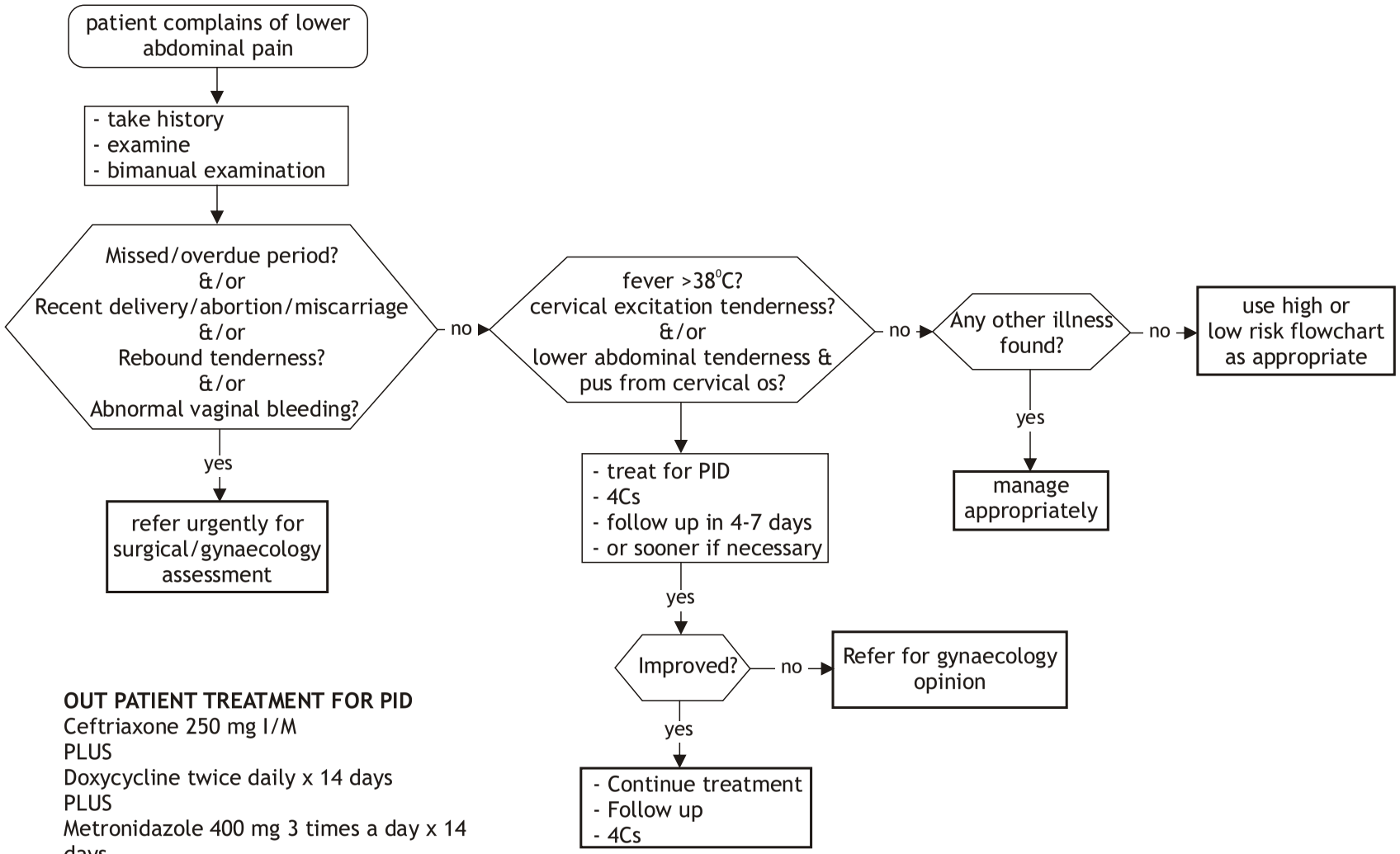
FHI STI SERVICE DELIVERY
MANAGEMENT OF WOMEN AT BELIEVED LOWER RISK



Behavioral factors
1. Age 25 or less
2. Has has multiple partners in the last three month
3. 'Thinks' that partner has other sexual partners
4. Sexual intercourse with a partner within a week of their return from travel, in the last three months

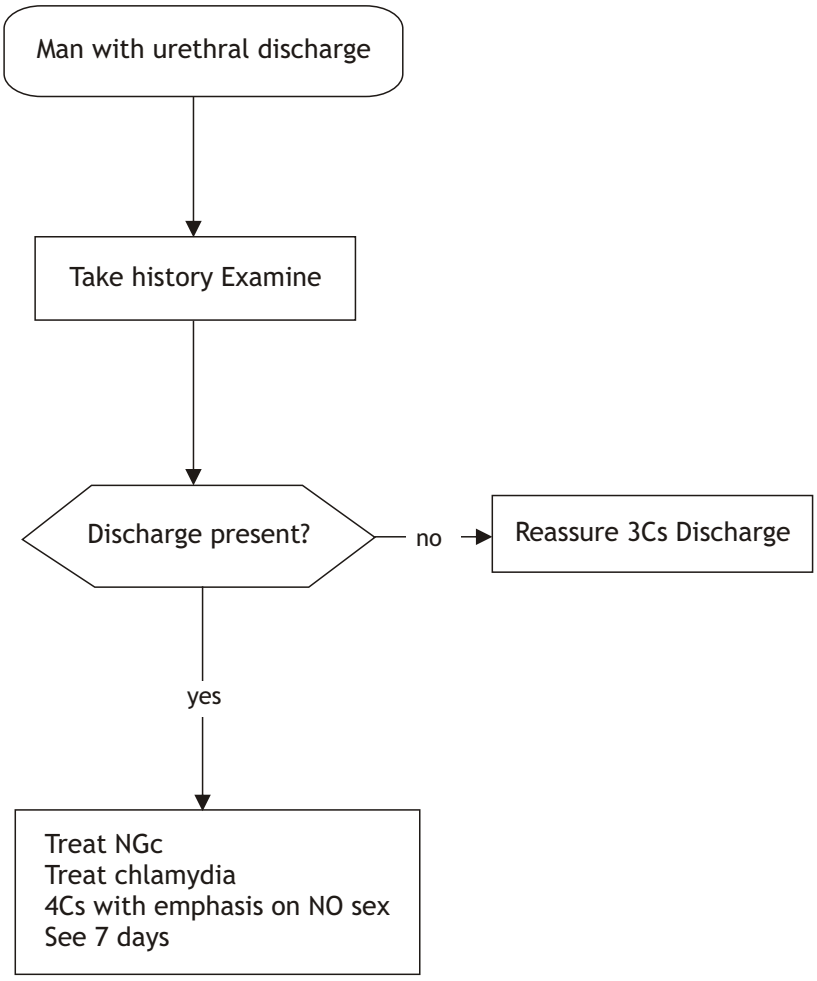
Clinical factors
1. Abdominal tenderness
2. Cervical bleeding on touch
3. NON-CLEAR endocervical discharge
4. Cervical excitation (pain or discomfort on moving the cervix during a bimanual examinaion)

FHI STI SERVICE DELIVERY
LOWER ABDOMINAL PAIN IN WOMEN

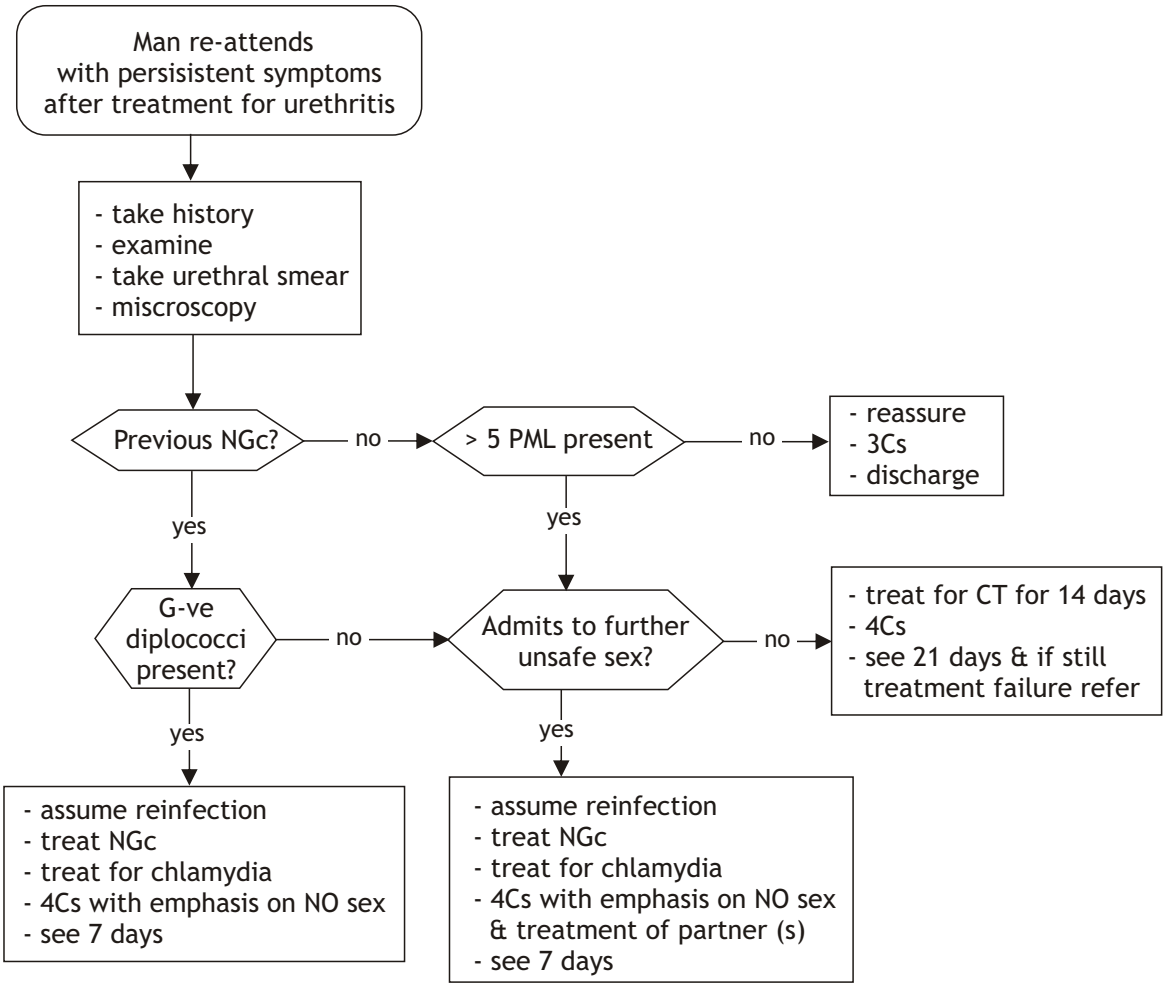


OUT PATIENT TREATMENT FOR PID
Ceftriaxone 250 mg I/M
PLUS
Doxycycline twice daily x 14 days
PLUS
Metronidazole 400 mg 3 times a day x 14 days

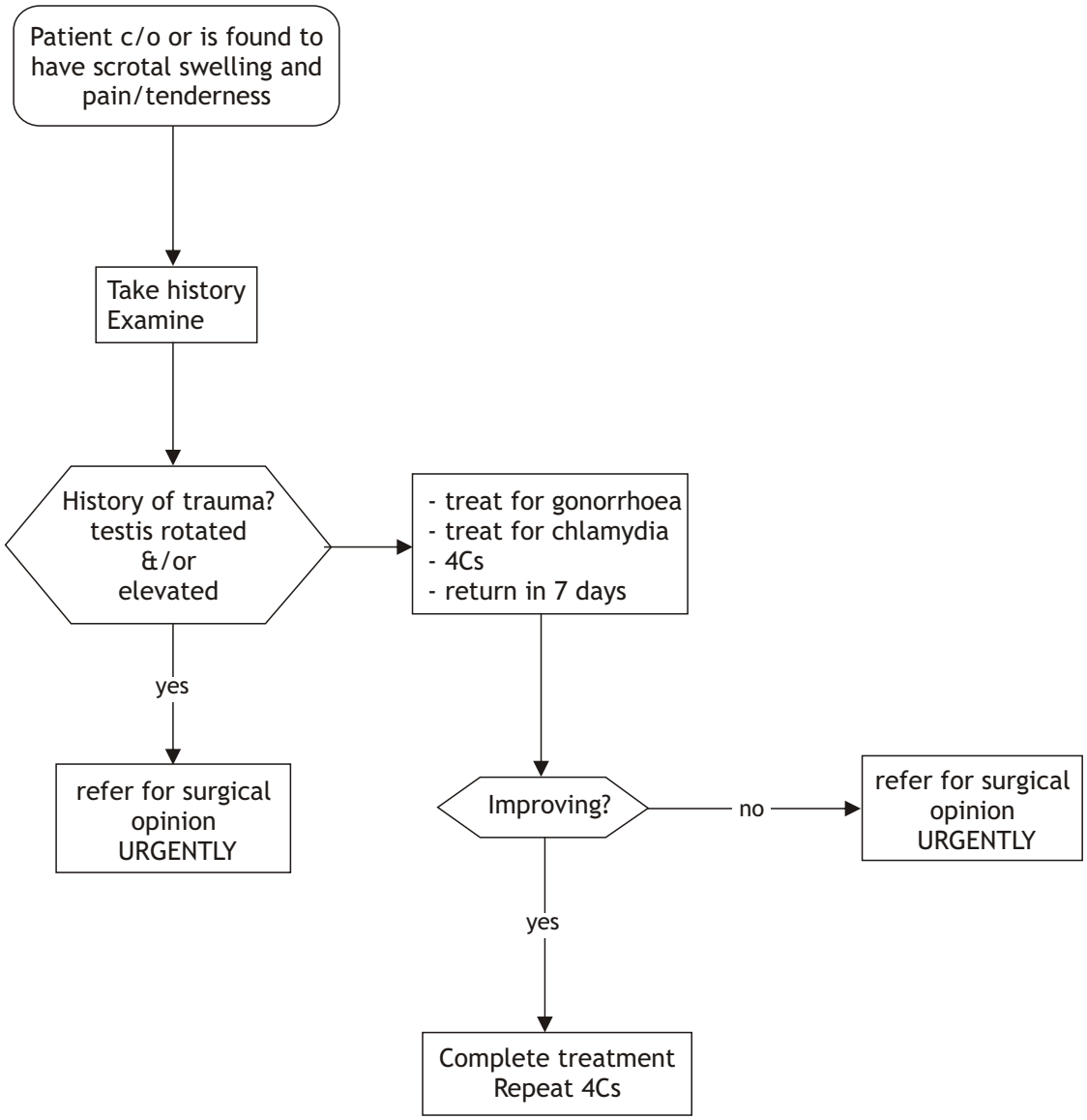
FHI STI SERVICE DELIVERY
URETHRAL DISCHARGE



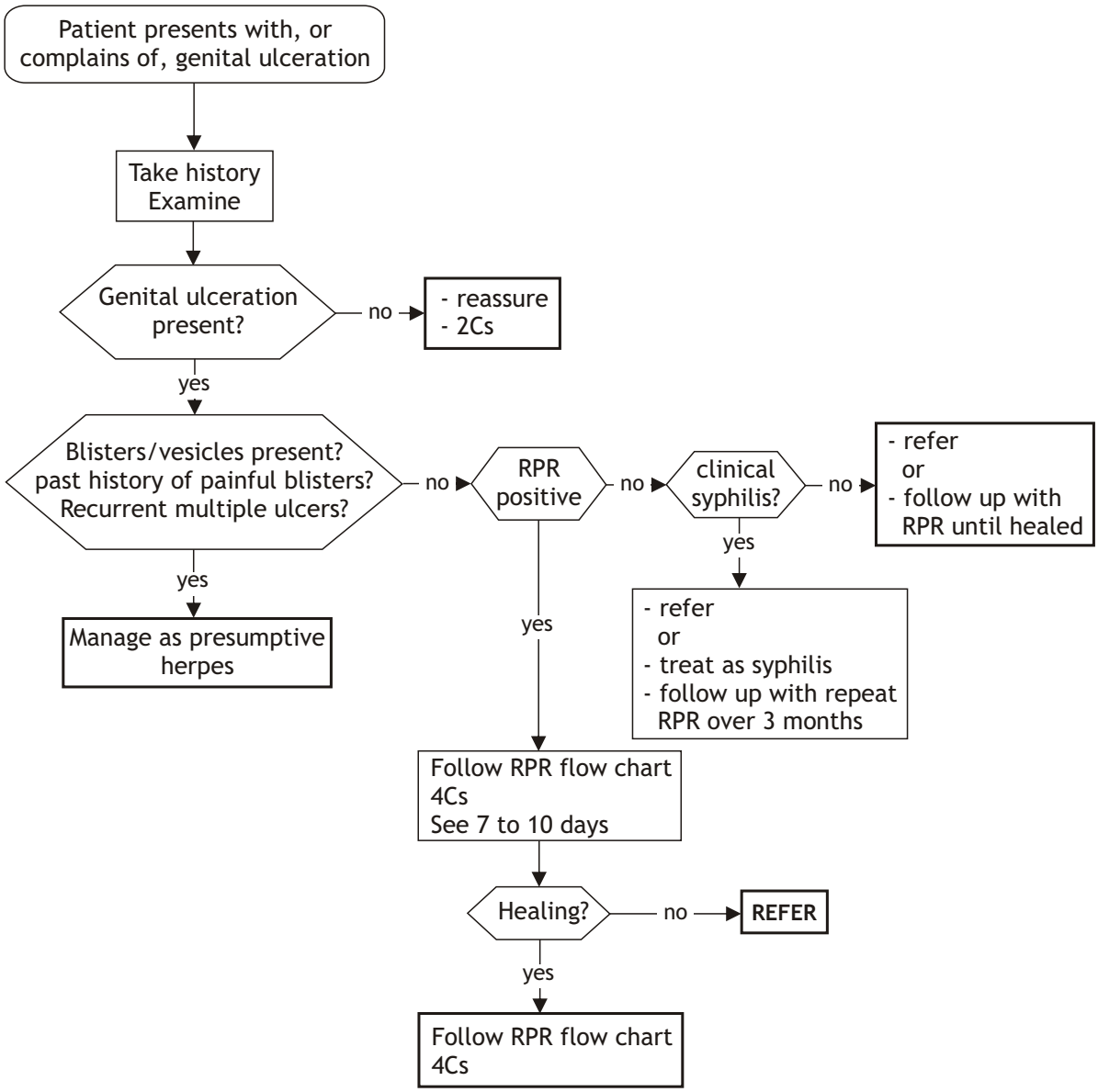
FHI STI SERVICE DELIVERY
URETHRALL DISCHARGE
TREATMENT FAILURE OR REINFECTION



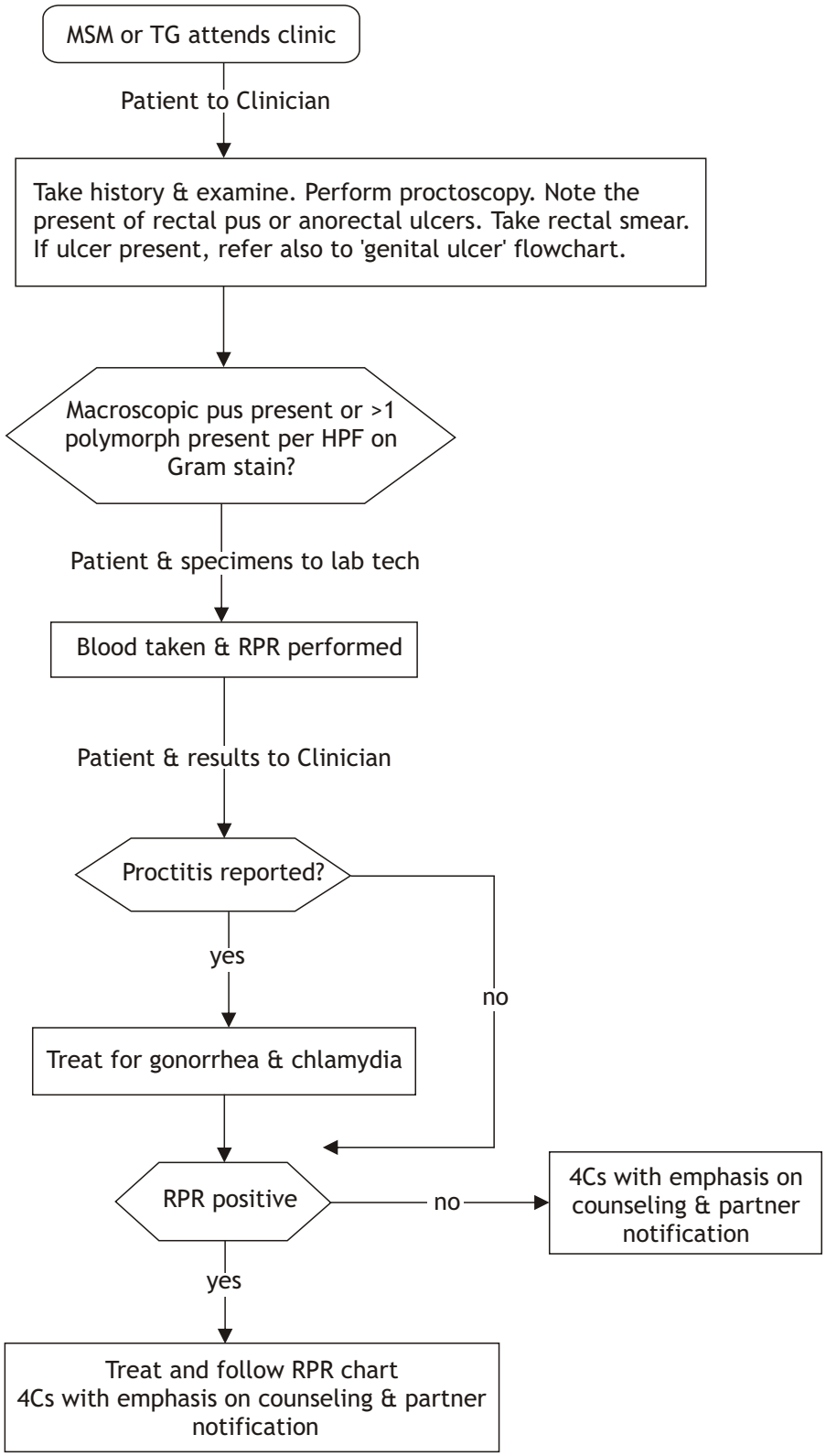
NO LABORATORY
FHI STI SERVICE DELIVERY
SCROTAL SWELLING



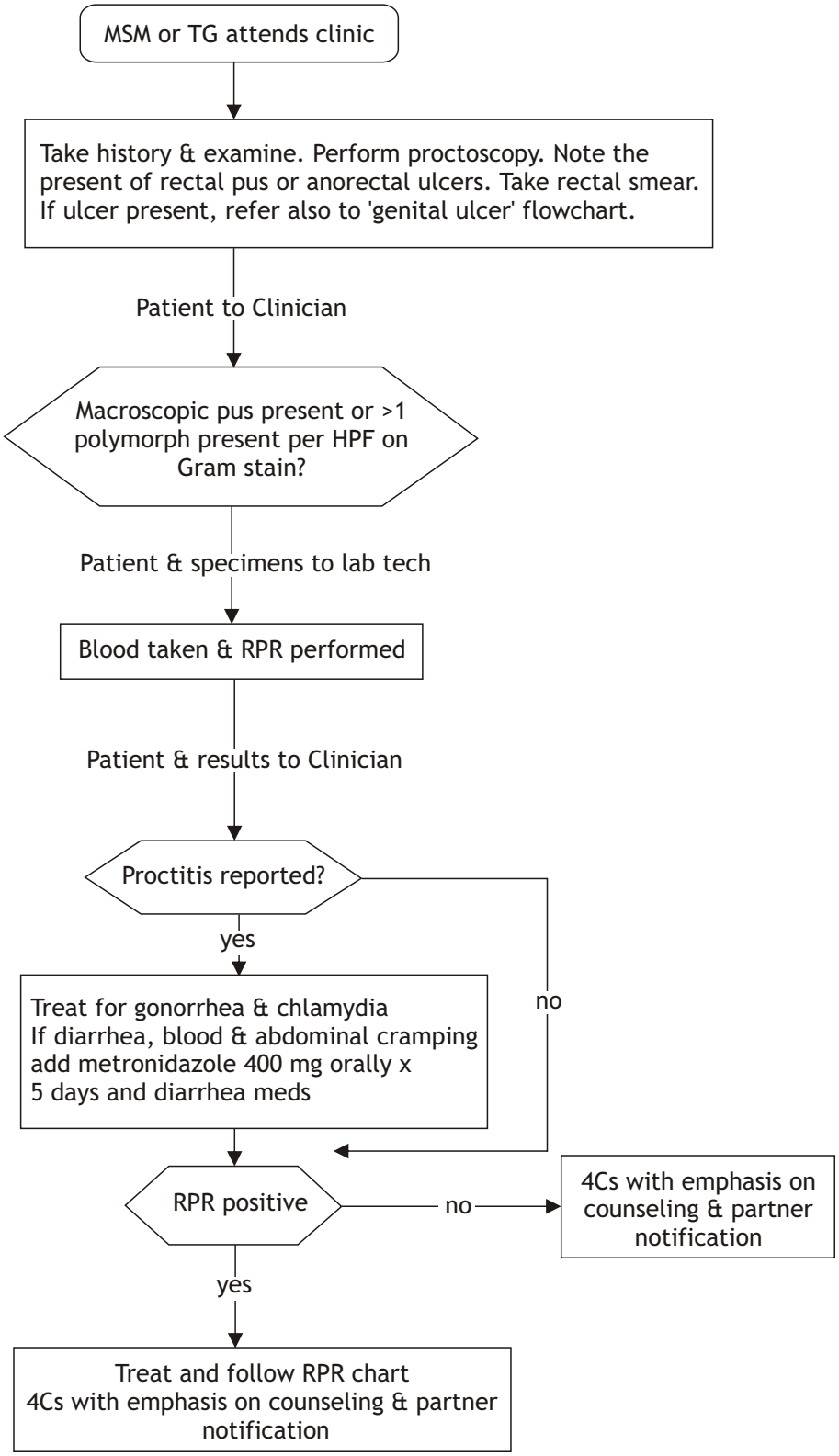
FHI STI SERVICE DELIVERY
GENITAL ULCER DISEASE



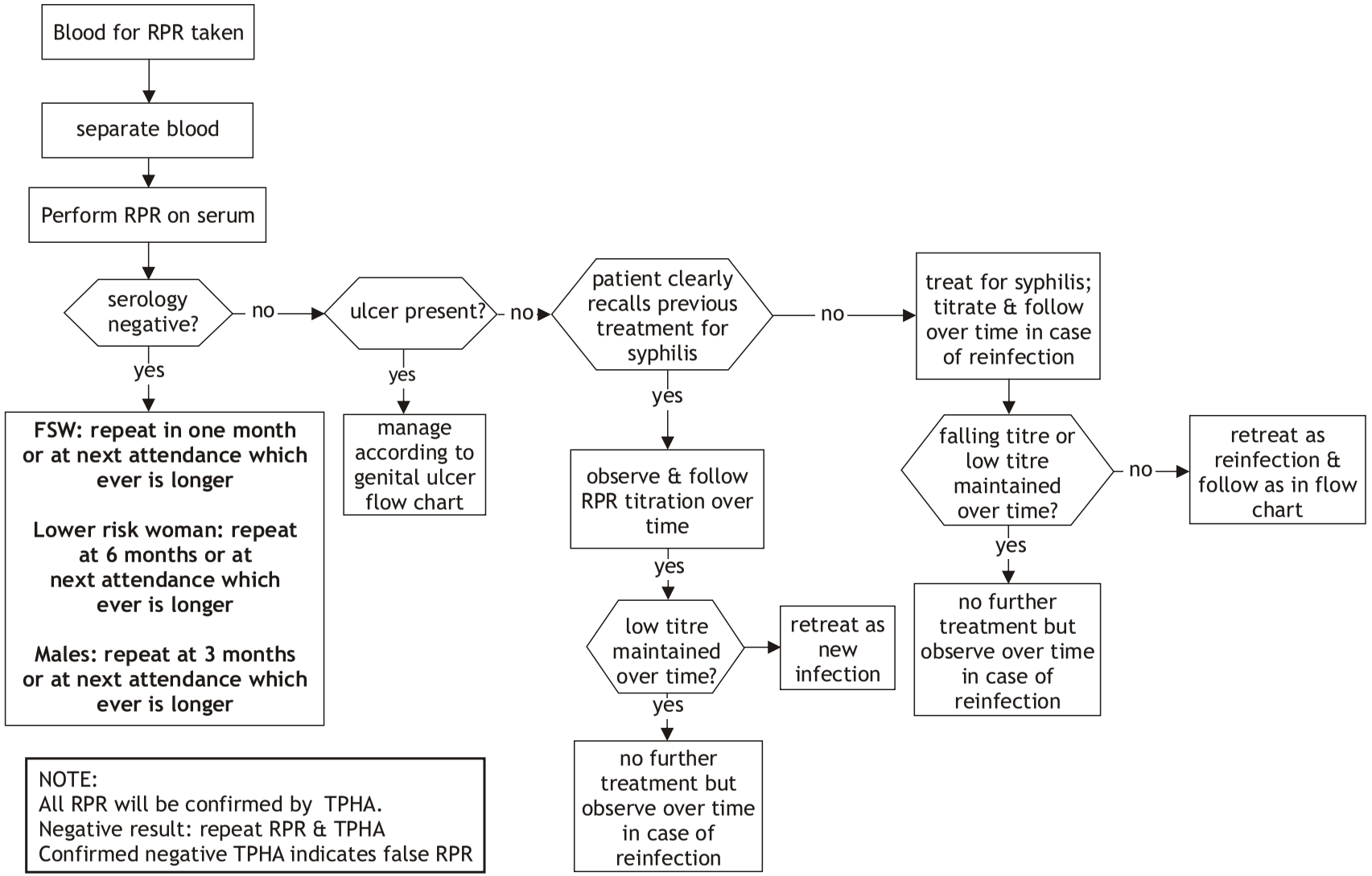
FHI STI SERVICE DELIVERY
MSM & TRANSGENDER CASE MANAGEMENT
NO SYMPTIOMS



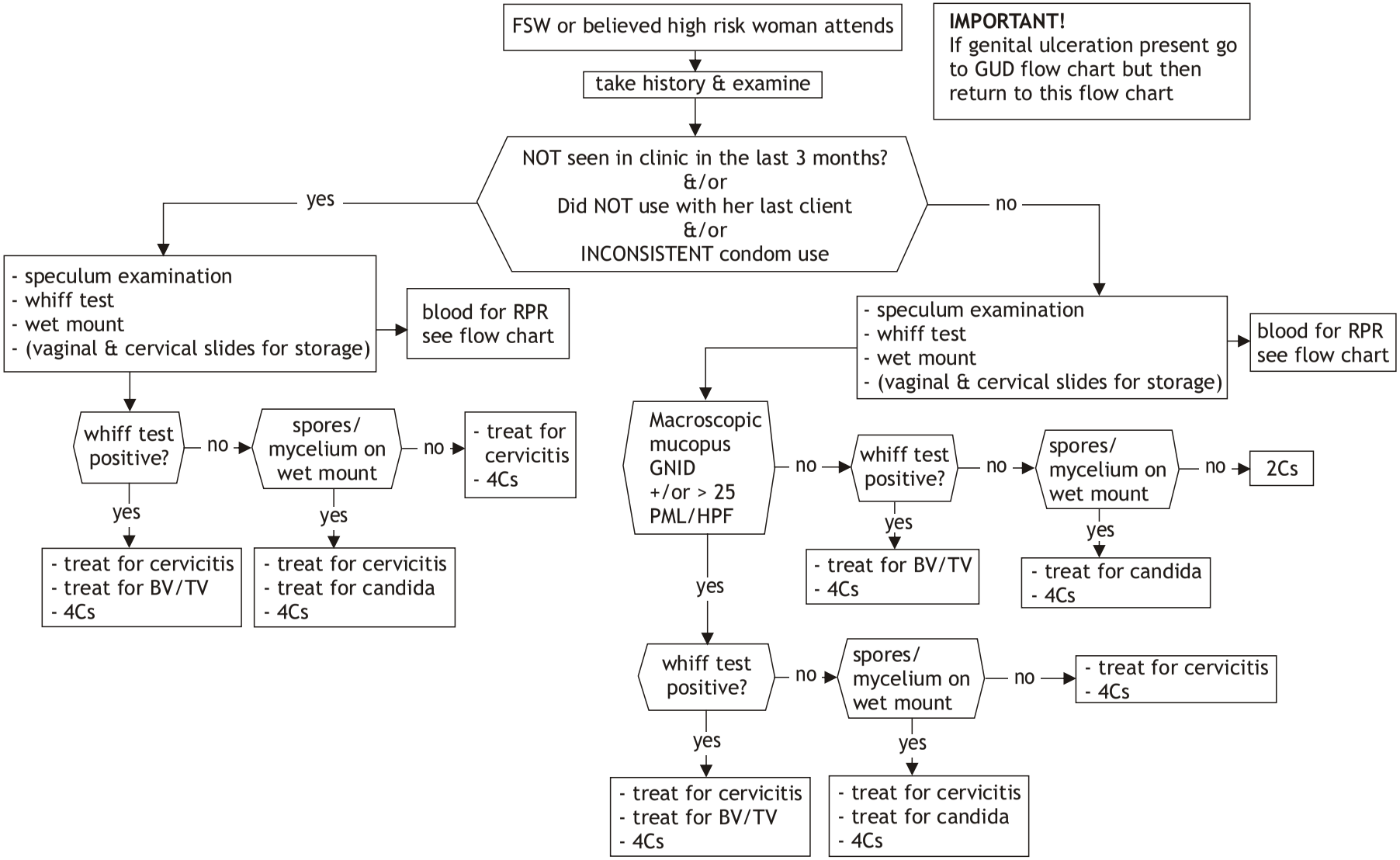
FHI STI SERVICE DELIVERY
MSM & TRANSGENDER CASE MANAGEMENT
SYMPTIOMATIC



MANAGEMENT OF RPR TEST



The Core Management of STIs in Sex Worker Or Believed High Risk Woman



Annex V: Laboratory Procedures in a STI Clinic

The Role of the Laboratory Technician

Is to enable the provision of laboratory support to the diagnosis of STIs as required by the clinician.

The Laboratory Technician must Ensure that:

- Universal precautions are observed in the laboratory areas of all the clinics
- The confidentiality of patient information acquired during his or her work is maintained and that the laboratory service is non-discriminatory and non-judgmental and patients are given full respect and dignity

Preparation of Laboratory at STI clinics:

Prior to Start the Clinic:

- Assemble and prepare laboratory equipment required for the clinic including microscope, centrifuge & centrifuge tubes, RPR rotator, needle destroyer, used syringe/needle container and cold box
- Assemble and prepare materials including bacteriological loops, diamond glass marker, spirit lamp gloves, blood containers, swabs, syringes and needles, and cold box/es (if required); with RPR cards and reagents;
- Assemble and prepare laboratory consumables and reagents including microscope slides and cover slips, swabs, disinfectant, Gram's stain reagents in dropper bottles, KOH 10%, methanol, RPR cards and reagents
- Ensure a sufficient water supply is available;
- Enter any additional test results obtained from the reference laboratories (e.g. NGc cultures) in the patient notes.

In a Mobile Clinic

All Procedures Should Be Carried Out According To Manufacturer's Instructions or according to the Attached Protocols

- Receive patients from the clinician, clinical notes and any specimens which have already been taken by the MO or nurse/medical assistant;
- Ensure patient's clinic number is on specimens;
- Obtain and mark containers with patient's clinic number for
  - Venous blood,
- Fix smears with methanol, Gram stain and read with microscope;
- In appropriate batches, centrifuge blood, separate serum into screw top universal containers marked with patient's clinic number;

Perform RPR card tests according to manufacturer's instructions;

- Retain RPR negative sera in cryo-tube and store in deep freeze of refrigerator for later External Quality assessment.
- Store positive RPR sera for TPHA;
- Enter all results on the clinical sheets & take to clinician ensure clinician is aware of any positive results

At the End of the Clinic

- Disassemble and pack equipment for storage as appropriate;

- Dispose of contaminated material appropriately;
- Store unused consumables and reagents;
- Note replacement supplies required for next clinics;
- Wash all used instruments and pack for transport to the referral clinic;
- Clean laboratory area and wipe all working surfaces with disinfectant,
- Safely pack all specimens for further examination or quality control for transport to the static/referral laboratory.

On Return to the Static Clinic Laboratory

- Unpack equipment, consumables, etc.
- Autoclave instruments
- Repeat and titrate positive RPR tests;
- Perform TPHA on all positive RPR, according to manufacturer's instructions and enter in results book and in the patient's notes;
- Decant serum for quality control into cryotubes and place in deep freeze.

INVESTIGATION PROTOCOLS

Collection of Blood:

Materials needed:

- Gloves;
- Tourniquet;
- Spirit;
- Cotton ball;
- Disposable syringe and needle;
- Plain test tube labeled with the patient's CLINIC NUMBER and date/time of collection;
- Adhesive dressing and
- Needle destroyer or needle disposal container.

Before taking blood the technician will verify the patient's CLINIC NUMBER.

Procedure for blood collection by venipuncture:

The technician should wear disposable gloves.

With the patient seated and with the forearm pronated in a stable position on a table beside their chair (the arm MUST NOT be positioned so that the patient can move their arm suddenly in response to the pain of the needle entry - this can lead to more pain and potential injury to the vein or even a nearby artery):

- Identify the position of the median cubital vein in the medial aspect of the forearm just below and lateral to the elbow joint;
- Place a tourniquet on the middle of the upper arm to occlude venous return and ask the patient to clench the fist;
- Clean the area with an alcohol pad;
- Re-palpate the vein, if necessary, to reassess location, depth and direction and stabilize the vein between the index finger and thumb;
- Enter the needle, bevel side up, directly above and parallel to the vein;

- Enter into the vein smoothly, quickly and at an approximately 15-degree angle relative to the skin.
- Withdraw 5 - 10 mls of blood.
- Release the tourniquet and ask the patient to open the hand;
- Take the needle out and apply pressure on the puncture site with a sterile cotton gauze and ask the patient maintain pressure over the puncture site and apply an adhesive dressing.

> *NOTE: Avoid skin contact with blood. Any spillage should be immediately cleaned up using a hypochlorite or similar disinfectant liquid.*

Handling of the specimen of blood:

- After collection of blood, **DO NOT RECAP THE NEEDLE** but place the needle in the destroyer. Take precautions not to injure yourself;
- Transfer the blood directly from the syringe into the pre-labeled container;
- Allow blood to clot (for 15-30 minutes).
- Centrifuge the blood for 15 minutes at 3000 rpm;
- Separate the upper, clear portions (serum) from the blood with a Pasteur pipette into a universal container labeled with the patient's CLINIC NUMBER;
- Perform the RPR test according to the manufacturer's instructions;
- Transfer the remaining serum to the cold box and maintain at 2 - 8°Celsius until return to the office and there keep in the refrigerator at 2 - 8°C and
- After all investigations (RPR titration and TPHA if required) deep freeze after transfer to a cryotube labeled with the patient's CLINIC NUMBER.

Simple Laboratory Tests

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

1. Microscopic Examinations:

- Wet mount: The saline wet prep is easily prepared and is used for the rapid detection of Trichomonas vaginalis, and “clue” cells associated with bacterial vaginosis.
  - Materials Required: Microscope, slides, cover slips (22 x 22 mm), saline, cotton-tipped swabs, bright ?eld microscope.
  - Preparation of Wet Mount Slide:
    - Place a drop of saline on a glass slide; then mix with a drop of vaginal fluid collected on swab.
    - Cover a wet preparation with a coverslip and examine microscopically at x 100 magnification prior to examination at x400 magnification.
  - Interpretation:

    Trichomonads are best recognized by their typical jerky motility. *Trichomonas vaginalis* is a pear shaped parasite. It contains a central nucleus, four anterior flagella and an undulating membrane.

    Clue cells are squamous epithelial covered with many small coccobacillary organisms, giving a

stippled,granular aspect ; the edges of these cells are not clearly defined, owing to large number of bacteria present and the apparent disintegration of the cells. In most patients with BV, a mixture of normal exfoliated vaginal epithelial cells and 20% or more clue cells will be seen.

- KOH Mount: The KOH preparation is used to detect yeast.
  - Materials Required: Microscope, slides, coverslips (22 x 22 mm), 10% KOH, cotton-tipped swabs, bright?eld microscope.
  - Preparation of KOH Mount Slide:
    - Collect the vaginal specimen on a swab, and then roll the swab on a small area of the slide.
    - Add a drop of 10% KOH (potassium hydroxide) and mix with a wooden applicator or swab.
    - Sniff for a "?shy" odor (Whiff test).
    - Cover with a coverslip; avoid trapping air bubbles.
    - Examine the slide microscopically. Scan for pseudohyphae on low power. Confirm the presence of pseudohyphae and locate yeast buds on high dry.
  - Interpretation:

  Yeasts are round to ovoid cells, approximately 4 m in diameter, showing typical budding. Yeast cells may appear in chains known as pseudohyphae.
- Gram Staining: The Gram stain is useful in the diagnosis of gonorrhea. Both the numbers of polymorphonuclear leukocytes (PMNLs) and microbial ?ora present can be assessed.
  - Materials required: Cotton-tipped swabs, microscope, slides, methanol, Gram stain reagents: crystal violet, Gram's iodine, decolorizer (50:50 mixture of acetone and 95% ethanol), safranin, sink or staining tray with water source, paper towels or blotting paper, immersion oil.
  - Preparation of Smear:
    - Carefully roll the swab (urethral or cervical) onto a slide to avoid disrupting cells.
    - Let the smear air-dry rather than drying it over a ?ame.
    - Fix the smear with 2-3 drops of absolute methanol. Allow the methanol to dry on the smear (for about 2 minutes).
  - Staining Procedures:
    - Flood the slide with crystal violet for 1 min, and then rinse with a gentle stream of tap water.
    - Flood the slide with Gram's iodine for 1 min, and then rinse with a gentle stream of tap water.
    - Rinse the slide with decolorizing solution until purple no longer runs from the thinnest part of the smear.
    - Flood the slide with safranin for approximately 1 minute, and then rinse with water.
    - To dry the smear, blot it gently on a clean paper towel (do not rub).
  - Examination:
    - Place a drop of immersion oil on the stained smear.
    - Examine the smear at low power (10X) to check for proper staining and to locate areas of the smear containing many cells.
    - Then use the oil immersion objective (100X) to search in these areas for bacterial morpho types and to count PMNLs. This means that each field is at 1000X magnifcation for identification and counting

purposes.

- Interpretation:

Cells and mucus stain red. Bacteria are characterized as Gram-positive (violet) or Gram-negative (red), and as cocci (round), bacilli (rod-shaped), or coccobacilli (small in size with morphology in between rods and cocci).

Always describe exactly what is seen on the smear: epithelial cells, PMN (Polymorphonuclear) leukocytes, types of bacteria, intracellular and extracellular position. Gonococci appear as Gram-negative diplococci with in polymorphonuclear leukocytes. A slide should be examined for at least 2 minutes before concluding it does not contain any Gram-negative intracellular diplococci.

2) Syphilis Serology:

- RPR test: The RPR is a *"non-treponemal"* test, in that the antibodies detected are not specific for T. *pallidum*, although their presence in patient's serum or plasma is strongly associated with infection by the infecting organism. These antibodies tend to disappear after successful cure of infection. RPR kits use carbon particles coated with a mixture of lipid antigens, which will combine with antibody present in patient's serum or plasma. Positive reactions are shown by macroscopic aggregation of the particles.
  - Equipment required: Micropipette, rotator
  - Test procedures:
    - Qualitative Test:
      - The positive and negative kit controls must be run with each batch of tests.
      - Place 50 ml of specimen or control into a circle on the test card.
      - Spread the specimen evenly over the test circle area.
      - Shake the vial of RPR antigen to ensure thorough mixing.
      - Holding the dropping bottle vertically over the test specimen, dispense a single drop of antigen.
      - Place test card on a card rotator and rotate at 100 rpm for 8 minutes.
      - Read and interpret results visually in good light.
    - Quantitative Test:
      - Make doubling dilutions of specimen in normal saline.
      - Place 50μl of each dilution into a separate circle on the test card.
      - Spread each dilution evenly over the test circle.
      - Continue as from Qualitative test section 5.

    The titer of specimen is expressed as the reciprocal of the highest dilution showing aggregation of the carbon particles.
  - Interpretation:
    - Reactive: Clumps of carbon particles with a clear back ground
    - Non-reactive: A smooth grey pattern or a button of non-aggregated carbon particles in the centre of the test circle.

    > *Note: It is important to follow the procedure as described in manufacturer's instruction provided with the test kit because some steps may differ from one type of testing kit to another.*

- TPPA test: TPPA test is very specific for the diagnosis of syphilis. This test is carried out in microwell plate.

The antigen, in this TPPA test, is coated on latex particles which are is known as sensitized particles. Antibodies become detectable after 3-4 weeks of infection and may remain detectable for long periods.

- Equipment Required: Micropipette, automatic vibratory shaker, micro-well plate (having "U" shaped bottom).
- Test Procedure:
  - Keep 100 µl of diluent (provided in the testing kit) into the well no.1.
  - Keep 25 µl of diluent into the well no. 2, 3 and 4.
  - Keep 25 µl of patient serum into the well no. 1 and mix thoroughly by filling and discharging by micropipette 4-5 times. Transfer 25 µl of the mixture of specimen and sample diluent into well #2. Then mix well and repeat this procedure again with wells #2, #3 and #4 to obtain serial doubling dilutions.
  - Place 25 µl of unsensitized particles in well #3, 25 µl of sensitised particles in well #4.
  - Mix the contents of well thoroughly using a plate mixer. DO NOT USE A ROTATOR. Then cover the plate and let it stand at room temperature (15-30 ºC) for 2 hours before reading.
- Interpretation:
  - Positive: Agglutinated particles spread out covering the bottom of the well uniformly.
  - Negative: Particles concentrated in the shape of a button in the center of the well with a smooth round outer margin.

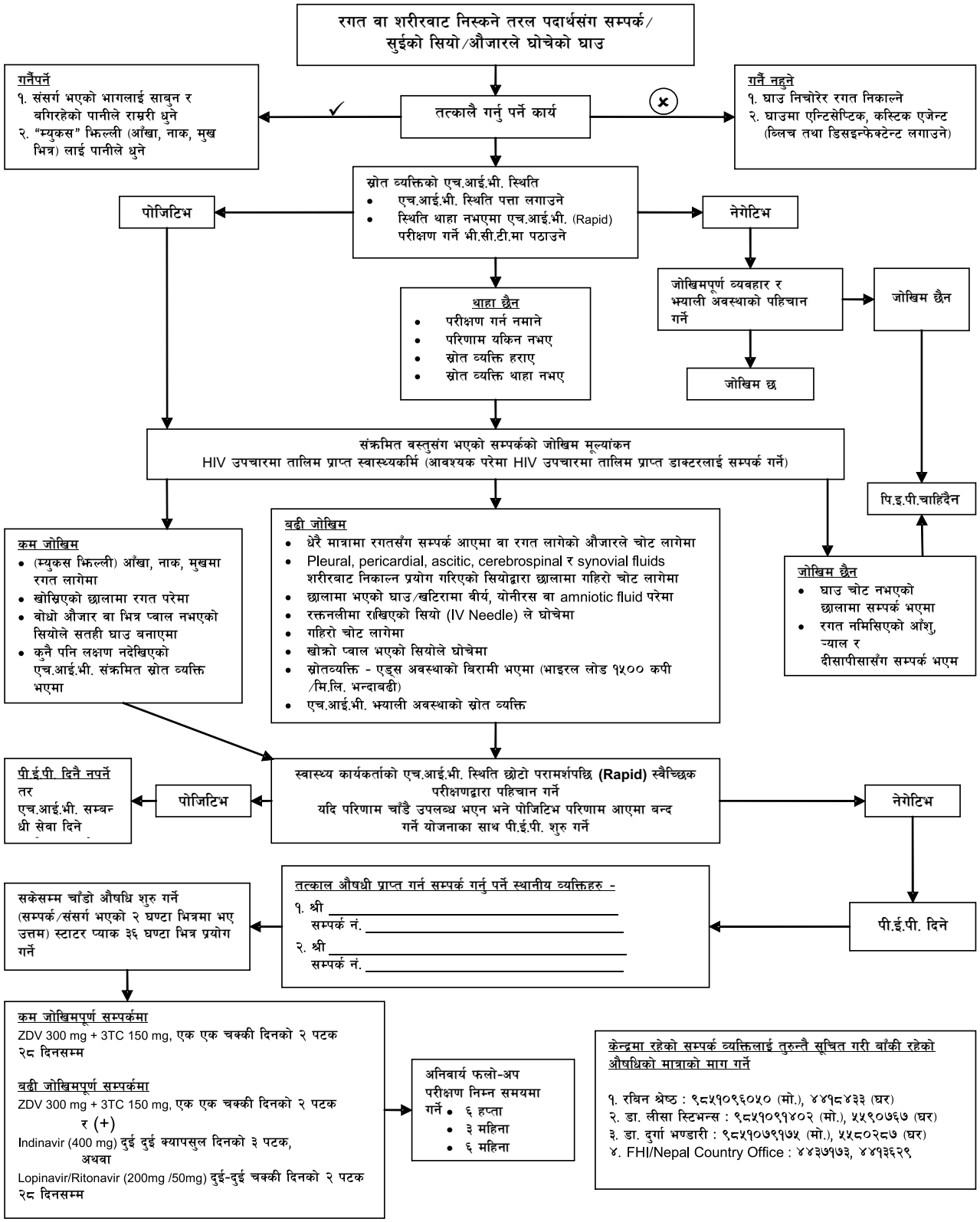
> *Note: It is important to follow the procedure as described in manufacturer's instruction provided with the test kit because some steps may differ from one type of testing kit to another.*

Other Laboratory Tests

1. Pregnancy testing should be provided whenever demanded and test kits are available
2. HIV testing should be provided to the STI client onsite or through referral to the nearest VCT center which follows national VCT guidelines.

Annex VI: PEP Flow Chart

रगत तथा शरीरबाट निस्कने तरल पदार्थसंग सम्पर्क व्यवस्थापन तालिका



Annex VII: STI Health Record Forms

STI CLINIC Male Health Record

Target group ☐☐

Date: _____

1.History of Present illness:

2. Present Complaints (please circle one or more):

a. Discharge (Urethral/Anal) b. Ulcer (Penile/Anal) c. Scrotal Swelling

d. Genital/Groin Itching e. Burning urination/frequency f. Vesicles/Pustules

g. Others.....

3. Previous Illnesses (including STIs) and Operations:

4. Drug History:

A Any medications used for present problem (circle one) yes/no

Details: _____

B Drug Allergy (circle one) Yes/No

Details: _____

C Illicit drug use (circle one) Yes/No

Details: _____

5. Sexual History:

Date of last sexual encounter: Male partner? Yes ☐ No ☐ Female partner? Yes ☐ No ☐

Method of Contraception:.....

Sexual practice:

- Vaginal Yes ☐ No ☐ Anal Yes ☐ No ☐ Oral Yes ☐ No ☐
- Condom used correctly: Yes ☐ No ☐ Don't know ☐ Not applicable ☐
- Total number or lifetime partners: Number of males: Number of females:

HIV Test done before: Yes No ☐ Result: Positive ☐ Negative ☐ Don't know

6. Condom use in last 3 months (tick one only):

☐ Every time ☐ Almost every time ☐ Sometimes ☐ Never

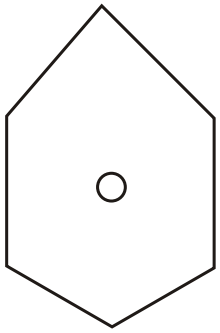
☐ Don't know ☐ No response ☐ Not applicable

7. Partner has signs of STI (tick one): ☐ Yes ☐ No ☐ Don't know

If yes, please describe:

8. Contraception (if relevant):

9. General Examination:



Abdominal Examination

Weight (kgs): _____ B/P: _____ Temp (^{0}C): _____ Pulse: _____

Jaundice: Yes ☐ No ☐ Pallor: Yes ☐ No ☐

Lymph Nodes: _____ Skin Lesions: _____

10. Locally: Ulcer _____ Yes/No Site: _____ Size: _____

Single/ Multiple, Tender/ Non Tender, Vesicular

Urethral discharge _____ Yes/No Description _____

Scrotum: Penis: Epididymis:

Testis: Vas deferens Anal/Proctoscopy:

11. Systemic: Chest: _____ CVS: _____ CNS: _____ Other: _____

12. Provisional Diagnosis: _____

13. Investigations:

RPR Yes ☐ No ☐ Result: Positive ☐ Negative ☐ Titer: ☐

TPHA Yes ☐ No ☐ Result: Positive ☐ Negative ☐

HIV antibody: Yes ☐ No ☐ Result: Positive ☐ Negative ☐

14. Diagnosis: _____

15. Treatment:

16. Other Management (4Cs etc):

17. Follow up

18. Referalls

STI CLINIC Female Health Record

Target group ☐☐

Date:

1. History of Present illness:

2. Present Complaints (please circle one or more):

a. PV Discharge
b. Urethral Discharge
c. Burning urination/ urgency
d. Genital Itching
e. Genital Swelling
f. Coital pain/ bleeding
g. Lower Abd / back pain
h. Ulcer/ Vesicles/ Pustules
i. PV bleeding
j. Others.....

3. Previous Illnesses (including STIs) and Operations:

4. Drug History:

A Any medications used for present problem (circle one) yes/no

Details: _____

B Drug Allergy (circle one) Yes/No

Details: _____

C Illicit drug use (circle one) Yes/No

Details: _____

5. Gyane/ Obs History: L.M.P (date):.....

Menstrual Cycle (regular/ irregular):.....

G:..... P:..... A:..... Contraception:.....

6. Sexual History:

Date of last sexual encounter: Male partner? Yes ☐ No ☐ Female partner? Yes ☐ No ☐

Sexual practice:

- Vaginal Yes ☐ No ☐ Anal Yes ☐ No ☐ Oral Yes ☐ No ☐
- Condom used correctly: Yes ☐ No ☐ Don't know ☐ Not applicable ☐
- Total number or lifetime partners: Number of males: Number of females:

HIV Test done before: Yes No ☐ Result: Positive ☐ Negative ☐ Don't know

7. Condom use in last 3 months (tick one only):

☐ Every time ☐ Almost every time ☐ Sometimes ☐ Never

☐ Don't know ☐ No response ☐ Not applicable

8. Partner has signs of STI (tick one): ☐ Yes ☐ No ☐ Don't know

If yes, please describe:

9. Risk Assessment (For High Risk Women)

From history and/ or BCI referral: Is patient high-risk woman?	☐ Yes	☐ No
Has she been seen in the clinical in last three months?	☐ Yes	☐ No
Did she use a condom with her last client?	☐ Yes	☐ No
Does she use condoms consistently?	☐ Yes	☐ No

Yes *to the first question or* ***No*** *to any of the remaining three is the indication for the presumption treatment of cervicitis.*

10. Risk Assessment (For Lower Risk Women)

BEHAVIORAL FACTORS

Sexual intercourse with partner with urethral discharge in the last 3 months?	☐ Yes	☐ No
Aged 25 years or less?	☐ Yes	☐ No
Has had multiple partners in the last three months?	☐ Yes	☐ No
'Thinks' that a partner has other sexual partners?	☐ Yes	☐ No
In last 3 months, had sexual intercourse with partner within one week of their return from travel?	☐ Yes	☐ No

11. CLINICAL FACTORS

Abdominal tenderness?	☐ Yes	☐ No
Cervical bleeding on touch?	☐ Yes	☐ No
Non-clear endocervical discharge (i.e. mucopus, pus)?	☐ Yes	☐ No
Cervical excitation (pain or discomfort on moving the cervix during bimanual examination)?	☐ Yes	☐ No

NOTE: One behavioral factor 'Yes' + One clinical factor 'Yes' = cervicitis treatment

12. General Examination:

Weight (kgs): _____ B/P: _____ Temp (^{0}C): _____ Pulse: _____

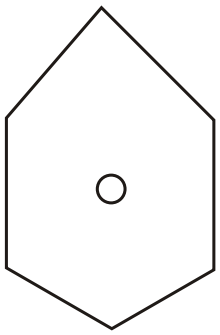
Jaundice: Yes ☐ No ☐ Pallor: Yes ☐ No ☐

Lymph Nodes: _____ Skin Lesions: _____

13. Systemic:

Chest: _____ Breast/ Nipples: _____

CNS: _____ CVS: _____



Abdominal Examination

14. Local:

External Genitalia: _____ Perineum/ Perianal: _____

Speculum findings: _____ Bimanual examination findings:

Whiff Test: Positive: ☐ Negative: ☐ Not done: ☐

15. Investigations Requested:

RPR Yes ☐ No ☐ Result: Positive ☐ Negative ☐ Titer: ☐

TPHA Yes ☐ No ☐ Result: Positive ☐ Negative ☐

Gram stain (vaginal specimen): Yes ☐ No ☐ Result:

Gram stain (cervical specimen): Yes ☐ No ☐ Result:

HIV antibody: Yes ☐ No ☐ Result: Positive ☐ Negative ☐

Pregnancy test: Yes ☐ No ☐ Result: Positive ☐ Negative ☐

Other investigations/ Results:

16. Provisional Diagnosis: _____

17. Diagnosis:

18. Treatment:

19. Other Management (4Cs etc):

20. Follow-up:

21. Referalls

STI CLINIC Male Health Follow-up FormRecord

Target group ☐☐

Date: _____

1. History of Present illness:

2. Present Complaints (please circle one or more):

a. Discharge (Urethral/Anal) b. Ulcer (Penile/Anal) c. Scrotal Swelling

d. Genital/Groin Itching e. Burning urination/frequency f. Vesicles/Pustules

g. Others.....

3. Drug History:

1. Medications used for present problem (circle one) yes/no

Details: _____

4. Sexual History:

Date of last sexual encounter: Male partner? Yes ☐ No ☐ Female partner? Yes ☐ No ☐

Method of Contraception (inadequate, male condom, female condom, emergency contraception, pill, implant, injectable, IUD, vasectomy, minilap) Please specify

Sexual practice since previous visit:

- Vaginal Yes ☐ No ☐ Anal Yes ☐ No ☐ Oral Yes ☐ No ☐
- Condom used correctly: Yes ☐ No ☐ Don't know ☐ Not applicable ☐
- Total number or lifetime partners: Number of males: Number of females:

5. Condom use in last 3 months (tick one only):

☐ Every time ☐ Almost every time ☐ Sometimes

☐ Never ☐ Don't know ☐ No response ☐ Not applicable

Comments: _____

6. Partner has signs of STI (tick one): ☐ Yes ☐ No ☐ Don't know

If yes, please describe:

7. Contraception (if relevant):

8. General Examination:

Weight (kgs): _____ B/P: _____ Temp (^{0}C): _____ Pulse: _____

Jaundice: Yes ☐ No ☐ Pallor: Yes ☐ No ☐

Lymph Nodes:_____ Skin Lesions:_____

If lesion or discharge present at previous visit, comment on changes: _____

New Ulcer?_____ Yes/ No Site:_____ Size:_____

Single/ Multiple, Tender/ Non Tender, Vesicular

New Urethral discharge _____ Yes/ No **Description** _____

Scrotum:

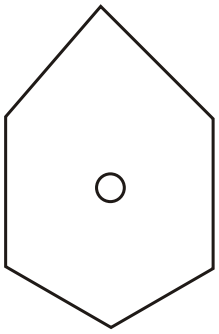
Penis:

Epididymis:

Testis:

Vas deferens

Anal/ Proctoscopy



Abdominal Examination

10. Systemic:

Chest:_____ CVS:_____

CNS: _____ Other:_____

11. Provisional Diagnosis: _____

12. Investigations:

RPR Yes ☐ No ☐ Result: Positive ☐ Negative ☐ Titer: ☐

TPHA/TPPA (do not re[peat if known to be positive)

TPHA/TPPA Result: Positive ☐ Negative ☐

Previous HIV status: Positive ☐ Negative ☐ Unknown ☐

HIV antibody: Yes ☐ **No** ☐ **Result: Positive** ☐ **Negative** ☐

Gram stain (urethral specimen) for recurrent infections only. Yes ☐ No ☐ Result:

13. Diagnosis: _____

14. CHECK ALLERGY STATUS

15. Treatment:

16. Other Management (4Cs etc):

17. Follow-up:

18. Referalls

STI CLINIC Female Health Follow-up Form

Target group ☐☐

Date: _____

1. History of Present illness:

2. Present Complaints (please circle one or more):

a. PV Discharge
b. Urethral Discharge
c. Burning urination/ urgency
d. Genital Itching
e. Genital Swelling
f. Coital pain/ bleeding
g. Lower Abd / back pain
h. Ulcer/ Vesicles/ Pustules
i. PV bleeding
j. Others.....

3. Drug History:

A Medications used for present problem (circle one) yes/no

Details:_____

B Illict drug use since previous visit? Yes/No

Details:_____

4. Gyane/ Obs History: **L.M.P (date):.....**

Menstrual Cycle (regular/ irregular):.....

G:..... P:..... A:.....

Method of Contraception (inadequate, male condom, female condom, emergency contraception, pill, implant, injectable, IUD, vasectomy, minilap) Please specify

5. Sexual History:

Date of last sexual encounter: Male partner? Yes ☐ No ☐ Female partner? Yes ☐ No ☐

Method of Contraception .....

Sexual practice:

- Vaginal Yes ☐ No ☐ Anal Yes ☐ No ☐ Oral Yes ☐ No ☐
- Condom used correctly: Yes ☐ No ☐ Don't know ☐ Not applicable ☐
- Total number or lifetime partners: Number of males: Number of females:

HIV Test done before: Yes No ☐ Result: Positive ☐ Negative ☐ Don't know

6. Condom use in last 3 months (tick one only):

☐ Every time ☐ Almost every time ☐ Sometimes
☐ Never ☐ Don't know ☐ No response ☐ Not applicable

7. Partner has signs of STI (tick one): ☐ Yes ☐ No ☐ Don't know

If yes, please describe:

8. Risk Assessment (For High Risk Women)

From history and/ or BCI referral: Is patient high-risk woman?	☐ Yes	☐ No
Has she been seen in the clinical in last three months?	☐ Yes	☐ No
Did she use a condom with her last client?	☐ Yes	☐ No
Does she use condoms consistently?	☐ Yes	☐ No

Yes *to the first question or* ***No*** *to any of the remaining three is the indication for the presumption treatment of cervicitis*

9. Risk Assessment (For Lower Risk Women)

BEHAVIORAL FACTORS

Sexual intercourse with partner with urethral discharge in the last 3 months?	☐ Yes	☐ No
Aged 25 years or less?	☐ Yes	☐ No
Has had multiple partners in the last three months?	☐ Yes	☐ No
'Thinks' that a partner has other sexual partners?	☐ Yes	☐ No
In last 3 months, had sexual intercourse with partner within one week of their return from travel?	☐ Yes	☐ No

10. CLINICAL FACTORS

Abdominal tenderness?	☐ Yes	☐ No
Cervical bleeding on touch?	☐ Yes	☐ No
Non-clear endocervical discharge (i.e. mucopus, pus)?	☐ Yes	☐ No
Cervical excitation (pain or discomfort on moving the cervix during bimanual examination)?	☐ Yes	☐ No

11. General Examination:

Weight (kgs): _____ B/P: _____ Temp (^{0}C): _____ Pulse: _____

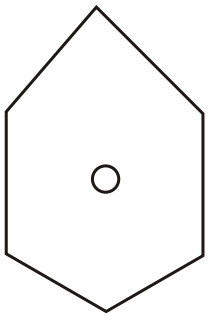
Jaundice: Yes ☐ No ☐ Pallor: Yes ☐ No ☐

Lymph Nodes: _____ Skin Lesions: _____

12. Systemic:

Chest: _____ Breast/ Nipples: _____

CNS: _____ CVS: _____



Abdominal Examination

13. Local

External Genitalia: _____ Perineum/ Perianal: _____

Speculum findings: _____ Bimanual examination findings:

Whiff Test: Positive: ☐ Negative: ☐ Not done: ☐

14. Investigations Requested:

RPR Yes ☐ No ☐ Result: Positive ☐ Negative ☐ Titer: ☐

TPHA Yes ☐ No ☐ Result: Positive ☐ Negative ☐

Gram stain (Vaginal specimen): Yes ☐ No ☐ Result:

Gram stain (cervical specimen): Yes ☐ No ☐ Result:

Previous HIV status: Positive ☐ Negative ☐ Unknown ☐

HIV antibody: Yes ☐ No ☐ Result: Positive ☐ Negative ☐

Pregnancy test: Yes ☐ No ☐ Result: Positive ☐ Negative ☐

Other Investigations/ Result:

15. Provisional Diagnosis: _____

16. Diagnosis:

17. CHECK ALLERGY STATUS

18. Treatment:

19. Other Management (4Cs etc):

20. Follow-up:

21. Referalls

Occupational Exposure Report

Name:		Address (workplace):	Address (home):
Birth date:	Sex:	Position:	Telephone No.
Date/Time of exposure:		Location exposure occurred:	Activity at time of exposure
Nature of injury (e.g. needle stick, cut, splash):			
Details of the procedure being performed, including where and how the exposure occurred:			
Details os the exposure, including the type and amount of fluid or material and the severity of the exposure			

Details about the source (client): The source material contained: HBV: HCV: HIV: Is the source HIV- infected: Stage of disease: History of antiretroviral therapy: Antiretroviral resistance: Pre- test counseling provided: <u>Result of the test:</u> HIV: Post- test counseling provided: Referral:	Details about the exposure person: Infected with: HBV: HCV: HIV: Concomitant diseased: Hepatitis B vaccination: Vaccine- response status: Pre- test counseling provided <u>Result of the test:</u> HIV: Post- test counseling provided: Referral:

PEP prophylaxis commenced:

Drugs provided:

Counseling on protecting others: avoiding unprotected intercourse and breastfeeding

Postexposure management:	CBC	Serum Liver Enzymes	Renal Function tests
Baseline visit			
2 week visit			
HIV Antibody test results: 6 weeks 3 months 6 months			

Signature	Date:

Annex VIII: STI Ledger Book for Recording Daily STI Cases

Month: **Year:**

STI DAILY DATA COLLECTION LEDGER

SERVICE TRACKING											Source of Info.	Type of Visit		Patient Category and Diagnosis																						
Total Records		ID						Demography																												
	M F MF FF	ASHA ID						R			R	R - B			L - S	L - S	L - S		F-17 M-14 MF-13 FF-16	F-17 M-14 MF-13 FF-16	F-17 FF-16	F-17 FF-16	F-17 FF-16	F-17 FF-16	F-17 FF-16	F-17 FF-16	F-17 FF-16	F-17 M-14 MF-13 FF-16	M-14 MF-13	F-17 M-14 MF-13 FF-16	F-17 M-14 MF-13 FF-16	F-17 M-14 MF-13 FF-16	F-17 M-14 MF-13 FF-16	F-17 M-14 MF-13 FF-16	F-17 M-14 MF-13 FF-16	
															Lab																					
Rec No.	Date	District #	IA #	IHS #	Reg. month	Reg. year	Reg. #	TG #	Gender (M/F)	Age		1st Visit	F/U	Sy (Y/N)	SypS	RPR +ve	TPPA +ve	Non STI	HSV	GUDS	PCerv	DCerv	BV	TV	CAN	VDS	PID	UDS	SSS	ARS	GW	IB	Other (Specify)	Nw STI	PSD	

ASHA ID = ASHA ID Number R - B = Registration form back page M = STI Male health record form GS = Gram Staining WM = Wet Mount KM = KOH Mount LS = Client Test Result form (STI) MF = STI Male health record follow up form FF = STI Female health record follow up form
R = Registration form F = STI Female health record form TV = Trichomonas vaginosis BV = Bacterial Vaginalis FE = Funcal elements GNID = Gram Negative Intracellular Diplococci

Source of info: 01-prevention (PE/OE/CM), 02-VCT, 03-Sexual/Injecting Partners, 04-Friends/Family members, 05-Self, 06-Media, 07-Others, **Patient Category and Diagnosis:** Sy-presents with symptoms, SypS-syphillis screening, RPR +ve-RPR reactive, TPPA +ve- TPPA reactive, HSV-genital herpes, GUD-genital ulcer disease, Pcerv-Presumptive cervicitis, BV-bacterial vaginosis, TV-trichomonas vaginalis, CAN-candid albicans, VDS-Vaginal discharge, PID-pelvic inflammatory, UDS-urethral discharge, SSS-scrotal swelling syndrome, ARS-anorectal STI, GW-genital warts, IB- inguinal bubo, Other-other STI, NwSTI-new STI diagnosis

→ Continue from annex VIII

Treatment Provided	Referrals				Condum Distribution			Test Done			Result				Remarks
F-18 M-15 FF-18 MF-15	F-21 M-18 FF-21 MF-18				F-19 M-16 FF-19 MF-16	M-17 F-20 MF-17 F-20	Mobile or Static	LS	LS	LS	LS	LS	LS	LS	
	PN	VCT	OP-STI	Other (Specify)		Follow-Up Dates		GS	WM	KM	GNID	TV	BV	FE	

Referral: PN-partner notification given, VCT-VCT referral given, OPR-Outpatient referral, **Target Group:** 01, Female Sex Workers, 02, Clients of Sex Workers, 03, Male IDUs, 04, Female IDUs, 05, Male Migrants, 06, Female Migrants, 07, Wife of Migrants, 08, Husband of Migrants, 09, MSM, 10, MSW, 11 Male Child, 12, Female Child, 66, Other Male, 67, Other Female, 68, Not Known Male, 69, Not Known Female

Annex IX: Laboratory Register

SAMPLE OF LABORATORY TEST RESULT REGISTER

S. No.	Date	Client's ID	Age/Sex	Type of Visit	Laboratory Test Result													Remarks
					Rapid HIV Testing				Syphilis Serology			Microscopic Investigations						
												Gram Staining		Wet Mount		KOH Mount		
					Determine HIV-1/2	Uni-Gold HIV	Capillus HIV-1/2	Final test result	RPR	Titer	TPPA	GNID	PMN	TV	Clue cells	Fungal elements		

Annex X: Monthly PIF for Monthly Reporting

ASHA

Advancing Surveillance, Polices, Prevention, Care and Support to Fight HIV/AIDS (ASHA)
Managed By Family Health International/ Nepal
STI Daily Collection Format

IA Code:
ISH Code:
Clinic Type:
Month:
Year:
FCO:

For IAs Staff only

Prepared by:
Date:
Verified by:
Date:

For ASHA Staff only

Reviewed by:
Date:

Service Tracking												Type of Visit		Patient Category and Diagnosis																										Referrals				Distribution
Total Records					ID			Demography			Source of Information				Lab																														
Rec. No.	Date	District #	IA #	ISH #	REG. Month	Reg. Year	Reg. #	TG #	Gender (M/F)	Age		1st visit	F/U	Sy (Y/N)	Syps	RPR +ve	TPPA +ve	Non STI	HSV	GUDS	PCerv	DCerv	BV	TV	CAN	VDS	PID	USD	SSS	ARS	GW	IB	Other	Nw STI\PSD	PSD	Rx (Y/N)	PN	VCT	OP-STI	Other	Co
1																																											
2																																											
3																																											
4																																											
5																																											
6																																											

Annex XI: HIV/STI Lab Commodity Usage Report & Request

AHSA MONTHLY HIV/STI LAB COMMODITY USAGE REPORT & REQUEST

IA/Clinic Location: Month/Year:

SN	Commodity	Unit	Batch No./ Expiry	Beginning Balance	Quantity Received	Quantity Used	Loss (-)/ Adjustment (+/-)	Ending Balance	Minimum stock (stock for 2 months)	Maximum stock (stock for 4 months)	Order quantity (when E ≤ F)	Remarks
				A	B	C	D	E = A + B - C +/- D	F	G	H = G - E	
	HIV TESTS											
1	Determine HIV-1/2 (100 tests/kit)	test										
2	Determine Chase Buffer (100 tests/2.5 ml)	test										*No. of whole blood tests done:*
3	Uni-Gold (20 tests/kit)	test										
4	Capillus HIV-1/ HIV-2 (100 tests/kit)	test										*Qty. for QC:*
	STI TESTS											
1	BD Macro-Vue RPR Card Test (500 tests/kit)	test circle										
2	BD Macro-Vue Liquid Control (3 x 1.5 ml/pack)	test										*No. of control tests done:*
3	Serodia TPPA (20 tests x 5)	test (20's)										*No. of patient serum samples tested:*

	Total No. of Clients Tested	Total No. of Clients Positive	Total No. of Clients Negative
HIV Tests			
STI Tests		RPR+: TPPA+:	

Prepared by:- Name: Designation: Date:

Annex XII: Commodity Expiry Tracking Chart

COMMODITY EXPIRY TRACKING CHART

SN	COMMODITY (Catalog No)	PACK SIZE	STORAGE TEMP.	RECEIVED DATE (dd/ mm/yy)	SHELF LIFE ON DELIVERY	BATCH NO.	EXPIRY DATE	QTY. (Kits/ Packs)	Year:												Year:											
									Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1	Capillus HIV-1/HIV-2 (6048G)	100 tests/kit	2-8^0 C																												
2	Determine HIV-1/2 (7D23 -13)	100 tests/kit	2-30^0 C																												
3	Determine Chase Buffer (7D22-11)	2.5 ml pack	2-30^0 C																												
4	Uni-Gold (1206502)	20 tests/kit	2-27^0 C																												
5	BD Macro-Vue RPR Care Test (275005)	500 tests/kit	2-8^0 C																												
6	BD Macro-Vue RPR Liquid Controls (276909)	3x1.5 ml/pack	2-8^0 C																												
7	Serodia TPPA (6384)	100 tests/kit	2-10^0 C Do not freeze																												
8	SD Bioline HIV-1/2 3.0 (03FK10)	30 tests/kit	1-30^0 C Do not store in refrigerator																												
9	Medipoint Blood Lancets	100/pack																													
10	EDTA Capillary Tubes	100/pack																													

Annex XIII: STI and OI Drug Dispensing Record

STI DRUGS DAILY CONSUMPTION RECORD

Faculty Name: ____________ Month: ____________ Year: ____________ Number of Patients Treated: ____________

SN	Date	Patient No.	Provisional Diagnosis	Acyclovir 200mg tab	Acyclovir Ointment	Adrenaline Inj.	Azithoromycin 500gm	Benzathine Penicillin 1.2 mIU	Cefixime 200gm	Ceftriaxone 250gm Inj.	Clotrimazole cream 1% tube	Clotrimazole 100mg pessary	Doxycycline 100mg	Fluconazole 150mg tab	GammaBenzene Hexachloride	Hydrocortisone Injection	Metronidazole 400mg tab	paracetemol 500mg tab	podophyllin (10-25)%																	
Total Quantity Dispensed:																																					
Monthly Total So Far:																																					

	Page Total	Monthly Total So Far		Page Total	Monthly Total So Far		Page Total	Monthly Total So Far
GUD-Syphilis (1a):			GUD-Chancroid (1b):			GUD-Herpes Genitalis(1c):		
UDS (2):			Vaginitis(3a):			Cervicitis(3b):		
LAP/PID (4):			IBS (5):			Genital wart (6):		
SSS (7):			Others -					

Syphilis(1a); Chancroid(1b); Herpes genitalis(1c); Urethral Discharge Syndrome(2); Vaginal Discharge Syndrome-(3) Vaginitis(3a); Cervicitis(3b); Lower Abdominal Pain(PID) (4); Inguinal Bubo Syndrome(5); Genital wart(6); Scrotal Swelling Syndrome(7); Other-specify.

OI DRUGS DAILY CONSUMPTION RECORD

Faculty Name: _____ **Month:** _____ **Year:** _____ **Number of Patients Treated:** _____

SN	Date	Patient No.	Provisional Diagnosis (Code1-10 or other)	Acyclovir 200mg	Albendazole 40mg	Albendazole 400mg/ ml Sulp.	Cotrimoxazole 960gm	Ciprofloxacin 500mg	Clotrimazole Cream 1% tube	Cclotrimazole Mouth Paint (1%wiv)	Clotrimazole 100mg pessary	Cloxacillin 500mg	Cetirizine 10mg	Fluconazole 100mg	Fluconazole 200mg	Metronidazole 400mg	Omeprazole 20mg	Amoxycillin 500mg	Clarithromycin 500mg	Dapsone 100mg	Ethambutol 800mg	Itraconazole 100mg	Metoclopramide 10mg	Rifabutin 300mg	Amphoteracin B 50mg vial	Sulfadoxine/Pyri methamine 500/ 25mg	Valganciclovir 500mg	Ganciclovir 500mg vial							
			Total Quantity Dispensed:																																	
			Monthly Total So Far:																																	

	Page Total	Monthly Total So Far		Page Total	Monthly Total So Far		Page Total	Monthly Total So Far
Tuberculosis (1):			Candidiasis (2):			Diarrhea (3):		
Cryptococcal meningitis (4):			PCP (5):			Cytomegalovirus disease (6):		
Penicilliosis (7):			Herpes Zoster (8):			Genital Herpes (9):		
Toxoplasmosis (10):			Others -					

OI Code: Tuberculosis (1); Candidiasis (2); Diarrhea (3); Cryptococcal meningitis (4); PCP Pneumocystic Cornii Pneumonia (5); Cytomegalovirus disease(6); Penucilliosis (7); Herpes Zoster (8); Genital Herpes (9); Toxoplasmosis (10); Other - specify

Annex XIV: Stock Book

STOCK BOOK FOR CONSUMABLE COMMODITIES

Commodity Name :

Property Classification Number :

Page #.....

Unit :

Specification :

Date	Received # Issued #	Received			Issued			Losses / Adjustments	Stock on Hand			Remarks
		Quantity	Rate	Amount	Quantity	Rate	Amount		Quantity	Rate	Amount	
1	2	3	4	5	6	7	8	9	10 (10=3-6-9)	11	12	13

FAMILY HEALTH INTERNATIONAL

Nepal Country Office
PO Box 8803, Gopal Bhawan, Anamika Galli
Baluwater, Kathmandu, Nepal
Tel: 977-1-4437173, Fax: 977-1-4417475
E-mail: fhinepal@fhi.org.np
Web: www.fhi.org

Family Health International

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