



Supplementary Manual

For Counsellors at STI/RTI Clinics



National AIDS Control Organisation
Ministry of Health and Family Welfare
Government of India
6th & 9th Floor, Chandralok Building
36, Janpath, New Delhi - 110001

DAY ONE



DAY ONE

Session 2 Pre - Training Assessment

Pre and Post-Training Questionnaire

- 1. What are the routes of HIV transmission?**
 - a) Unprotected sexual intercourse
 - b) Exposure to infected blood, blood products, or transplanted organs or tissues
 - c) Mosquito bite
 - d) Mother-to-child (infected mother to her infant before, during, or after birth)

- 2. How does one prevent STI/RTI?**
 - a) Using a condom consistently and correctly
 - b) Abstinence or being faithful with one sexual partner
 - c) Maintaining genital hygiene
 - d) All of the above

- 3. What are different categories of High Risk Behaviour Groups?**
 - a) Injecting drug users
 - b) Men who have sex with men
 - c) Female sex workers
 - d) Bridge populations (e.g, truck drivers and migrant workers)
 - e) All of the above

- 4. Give 3 reasons why STI/RTI counselling is important.**

- 5. Which of the following statements is correct?**
 - a) A person undergoing treatment for STI should abstain from sex until treatment is over
 - b) A person undergoing treatment for STI should encourage her/his partner to come to the clinic
 - c) A person undergoing treatment for STI may get re-infected if the partner is not treated
 - d) A person undergoing treatment for STI may feel well and appear well
 - e) All of the above statements

- 6. Which of the following are the three highest risk behaviours for the transmission of HIV?**
 - a) Sharing needles to inject drugs
 - b) Kissing
 - c) A woman getting semen into her mouth
 - d) Mutual masturbation (male to male)
 - e) A baby in womb during mother's seroconversion to HIV
 - f) Mopping up blood spill
 - g) A man receiving oral sex from a woman
 - h) Anal sex with ejaculation

- 7. What should be covered in a pre-test counselling session?**
 - a) Clinical Risk assessment
 - b) HIV counselling and testing
 - c) Safer sex and safe injecting information



- d) Personal risk reduction plan
- e) Assessment of personal coping strategies if test was to come back HIV positive
- f) All of the above

8. What are the ways to show you are listening to a client?

- a) Making eye contact
- b) Having a blank facial expression or staring
- c) Using minimal encouragers (mmmh, ah ah etc.)
- d) Interrogating, using 'why' questions
- e) Summarising (paraphrasing) information the client has told you and repeating back to check that you have understood

9. What should be covered under risk-reduction counselling?

- a) Exploring risk associated with high risk behavior – unsafe sex practices/number of encounters
- b) Providing preventive education – on safer sex, proper use of condoms, new needle for every use
- c) Exploring STI/RTI and HIV/AIDS knowledge – clarification of myths and misconceptions
- d) Encouraging medical check for STI/RTI and/or HIV testing
- e) All of the above

10. What should be covered in communicating a positive HIV test result?

- a) Providing the report and explaining the meaning
- b) Assessing for ability to cope with result including suicide risk assessment
- c) Disclosing status to family of client
- d) Asking client to not have sex with anyone

11. You are a counsellor at an STI clinic. A male client has come for a test today. He admits he has visited sex workers when he goes out of town on business. You later recognize this man to be the husband of a woman whose child and your daughter attend the same school. This woman has become a friend and you feel you should warn her about her husband's behaviour. As a counsellor, you should warn this woman of her husband's behaviour.

True / False

12. Empathy is more important than sympathy in counselling

True / False

13. Name three essential qualities of a counsellor.

- a) Caring
- b) Sympathetic
- c) Self-aware
- d) Blunt
- e) Patient

14. Name the four essential stages of counselling.



- 15. What are the ways in which HIV can be transmitted among prison inmates?**
- a) Sharing of injecting equipment
 - b) Eating food prepared by HIV positive person
 - c) Unsafe sexual practice
 - d) All of the above
- 16. What are the reasons for adolescents to be at risk of STI/RTI?**
- a) Belief in their own invincibility/inaccurate risk perception
 - b) Inability (and inexperience) to negotiate safe sex
 - c) Both a and b
- 17. STI is passed from person to person mainly through sexual contact** True False
- 18. Safer sex refers to practices that allow partners to reduce their sexual health risks** True False
- 19. It is possible to have a STI/RTI without having any signs or symptoms of infection** True False
- 20. Health Care Providers can accurately diagnose STI/RTI based solely on her/his past experience, the client's symptoms and the clinical signs observed during physical examination** True False
- 21. An injection of penicillin cures all STI** True False
- 22. If left untreated, STI/RTI can cause serious complications** True False
- 23. Asymptomatic infections cannot be passed to a partner during sexual contact** True False
- 24. Partners need not be referred for STI/RTI diagnosis and treatment unless they have signs and symptoms of infection** True False
- 25. STI treatment and prevention can be important tools for limiting the spread of HIV** True False
- 26. Condoms are the only barrier method proven to be highly effective against STI/RTI transmission and pregnancy prevention** True False
- 27. Genital ulcers or discharges are the most common symptoms of STI in men and women** True False
- 28. Patients can have more than one STI at a time** True False
- 29. VDRL blood test detects all STI** True False
- 30. STI are prevented by washing genitals with one's own urine or soap and water or by passing urine soon after sex** True False
- 31. STI are prevented by applying antiseptic or by taking antibiotics or injection penicillin** True False
- 32. Sex with a menstruating women causes STI** True False
- 33. STI is caused by using common toilets** True False
- 34. Hospitalization is necessary for all STI/RTI patients** True False
- 35. Physical, including genital, examination of STI/RTI patient is important** True False

Session 3

Overview of NACP III and The National STI/RTI Control & Prevention Programme Guidelines



Understanding NACP III

National AIDS Control Organization

- **First case was identified in 1986**
- **The National Health Committee was formed by the Ministry of Health and Family Welfare**
- **NACO came into being in 1992**
- **NACP I: 1992 – 1999**
- **NACP II: 1999 – 2006**
- **NACP III: 2007 – 2012**

NACP – I

- The **objectives of NACP-I** were:
 - To control the spread of HIV infection
 - To expand infrastructure of blood banks
 - To develop infrastructure for the treatment of sexually transmitted diseases in district hospitals and medical colleges
 - To initiate HIV sentinel surveillance system
 - To involve NGOs in prevention interventions with the focus on awareness generation
- This programme led to the capacity-development at the state level with the creation of State AIDS Cells in the Directorate of Health Services in states and union territories.

NACP – II

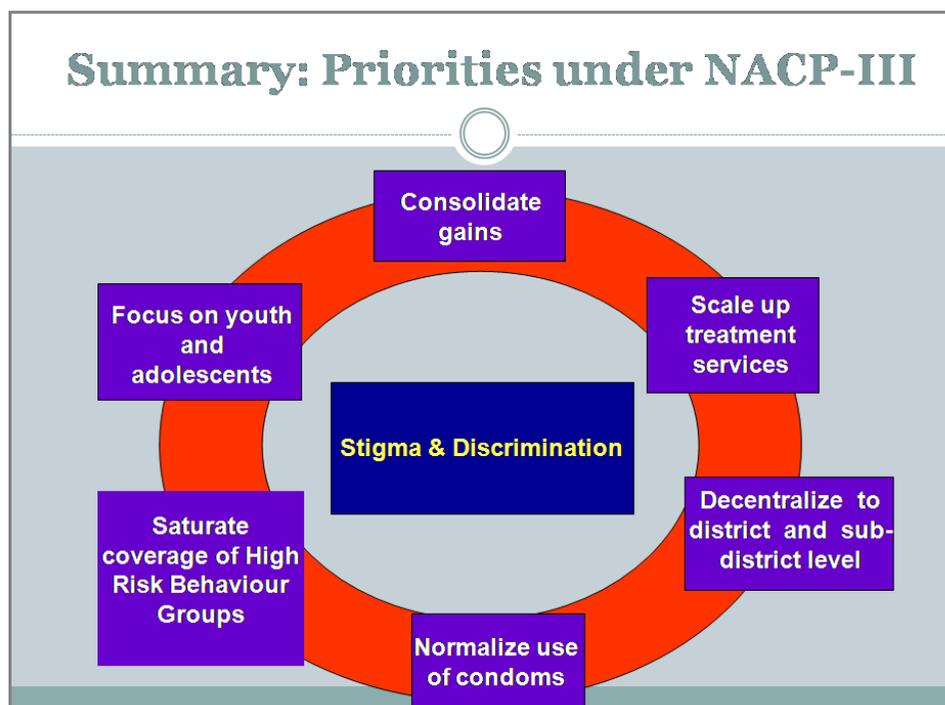
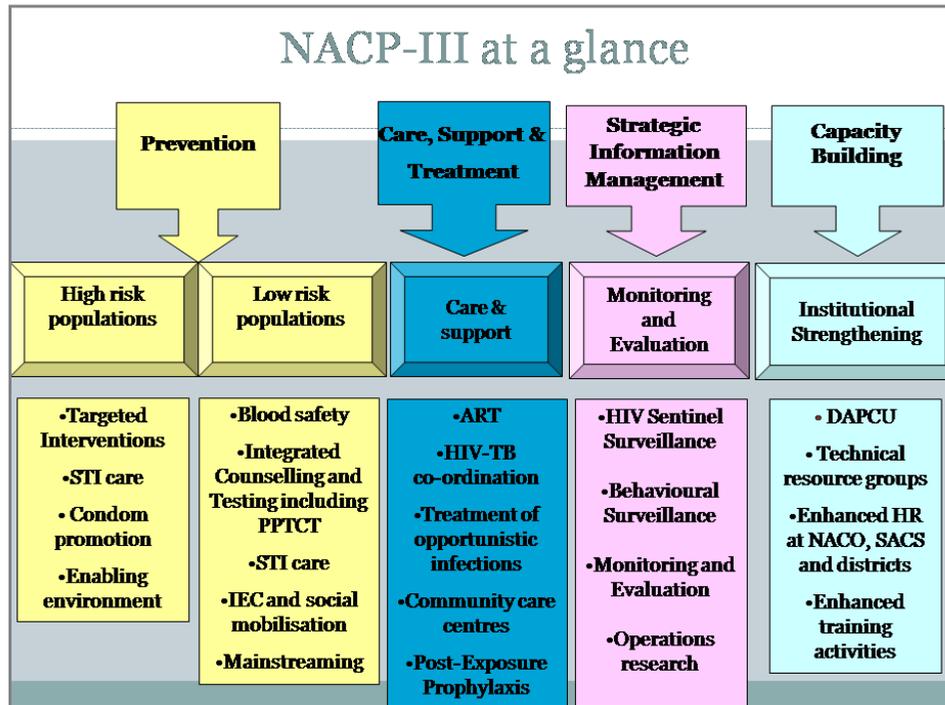
- The **objectives of NACP-II** were:
 - To reduce the spread of HIV infection in India
 - To strengthen India's capacity to respond to HIV/AIDS on a long term basis

National AIDS Control Policy - 2002

- HIV/AIDS was considered to be a development problem and not merely a health issue.
- The policy aimed at
 - Prevention of further spread of HIV
 - Reducing the impact of HIV on people and on the health and socio-economic system
 - Integrating horizontally with other national programs (RCH, TB, PHC system)

NACP-III

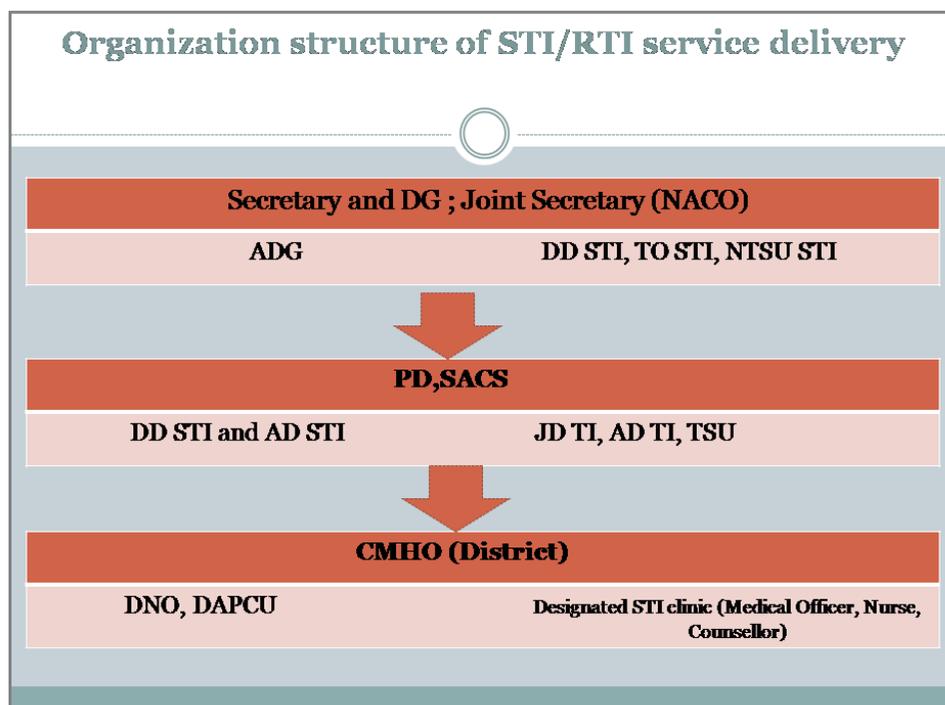
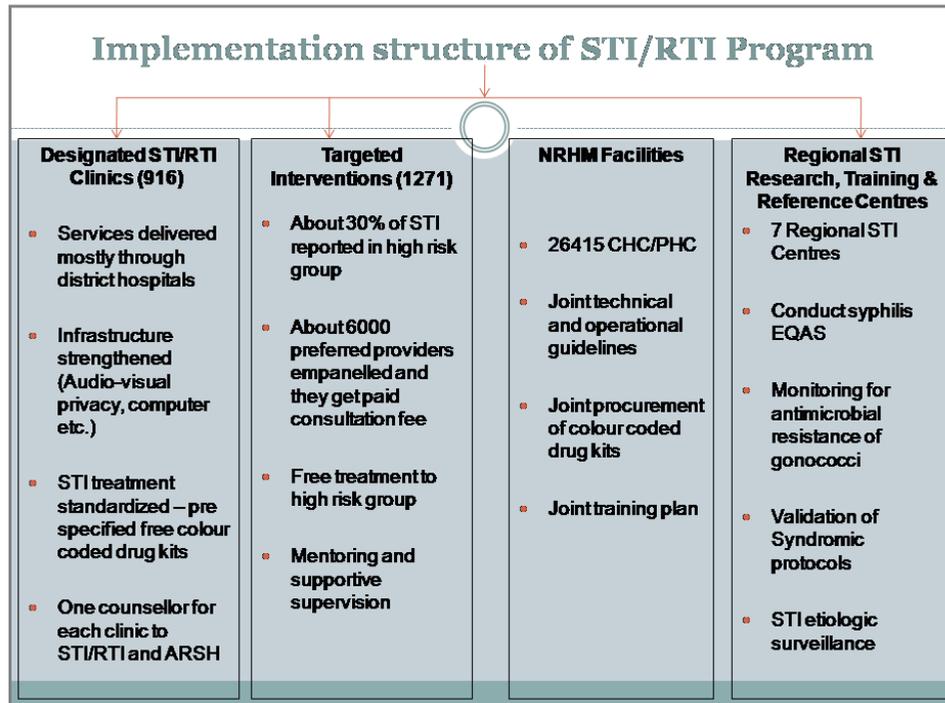
- **Goal:** To halt and reverse the epidemic in India over the next five years
- The **objectives of NACP-III** are:
 - Prevention of new infections (saturation of High Risk Groups (HRGs) coverage and scaling up interventions for the general population)
 - Increased proportion of PLHIV receiving care, support and treatment
 - Strengthening capacities at district, state and national levels
 - Building strategic information management systems



STI/RTI Guidelines

Universe of Problem

- **2002-03, ICMR, Community based STI/RTI prevalence study showed that about 6% of adult Indian population suffer from STI/RTI**
- **An estimated 30 million episodes occur in adult population annually**
 - 10 million seeks treatment from the government sector - NACO (3.4 million) and NRHM (6.6 million)
 - 20 million seek care from the private sector
- **NACP III envisages to treat 15 million episodes by 2012**



Salient Features of NACP III

- **Syndromic case management**
- **Standardized treatment regimens through colour coded drug kits**
- **Infrastructure strengthening of designated clinic**
- **Standardized training of service providers**
- **Inclusion of oral and anal STI**
- **Provision of computers and counsellors at every designated STI clinic**
- **Computerized data capture systems with data analysis and feedback**

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- **Strengthening etiological surveillance through identified sentinel sites**
- **Screening for syphilis of all ANC and STI patients**
- **Cross referrals between ICIC/PPTCT/ART centres and STI clinic**
- **Focus on adolescent sexual and reproductive health needs**
- **Supportive supervision through trained faculty**
- **STI service delivery through HRG preferred providers**
- **Presumptive treatment for HRG along with biannual screening for syphilis and once a quarter regular medical checkup**

Session 4
Roles & Responsibilities of Counsellors



Roles & Responsibilities of Counsellors

Group Work!

Discuss and present:

- **Group 1:** “What counsellors do specifically in relation to STI/RTI and HIV/AIDS counselling?”
- **Group 2:** “What are the broad or other roles of counsellors, apart from counselling on STI/RTI and HIV/AIDS?”

Importance of Counsellors

Counsellors at STI/RTI clinics play a vital role in strengthening the STI services provided by the clinic by:

- Increasing the uptake of services by clients
- Increasing the follow-up of clients
- Establishing referrals and networking for expanded STI and HIV care and support

Roles & Responsibilities

- Provide information about STI, HIV/AIDS, Opportunistic infections, healthy lifestyles and explore any myths and misconception and clarify the same
- Assist clients to correctly assess their risk for STI and HIV and motivate and help them to make plans for reducing their risk and help/enable/empower the client through the process of adaptation of healthy behaviours & coping with the same

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- Act as an interface between the client and the provider, organize the treatment schedule, follow up, compliance to treatment, condom usage and partner management, syphilis screening and other lab tests for STI/RTI
- Ensure that every HRG individual receives essential STI/RTI service package including early diagnosis and treatment of current STI episode, quarterly regular check up, presumptive treatment of sex workers and biannual syphilis screening by closely working with respective TI NGO

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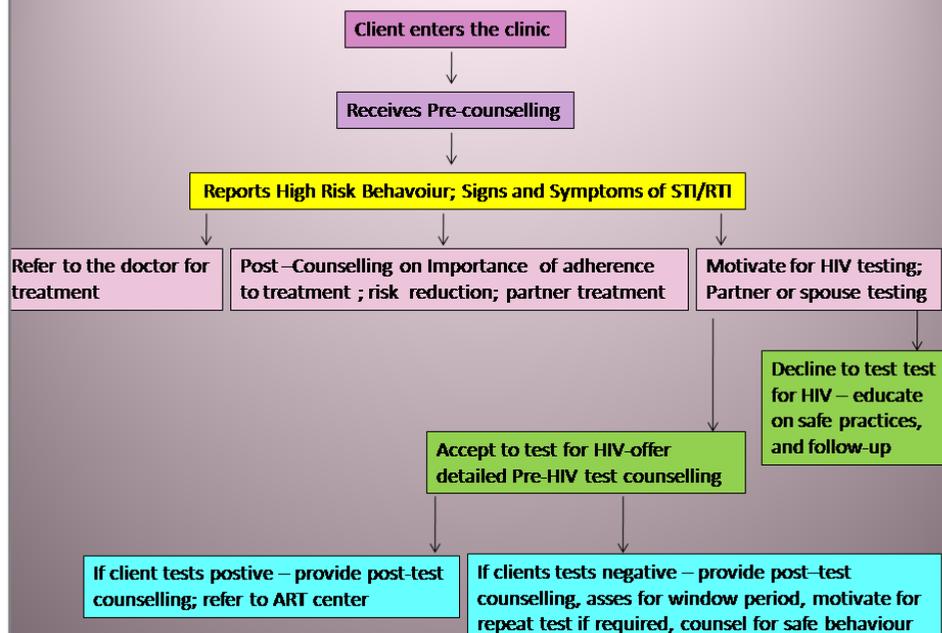
- Explain and encourage HIV testing, establish referral services to other centres and network for expanded STI and HIV Care & Support-General Laboratory, ICTC, PPTCT, ART, CCC, and TB-HIV etc
- Ensure documentation of history taking, counselling and risk reduction plans and filling up and maintaining patient wise cards and clinic register



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- Collect, compile reports on computer from both Gynae and STI OPDs and prepare and submit timely the monthly CMIS format in consultation with Medical Officer-in-charge
- Closely monitor the drug kit and condom consumption and place appropriate indent in consultation with Medical Officer-in-charge and other designated staff, if available
- Facilitate visits of the clinic by supervisory teams

FLOW CHART FOR STI/RTI COUNSELLING

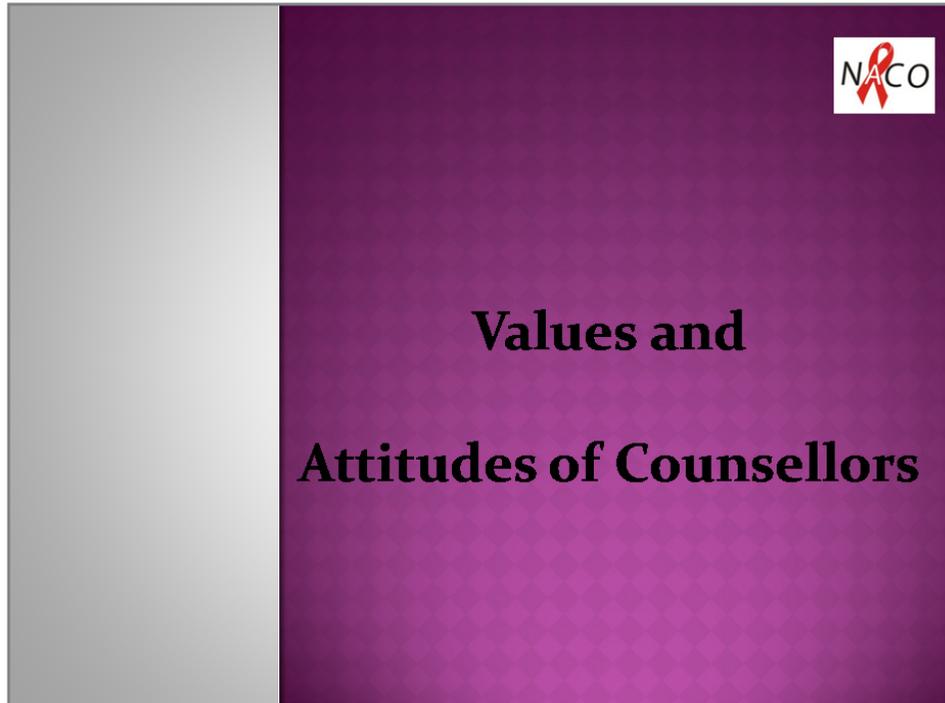


DAY TWO



DAY TWO

Session 1
Values and Attitudes of Counsellors



DISCUSSION

- How did one feel about the difference in opinions that were reflected?
- Were their incidences of change in position due to opinions expressed by other participants?
- What made one change their position?

SITUATION CARD 1

- ◉ **Client:** Prathap is a 25 year old male who comes to a counsellor. He mentions that he is a homosexual, which none of his family members know about. His parents want him to get married, and have finalized a proposal. He is confused and does not know what to do. He has come to the counsellor for help.
- ◉ **Counsellor:** The counsellor, has been brought up in a traditional family, which considers homosexuality as a sin, the counsellor also dislikes the concept of homosexuality and is open about it.

QUESTIONS FOR PARTICIPANTS

- Q1. In what ways could the counsellor's opinion affect the counselling process?
- Q2. If you were a counsellor how would you have proceeded?
- Q3. Why is it important for a counsellor to examine and understand her/his own attitudes?

SUMMARY – REMEMBER!

- Our culture and experiences mould our value system
- The environment often influences us and leads to the formation of biases and prejudices that we are not always conscious of
- Values and attitudes are unconscious but influence our work in strong ways
- We need to be aware of our values, attitudes and beliefs and how they could hamper our work in the area of sexual health

QUESTIONS TO ASK ONESELF

- ◉ Read each statement (refer to handout in supplementary manual) and reflect on it
- ◉ No need to share, unless willing to

IMPORTANT!

Counselling regarding sensitive and deeply personal topics requires counsellor to:

- ◉ Feel secure and at ease when enquiring about intimate matters
- ◉ Be able to convince clients of the need to talk about taboo topics
- ◉ Focus the discussion on specific practices and behaviours
- ◉ Find culturally acceptable ways of dealing with sensitive topics (e.g. instructing clients in “safer” or “protected” sex)

GROUP WORK – 3 GROUPS

Situation Card 2 - Maya's Story

Maya is 19 years old and is in love with Prakash who is 21 years. They are in college. Prakash feels that a way to show affection towards one's partner is by having sex. Maya feels that one should remain a virgin until marriage. Prakash and Maya go to a guesthouse and Prakash makes overtures to her. Maya now feels compromised.

What happened next? Complete the story...

EXPLORING CULTURAL ATTITUDES

- Refer to handout - additional reading material

Handout 1 - Questions to Ask Oneself

- What are my own feelings about people whose behaviour has placed them at risk of infection? About people with HIV infection or AIDS? Am I afraid, critical, overwhelmed?
- In view of the ways in which the infection is sometimes contracted, can I treat certain persons as fellow humans, or will I see them as being at fault and immoral?
- Which sexual practices would be most difficult to talk about given my own personal and cultural values?
- What everyday/slang words would I use, or never use, to explain risk practices or behaviour, especially to clients who differ from me racially, culturally or sexually, or are much younger or older?
- Can I maintain my own values of individual worth and dignity for everyone, even if my clients cultural background and way of life are very different from mine?
- How would I explain the need to discuss behaviour that is seen as strange or deviant in a particular society or culture?
- In this culture, to what extent am I ready to let clients do what they decide to do and take responsibility for their own care? Will I involve others in decisions if it is the accepted thing to do, or always try to be in control?
- How much do I want to influence, control or dominate other people?
- Are there some kinds of people or types of behaviour of which I disapprove so strongly that I probably could not counsel those concerned competently?

Handout 2 - Exploring Cultural Attitudes

Values vary from one individual to another. Counsellors must never allow their own personal values and prejudices to influence their counseling. Counsellors must explore and reflect their own feelings and prejudices which can interfere in their work.

- People are influenced by the culture within which they grow up.
- Every culture has certain kinds of behaviour, ceremonies, rites of passage and points of view that are preferred above all others. These are called values. Some values are practically universal but the values which guide and direct day-to-day behaviour are usually specific to the culture in which they evolved.
- The counsellor must understand and accept that people from different backgrounds have different values, and that these values influence attitudes towards HIV infection or AIDS. Values determine the degree to which a person asks for help, or attempts to handle a problem alone. They also determine how people view health, illness and death.
- Counsellors will have their own values, attitudes and beliefs but have to work with clients who may have quite different ones. Fear and prejudice against people with STI/HIV/AIDS causes stigma, discrimination, hostility and oppression, and may even be stronger than the values, which underlie the humane care of the sick. Counsellors themselves share their culture's prejudices, and must therefore examine and recognize their own prejudices and values. Competent counsellors do not have to like all their clients, but should be keenly aware of their own feelings, opinions, attitudes and prejudices. They must learn to recognise when they are not communicating clearly, or are distracted by the background or appearance of their clients, or are being influenced by bias rather than facts.
- Counsellors must never allow their own personal values or prejudices to influence their counselling. If a serious conflict seems likely, the client should, if possible, be transferred to another counsellor. If this is not possible, the counsellor should consult a supervisor or colleague for help in resolving the difficulty.
- Some institutions may benefit from operating a formal policy of reducing or eliminating prejudice or discrimination, implemented with the help of staff training at all levels, and supervision or staff support groups.
- Counsellors must explore and reflect on their own feelings and prejudices, which can interfere with the objective assessment of clients or, in the case of unremitting work with distressed and dying clients, can cause severe depression and inability to relate to other people. They will also need to decide how ready they themselves are to discuss sensitive topics and to what extent their own inhibitions and attitudes will complicate the task.
- Maintaining confidentiality is essential in any kind of counselling. The counsellor must assure a client that her/his sharing personal or intimate feelings and events will be respected and kept confidential. This is very important in building trust in the counselling process.
- Counsellors must view clients as individuals with problems and respect them without judging or condemning their past behaviour. They should not add to the self-blame or guilt which characterizes many clients.
- Counsellors need to appreciate the stress caused by the fear of being infected or the need to change behaviour. They must accept the resulting emotions and reactions of clients and their close associates, even including resistance and hostility to the counsellor. People with HIV infection and/or disease (including AIDS) should always be encouraged to feel that they are fully accepted by the counsellor, irrespective of their life-style, sexual preference, and socio-economic, ethnic or religious background. While responses to their needs should be technically sound, counsellors should, at the same time, be sensitive to their personal circumstances and not be affected by subjective feelings about a person's background.
- Empathy is more important than sympathy, which is generally not very useful in counselling, although it may be expressed as a statement of support (e.g., "I am sorry that you are having to go through this pain."). Empathy involves trying to place oneself in another's situation. The counsellor cannot truly say "I know how you feel," because that is impossible with HIV infection. The counsellor can demonstrate empathy by changing the counselling approach to make it culturally more acceptable to a person, or modifying the mode of communication to make it more understandable. Empathy is very often conveyed not in words, but through non-verbal communication, e.g.,

- by nodding the head, changing position, or using gestures understood within the culture to mean “I am listening and responding to you.”
- Ideally, people take responsibility for their own conduct and how they behave when they are ill, but the degree to which they can do so is strongly influenced by culture and tradition. Some cultures are fatalistic about illness, for example, and have little place for self-determination. In other cultures, people are expected to do as they are told by someone above them. Still others attach great importance to self-determination. So far as cultural norms allow, the counsellor should encourage self-determined behaviour, but appreciate that people who are frightened or ill may not feel disposed to exercise self-determination. Rather, they will be disposed to look to others for support and decisions. The counsellor should always try to counter this inclination and support the client’s autonomy with information and guidance on sound decisions, even at times of severe stress.
 - People or their families often grieve for, and mourn prematurely their anticipated loss. The counsellor needs to focus during her /his training and experience on what loss means, become familiar with the various cultural ways of expressing grief, and become skilled in discussing with clients, and helping them have recourse to, their spiritual sources of comfort and support.
 - The counsellor should not try to provide everything the client needs, but rather be fully aware of, and able to use competently the formal and informal resources on which people can call. Formal resources include medical care services, income or food supplements, and counselling. Informal resources include families and friends, religious groups, civic clubs, and peer-support groups. The counsellor can also encourage the development of new social resources if the need arises.
 - The counsellor’s efforts to motivate behavioural change must take into account the client’s and family’s belief systems. Having clarified how the disease is regarded and explained, the counsellor must then take care to use readily comprehensible words, images and symbols, as well as to avoid those that are not acceptable. If the counselling methods are not adapted to the client’s culture and belief systems, counselling will fail.

Session 2 Counselling Micro-skills



Effective Counselling

What is Counselling?

- Information, education and psychosocial support that allows individuals to make decisions that facilitate coping and preventive behaviours
- A two-way communication process that is ongoing and in which both client and counsellor actively participate

What is STI/RTI Counselling?

- Confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to STI/RTI
- The counselling process includes an evaluation of personal risk of STI/RTI and facilitation of preventive ways

Communication

- A counsellor's principal tool
- Employed to ensure that client and counsellor correctly interpret each other's messages and comments, and their responses are consistently appropriate and helpful

Effective counsellors adapt their counselling style to the characteristics of the person or family being counselled.

Essential attributes of counselling (Qualities of a Counsellor)

- Positive regard or respect for people
- Open, non judgmental and high level of acceptance
- Care and empathy
- Self-awareness and self-discipline
- Knowledge about subject and awareness of resources available within the community
- Cultural sensitivity
- Patience and good listening
- Ability to maintain confidentiality
- Objectivity

Micro-skills of Counselling

Active Listening

- Paying Attention – Eye contact, nodding, etc.
- Hearing before Evaluating
- Listening for the Whole Message
- Paraphrasing what was heard
- Probing for Causes and Feelings

Poor Listening Habits

- Not paying attention
- Assuming in advance that the subject is unimportant
- Mentally criticizing
- Permitting the speaker to be inaudible or incomplete
- Pretending to be attentive
- Hearing what is expected
- Feeling defensive
- Listening for a point of disagreement
- Rehearsing

Attributes of Active Listening

- Listen for the entire message
- Avoid interrupting
- Don't be afraid of silence
- Be mindful of your non-verbal messages

If there is an interested listener the client will open up!

Effective Counselling Skills

- **Reflection of feeling and meaning:** Recognizing client's feelings and letting her/him know you have understood her/his feeling
- **Questioning:** Asking open-ended questions which allow for more explaining Help the client to go deeper into her/his problems and gain insight
- **Paraphrasing:** Repeating in one's own words what the client has said
- **Interpretation:** Giving back to the client the core issue that she/he is struggling with

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- **Repeating:** Helping clients understand everything they are told
- **Summarizing:** Highlighting decisions which have been made and need to be acted on providing guidance and direction to both, counsellor and client
- **Confrontation:** Directly examining incongruities and discrepancies in the clients' thinking, feeling and/or behaviour, timing being very important

Contd.

- **Respecting:** Respecting clients' views and beliefs and building on them appreciating that people see and cope with their predicaments in uniquely personal ways, determined by culture, social class and personality
- **Structuring and Prioritization:** Helping client see things objectively and prioritizing issues and actions - what needs to be done immediately and what can be done later
- **Empathizing:** Experiencing emotions that match another person's emotions, knowing what the other person is thinking or feeling

Group Work

- Groups of 3 – counsellor, client and observer
- Practice 4 main counselling micro-skills – active listening/attending, reflection of feeling, questioning, paraphrasing/interpretation
- Five minutes for each session
- Rotate the roles – comments by observer and client

Role of Client

Share your situation with the counsellor during the 5 minutes that you play the role of the client and respond spontaneously to whatever the counsellor says or does

Role of Counsellor

Become the counsellor for the person playing the client for 5 minutes while she/he shares her/his concern or situation with you. Practice using the skills that you have learned about. Also give the client your undivided attention and try to avoid noticing the observer.

Role of Observer

- Carefully and silently observe the interaction between the client and the counsellor during their 5 minute session
- Pay careful attention to the usage of the skill in question by the counsellor
- Also observe to what extent the counsellor can help and support the client in understanding her/his situation
- Please remain strictly apart from the interactions
- Do not get drawn into the session even if the client or counsellor looks at you or turns to you

Cases for Role Play

- **Case 1:** Rajesh, aged 32, works in a nearby factory. He had a discharge and pain when urinating a month back. He got it treated from a local quack. The discharge and pain have come back and Rajesh is worried
- **Case 2:** Priti, A 25 year old young woman, has come for her first visit. She is working a few nights a week in a bar. She has come to the clinic today because she is having a discharge
- **Case 3:** Sunita has come in with her husband (who refuses to come in with her to see the doctor). She has been having a pain in her lower abdomen and is worried about it

Rules for Effective Feedback

- Begin your sentences with “I” as these are only your subjective feelings and views. Someone else may feel differently about the same issue. So, make ‘I feel’ and ‘I think’ statements
- Give positive comments/feedback first and then the weaknesses/mistakes you saw – the idea is to help the person learn more and improve, not to demoralize her/him
- Also try to offer alternatives or suggestions (things you feel would have been more effective) when talking about the mistakes or weak spots

Contd.

- Use simple words and short sentences
- Do not interrupt or side-talk during the client counsellor interaction
- Give specific comments about the actions or behaviours of the person – not about the whole person or her/his traits. The comments should be about things the person can do something about

Handout - 3 Effective Counselling

Communication is the counsellor's principal tool employed to ensure that client and counsellor correctly interpret each other's messages and comments, and their responses are consistently appropriate and helpful. Effective counsellors adapt their counselling style to the characteristics of the person or family being counselled.

The essential attributes of counselling, include positive regard or respect for people; open, non judgmental and high level of acceptance; care and empathy; self-awareness and self-discipline; knowledge about subject and awareness of resources available within the community; cultural sensitivity; patience and good listening; ability to maintain confidentiality; objectivity.

Active Listening: The counsellor indicates by words, expression and posture/gesture that very careful attention is being given to what is being said, clarifies uncertainties by interrupting and asking questions, and then helps the client resume the narrative. This facilitates free expression of whatever is in the client's mind.

Reflection of Feeling: The counsellor focuses on the emotions of the client and her/his subjective experiences in coping with the situation, recognizing feelings such as anger, sadness, and fear in a direct, unemotional way, indicating both verbally and non-verbally.

Questioning: The counsellor asks questions in order to bring to awareness all the dimensions of the problem and help the client to go deeper and face the core issue underlying his/her fears or concerns.

Paraphrasing: The counsellor attempts to "feed back" to the client the essence or content of what the client has just said as many people can tell they are being understood accurately, if the counsellor repeats what they have said in different words.

Interpretation: The counsellor helps to establish what is relevant, emphasizing the important points when people avoid focusing on the real problem and talk around the issue. Interpretation goes beyond what is explicitly expressed to the feelings and meanings only implied by the client's statements and which are somewhat below the surface of the client's awareness.

Repeating: At times of stress and crisis, people do not always understand everything they are told, as they are in a state of denial or feel overwhelmed. The counsellor should not hesitate to be repetitive. Someone who understands and accepts information correctly will show this in some way.

Summarizing: At the end of each session, the counsellor should summarize the salient points of the discussion, highlighting decisions which have been made and need to be acted on. It provides guidance and direction to both, counsellor and client, as they try to sort out emotions, deal with practical matters and make plans.

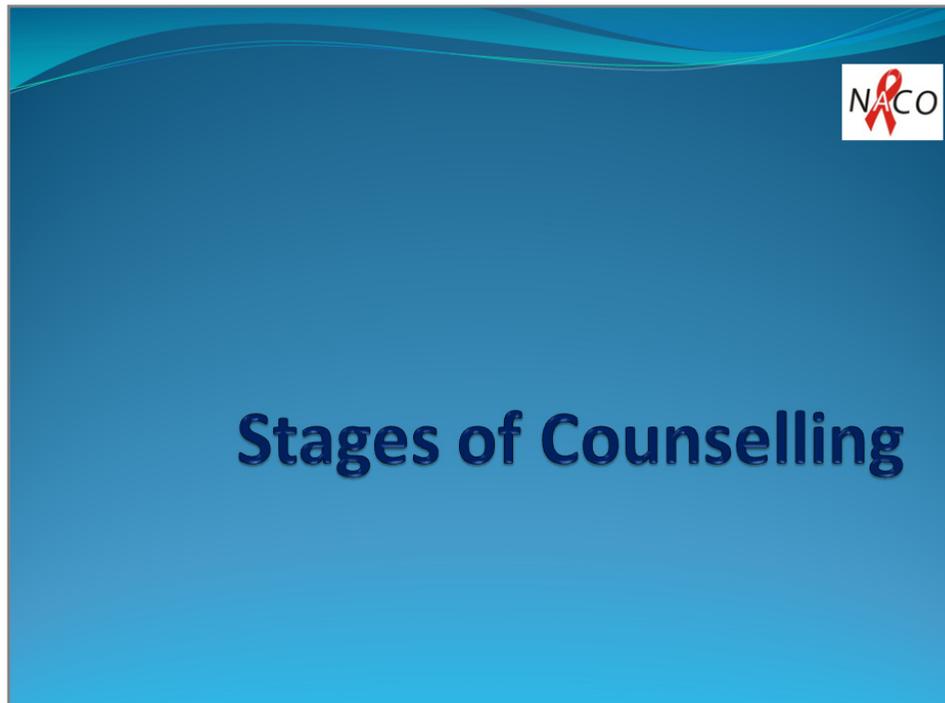
Confrontation: It involves a counsellor directly examining incongruities and discrepancies in the clients' thinking, feeling and/or behaviour. It challenges the client to begin new, less destructive ways of behaviour. Because it is a highly intrusive skill, timing is very important. A strong relationship and rapport must be established. The confrontation should be delivered in an atmosphere of warmth, caring and concern.

Respecting: The counsellor should appreciate that people see and cope with their predicaments in uniquely personal ways, determined by culture, social class and personality. Counsellors must respect clients' views and beliefs and build on them.

Structuring and Prioritization: The counsellor helps the client to see how facts and feelings are related, determining what needs immediate attention and what can be put off until later. It is an essential part of planning and probably one of the most critical skills in counselling.

Empathizing: Involves understanding the emotional state of other people, experiencing emotions that match another person's emotions, knowing what the other person is thinking or feeling. It is distinct from sympathy and pity.

Session 3
Stages and Process of Counselling



- Stage 1 – Building Rapport and Gaining Trust
- Stage 2 – Defining Roles and Boundaries
- Stage 3 – Ongoing Supportive Counselling
- Stage 4 – Closure or Ending the Counselling Relationship

Building Rapport and Gaining Trust- Introduction Between Client and Counsellor

- Spend time in encouraging trust and building a rapport
- Do this by letting the clients tell their life/event stories in their own way
- One may find the stories disjointed or rambling but must let the client continue, while noting what is highlighted or played down or ignored

Defining Roles and Boundaries

- Is an essential part of counselling
- Establishing and clarifying the client's needs and goals - with the most urgent and important ones to be addressed first, followed by more general, long-term issues also need to be done before ongoing counselling sessions can begin

Ongoing Supportive Counselling, Risk Assessment and Risk Reduction Plan

- Encouraging the client to begin a consideration of possible options and assessing possible solutions/decisions and their implications
- Focuses on enabling the client to take charge and move towards change
- Also involves supporting and encouraging the expression of intense emotions like fear and anger by the client

Closure or Ending the Counselling Relationship

- End the relationship only when it is certain that the client
 - Is maintaining the necessary changes in behaviour
 - Can cope and adequately plan for day-to-day functioning
 - Has a support system (family, friends support groups, etc.)
- Must be carefully planned and discussed with the client
- Client should be assured of being able to return to counselling whenever this is necessary

Group Work – 2 Groups

- **Group 1:** List factors that help counselling
- **Group 2:** List factors that hinder counselling

Supportive and Non-Supportive Behaviour

- Some parts of a counsellor's behaviour readily support the counselling process, while others can bring it to a halt very quickly
- These behaviours are supportive or non-supportive within a particular cultural context

Examples of supportive behaviour in a selected culture

Verbal:

- Using language that the client understands
- Repeating in other words and clarifying client's statement
- Explaining clearly and adequately
- Summarizing
- Responding to primary message
- Encouraging: "I see", "Yes, go on"
- Addressing client in a manner appropriate to the client's age
- Giving needed information
- Not criticizing or censuring the client
- Using colloquial language

Contd.

Non-Verbal:

- Using a tone of voice similar to the client's
- Looking client in the eye
- Nodding occasionally: using facial expressions
- Using occasional gestures
- Keeping suitable conversational distance
- Not speaking too quickly or too slowly

Examples of non-supportive behaviour in a selected culture

Verbal:

- Advising
- Preaching and moralizing
- Blaming, judging and labeling
- Cajoling (persuading by flattery or deceit)
- “Why” questions, interrogation
- Directing, demanding
- Excessive reassuring
- Straying from the topic
- Encouraging dependence
- Patronizing (condescending) attitude

Contd.

Non-Verbal:

- Looking away frequently
- Keeping an inappropriate tone of speech
- Sneering
- Frowning, scowling and yawning
- Using an unpleasant tone of speech
- Speaking too quickly or too slowly
- Moving around too much, fidgeting
- Having a blank facial expression or staring

Handout - 4 Stages and Process of Counselling

Building Rapport and Gaining the Client's Trust:

At the beginning, clients may react in many different - sometimes contradictory - ways to a counsellor. The counsellor must spend time in encouraging trust and building a rapport with the client. She/he may do this by letting the clients tell their life/event, stories in their own way. The counsellor may find the stories disjointed or rambling but must let them continue, while noting what is highlighted or played down or ignored.

Defining Roles and Boundaries:

Explaining and making clear to the client the roles and boundaries of the counselling relationship is an essential part of counselling. Establishing and clarifying the client's needs and goals - with the most urgent and important ones to be addressed first, followed by more general, long-term issues also need to be done before ongoing counselling sessions can begin. At this point, the counsellor also begins taking a case history, in effect just helping the client to tell her/his story in a different, and more orderly way. The history will include basic personal data as well as information on a client's beliefs, knowledge and concerns about HIV infection. The counsellor should use the history-taking as a means of solidifying the helping relationship, asking questions that are directly related to the client's concerns and at the same time, geared to the client's needs in terms of her/his ability to use the resources available.

Ongoing Supportive Counselling, Risk Assessment and Risk Reduction Plan:

Encouraging the client to begin a consideration of possible options and assessing possible solutions/decisions and their implications is the next step. Ongoing counselling focuses on enabling the client to take charge and move towards change. This stage also involves supporting and encouraging the expression of intense emotions like fear and anger by the client. Basically, counselling consists of supporting and sustaining work on the selected problems and monitoring of the progress towards the mutually decided goals.

Closure or Ending the Counselling Relationship:

After the client has shown willingness to formulate plans and has carried some of them through with a fair degree of success, counselling enters the end stage. The counsellor ends the relationship only when it is certain that the client:

1. Is maintaining the necessary changes in behaviour;
2. Can cope and adequately plan for day-to-day functioning; and
3. Has a support system (family, friends, support groups, etc.).

The ending must be carefully planned and discussed with the client as the client, although functioning adequately, may feel unable to carry on without the counsellor's help and a strong attachment/bond will have developed between the two people. The counsellor may increase the intervals between visits so as to let the client try and be independent, while knowing the counsellor is still available. Also, the client should be assured of being able to return to counselling whenever this is necessary.

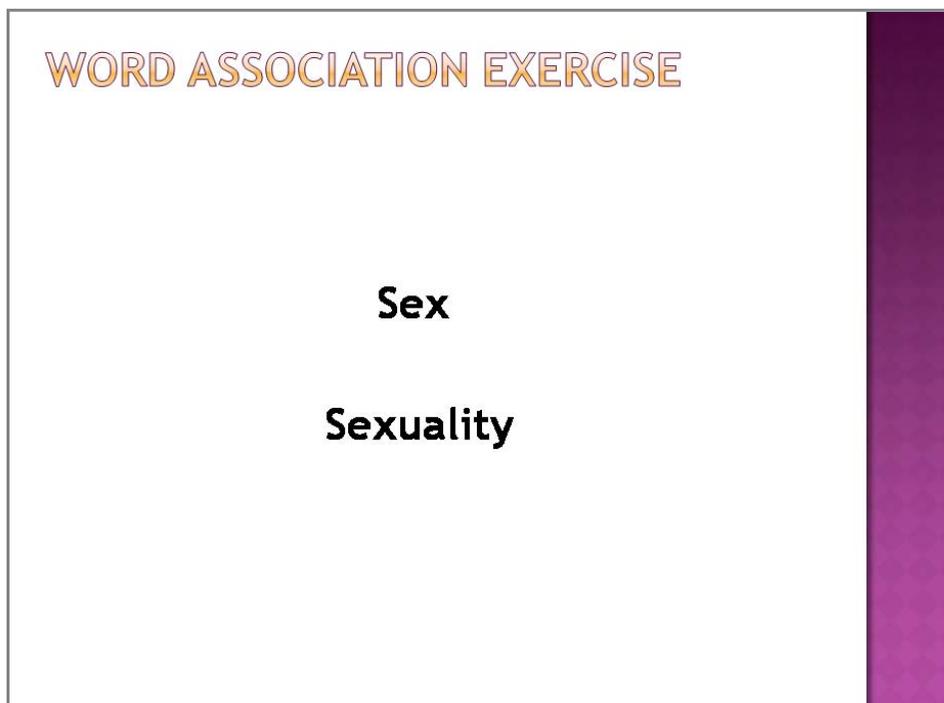
DAY THREE



DAY THREE



Session 1
Sex, Sexuality and Gender





WHAT IS SEX?

- Sex is a way of distinguishing male and female members of a species, usually by referencing their reproductive functions
- Sex refers to coitus or intercourse, an act that can result in reproduction
- Sex refers to the genitals

Sex can be paid as well as unpaid.

SEXUALITY

“Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.

Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.

While sexuality can include all of these dimensions, not all of them are always experienced or expressed.

Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.”

World Health Organization working definition



CONTD.

Sexuality includes:

- ⊗ Our awareness and feelings about our own body and other people's bodies
- ⊗ Our ability and need to be emotionally close to someone else
- ⊗ Our understanding of what it means to be female or male (gender identity)
- ⊗ Our feelings of sexual attraction to other people
- ⊗ Our physical capacity to reproduce

The absence of sexual activity and reproductive capacity does not make one asexual

SEXUALITY

- ⊗ It is an expression of who we are
 - It involves the mind and body - is a natural and inviolable component of every human being's personality
 - It's not the only way to prove oneself - it represents our attitude toward ourselves and toward others and includes the feelings, thoughts, and behaviour associated with being a male or female, how our bodies are formed, clothing, contacts, being attracted and being in love as well as in relationships that include sexual intimacy and sexual activity and our knowledge about it
 - It includes our feelings of attraction or desire for other males and/or females
 - It's influenced by culture and society



SEXUALITY INCLUDES:

- ⦿ Sensuality
- ⦿ Sex
- ⦿ Gender
- ⦿ Sexual Orientation
- ⦿ Sexual Identity
- ⦿ Sexual Behaviour

SENSUALITY

- ⦿ Our feelings about how our bodies look and feel and what they can do
- ⦿ Enjoying the pleasure our bodies can give us and others

SEX

- ◉ Whether we are biologically male or female
- ◉ Sexual activity like having intercourse or other

GENDER

- ◉ The expectations for 'males' and 'females'
- ◉ The roles, behaviour and expectations for males and females - There are many 'rules' about what men and women can/should do, or cannot/shouldn't do, that have nothing to do with the way their bodies were formed or built
- ◉ Gender has both privileges and burdens

SEXUAL ORIENTATION

- Whether a person's attraction is to the people of the other sex (heterosexuality) or to the same sex (homosexuality) or to both sexes (bisexuality)
- Sexual orientation is fluid

The debate on reasons for homosexuality (the nature vs nurture debate) is inconclusive; what is important is acceptance that sexual orientations may vary

SEXUAL IDENTITY

- How people view themselves sexually includes:
 - How a person identifies as male, female, masculine, feminine, or some combination
 - A person's sexual orientation or preferences
 - Gender roles
 - A person's biological sex

SEXUAL BEHAVIOUR

- The range of sexual acts, expressions and partners that an individual has

LESBIAN GAY BISEXUAL TRANSGENDER (LGBT) TERMINOLOGY

TRANSGENDER - Person anatomically born of one sex but more comfortable with a different gender identity; seeks to express this through attire, sex-reassignment surgery etc. and includes transsexuals, transvestites, inter-sex, hermaphrodites and cross-dressers.

- TRANSSEXUAL - Person anatomically born of one sex but is convinced that she/he is of a different gender identity

CONTD.

- ◉ TRANVESTITE-Person anatomically born of one sex but prefers to wear clothes of the other gender largely as a fetish
- ◉ HERMAPHRODITE-Person whose external genitalia is indeterminate
- ◉ INTER-SEX-Person whose biological sex cannot be classified as male or female

CONTD.

LESBIAN - Woman emotionally, sexually and romantically attracted to other women.

GAY - Man emotionally, sexually and romantically attracted to other men.

BISEXUAL - Person who is attracted emotionally, sexually and romantically to both men and women, wherein act of sex might not be there in each case.

KOTHI - Male homosexual who is effeminate and usually takes a passive/receptive role in sex.

PANTHI - Male 'masculine' partner of Kothi.



WORD ASSOCIATION EXERCISE

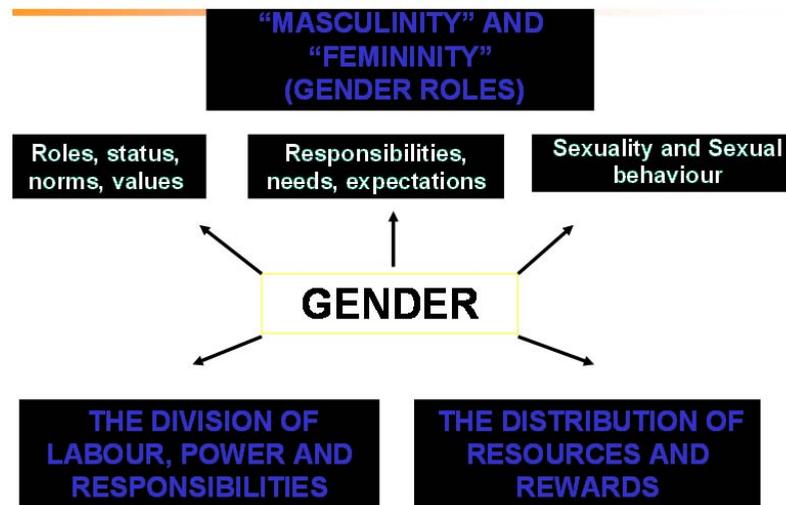
Gender

WHAT IS GENDER?

- Is the social construction of the biological differences between men and women
- Is learned, socially determined behaviour
- Is a focus on the unequal relations between men and women



GENDER DETERMINES



GENDER DIFFERENCE

Social: Different perceptions of men's and women's social roles - the man is seen as head of the household and chief breadwinner, while the woman is seen as nurturer and caregiver.

Political: Difference in the ways in which women and men assume and share power and authority.



CONTD.

Educational: Difference in the educational opportunities and expectations of girls and boys: family resources are directed to boys' rather than girls' education, and girls are streamed into less-challenging academic tracks

Economical: Differences in women's and men's access to lucrative careers and control over financial and other productive resources, such as credit, loans, and land ownership

CONTD.

Thus, there is a co-relation between Gender and Vulnerability due to access to or control over resources



GENDER HAS AN IMPACT ON

- Male and female sexual activity, vulnerability and risk behaviour
- The transmission of HIV/AIDS in both heterosexual and homosexual relationships
- The differential experiences of infected and affected women and men

GROUP WORK

- Take up one population group (e.g., wife of migrant worker; injecting drug user; truck driver; migrant worker; female sex worker; male sex worker; men who have sex with men; transgender)
- Develop a role play to depict its vulnerability, especially in relation to sex, sexuality and gender expression and gender expectation
- Role Play presentation

MEN'S VULNERABILITY TO STI OR HIV

Is derived primarily from their risk taking behaviour

- Boys are taught to associate prolific sexual activity with masculinity
- Young men have greatest number of sexual partners
- Men are more likely than women to engage in substance abuse

WOMEN ARE MORE VULNERABLE TO STI OR HIV

Physiologically.....

- Soft tissue in the female reproductive tract tears easily, producing a transmission route for the microorganism
- Vaginal tissue absorbs fluids more easily, including sperm, which has a higher concentration of HIV virus
- Women are more likely than men to have other untreated STI

Socially.....

- **Women often cannot control with whom or under what circumstances they have sex**
- **Women are not always empowered to discuss use of protection**
- **Women have less access to sexual health information and services**

Economically....

- **Economically vulnerable women are less likely to terminate a dangerous relationship**
- **Women may exchange sex for money, food or other favours because of their economic situation**
- **On matters such as sexual relations, use of protection, household spending on health and access to healthcare, men tend to dominate the decision-making**
- **Women employed in the informal economy, and women who work at home, are less likely to have access to health insurance to cover the cost of testing, counselling and prescription drugs**



GENDER AFFECTS WOMEN'S VULNERABILITY

GENDER BASED VIOLENCE...

Increases women's vulnerability to HIV

- ⦿ Women have less control than their male partners on use of protection, and access to health services, its more dangerous for them to refuse unsafe sex
- ⦿ Women are the majority of rape victims, a direct risk factor for HIV
- ⦿ Girls and boys who are victims of physical and/or sexual abuse are more likely to exhibit high risk sexual behaviour later in life, lowered self-esteem and decreased ability to negotiate safer sex

SEX WORKER AND SEX TOURISM...

- ⦿ Poverty, economic disparity and migration are forcing women and men into commercial sex work, often with tourists
- ⦿ Health insurance, information and services are often out of reach of this crucial population



TRAFFICKING FOR SEXUAL EXPLOITATION...

- ⊗ Trafficked women present many of the same vulnerabilities and risks for HIV as sex workers
- ⊗ Their situation is complicated by the fact that they are often unable to access health information and services because :
 - They are being held captive
 - They are unfamiliar with the local environment and do not speak the local language
 - They are afraid of being deported/of violence by their traffickers, pimps or brothel owners

MIGRATION AND DISPLACEMENT

VOLUNTARY MIGRATION.....

- ⊗ Male and female migrants are isolated from family and community relations and social support networks
- ⊗ They may engage in sexual activity with sex workers and/or multiple partners
- ⊗ The marginalized status of migrants increases their vulnerability to HIV/AIDS
- ⊗ Cultural and linguistic barriers often prevent migrants from accessing health and social services

Others

- The risk of HIV transmission, barriers to care and women's burden of work are all increased in the crisis and post-crisis period such as inter or intra-state conflict
- Rape has been used as a weapon of war to degrade and debilitate communities
- Armed forces personnel of all types have a higher rate of HIV infection
- Women may be forced to offer sex in exchange for money or protection during times of conflict or war

WOMEN INFECTED AND AFFECTED

INFECTED...

- Women face a number of barriers to HIV prevention, testing and counselling, including:
 - Embarrassment or fear of rejection and stigma
 - Partner's objection to testing
 - Lack of access to financial resources, time or transportation
 - Lack of access to reliable information and health services



AFFECTED...

- Women carry the greatest psycho-social and physical burden of care for HIV/AIDS infected individuals
- Care-giving is a 24 hr-a-day job for many women, leaving them little or no time to care for their own physical or psychological health



Session 2

Understanding the body: Reproductive and Sexual Organs



Understanding the Body

Reproductive and Sexual Organs

Sexual Health

Sexual Health means being able to have a responsible, satisfying and safer sex life.

Achieving sexual health requires a positive approach to sexuality and mutual respect between partners.



Basic Elements of Sexual Health

- Having factual information about our bodies so that we understand how male and female reproductive systems function and about male and female sexual response, and how STI/RTI and HIV can be transmitted and prevented
- Being able to make appropriate decisions that affect our health such as knowing how to have safer sex and being able to make that choice

Contd.

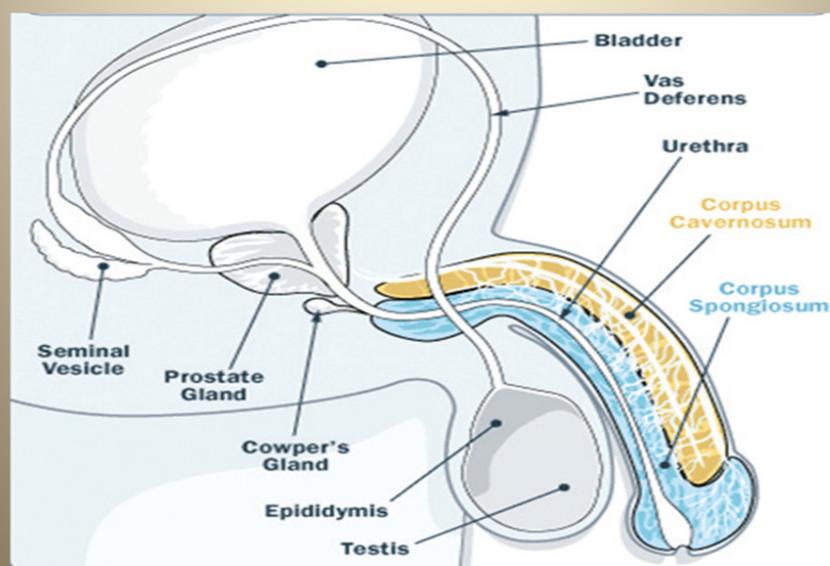
- Being able to enjoy and control our sexuality and reproduction
- Living in a safe environment free of sexual or other forms of violence which women and non-masculine males are often the most vulnerable to



Group Work

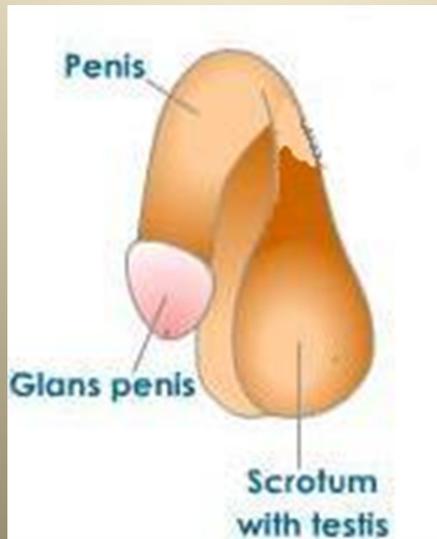
Labelling Internal and External Sexual and Reproductive Organs

MALE ANATOMY

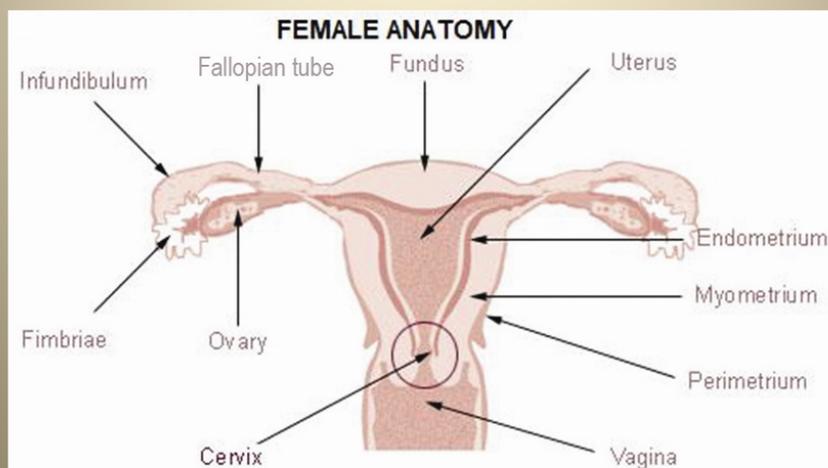




MALE ANATOMY (EXTERNAL VIEW)

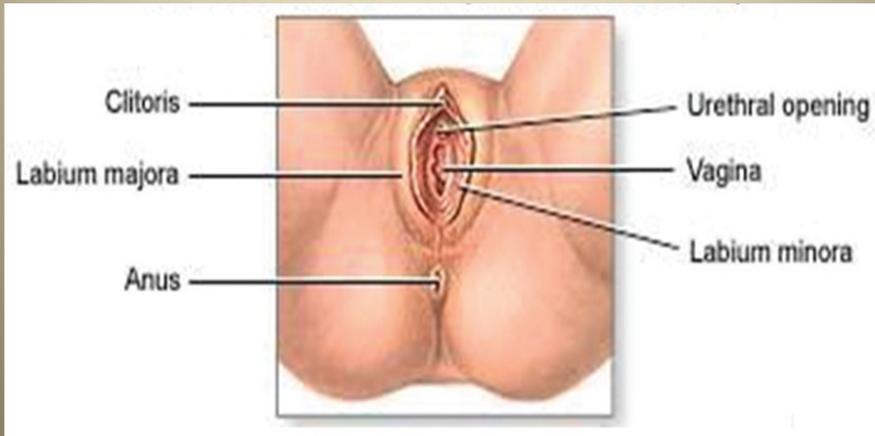


FEMALE ANATOMY





FEMALE ANATOMY (EXTERNAL VIEW)



Session 3 STI/RTI: Basics Information



Basics of STI/RTI

What are signs and symptoms?

- ▶ Sign/s are observed by doctors during examination
- ▶ There are external and internal 'signs' – and some may only be seen during an internal examination
- ▶ Symptoms are complaints told by the patient to the doctor
- ▶ When the person with the infection shows no symptoms of that infection, they are called asymptomatic

Group Work – 2 Groups

- ▶ Complete the STI/RTI table – one for males and one for females (handout)
- ▶ Use the list of jumbled names of STI/RTI, signs and symptoms given to complete the table (handout)

What is STI and RTI?

- ▶ **Reproductive Tract Infections (RTI):** Any infection of the reproductive tract in males, females and transgender/transsexual
- ▶ **Sexually Transmitted Infections (STI):** Infections caused by germs that are passed from one person to another mainly through sexual contact

HIV infection spreads mostly through unsafe sexual practices. HIV infection is also an STI.



Reproductive Tract Infections

Reproductive Tract Infections (RTI) – are transmitted in three ways

- ▶ Overgrowth of normal organisms in the genital system – Eg. Bacterial Vaginosis, Candidiasis
- ▶ Physician/practitioner/procedure induced infections – Infection following improper procedures during catheterization, IUD insertion, termination of pregnancy, delivery, etc.
- ▶ Through unsafe sexual practices. these are called as Sexually Transmitted Infections (STI)

What are STI?

A group of communicable infections transmitted predominantly by unsafe sexual practices including close body contact

How big is the problem of STI?

- ▶ WHO estimates occurrence of 340 million new cases every year! Almost 1 million per day!! 650 per minute!!!
- ▶ In India 30 million episodes happen every year
- ▶ Almost 1 lakh episodes a day
- ▶ Most affected are men and women in the age group of 15 to 49 years

Common symptoms and signs of STI/RTI in males

- ▶ Urethral discharge/Burning or pain during urination/frequent urination
- ▶ Genital itching
- ▶ Swelling in groin/scrotal swelling
- ▶ Blisters or ulcers on the genitals, anus, mouth, lips
- ▶ Itching or tingling in genital area
- ▶ Ano rectal discharge
- ▶ Warts on genitals, anus or surrounding area

Common symptoms and signs of STI/RTI in females

- ▶ Unusual vaginal discharge
- ▶ Genital itching
- ▶ Abnormal and/or heavy vaginal bleeding
- ▶ Pain during sexual intercourse
- ▶ Lower abdominal pain (pain below the belly button, pelvic pain)
- ▶ Blisters/ulcers on the genitals, anus or surrounding area, mouth, lips

Common Reproductive Tract Infections / Sexually Transmitted Infections syndromes

- ▶ Genital Ulcer Diseases syndrome – Non Herpetic
- ▶ Genital Ulcer Disease syndrome – Herpetic
- ▶ Vaginal /Cervical Discharge Syndrome
- ▶ Urethral Discharge Syndrome



Contd.

- ▶ Inguinal Bubo Syndrome
- ▶ Painful Scrotal Swelling Syndrome
- ▶ Ano-rectal Discharge syndrome
- ▶ Oral – Anal STI syndrome
- ▶ Genital Skin Conditions (Other STI/RTI) –
 - ▶ Genital Scabies
 - ▶ Genital Warts
 - ▶ Pubic louse infestation
 - ▶ Molluscum Contagiosum

Urethral Discharge



- ▶ **Pain or burning while passing urine**
- ▶ **Increased frequency of urination**
- ▶ **May be cream or yellow coloured discharge coming from urine passing hole (Urethra)**
- ▶ **Discharge may be thick or thin like mucus**



**TAB. AZITHROMYICIN (1 GM) OD STAT +
TAB. CEFIXIME (400MG) OD STAT**



Painful Scrotal Swelling



- ▶ **Swelling and Pain in the scrotal region**
- ▶ **Pain or burning while passing urine**
- ▶ **Systemic symptoms like malaise, fever**
- ▶ **History of urethral discharge**



**TAB. AZITHROMYICIN (1 GM) OD STAT +
TAB. CEFIXIME (400 MG) OD STAT**



Inguinal Bubo



- ▶ **Swelling in inguinal region which may be painful**
- ▶ **Preceding history of genital ulcer or discharge**
- ▶ **Systemic symptoms like malaise, fever etc**



**TAB. AZITHROMYICIN (1 GM) OD STAT +
TAB. DOXYCYCLINE (100 MG) BID FOR 21 DAYS**

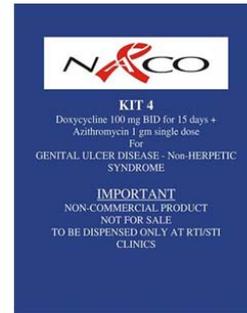
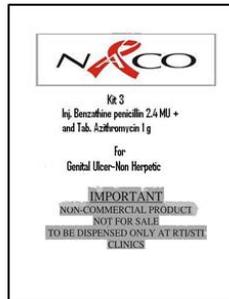




Genital Ulcer – Non Herpetic



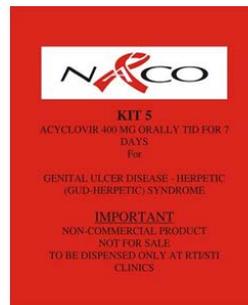
- ▶ **Genital ulcer, single or multiple, painful or painless**
- ▶ **Burning sensation in the genital area**
- ▶ **Enlarged lymph nodes**



**TABLET AZYTHROMYCIN (1 GM) SINGLE DOSE +
INJ. BENZATHINE PENICILLIN 2.4 MU**

Genital Ulcer – Herpetic

- ▶ **Eruption of vesicle, painful, multiple Genital ulcer**
- ▶ **Burning sensation in the genital area**
- ▶ **Recurrence**



TAB. ACYCLOVIR (400 MG) TDS FOR 7 DAYS



Vaginal Discharge Syndrome

- ▶ **Vaginal discharge (cheese, white)**
- ▶ **Nature and type of discharge (quantity, color and odor)**
- ▶ **Itching around genitalia**



**TAB. SECNIDAZOLE (2 GM) OD STAT +
TAB. FLUCONAZOLE (150 MG) OD STAT**

Cervical Discharge Syndrome (Cervicitis)

- ▶ **Yellowish discharge with bad odour**
- ▶ **Nature and type of discharge (quantity, color and odor)**
- ▶ **Burning while passing urine, increased frequency**



**TAB. AZITHROMYCIN (1 GM) OD STAT +
TAB. CEFIXIME (400 MG) OD STAT**



Lower Abdominal Pain (LAP)

- ▶ **Lower Abdominal Pain**
- ▶ **Fever**
- ▶ **Vaginal Discharge**
- ▶ **Menstrual irregularities like heavy, irregular vaginal bleeding**
- ▶ **Dysmenorrhoea, dyspareunia, dysuria, tenesmus**
- ▶ **Lower backache**
- ▶ **Cervical motion tenderness**



**TAB. CEFIXIME 400 MG OD STAT +
TAB. METRONIDAZOLE 400 MG BD X 14 DAYS +
TAB. DOXYCYCLINE 100 MG BD X 14 DAYS**



Ano-Rectal STI syndromes



**TREAT AS PER GUD
SYNDROME**

**TREAT AS PER UD
SYNDROME**





Warts



- Can be, single or multiple, soft painless growths which look like a cauliflower
- They may appear around anus and oral cavity in both men and women
- In women, they may occur at vulva. In men, they may occur on penis



**LOCAL APPLICATION OF 20%
PODOPHYLLIN SHOULD BE REPEATED
WEEKLY TILL THE LESIONS ARE CLEARED**

**SOMETIMES THE WARTS ARE TREATED
BY CAUTERY**



Genital Louse Infestation



- ▶ Itching, leading and scratching which may be limited to genital area all over the body
- ▶ Nits can be seen over the shaft of pubic hair

**APPLICATION OF PERMETHRIN 1%
AROUND THE GENITAL AREA AND
WASHED OFF AFTER 10 MINUTES**

**IN FEW CASES, RE-TREATMENT IS
REQUIRED AFTER 7 DAYS**





Molluscum Contagiosum



- ▶ These are multiple, soft, painless smooth, pearl like swellings
- ▶ They may appear anywhere on the body. When acquired due to unsafe sexual practices, they occur on genital area

EACH MOLLUSCI IS OPENED WITH A NEEDLE (EXTIRPATION) AND THE INNER SIDE IS TOUCHED WITH 30% TCA. (TRICHLORO ACETIC ACID)

SOMETIMES THE MOLLUSCUM ARE TREATED BY CAUTERY



Genital Scabies



- ▶ Itching of genitals, especially at night
- ▶ Other members of the family may also have similar symptoms
- ▶ They may appear on any of the body folds. If acquired due to unsafe sexual practices, they occur on genital area

OVERNIGHT APPLICATION OF BENZYL BENZOATE LOTION OR PERMETHRIN CREAM ALL OVER THE BODY AND BATHING NEXT MORNING IS REQUIRED





Most STI are Asymptomatic

Symptomatic

Asymptomatic

STI/RTI-IN WOMEN

- ▶ More than 50% of STI in women are without symptoms!
- ▶ Women are more easily infected than men
- ▶ More complications in women-infertility, cancer
- ▶ Untreated STI/RTI in women can affect her child - still born, abortions, eye infections at birth

Complications of STI

- ▶ HIV transmission
- ▶ Mother to child transmission
- ▶ Abortions
- ▶ Infertility
- ▶ Congenital Malformations
- ▶ Pelvic Inflammatory Disease
- ▶ Cervical cancer
- ▶ Painful scrotal swelling
- ▶ Ectopic pregnancy

STI-HIV Inter-Relationship

- ▶ Both are sexually transmitted
- ▶ Populations with high STI rates show a very high rate of sexually transmitted HIV
- ▶ STI causes changes in mucosa which facilitates HIV acquisition and transmission
- ▶ Presence of an STI can increase risk of acquisition and transmission of HIV FIVE to TEN FOLDS!
- ▶ Correct treatment of STI can reduce of HIV infection



Are STI curable?

All STI except

- ▶ HIV
- ▶ Herpes
- ▶ Hepatitis B

Are curable!

Treatment

- ▶ To be taken from a trained Doctor
- ▶ To be taken for the duration prescribed
- ▶ To be taken in the dosage prescribed
- ▶ To be given to the sexual partner
- ▶ To use condoms during treatment



Prevention of STI

Practice safer sex:

- ▶ Use condom
 - ▶ Non Penetrative Sex
 - ▶ Mutual masturbation
 - ▶ Kiss, cuddle, massage, embrace
-

Some Basics about STI

SIGNS AND SYMPTOMS OF STI

Main symptoms of STI in females:

- Discharge from vagina/anus
- Sores, ulcers, blisters, small hard lumps, rashes around and in the sexual organs
- Pain, itching, burning, swelling in and around vaginal area
- Lower belly pain
- Frequent urination (there may be other causes for this)
- Sore throat

Main symptoms of STI in males/transgenders:

- Sores, ulcers, blisters, small hard lumps, rashes around and in the sexual organs, including mouth/anus
- Burning sensation while passing urine, frequent urination
- Discharge from penis/anus
- Swelling of the scrotum/groin area
- Sore throat

SYNDROMES

- Gonorrhea
- Non-gonococcal urethritis (NGU) or Cervicitis
- Trichomoniasis
- Bacterial Vaginosis (BV)
- Candidiasis
- Syphilis
- Chancroid
- Lymphagranuloma Venereum
- Granuloma Inguinale (Donovanosis)
- Genital Herpes
- Genital Warts
- Molluscum Contagiosum
- Scabies
- Pelvic Inflammatory Disease (PID)/Lower Abdominal Pain
- Pediculosis Publis

COMMON COMPLICATIONS OF UNTREATED STI

- Infertility in women and men
- Ectopic pregnancies
- Damage to the heart and brain in late stages of syphilis, leading to death
- Cervical cancer in women
- Miscarriage
- Death or blindness in newborns due to infection from mothers
- Low birth weight infants
- Infants born with the infections – some can be cured, some cannot

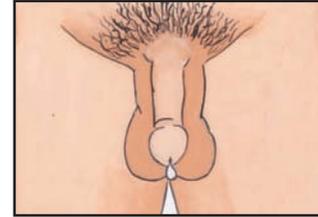
SOME PREVENTIVE MEASURES AND ISSUES IN STI PREVENTION AND TREATMENT

Care to effectively prevent and treat STI requires attention to both symptomatic and asymptomatic infections; risk reduction; using condoms consistently and correctly; building negotiation skills; alternatives to penetrative sex; limiting number of partners; early detection and treatment of signs and symptoms; antimicrobial therapy; detection of asymptomatic individuals who do not go for treatment; STI management in partners; follow up management of side effects; standard precautions for healthcare workers/providers.

Urethral Discharge Syndrome

COMMON SYMPTOMS

- The syndrome is seen only in males
- Discharge is from the private parts of the body. The discharge could be pus; the quantity may be copious or scanty
- There may be burning or discomfort while passing urine
- There may be pain during erection or during sexual intercourse



TRANSMISSION

- The syndrome is caused by Gonorrhoea, Chlamydial and/or Trichomonas infection.
- The client can get the infection from an infected partner by having unsafe sexual practices. It may have transmitted through genital, oral or anal unsafe sex with either a male or a female partner who is infected.
- The sexual partner who is infected with Gonorrhoea, Chlamydial and Trichomonas infections, may be symptomatic or asymptomatic (when the symptoms are not present however infection is there).

PREVENTION

- The client should avoid any sexual contact with partner/s until the treatment is completed and until the discharge is fully stopped. If abstinence is not possible the client should use a condom, consistently and correctly, during each and every sexual act.
- It is important to inform the doctor, if the partner is pregnant, as treatment will help in preventing spread of infection to new born.

TREATMENT

- There is cure for the urethral discharge syndrome provided the client and his/her Partner/s takes proper and full course of treatment.
- The treatment should be taken at the clinic under the supervision of the staff DOTS-STI (Directly Observed Treatment - Short Term)
- The prescribed medication should be taken along with plenty of water.

DRUG REGIME

- Azithromycin (1gm) - single dose
- Cefixime (400 mg) - single dose

COMPLICATIONS

- If not diagnosed and treated early, complications such as epididmo-orchitis and urethral narrowing may occur in male. The male may also become sterile. Very rarely, the infection may spread to other parts of the body (disseminated gonococcal infection).
- In case, a mother is infected with Gonorrhoea and Chlamydia, she may transmit it to the baby during delivery. It may affect the baby's eyes even leading to loss of eyesight.

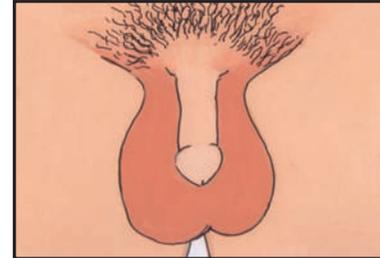
PARTNER REFERRAL

- It is important to inform any sexual partner/s he or she has had in the last one month about the infection and to encourage these partner/s to come to the clinic for treatment.

Painful Scrotal Swelling Syndrome

COMMON SYMPTOMS

- The painful scrotal swelling syndrome is seen only in males
- Patient will present with pain and swelling in scrotum
- There might be discharge from private parts of the body. The discharge is usually mucus/serous and the quantity may be scanty
- There may be burning sensation or discomfort while passing urine
- There may be pain during erection or during sexual intercourse



TRANSMISSION

- It is caused by Gonorrhea, and Chlamydial infections
- This syndrome is due to complication of untreated or inadequately treated urethral discharge syndrome

TREATMENT

- Painful scrotal swelling syndrome can be cured provided if the client and his/her partner/s take proper and full course of treatment.
- The treatment should be taken at the clinic under the supervision of the staff DOTS-STI (Directly Observed Treatment - Short Term)
- The prescribed medication should be taken along with plenty of water.
- The client should return to the clinic if he has problems with the medicine or if the symptoms do not go away.
- The client should avoid sex until treatment is completed (for seven days after completion of therapy) and make sure he does not pass the infection to others. Also, sex should be avoided until a partner completes treatment (for seven days after completion of therapy) so that there is no re-infection. If abstinence is not possible, the client should use a condom, consistently and correctly, during vaginal, anal, and oral sex.
- After seven days, the client should return to the clinic for follow up

DRUG REGIME

- Azithromycin (1gm) - single dose
- Cefixime (400 mg) - single dose

COMPLICATIONS

- If left untreated or inadequately treated, the painful scrotal swelling can cause urethral stricture and infertility.

PARTNER REFERRAL

- It is important to inform any sexual partner/s he or she has had in the last two months about the infection and to encourage these partner/s to come to the clinic for treatment.

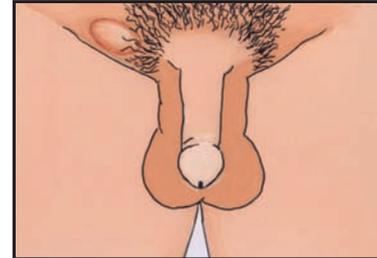
Be careful!

Some medicines are not safe to take during pregnancy so the pregnancy status of the Client's female partner should be confirmed

Inguinal Bubo Syndrome

COMMON SYMPTOMS

- Painful swelling in one or both groins
- Usually there are no ulcers on genitals
- Sometime the swelling may rupture causing discharge which may lead to sinus formation
- The syndrome is also known as Lympho Granuloma Venerum (LGV)



TREATMENT

- The treatment schedule of the syndrome should be explained to the client. It is important to take the medicines regularly and complete the treatment even if the symptoms go away.
- The client should return to the clinic if she/he has problems with the medicine or if the symptoms do not go away.
- The client should avoid sex until treatment is completed (for twenty one days) so as to make sure he does not pass the infection to others. Also she/he should avoid sex until his/her partner completes treatment (for twenty one days) so that she/he does not get re-infected. If abstinence is not possible, the client should use a condom, correctly and consistently, during vaginal, anal, and oral sex.
- The client has to attend the clinic on the 7th, 14th and 21st day.
- The partners should be treated for 21 days with the same medicines.

DRUG REGIME

- Doxycycline (100 mg) - BID for 21 days
- Azithromycin (1gm) - single dose

COMPLICATIONS

- If left untreated or inadequately treated, Inguinal Bubo can cause swelling in the inguinal region, leading to multiple painful ulcers, discharging sinuses, genital swelling, rectal discharge, bleeding, and rectal strictures.
- If left untreated, it could produce swelling and distortion of external genitalia.

Be careful!

Some medicines are not safe to take during pregnancy so the pregnancy status of the Client (or the female partner) should be confirmed



Genital Ulcer Disease Syndrome - (Non-herpetic)

COMMON SYMPTOMS

- There may be sores on genitals/anal/oral and lips
- The ulcers may be single or multiple. They may be painful or painless.
- There may also be swelling of lymph nodes on one or either groin.



PREVENTION

- To reduce the chances of infecting sexual partners, partners should avoid any contact with the sores until they are completely healed
- The easiest way to avoid contact is not to have sex until the sores are fully healed or to use a condom during sex (however, transmission can still occur if the condom does not cover the sores).

TREATMENT

- Genital ulcer disease syndrome – non herpetic can be cured with a single dose of Benzathine penicillin (injection) and a single dose of Azithromycin (tablet) under the supervision of clinic staff.
- Check for drug allergy
- The client should return to the clinic if there are problems with the medicines.
- The client should attend the clinic for follow up after seven days of treatment.

DRUG REGIME

Injection Benzathine penicillin 2.4 million unit to be given in divided dose in each buttock after skin testing Azithromycin (1gm) – single dose

If allergic then use:

- Doxycycline (100 mg) - BID for 15 days
- Azithromycin (1gm) - single dose

COMPLICATIONS

- If left untreated or inadequately treated, the genital ulcer disease – non herpetic syndrome may lead to complications over a period of time.
- If left untreated, syphilis could damage the cardio-vascular and central nervous system, eventually causing death.
- If left untreated, Chancroid could cause swollen lymph nodes (glands) in the groin that can rupture and drain pus.
- In pregnant women, Syphilis could be transmitted to the baby, causing stillbirth or the death of the baby. This can be avoided if the woman is treated early in pregnancy.
- Most importantly, like in case of all STI/RTI, an individual with genital ulcer disease syndrome has five to ten times more risk of getting HIV infection.

PARTNER REFERRAL

- It is important to inform any sexual partner/s he or she has had in the last three months about the infection and to encourage these partner/s to come to the clinic for treatment

Be careful!

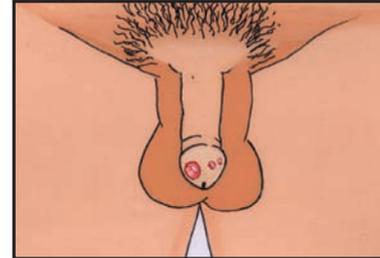
Some medicines are not safe to use during pregnancy. All pregnant clients and their partner(s) should let their Doctor know that they are pregnant so that the doctor can help to protect the baby from transmission during delivery



Genital Ulcer Disease Syndrome - (Herpetic)

COMMON SYMPTOMS

- There may be sores on genitals/anal/oral and lips
- There may be vesicles/erosions and they may be painful
- There may also be swelling of lymph nodes on one or either groin
- If the client has Genital vesicles/erosions, it is caused by Genital herpes
- Sometimes, the client may experience tingling in the genital area preceding the herpetic vesicular eruption
- They may complain of recurrence of symptoms



TRANSMISSION

- Genital ulcers are transmitted through contact with sores on the vagina, penis, anus, rectum, mouth, or lips.
- The infections, particularly herpes, can also be passed to others even after the sores have healed or when they are not present.
- Herpes can be transmitted from the mouth to the genitals or from the genitals to the mouth during oral sex.

PREVENTION

- To reduce the chances of infecting sexual partners, partners should avoid sex until the sores are fully healed or use a condom, consistently and correctly, during sex
- Some people have attacks of herpes during stressful times so one should look at ways to reduce stress.
- A person with herpes infection often feels a tingling or itchy feeling at the site where an attack is about to occur. The risk of transmission is high just before and during an outbreak. If possible, the client should avoid sex at these times.

TREATMENT

- The genital ulcer disease syndrome herpetic can be treated. Herpes sores heal on their own after 10–14 days, but the virus stays in the body after the sores are healed. Medicines can shorten the time of healing.
- The client should return to the clinic after 7 days.

DRUG REGIME

- Acyclovir (400 mg) - Orally TID for 7 days

COMPLICATIONS

- Some people experience repeated attacks of herpes sores.

PARTNER REFERRAL

- There is no need to routinely treat the partners unless they too have symptoms.

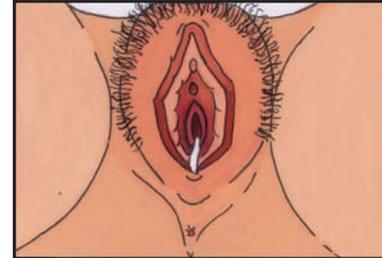
Be careful!

All pregnant clients and their partner(s) should let their Doctor know that they are pregnant so that the doctor can help to protect the baby from transmission during delivery.

Vaginal Discharge Syndrome (Vaginitis)

COMMON SYMPTOMS

- The common symptoms of vaginal discharge syndrome are unusual quantity of vaginal discharge, itching around genitalia, bad odour of the discharge and change in colour of the discharge.



TRANSMISSION

- Sometime vaginal discharge is caused by change in the normal environment in the vagina.
- It is also likely to be transmitted through unprotected sexual intercourse.
- Sometime the causes for vaginal discharge are yeast infections, which can occur with excessive antibiotic use, diabetes or not maintaining proper hygiene of genitals, including menstrual hygiene.

PREVENTION

- To reduce the chances of getting a vaginal infection in the future, the client should avoid using feminine-hygiene products and scented soaps, douching, wearing tight pants and synthetic underwear.
- Condom use for vaginal sex might also help prevent recurrence.

TREATMENT

- Vaginal discharge syndrome can be cured with single dose treatment.
- It is important that every client, who comes in with a vaginal discharge complaint, should undergo internal examination using a speculum.
- The client should be motivated to take the medicine under supervision at the clinic itself.
- The client should avoid sex until treatment is completed (for seven days after completion of therapy). If abstinence is not possible, the client should use a male or female condom during vaginal, anal, and oral sex.
- The partner of the Client needs to be treated only when the partner has complaints.
- After seven days of treatment, the client should return to the clinic.

DRUG REGIME

- Secnidazole (1gm) - 2 tablets stat
- Fluconazole (150 mg) - single dose

COMPLICATIONS

- In pregnant women, the Vaginitis infection can cause early labor and delivery

PARTNER REFERRAL

- It is important to inform any sexual partner/s if he/they is/are symptomatic and to encourage them to come to the clinic for treatment.

Be careful!

- In some cases, vaginal discharge may not be caused by an STI. To prevent negative reactions from clients and their partner/s it is important for the Counsellor to consider each case on an individual basis
- Some medicines are not safe during pregnancy so pregnancy status of the client should be confirmed

The medicines used to treat vaginal discharge syndrome can make the client sick (nausea, vomiting, flushing, sinking feeling) if she drinks alcohol (beer, liquor, or wine) during treatment. To prevent this the Counsellor should advise the client to not drink any alcohol until 24 hours have passed since taking the last dose.

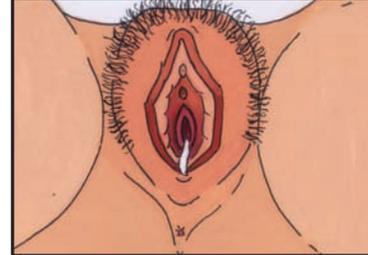
Cervical Discharge Syndrome (Cervicitis)

COMMON SYMPTOMS

- In case of cervicitis, the common symptom is vaginal discharge which releases foul smell and has a change in colour. The quantity of discharge is usually scanty.

TRANSMISSION

- To reduce the chances of getting a cervical infection in the future, correct and consistent use of condoms for every sexual encounter is important.



TREATMENT

- Cervical discharge can be cured with single dose treatment.
- It is important that every client, who comes to the clinic with vaginal/cervical discharge complaint, should undergo internal examination using a speculum.
- The client should be motivated to take the medicine, under supervision, at the clinic itself.
- The client should avoid sex until treatment is completed. If abstinence is not possible, the Client should use a condom, consistently and correctly, during vaginal, anal, and oral sex.
- The Client should return to the clinic after seven days of treatment.
- The partner should be treated with the same medicines.

DRUG REGIME

- Azithromycin (1gm) - single dose
- Cefixime (400 mg) - single dose

COMPLICATIONS

- The infection can spread to the uterus (womb) and fallopian tubes, causing pelvic inflammatory disease (PID), which can make it difficult for the client to become pregnant. It can make her infertile, or can increase the risk of ectopic pregnancy (pregnancy outside the uterus).
- In pregnant women, the infection can cause early labor and delivery and can be passed to the baby.

PARTNER REFERRAL

- It is important to inform any sexual partner/s he or she has had in the last one month about the infection and to encourage these partner/s to come to the clinic for treatment.

Be careful!

Some medicines are not safe during pregnancy so pregnancy status of the client should be confirmed

Lower Abdominal Pain Syndrome (LAP)

COMMON SYMPTOMS

- The most common symptom is pain in lower abdomen, with pain during sexual intercourse
- There could be irregularities in menstrual cycle
- Sometimes there might be discharge from vagina and complain of backache
- Sometimes there could be constitutional symptoms such as fever, body aches, nausea and vomiting



TREATMENT

- PID (Pelvic Inflammatory Disease)/LAP (Lower Abdominal Pain) syndrome can be treated.
- It is important to take the medicine the right way and complete treatment even if the symptoms go away.
- The client should return to the clinic if she has problems with the medicine or if the symptoms do not subside within 72 hours.
- The client should avoid vaginal sex until after treatment to promote healing and to make sure she does not pass the infection to others. Also vaginal sex should be avoided until after the partner completes treatment so that the client does not get re-infected. If abstinence is not possible, the client should use a male or female condom during vaginal, anal, and oral sex.
- The client should return to the clinic for follow-up on the 3rd, 7th and 14th day from the day of treatment.

DRUG REGIME

- Cefixime (400 mg) - single dose
- Metronidazole (400 mg) - BID for 14 days
- Doxycycline (100 mg) - BID for 14 days

COMPLICATIONS

- PID can make it difficult for the client to become pregnant. It can make her infertile, or can increase her risk of ectopic pregnancy (pregnancy outside the uterus).
- PID can cause chronic lower abdominal pain and painful intercourse.

PARTNER REFERRAL

- It is important to inform any sexual partner/s he or she has had in the last two months about the infection and to encourage these partner/s to come to the clinic for treatment.

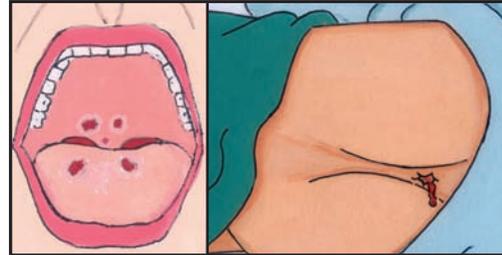
Be careful!

- The Counsellor should explore the recent incidents of intrauterine contraceptive devices (insertion,) abortions etc.
- Since the risk of ectopic pregnancy (a life-threatening condition) is increased in women who have had PID, the Counsellor should tell the Client that ...
 - If she is pregnant, she should report to a hospital at the earliest to rule out ectopic pregnancy.
 - She should go to a health care facility immediately if she experiences the following signs of ectopic pregnancy:
 - Irregular bleeding or spotting with abdominal pain when her period is late or after an abnormally light period.
 - Sudden intense persistent pain or cramping pain in the lower abdomen, usually on one side or the other.
 - Faintness or dizziness that lasts for more than a few seconds (may be signs of internal bleeding).

Oral and/or Anal STI

COMMON SYMPTOMS

- The individual may have symptoms of ulcers/sores/blisters/ discharge/growth at oral and/or anal regions
- These may be caused due to Gonorrhoea, Chlamydia, Syphilis, Chancroid, Granuloma inguinale, warts and Genital herpes.



TREATMENT

- Oral and anal STI can be cured with single dose treatment. Some oral and anal STI require different types of treatment along with medicines.
- The client should be motivated to take the medicine under supervision at the clinic itself.
- The partner is to be treated with the same medicines.
- The client should avoid sex until treatment is completed. Sex should also be avoided until the partner completes treatment so that the client does not get re-infected. If abstinence is not possible, the client should use a condom, consistently and correctly, during vaginal, anal, and oral sex.
- The client should return to the clinic after seven days of treatment.

DRUG REGIME

- Azithromycin (1gm) - single dose
- Cefixime (400 mg) - single dose

COMPLICATIONS

- In men, anorectal discharge can cause pain, tenesmus and rectal stricture, leading to difficulty in passing stools.
- In men and women, anal ulcers can cause swelling of the regional lymph nodes, leading to multiple painful ulcers and discharging sinuses.
- In pregnant women, infections transmitted to the baby, cause serious consequences such as abortion, still birth and conjunctivitis in newborn.

Be careful!

Some medicines are not safe during pregnancy so pregnancy status of the client should be confirmed



Warts

COMMON SYMPTOMS

- These are seen in both men and women
- These can be, single or multiple, soft painless growths which look like a cauliflower
- They may appear around the anus and oral cavity in both men and women
- In women, they may occur at the vulva. In men, they may occur on the penis

PREVENTION

- The client should avoid any sexual contact with partner/s until the treatment is completed and all warty lesions are cleared. If abstinence is not possible, the client should use a condom, consistently and correctly, during vaginal, anal, and oral sex.
- It is important to inform the doctor if the partner is pregnant as treatment helps in preventing the spread of infection to the newborn.

TREATMENT

- There is a cure for the warts provided the client and partner/s take proper and full course of treatment.
- Local application of 20% Podophyllin should be repeated weekly until the lesions are cleared.
- Sometimes the warts are treated by cautery

COMPLICATIONS

- Certain varieties of warts may cause cervical cancer in women.
- Genital warts in a pregnant woman can be transmitted to a baby during delivery.

Be careful!

Podophyllin is not safe to use during pregnancy so the doctor should know the pregnancy status of women patients and female partners of male patients.



Genital Louse Infestation

COMMON SYMPTOMS

- Itching, leading and scratching which may be limited to genital area all over the body.
- Nits can be seen over the shaft of pubic hair

PREVENTION

- The client should avoid any sexual contact with partner/s until the treatment is completed and until all genital louse are cleared. If abstinence is not possible, the client should use a condom, consistently and correctly, during vaginal, anal, and oral sex.

TREATMENT

- There is cure for genital louse infestation provided the client and his/her partner/s take proper treatment.
- Treatment includes application of Permethrin 1% around the genital area and washed off after 10 minutes
- In few cases, re-treatment is required after 7 days.

COMPLICATIONS

- Eczematization
- Secondary infection leading to pus formation



Molluscum Contagiosum

COMMON SYMPTOMS

- These are multiple, soft, painless smooth, pearl like swellings.
- They may appear anywhere on the body. When acquired due to unsafe sexual practices, they occur on genital area.
- In case of PLWH Mollusci, it may occur on the face and may be big in size

PREVENTION

- The client should avoid any sexual contact with partner/s until the treatment is completed and until all Molluscum lesions are cleared. If abstinence is not possible, the client should use a condom, consistently and correctly, during vaginal, anal, and oral sex.

TREATMENT

- There is cure for mollusci provided the client and his/her partner/s takes proper treatment.
- Each mollusci is opened with a needle (extirpation) and the inner side is touched with 30% TCA (Trichloro Acetic Acid).
- Sometimes the Molluscum are treated by cauterization

COMPLICATIONS

- If not diagnosed and treated early, they may spread all over the body.
- They may get infected causing pain and pus formation.

Genital Scabies

COMMON SYMPTOMS

- Itching of genitals, especially at night
- Other members of the family may also have similar symptoms
- They may appear on any of the body folds. If acquired due to unsafe sexual practices, they occur on genital area.

PREVENTION

- The client should maintain hygiene.

TREATMENT

- There is cure for scabies provided if the client and his/her partner/s take proper treatment.
- Overnight application of Benzyl benzoate lotion or Permethrin cream all over the body and bathing next morning is required.

COMPLICATIONS

- Eczematization
- Kidney damage
- Contact dermatitis

DAY FOUR



DAY FOUR

Session 1 Risk Reduction Counselling



WHAT IS RISK?

- Any stimulus that could cause an undesirable response
- Any behaviour that could cause harm to self
- Any behaviour that could result in harm/danger to others
- All of these behaviours could be done in full knowledge or without knowledge of the resultant response

Risk is UNCERTAINTY

WHAT IS RISK REDUCTION?

- Process of reducing any behaviour that could cause harm
- Helping unlearn undesirable behaviour
- Helping learn new beneficial behaviour
- Helping to maintain/sustain new behaviour

REMEMBER: Risk reduction is a process

RISKY BEHAVIOURS

Personal sexual behaviour

- High number of sexual partners (multiple partners)
- Exchanging sex for money/food/drugs (given or received)
- Use of substances before sex

Other personal risk behaviours

- Skin piercing
- Blood transfusion
- Injecting drugs
- Drinking alcohol

CONTD.

Partner/s sexual and other risk behaviours

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

WHAT IS HIGH RISK SEXUAL BEHAVIOUR?

UNPROTECTED SEXUAL INTERCOURSE WITH...

- Anyone who had unsafe sex with other men
- Anyone who had unsafe sex with other women
- Anyone who has received untested blood or blood products
- Anyone who had unsafe sex with anyone who has received untested blood or blood products

WHY RISK REDUCTION?

- STI and HIV is preventable
- Changes in ATTITUDES and BEHAVIOUR is possible
- Risk-taking is a behaviour

RISK REDUCTION COUNSELLING

- Is a client-centered approach designed to support individuals in making behaviour changes
- These behaviour changes will reduce their risk of acquiring or transmitting HIV or other STI
- Risk reduction plan must be client driven, based on readiness & ability to adopt safer behaviours

CONTD.

- Process should be interactive and respectful of the client's circumstances and readiness to change
- The first step is to make sure the client believes she or he is at risk and knows what the risks are
- While making a risk reduction plan the counsellor should help the client identify any difficulty that may be faced when carrying out the plan

MODEL OF RISK REDUCTION

- Level of readiness for change/Stages of change:-
 - Pre-contemplation (Have not considered that they are at risk and need to use condoms)
 - Contemplation (Become aware of their risk and subsequent need to use condoms)
 - Preparation (Begin to think about using condoms in the next months)
 - Action (Use condoms effectively for fewer than 6 months)
 - Maintenance (Use condoms effectively for 6 months or more)



CLINICAL RISK ASSESSMENT

RISK ASSESSMENT

Requires the counsellor to ask explicit questions about an individual's various practices including:

- Sexual practices
- Drug using practices
- Occupational practices
- Age
- Past history of STI

WHY IS IT IMPORTANT TO TAKE A RISK PRACTICE HISTORY?

- To promote greater awareness and concern about STI and HIV
- To inform on prevention and education
- To determine necessary health investigations
- To provide feedback to the client regarding levels of risks associated with various practices
- To understand implications for treatment

ASSESSMENT IS DONE IN THE FOLLOWING AREAS

- Sexual history
- Factors causing high risk sexual behaviour
- Personalizing risk or perceived risk

ASSESSMENT – SEXUAL HISTORY

While taking sexual history focus on :

- Sexual preferences
- Sex partners
- Fantasies
- Condom use

ASSESSMENT – FACTORS CAUSING HIGH RISK SEXUAL BEHAVIOUR

- Attitudes towards Sex, STI, HIV and AIDS
- Knowledge related to sex, STI, HIV and AIDS – including misconceptions

ASSESSMENT – PERSONALIZING HIV RISK

- Also called perceived risk
- It is measure to see how much the client with High Risk Sexual Behaviour perceives her/his risk

—————→
No Risk Medium Risk High Risk

GROUP WORK

- Break into small groups
- Identify the associated level of risk with each activity
- Indicate the level (low/medium/high) against each activity

ACTIVITY CARDS/STATEMENTS

- Card 1: Abstinence
- Card 2: Masturbation
- Card 3: Sex with a monogamous, uninfected partner
- Card 4: Unshared sex toys
- Card 5: Shaking hands with an HIV-infected person

CARDS/STATEMENTS CONTD.

- Card 6: Sitting on a public toilet seat
- Card 7: Getting bitten by a mosquito
- Card 8: Massage
- Card 9: Hugging an HIV positive person
- Card 10: Sharing sex toys with cleaning or use
of new condom

CARDS/STATEMENTS CONTD.

- Card 11: Sexual stimulation of another's genitals using hands
- Card 12: Deep (tongue) kissing
- Card 13: Oral sex on a woman with a barrier
- Card 14: Oral sex on a man with a condom
- Card 15: Vaginal sex with a condom

CARDS/STATEMENTS CONTD.

- Card 16: Vaginal sex with multiple partners, condoms used every time
- Card 17: Anal sex with condom
- Card 18: Oral sex on a man without a condom
- Card 19: Oral sex on a woman without a barrier
- Card 20: Withdrawal - removing the penis before ejaculation

CARDS/STATEMENTS CONTD.

- Card 21: Pre-ejaculation
- Card 22: Vaginal sex without a condom
- Card 23: Anal sex without a condom
- Card 24: Fingers/hands/objects put into anus
- Card 25: Vaginal sex using hormonal contraceptives
or IUD and no condom

CARDS/STATEMENTS CONTD.

- Card 26: Sharing needles, syringes, drug solutions, or
other drug paraphernalia
- Card 27: Injection in clinical settings
- Card 28: Breastfeeding from an HIV-infected mother
- Card 29: Making love to your spouse
- Card 30: Receiving blood transfusion
- Card 31: Occupational exposure to blood or body fluids

RISK CONTINUUM

Refer to risk continuum as available in supplementary manual

RISK REDUCTION

- Risk reduction means making steps that reduce, but do not completely eliminate risk of STI, including HIV infection
- Most people will make behavioural changes gradually, over time, testing and assessing the outcomes of any new effort
- There are also many external influences on behaviour that may not allow for 100% elimination of risk



RISK REDUCTION COUNSELLING

- Refer to the checklist on risk reduction counselling
- Role play

Practices & Risk Table

Practice	Risk	Notes
Abstinence	No risk	
Masturbation	No risk	
Sex with a monogamous, uninfected partner	No risk	It is difficult to know if partner is monogamous and uninfected
Unshared sex toys	No risk	
Shaking hands with an HIV-infected person	No risk	
Sitting on a public toilet seat	No risk	
Getting bitten by a mosquito	No risk	
Massage	No risk	
Hugging an HIV positive person	No risk	
Sharing sex toys with cleaning or use of new condom	Low/No risk	
Sexual stimulation of another's genitals using hands	Low/No risk	Risk of HIV is very low if there are no cuts or broken skin on hands, especially if there is no contact with vaginal secretions, semen, or menstrual blood. Some STI that are passed through skin to skin contact are possible
Deep (tongue) kissing	Low/No risk	Risk is higher if bleeding gums, sores, or cuts in mouth. No risk due to saliva itself
Oral sex on a woman with a barrier	Low/No risk	Risk is very low. Barrier/condom must be used correctly. Some STI (eg herpes) can be transmitted through contact with skin not covered by barrier/condom
Oral sex on a man with a condom	Low/No risk	
Vaginal sex with a condom	Low risk	Small risk of condom slippage or breakage - reduced with correct use. Some STI (eg herpes) can be transmitted through contact with skin not covered by condom
Vaginal sex with multiple partners, condoms used every time	Low risk	Multiple partners increase risk, however correct and consistent condom use lowers risk
Anal sex with condom	Low to Medium risk	Risk of condom breakage greater than for vaginal sex. Risk of breakage is decreased by use of water based lubricant. Some STI (eg herpes) can be transmitted through contact with skin not covered by condom. If after the anal sex the penis with condom is inserted into a female partner's vagina, both HIV and other infections can spread due to faecal contamination
Oral sex on a man without a condom	Medium risk	HIV and STI can be transmitted through oral sex; however, risk is lower than that of anal or vaginal sex. Safer if no ejaculation in mouth
Oral sex on a woman without a barrier	Medium risk	HIV and STI can be transmitted through oral sex; however, risk is lower than that of anal or vaginal sex.
Withdrawal – removing the penis before ejaculation	Reduced risk	HIV can be present in pre-ejaculate and therefore risk of transmission is high, however withdrawal may reduce risk of HIV transmission somewhat. Unlikely to reduce risk of other STI
Pre-ejaculation	High risk	

DAY FOUR

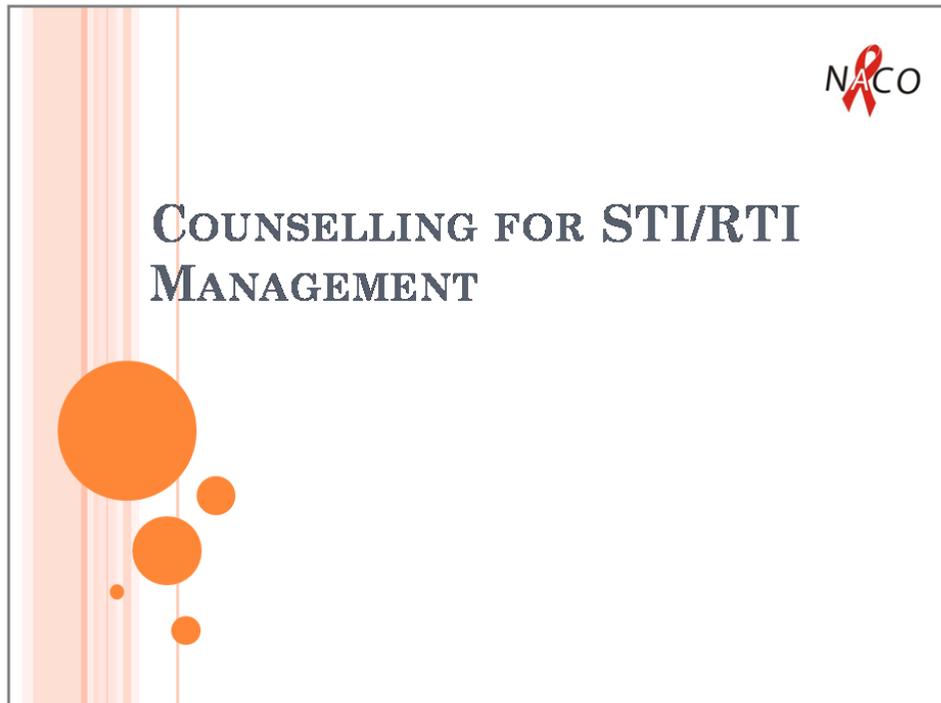


Vaginal sex without a condom	High risk	One of the highest risk activities. Receptive partner is at greater risk
Anal sex without a condom	High risk	One of the highest risk activities. Receptive partner is at greater risk but the risk of the 'active partner' is higher than originally thought. If the penis is then put into a female partner's vagina, infection can spread - both HIV and other infections - due to faecal contamination
Fingers/hands/objects put into anus	Medium risk of some infections	If the finger/hand/object is then put into a female partner's vagina or the partner's mouth, infection due to faecal contamination can spread
Vaginal sex using hormonal contraceptives or IUD and no condom	High risk	Hormonal contraceptives and IUDs do not protect against STI or HIV
Sharing needles, syringes, drug solutions, or other drug paraphernalia	High risk	HIV and hepatitis viruses can readily be transmitted from infected person through sharing of injection during drug use
Injection in clinical settings	Unknown	If the clinic uses disposable needles/cutting equipment one time or sterilizes needles/equipment there is no risk. If these are reused, there is high risk. This may be common in services provided by 'quacks' or other such pharmacists
Breastfeeding from an HIV-infected mother	High risk	Although risk is relatively high, if no other good source of nutrition is available, it is recommended that HIV-positive women breastfeed
Making love to your spouse	Unknown risk	It may be difficult to know whether your spouse engages in activities that put you at risk
Receiving blood transfusion	Unknown risk	In many countries, the blood supply is adequately screened for HIV
Occupational exposure to blood or body fluids	Varies depending on exposure	HIV and other pathogens can be transmitted through contact with blood or other body fluids. Risk can be minimized if universal precautions for infection control are followed with all clients

CHECKLIST 1 - RISK REDUCTION PLANNING

- Review client's current risk and her/his feelings about risk
- Check on level of concern (risk perception)
- Assess reasons for inaccurate perception of risk
- Correct any misconceptions the client may have
- If she/he is concerned, discuss what she/he is already doing
- Acknowledge efforts with praise and acceptance
- Point out other issues or actions that might affect risk such as drinking, drugs etc
- Correct any ideas that are not going to reduce risk - incorrect beliefs
- Help client set a realistic goal for reducing risk
- Help client think of practical steps for a given type of partner or situation
- Confirm steps the client would like to consider
- Offer to teach negotiation skills or condom use skills
- Check on possible obstacles she/he might run into
- Check on possible support
- Summarize plan
- Propose HIV test and explain why

Session 2 Counselling for STI/RTI Management



INTRODUCTION

Counsellors are responsible for:

- Making sure that clients understand their STI/RTI diagnosis and treatment, and are
- Assisted to take medicine at the clinic or to plan to take medicine over the period of days

WORKING WITH HIGH RISK GROUP (HRG)

- Those who are involved in sex work are always at risk of having an STI
- Hence, it is important for sex workers to go for a quarterly medical check-up, even if there are no symptoms of STI
- A complete check-up means that the oral, anal and genital area is also completely examined
- Speculum examination for females and proctoscopic examination for those involved with anal sex is part of health check-up

CONTD.

- A blood test to detect syphilis is needed at least once in six months
- Once in six months HRG members also need to undergo voluntary HIV counselling and testing
- During the first visit to clinic or if a check-up is not done for six months consecutively, the doctor prescribes medication even if there are no symptoms
- This is to treat hidden infections that could have gone unnoticed. This treatment is called 'Presumptive Treatment' also known in short as 'PT'

GROUP WORK – 2 GROUPS

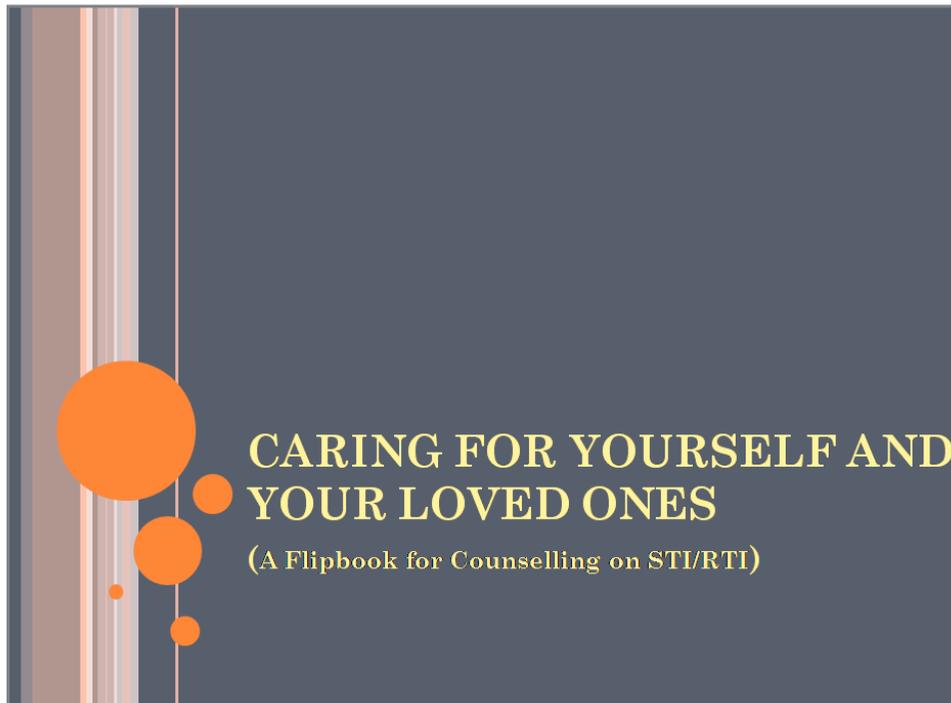
Case 1: A woman comes to you with a complaint of vaginal discharge that she has had for the last two weeks. She mentions that it is continuous and causes a foul odour. Recently, her husband also complained of a burning sensation while passing urine.

- In order to determine whether the vaginal discharge is normal or not, what questions will you ask the client?
- If it is likely to be an STI, what actions would you suggest?
- How do you prepare the patient for consultation by doctor?

CONTD.

Case 2: After attending a group education session on STI and HIV in the community, a youth walks up to you and informs you that his friend is suffering from a genital ulcer and wants to know what to do. You begin to explore his knowledge about STI. The youth admits that he himself has the ulcer, which he noticed a few days ago.

- What will you do?
- How do you facilitate the treatment and what other action will you recommend?



INTRODUCTION

The flip book has three sections:

- **Section 1** is a background or provides information on the basics of STI/RTI
- **Section 2** describes treatment for individual syndromes and other STI/RTI
- **Section 3** describes standard counselling communication to create awareness, and promote behaviour change and risk reduction strategies

Let's go through the flipbook and understand it better so as to use it as a tool during our counselling sessions!

COUNSELLING SPECIFIC STI SYNDROMES

- Refer to checklists in supplementary manual
- Role Play

KEY THINGS TO REMEMBER FOR COUNSELLORS

- STI treatment means treatment of two people - the patient and her/his partner
- Clients must be made to understand reasons for getting a partner treated
- During treatment it is important to use condom, correctly and consistently
- Counsellors will need to help clients identify safer sex options and to practice negotiation techniques

CONTD.

- Counsellors will need to explore situations in which a client is not consistently using condoms and what contributes to their difficulty in negotiating and using condoms
- Clients will need adequate skills to negotiate condom use or other safer sex activities with partners
- Abstinence or remaining mutually faithful is the surest way of avoiding another STI

CONTD.

- The presence of STI indicates risk of also being exposed to HIV
- Hence all patients with STI must be also referred for HIV integrated counselling and testing
- Counsellors must provide health education about STI and the importance of correct and timely treatment

CONTD.

- Counsellors must explain the purpose of the drugs being given for treatment and any interaction with alcohol or other side effects and what to do about them
- Counsellors must emphasise that the medication must be taken till the end of course, even though the symptoms may disappear

CHECKLIST 2 – EXPLAINING TREATMENT FOR CERVICAL INFECTION (CERVICITIS)

- Explain the diagnosis
- Explain causes of cervical infection
- Explain why she/he is getting two different medicines
- Explain possible consequences of incomplete or incorrect or no treatment and links of STI to HIV
- The doctor will have asked about allergies before prescribing the medicine. Check again about possible allergies to the medicine
- Help your client take the medicine at the clinic under your supervision
- Explain possible side effects of medicines
- Introduce partner treatment for symptomatic partner- Check history for regular partner or ask
- Introduce risk reduction planning - carry out planning or review risk reduction planning
- Demonstrate correct usage of condom and offer condoms; at least 20 pieces to cover up to the first follow up i.e. up to 7 days. Check on ability to use correctly
- Positively reinforce the importance of coming for examination
- Once again reinforce decision to complete the course of medication, report for follow up, partner treatment and consistent condom use

CHECKLIST 3 – EXPLAINING TREATMENT FOR VAGINAL DISCHARGE (VAGINITIS)

- Explain the diagnosis
- Explain the cause of the infection
- Help your client take the medicine
- Explain the importance of taking all the medicines correctly and completely at the clinic under your supervision
- Explain the long term effects of not curing the infections
- Explain alcohol interaction and emphasize need to not drink while taking the medicine
- Check on pregnancy prevention method
- Help client plan to take all the medicine
- Teach about side effects or reasons to contact a doctor
- Introduce partner notification/treatment for symptomatic partner - refer to sexual history
- Explain need to use condoms or abstain from sex until all the medicine has been taken
- Introduce risk reduction planning
- Plan for risk reduction or review previous plan
- Motivate to visit Laboratory for Syphilis screening and ICTC for free counseling and testing
- Make appointment for your client to return
- Reinforce decision to come for treatment
- Once again reinforce decision to complete the course of medication, report for follow up, partner treatment and consistent condom use

CHECKLIST 4 - EXPLAINING TREATMENT FOR URETHRAL DISCHARGE

- Explain the diagnosis
- Explain how your client caught the infection
- Explain the medicine
- Acknowledge the number of pills, help client take them
- Ensure that the patient takes the medicine under your supervision at the clinic itself
- Teach about side effects or reasons to contact a doctor
- Inform when he should return to clinic for a follow up visit
- Reinforce his decision to come for examination and treatment
- Introduce partner treatment - refer to history of partner
- Introduce and carry out or update risk reduction planning
- Offer condoms, check on ability to use correctly
- Motivate to visit Laboratory for Syphilis screening and ICTC for free counseling and testing
- Reinforce his decision to come for examination and treatment – include link between STI and HIV
- Once again reinforce decision to complete the course of medication, report for follow up, partner treatment and consistent condom use

CHECKLIST 5 - EXPLAINING TREATMENT FOR PAINFUL SCROTAL SWELLING

- Explain the diagnosis
- Explain the cause of STI
- Explain importance of treatment
- Reinforce decision to come for treatment
- Help client plan to take all the medicine
- Reinforce the plan
- Reinforce the need to take all the medicines, on time
- Teach about side effects or reasons to contact a doctor
- Teach other care - ask if there is anything/any position that makes this feel less painful
- Introduce partner treatment - refer to history of partner
- Introduce and carry out or update risk reduction planning
- Offer condoms, check on ability to use correctly
- Motivate to visit Laboratory for Syphilis screening and ICTC for free counseling and testing. Make appointment to return
- Reinforce his decision to come for examination and treatment - include link between STI and HIV
- Once again reinforce decision to complete the course of medication, report for follow up, partner treatment and consistent condom use

CHECKLIST 6 - EXPLAINING TREATMENT FOR ANO RECTAL DISCHARGE PROCTITIS: INFLAMMATION OF THE RECTAL WALL

- Explain the diagnosis
- Explain the cause of STI
- Explain importance of treatment
- Explain treatment - acknowledge number of pills and help client take them
- Reinforce decision to come for treatment
- Teach about side effects or reasons to contact a doctor
- Teach other care
- Introduce partner treatment - refer to history of partner
- Plan for partner treatment
- Introduce and carry out or update risk reduction planning
- Offer condoms, check on ability to use correctly
- Suggest and discuss an HIV and Syphilis test
- Make appointment to return
- Reinforce his decision to come for examination and treatment
- Once again reinforce decision to complete the course of medication, report for follow up, partner treatment and consistent condom use

CHECKLIST 7 - LOWER ABDOMINAL PAIN (LAP)

- Explain the diagnosis
- Explain the cause of the infection and emphasize the need to access treatment early
- Help your client to take the medicine
- Explain the importance of taking all the medicines completely and rationale for longer duration of treatment.
- Explain to the client to return for follow up after 3 days or earlier if the symptom does not subside
- Explain the long term effect of not curing the infection (infertility, ectopic pregnancy, etc)
- Explain alcohol interaction and emphasize to not drink while taking medicine
- Teach about the side effects of the medicine
- Introduce partner notification/ treatment
- Explain need to use condom or abstain from sex until treatment is complete
- Introduce risk reduction planning or review previous plan
- Motivate to visit laboratory for syphilis screening and ICTC for free counseling and testing
- Make appointment for your client to return. Educate the client on identifying early symptoms of lower abdominal pain syndrome and seek treatment at earliest
- Once again reinforce decision to complete the course of medication, report for follow up, partner treatment and consistent condom use
- Once again reinforce decision to complete the course of medication, report for follow up, partner treatment and consistent condom use

CHECKLIST 8 - EXPLAINING STI TREATMENT FOR INFECTION IN THE THROAT

- Explain the diagnosis
- Explain the cause of STI
- Explain importance of treatment
- Explain treatment
- Teach about side effects or reasons to contact a doctor
- Introduce partner treatment - refer to history of partner
- Introduce and carry out or update risk reduction planning
- Offer condoms, check on ability to use correctly
- Suggest and discuss an HIV and Syphilis test
- Make appointment to return
- Reinforce his decision to come for examination and treatment
- Once again reinforce decision to complete the course of medication, report for follow up, partner treatment and consistent condom use

CHECKLIST 9 - EXPLAINING AND PROMOTING INTERNAL (PELVIC) EXAMINATION

- Introduce the topic of pelvic or internal examination
- Explain the reasons and benefits of pelvic examination
- Use pictures and speculum, if available, to explain the examination. Encourage client to handle the speculum
- Encourage client to have an examination
- If client refuses or is reluctant, assess the reasons for reluctance to undergo the examination and reassure client
- If still undecided, help client weigh benefits against discomfort
- Once agreed, explain the steps of internal examination
- Ask if there are any questions and assure that she can visit again after the doctor conducts the internal examination
- Reinforce decision to undergo examination
- If client does not agree, accept the decision and acknowledge her right to decide
- Ask the client to still meet the doctor
- Reinforce decision to come to the clinic

CHECKLIST 10 - PROMOTING PROCTOSCOPY (RECTAL) EXAMINATION FOR MSM AND TG

- Introduce the topic of proctoscopy or rectal examination. Check on previous experience with the same.
- Explain the reasons and benefits of examination
- Explain the examination
- Use pictures and proctoscope, if available, to explain the examination. Encourage client to handle the proctoscope
- Ask if there are any questions. If there is reluctance, ask for concerns and respond to them
- If still undecided, help client weigh benefits against discomfort
- Reinforce decision to undergo examination
- If client does not agree, accept the decision and acknowledge his right to decide
- Ask the client to still meet the doctor
- Reinforce decision to come to the clinic

Session 3
Partner Notification and treatment



Partner Notification and Treatment

Need for Partner Notification and Treatment

Partner Notification and STI treatment are needed to prevent:

- STI re-infection
- Further spread of STI, and
- Possible long term effects of untreated STI for the partner

Group Work

- ▶ What are the barriers to partner notification?
- ▶ What are the possible ways to counsel clients to overcome those barriers?

Role play – Barriers and solutions to partner notification

Issues to be considered

- ▶ Telling a partner is often difficult as it can lead to conflicts and distrust in a relationship.
- ▶ Clients need to feel convinced that:
 - The benefits are greater than the possible problems
 - Partner notification and treatment is needed even if the partner does not show any symptoms
 - Partner notification is always voluntary
 - The partner will be provided with confidential STI treatment services

Contd.

- ▶ Once the client has agreed to tell a partner, counsellors will need to help the client explore the best way (for example, where, when, how) to tell the partner and the different ways a client can make sure the partner gets treatment
- ▶ Counsellors should discuss how the partner may react to the news and what the client could do to decrease the chance of rejection, conflict and abuse

Principles of Partner Notification

- ▶ Partner/s to be treated for same infection/s as client
- ▶ Provider should be reasonably sure of presence of STI, especially in vaginal discharge cases
- ▶ Special care of PID cases due to serious complications
- ▶ Provide “partner reporting card” or “coupon for free examination” as an incentive
- ▶ Call for follow up – for compliance/cure and to see test reports, if advised

Counselling for Partner Notification and Treatment

- ▶ **Refer to checklists on:**
 - Re-infection
 - Partner Notification

- ▶ **Role play**

CHECKLIST 11 - COUNSELLING FOR RE-INFECTION

- Go over the problem she/he is having today - check on reason for last visit
- Introduce possibility that this is the same infection your client had at last visit
- Remind client of previous visit and treatment
- Assess possibility your client did not take all the medicine if there was medicine to be taken outside of the clinic visit
- If she/he didn't take the medicine completely assess reasons
- If all medicines were taken correctly, assess possibility of re-infection
- Help client review and update risk reduction plan
- Offer condoms, lube and make sure client can use these correctly
- Motivate client for partner notification and treatment; help plan for partner treatment
- Document the discussion and plan

CHECKLIST 12 - COUNSELLING FOR PARTNER NOTIFICATION

- Check on regular partner relationships - refer to sexual history
- Assess condom usage in regular partner relationship/s
- Explain importance of having regular partners treated for the STI also
- Assess the barriers to informing and encouraging a partner that she/he needs STI treatment
- Assess for potential violence
- Discuss options for partner treatment, select option
- Rehearse telling the partner or make plan for other options
- Review risk reduction plan and updates
- Reinforce any positive steps already taken

DAY FIVE



DAY FIVE

Session 1 Counselling about Condom Use



What is a condom?

- A condom is a rubber sheath that is used on the erect penis, before any sexual contact is made
- After ejaculation, semen is collected in the tip of the condom
- A condom acts as a barrier preventing the contact between infective secretions (semen or genital fluids, vaginal fluids) and the mucus membrane of the vagina, anus, glans, penis or urethra
- Thus, condoms prevent transmission of STI and HIV infection. They also act as contraceptives by the same mechanism for preventing pregnancy

Uses of condom

- To prevent unwanted pregnancy
- To protect oneself and one's partner against STI
- To prevent the transmission of HIV
- To enhance the pleasure associated with sex

Why people do not use condoms?

- Condoms are sometimes not easily available or accessible
- A person who buys and asks for condoms is looked upon with suspicion and stigma that she/he could be indulging in high-risk behaviour
- There is lack of knowledge on the correct use of condoms and the existence of myths and misconceptions related to condoms

Myths about condoms

- ❑ Using condoms during sex is irritating
- ❑ Condom will tear during intercourse
- ❑ Condom is sticky and oily
- ❑ Condom reduces sexual pleasure
- ❑ Women do not like it
- ❑ Loss of erection
- ❑ Not 'manly'
- ❑ Condoms are reusable

Counsellor's role in condom promotion

- ❑ Make sure condoms are available in the clinic and are accessible to people who need them
- ❑ Explain the need for use of condoms as a part of treatment of STI
- ❑ Keep a penis model in the clinic and ask the client to demonstrate how to use the condom correctly. You will find that most people are ignorant about the correct use
- ❑ Keep the condoms in a visible transparent box

Contd.

- Explain need for correct and consistent use of condoms for prevention of STI and HIV and unwanted pregnancy
- Distribute free condoms, 20 pieces or 2 valets to each patient
- Ensure those who are involved in sex work have an adequate stock of free condoms to protect themselves
- Display and distribute information on STI and HIV/AIDS and on condom use
- Ensure that your clinic has a minimal 3 months supply of condoms (calculate based on the number of patients visiting the clinic)

Frequently Asked Questions

- **What can damage condoms?**
Oil-based lubricants, Vaseline
- **What are the different brands of condoms available in India?**
Nirodh (free), Deluxe Nirodh, Kamasutra, Fiesta, Kohinoor, and many others
- **How much do they cost?**
Rs.2-Rs.15 normally. Imported condoms: usually cost more than Rs.10

Contd.

- **Are condoms marketed socially?**
Yes, there are social marketing organizations (SMO) that market condoms, they sell condoms at a price lower than market rate
- **Are free condoms of poor quality?**
No every batch of condoms are tested the same way whether supplied freely or marketed
- **Can an HIV infected person have sex using a condom?**
Yes
- **Are there condoms for women?**
Yes! Called Femidom, it is costly and is marketed in India

Group Work

- **Group 1:** Myths and misconceptions surrounding condom usage
- **Group 2:** Barriers to usage

Strategies for addressing the same through the counselling process

Condom Demonstration

- Practice
- Refer to handout on condom demonstration

Condom Re-Demonstration

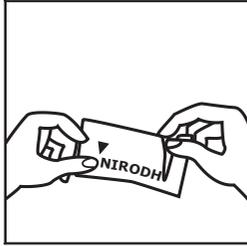
- No matter how well done, explaining and demonstrating are not sufficient to ensure correct condom use
- This is because using a condom is a skill, and a skill can be mastered only through practice
- Therefore, it is not enough to tell someone how to use a condom
- It is not enough to demonstrate how to use a condom
- It is necessary that the person practices doing what you have done. This process is called return or re-demonstration



Condom Use & Disposal

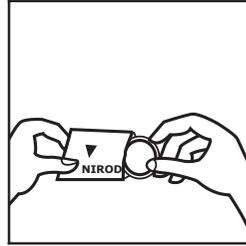
CONDOM DEMONSTRATION - MALE

1



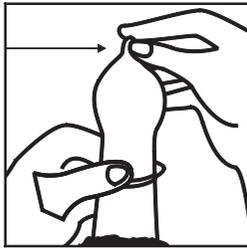
Check the expiry date of condom. Never use condom AFTER EXPIRY DATE.

2



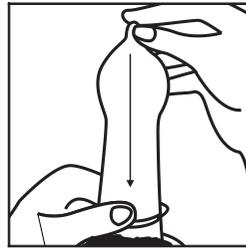
Open the condom packet by tearing it from one side. Roll out the condom by pressing on one side of the packet.

3



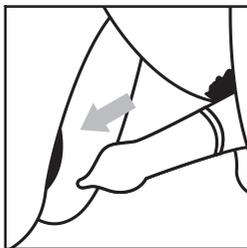
Press teat of the condom BEFORE putting it on tip of the fully erect Penis. Fix the condom on the tip with hand.

4



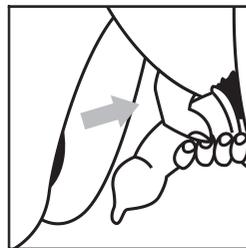
Start unrolling the condom on penis. Unroll it right up to the base of penis.

5



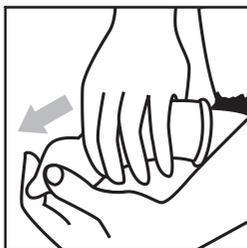
..... for SAFER SEX

6



After intercourse, withdraw the penis from the vagina, while the penis is semi-erect.

7



Hold onto the rim of the condom while withdrawing to prevent it from slipping off and the semen spilling into the vagina.

8



Tie knot at base of condom without spilling semen before disposing

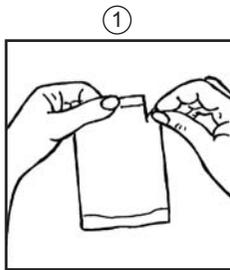
Adapted from: Pathfinder International Mukta Project



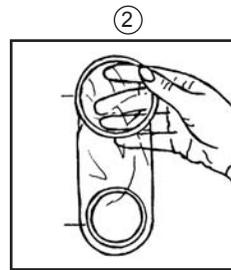
More information on Using Male Condoms

Steps for Using Male Condoms	More Information
Check the package and the expiry date	If the package is torn or damaged, or the expiry date passed, don't use the condom
Open it carefully and take out the condom	No teeth, scissors or other sharp instruments to be used. One can do it using the fingers
Put the condom on before there is any contact between the penis and partner's genital/mouth/anus	Condoms can only be put onto an erect penis
Hold the condom by the tip. The roll of the condom should be on the outside	If it doesn't unroll smoothly, it may be wrong side out so check
Pinch the tip, place the condom on the tip of the penis and roll it down the length of the erect penis	Air inside the condom can cause friction that will break the condom
Add water-based lubricant to the outside of the condom if more is wanted	Can also put a small amount (pea size) of lubricant inside the tip of the condom before putting it on to increase sensation. Too much will cause the condom to slip off
Pull the penis out after ejaculation, before the penis becomes soft	The condom is more likely to slip off and spill if the penis is soft. Hold onto the condom at the base of the penis while pulling out
Remove the condom without spilling any liquid from inside. Use a tissue to avoid touching inside or outside of a condom that has had contact with body fluids. Wrap used condom in a tissue/paper and dispose it off in dustbin/garbage	Don't flush in toilets as condoms can choke plumbing pipes

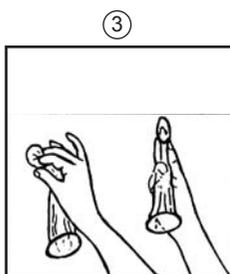
CONDOM DEMONSTRATION - FEMALE



① Open the female condom package carefully; tear at the notch on the top right of the package. Do not use scissors or a knife to open.



② The outer ring of the female condom covers the area around the opening of the vagina. The inner ring is used for insertion and to help hold the sheath in place during intercourse.



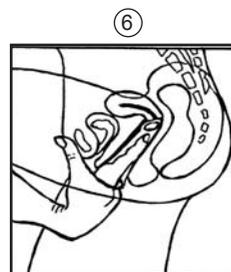
③ While holding the sheath at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow.



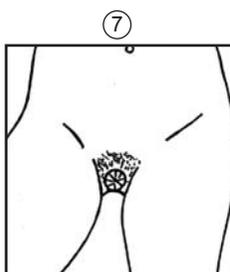
④ Choose a position that is comfortable for insertion; squat, raise one leg, sit or lie down.



⑤ Gently insert the inner ring of the Female Condom into the vagina. Feel the inner ring go up and move into place.



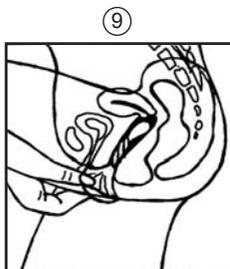
⑥ Place the index finger on the inside of the condom, and push the inner ring up as far as it will go. Be sure that sheath is not twisted. The outer ring should remain on the outside of the vagina.



⑦ The female condom is now in place and ready for use with your partner.



⑧ When you are ready, gently guide your partner's penis into the sheath's opening with your hand to make sure that it enters properly; be sure that the penis is not entering on the side, between the sheath and the vaginal wall.



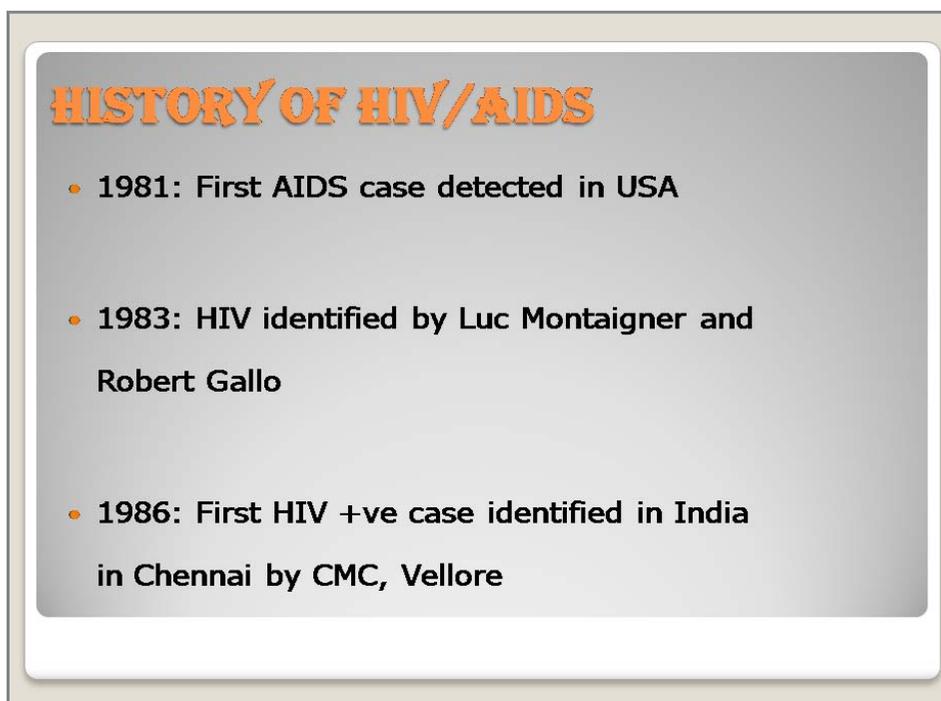
⑨ To remove the female condom, twist the outer ring and gently pull the condom out.



⑩ Wrap the condom in the package or in tissue, and throw it in the garbage. Do not put it into the toilet.

Adapted from www.condomdepot.com

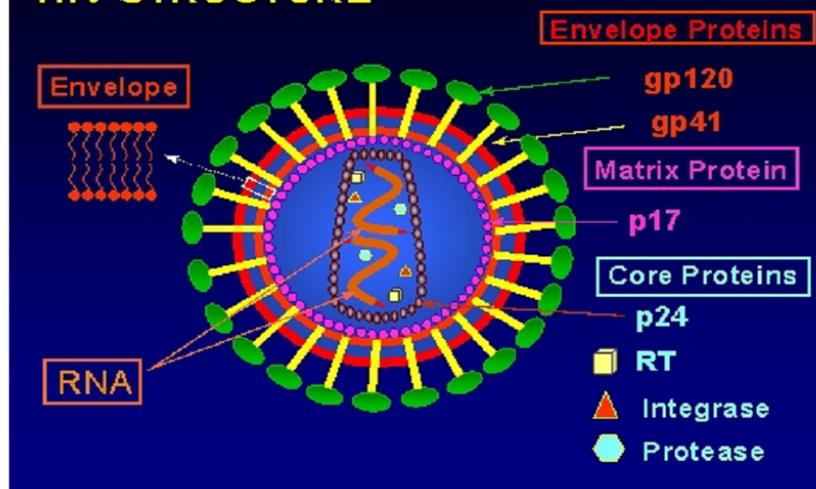
Session 2 HIV/AIDS - Basic Information



WHAT IS HIV

- H: Human (It is only found in humans)
- I: Immunodeficiency (Destroys the immune or defence system)
- V: Virus (A type of germ)

HIV STRUCTURE



HIV Transmission

ROUTES OF SPREAD OF HIV

- Unprotected sexual contact-vaginal/anal/oral
- Transfusion of untested blood or products
- Skin piercing instruments - unsterilized sharps
- needle, syringe, blades, dental/surgical instruments
- HIV infected parent to child

HIV DOES NOT SPREAD BY ANY OTHER ROUTE

WHICH FLUIDS CAN TRANSMIT HIV?

- Infected blood
- Infected semen
- Infected vaginal secretions
- Infected breast milk

Saliva, sweat , urine, faeces and vomitus does not spread HIV, unless mixed with blood

HOW DO WE KNOW IF ONE IS HIV +VE

- HIV test is done on a single sample of blood
- Before declaring a person HIV +ve, the sample is tested 3 times using Rapid tests
- HIV test is +ve after the window period

During this time:

- Client should be counselled before and after the test
- The test results should be maintained confidential

Testing is available at ICTCs (Integrated Counselling and Testing Centres)

CAN A PERSON HAVE AN HIV INFECTION, EVEN THOUGH THE TEST IS NEGATIVE?

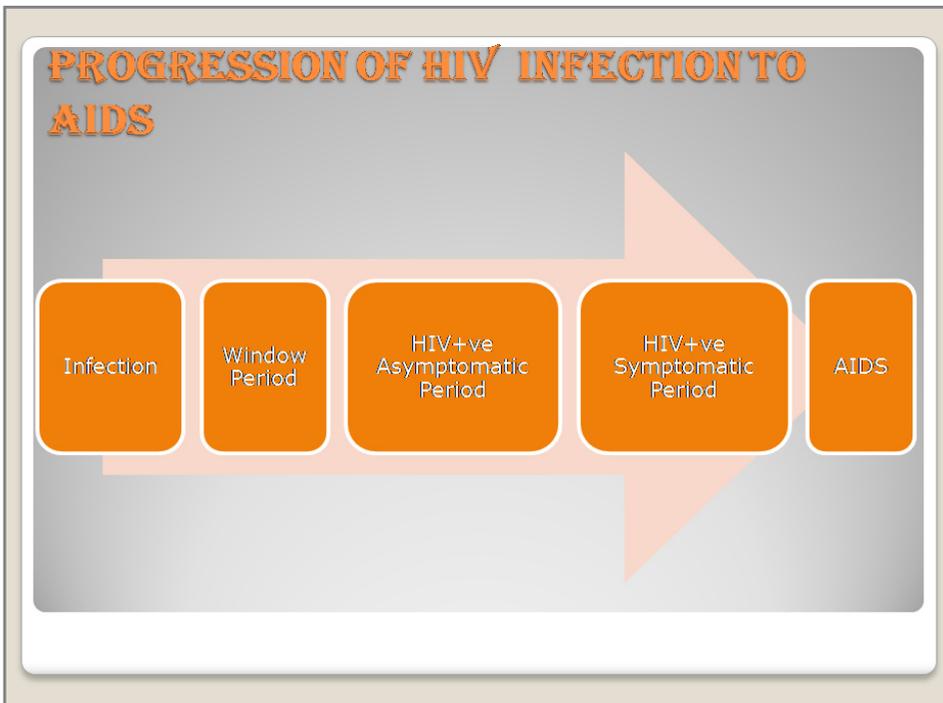
- YES! HIV test detects anti-bodies
- If a person does the test early after getting infected, she/he will not have enough of antibodies to be detected. This is called window period
- During window period the person maybe HIV infected

CONTD.

- Viral load is very high during the window period and hence the person could be very infectious
- In order to be sure of one's HIV status, the HIV test should be repeated after 4-6 weeks
- Alternately, other tests such as PCR or p24 antigen could be done. These tests are costly and are not available at the ICTC



AIDS



AIDS

- A: ACQUIRED ('Got-not caught')
- I: IMMUNO (Immune or defence system)
- D: DEFICIENCY (Depletion/decrease)
- S: SYNDROME (Group of signs/symptoms)

SIGNS AND SYMPTOMS OF AIDS

- Significant weight loss (>10% in 1 month)
- Chronic Diarrhoea lasting for more than 1 month
- Prolonged fever lasting for more than 1 month
- Unusual or severe forms of Tuberculosis (TB)
- Fungal infections (white patches) in the mouth and throat
- Life threatening or recurrent pneumonia
- Infections of the brain
- Sudden decrease of vision in young persons
- Recurrent or severe skin infections

GROUPWORK

- **Group 1:** What is HIV? What is the distinction between HIV and AIDS? How different is HIV from other infections? How can HIV be prevented?
- **Group 2:** What are the tests used to identify HIV? If infected blood is donated during the window period, what would the result be?
- **Group 3:** Should all HIV infected persons be put on ART? What is positive prevention? What can HIV positive people do to have a healthy lifestyle?

Prevention of HIV

HOW CAN WE PREVENT HIV?

- Prevent sexual transmission
- Prevent blood borne transmission
- Prevent transmission from used needles and syringes
- Prevent infected parents to child transmission

No effective vaccine against HIV has yet been identified.

PREVENTION OF SEXUAL TRANSMISSION

- Correct and consistent use of condoms
- Complete treatment of STI
- Adopt safer sex methods

PREVENTION OF BLOOD BORNE TRANSMISSION OF HIV

- Avoid unnecessary blood transfusions, injections and IV fluids
- Insist on the blood or blood products being tested for HIV before accepting for transfusion
- Use new or sterile blades, razors, scissors, dental or surgical instruments
- Use new or sterile needles and syringes for each injection
- Never reuse disposables. Eg-IV fluid sets

PREVENTION OF PARENT TO CHILD TRANSMISSION OF HIV

- The chances of the baby getting HIV from mother is only 30-35%
- This can be reduced by giving anti-HIV medicines to the mother and the baby, at the time of delivery
- Caesarean section reduces the chances of HIV transmission to the baby
- These services are available PPTCT (Prevention of Parent To Child Transmission) centres in medical colleges and district hospitals

TREATMENT OF AIDS

- There is treatment available for AIDS, however, there is no cure
- Treatment can prolong life and improve the quality of life
- Treatment has side effects and complications
- Treatment, once begun, has to continue lifelong

WHEN SHOULD A PERSON WITH HIV BE REFERRED FOR TREATMENT?

- Any person testing HIV positive - referred for registration at ART centre
- At centre - Screening for various symptoms based on which the person is clinically staged as Stage I, II, III, or IV. CD4 test also done
- Clinical Stage III+CD4 count<200, or Clinical Stage IV+ CD4 count<350 = requires ART

ANTI-RETROVIRAL THERAPY

- Combination of at least three anti-retroviral drugs
- To be taken life-long once it is started and at the same time every day
- ART adherence rates must be more than 95% for the medicines to be effective
- ART medications do have side effects and complications. Patients must be observed and monitored for these side effects and complications

CAN HIV INFECTION OR AIDS BE CURED?

- No! There is no cure for HIV and AIDS
- ART helps to increase the duration and quality of life. Complementary treatment includes yoga, meditation, diet and exercise
- Taking care of an HIV person does not put one at greater risk of HIV infection
- People living with HIV need care and compassion to deal with their illness

WHAT ARE OPPORTUNISTIC INFECTIONS?

- Occur commonly among people living with HIV and AIDS - commonest OI is TB
- To prevent some common OI that can be life-threatening, PLHIV are sometime prescribed cotrimoxazole
 - Single daily dose - prevents at least three common life-threatening OI
- OI prevention - continued until person is put on ART and the CD4 comes back to acceptable levels

QUIZ – TRUE OR FALSE

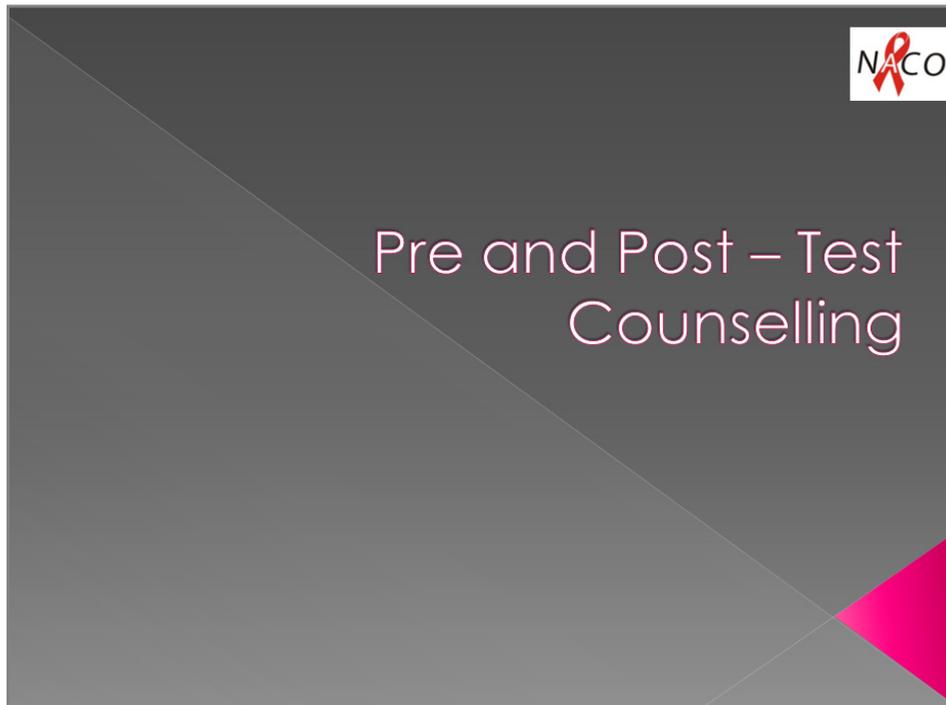
1. HIV can be transmitted by shaking hands
2. There is a cure for AIDS
3. Sexual intercourse with a virgin will cure AIDS
4. HIV cannot be transmitted through oral sex
5. HIV is transmitted by mosquitoes

QUIZ – CONTD.

6. Showering after intercourse will prevent AIDS
7. An HIV infected mother cannot have children
8. Sexual intercourse with an animal will cure AIDS
9. HIV can only infect men who have sex with men
10. HIV survives for only a short time outside the body



Session 3 Pre and Post - Test Counselling



Why should an STI counsellor know about HIV Counselling?

- ❑ HIV and STI have similar issues relating to stigma and discrimination from healthcare providers, family members and the community
- ❑ Unlike other STI, a person with HIV is often at risk of losing his or her job due to employment discrimination and may not be allowed to live a healthy and productive life due to her/his status
- ❑ Hence voluntary counselling and testing, ongoing counselling and psychosocial support are recommended

Counsellors must be equipped with information to make the necessary referrals and guide and assist the clients as required

What does an ICTC Offer?

- ◉ Preventive counselling
- ◉ Pre- Test counselling
- ◉ Post- Test counselling
- ◉ Follow-up counselling

Preventive Counselling

- ◉ Explain about risk associated with high risk behavior – unsafe sex practices or untested blood products received
- ◉ Explore HIV/AIDS knowledge – explain HIV/AIDS, clarify misconception
- ◉ Preventive education – on safe sex, proper use of condoms, clean needle and syringe use

Pre-Test Counselling

- ◉ Explain about risk associated with high risk behavior – unsafe sex practices or untested blood products received
- ◉ Explore HIV/AIDS knowledge – explain HIV/AIDS, clarify misconception
- ◉ Explore reasons for testing

Contd.

- ◉ Explain the test and meaning of results (negative as well as positive), meaning of window period, need to repeat test after 3- 6 months
- ◉ Explore test implication in relation to client's life situation (marriage, pregnancy, etc.)

Post Test Counselling - Test Negative

- ◉ Explain risks associated with high risk behavior - Unsafe sex practices or untested blood products received
- ◉ Explain negative result
- ◉ Evaluate need for re-test (She/he may be in window period – give next appointment)

Contd.

- ◉ Clarify doubts/ misconceptions
- ◉ Repeat preventive education - safer sex, proper use of condoms, clean needle use
- ◉ Check back to confirm understanding

Post Test Counselling - Test Positive

- ◉ Renew relationship
- ◉ Follow patients lead when to disclose
- ◉ State result clearly
- ◉ Wait

Contd.

- ◉ Explore understanding, clarify misconceptions
- ◉ Assess emotional impact, give adequate time/follow-up
- ◉ Assess commitment and understanding of risk
- ◉ Re-explore who to inform and how

Contd.

- ◉ Plan medical health
- ◉ Arouse hope
- ◉ Plan for future course of action – resources available
- ◉ Provide reading material

Provider Initiated Testing

- ◉ In order to improve HIV related diagnosis, treatment and care and to expand the availability and uptake of HIV testing and counselling in clinical settings

Key Point for Provider Initiated Testing

- ❑ Establish trust with the patient
- ❑ Ensure privacy and confidentiality
- ❑ Provide key information on HIV
- ❑ Provide information on HIV testing
- ❑ Explain procedures to safeguard confidentiality
- ❑ Confirm willingness to be referred to ICTC

Contd.

- ⦿ If patient requires additional information, discuss advantages and importance of knowing the HIV status
- ⦿ If the patient is unsure about or uncomfortable with having an HIV test or declines the test, treat existing condition and ask for a follow-up

DAY SEVEN



DAY SEVEN



Session 1
Counselling FSW

NACO

Counselling FSW

Word Association Exercise

Female Sex Worker

Female Sex Worker

- An individual who sells sex for money or favour
- May or may not identify herself as sex worker
- Different relations with different partners - and these different relationships have different values or meanings to them

Contd.

- These differences in relationships affect their willingness and ability to make changes in how they have sex with these partners:
 - Some may have taken up sex work for financial or material benefit
 - Others may be for financial reasons, but with a degree of personal intimacy on account of more extended relationships such as with a boyfriend and regular client

Contd.

- Some may place more importance on the intimacy involved such as with lovers, boyfriends and others
- A woman may be supporting her partner through her work
- A woman may have a husband and family who may or may not know of her work
- Women may be forced to have sex. Sex due to coercion may be on account of the threat of negative consequences

Typologies of sex workers

- **Street based** – Solicit clients on the street or public places
- **Brothel based** – Clients contact them in recognized brothels
- **Lodge based** – Live in lodges while lodge manager/pimps contact clients

Contd.

- **Dhaba based** – Accessed by clients at dhabas
- **Home based or Secret** – Operate from homes, contacting clients on phone or word-of-mouth
- **Highway based** – Solicit clients on highways

Typologies are often overlapping and fluid.

Group Work

- Brainstorm on:
 - Counselling issues for FSW
 - Strategies for counselling or important points to remember
- Group Presentation

Counselling issues

- Safer sex practices
- Condom use
- Condom negotiation with clients
- Regular check up/visits
- Complete treatment

Essential Services Package

- Treatment for symptomatic STI
- Treatment for asymptomatic STI
- Syphilis testing every 6 months
- Regular medical check up (internal examination) once every 3 months

Issues and Points to Consider while Counselling

Female Sex Workers may not identify themselves as sex workers

- Best not to label anyone unless the client herself uses the label
- It is not the label that is the source of vulnerability. It is the behaviour
- Some FSW clients may find it difficult to consider that their boyfriend/partner may also have other partners. In such cases, talking about the time “before you got together” may provide an opening for discussing risk

Contd.

FSWs are more likely to consider using condoms with a one-time client, less with a regular client and even less with a regular partner

- Important to help FSW find ways to present condoms/safer sex options to regular clients and partners as a way of showing love or caring for each other

Difficulty in negotiating safer sex especially in time of need and if client pays more for unprotected sex

- Some FSW clients will need to be counselled on assertiveness and negotiation skills, especially if they have clients who pay more for unprotected sex

Contd.

Risk of violence from police/goons/clients and regular partners

- Provide skills in sensing impending violent clients and avoiding them
- Assist FSWs to explore ways to refuse unsafe clients

Refusal of speculum examination

- Explain the importance and relevance of internal exams
- Show the client a speculum and allow her to handle it

Contd.

Some FSWs use drugs or alcohol to 'feel good' and to decrease negative feelings. Female drug users may often be partners of male IDU and may be selling sex to support the drug habits of both

- When counselling FSWs on safer sex, explore their use of drugs and how this might put them at risk
- Discuss ways to reduce risk with them e.g. practicing safer sex

Difficulty in partner notification

- Focus on partner notification with regular partners

Contd.

Poor compliance to STI treatment and schedule visits (Regular Medical Checkup; periodic Syphilis screening)

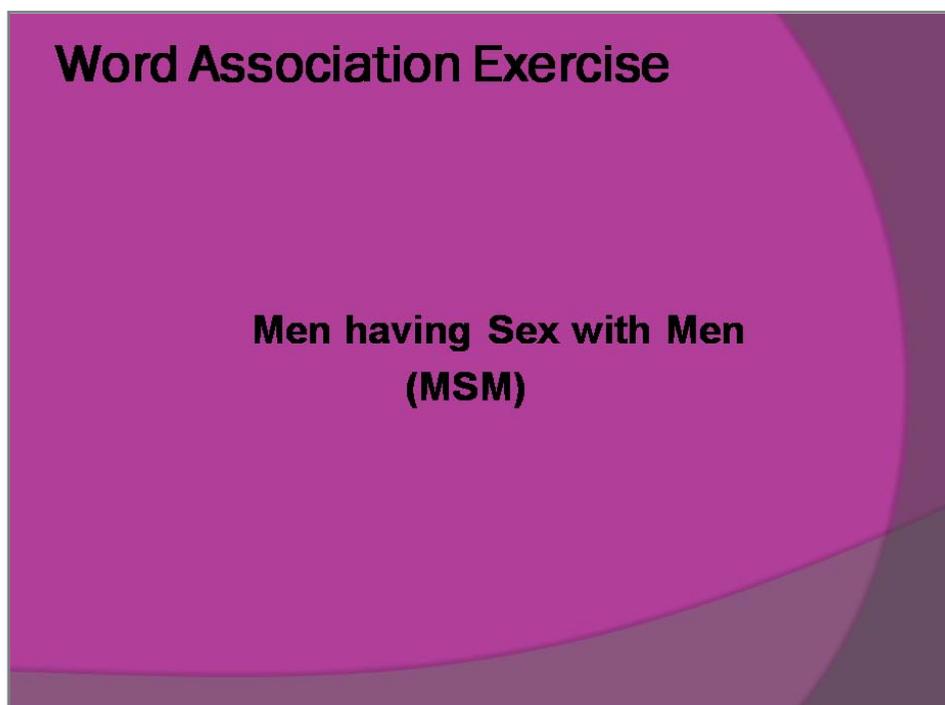
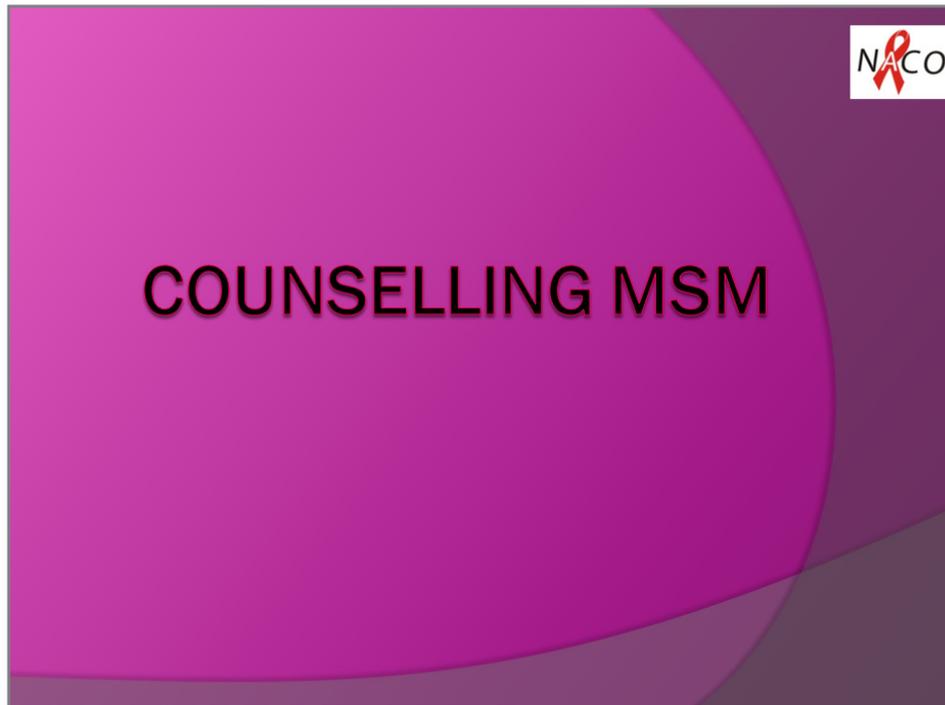
- Develop a plan and schedule for STI treatment
- Counsellor should know the follow up schedule for each STI syndrome

Recurrent STI

- Explore the client's reason for getting recurrent STI
- Explore barriers to prevention. Work on barriers one at a time through risk reduction planning. Link the complications of STI



Session 2 Counselling MSM



Men having Sex with Men

- ⦿ A term meant to describe a specific behaviour and not as an identity for any specific population group
- ⦿ Many men who think about themselves as heterosexuals may have sex with other men for a variety of reasons
- ⦿ A man may not even consider MSM behaviour a sexual act

Contd.

- ⦿ Often what influences male sexual identity is the role he takes within sexual relationships
 - Penetrating men are often likely to consider themselves heterosexual
 - The passive penetrated partner is likely to be more 'feminine'
 - Some men will alternate roles
- ⦿ Sexuality and sexual identity may influence vulnerability and risk. Receptive partners, especially during anal sex, are at higher risk of infection

Typologies of MSM

- **Hijras** – third gender: emasculated men (castrated, nirvana), non-emasculated men (not castrated, akva/akka), inter-sexed persons (hermaphrodites)
- **Kothis** – men who take female role on the sexual relationship with other men
- **Double Deckers** – men who both insert and receive during penetrative sexual encounters
- **Panthis** – masculine insertive male partner

Group Work

- Brainstorm on:
 - Counselling issues for MSM
 - Strategies for counselling or important points to remember
- Group Presentation

Issues and Points to Consider while Counselling

Many men who have sex with other men do not think of themselves as homosexual

- Never make assumptions about MSM
- Counsellors need to keep in mind that many of these males will also have sexual relationships with women, regardless of their sexual identity or preference
- Many MSM will marry in order to keep their secret
- Using the label 'homosexual' or asking about 'homosexual' activities may not get you the information you need for good counselling

Contd.

Secrecy may lead to hurried and unprotected sexual encounters increasing the risk of HIV transmission

- Explore barriers; help your client identify practical solutions
- Make sure your client is confident about the ability to negotiate and use safer sex techniques
- Make sure your client has adequate skills for using condoms in the settings where they are likely to have sex

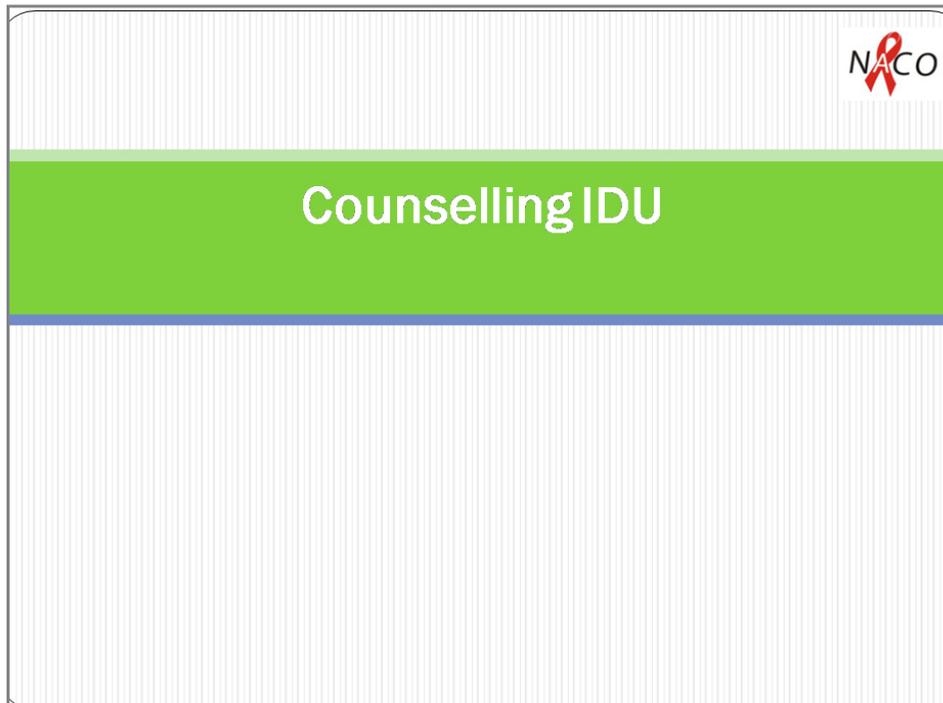
Contd.

Guilt feelings about homosexual behaviour. Fear of rejection after being discovered by family friends and community

- Assure confidentiality. Practice non-judgmental attitude and show acceptance



Session 3 Counselling IDU



Word Association Exercise

Injecting Drug User

Injecting Drug Users

- Defined as those who used any drugs through injecting routes in the last three months (for TI purpose)
- Users often share drug injecting equipments
- User may also be prone to STI and HIV as she/he engages in unsafe sex (after being high on drugs)
- Clients may sell sex to pay for their own and for their partner's drug habit

Group Work

- Brainstorm on:
 - Counselling issues for IDU
 - Strategies for counselling or important points to remember
- Group Presentation

Issues and Points to Consider while Counselling

Drug use may lead to unsafe sex because people are high on drugs and find it more difficult to think about safer sex and use of condoms

- When counselling, explore the client's use of drugs and how this may put her/him at risk
- Make sure the client knows the basics of risks associated
- Discuss how to use a condom and also keeping a condom at all times

Contd.

IDUs are at high risk of HIV because of sharing needles/syringes and also have a very high risk of Hepatitis B and C

- Talk to clients about preventing infection through injections
- Help the client understand the need for use of clean needle/syringe every time she/he takes drugs

Contd.

Male and female IDUs may have multiple sex partners. Females sometimes sell sex to support their own and their partner's drug habits. Males may have regular and commercial sex partners.

- Counsel on safer sex
- If a drug habit is a reason for selling sex and unsafe sex, discuss referral to drug rehabilitation services



Session 4
Counselling Mobile Population

Counselling Mobile Population

Word Association Exercise

**Mobile Populations
(truckers, construction labourers)**

Mobile Populations

- Mobile populations are often exposed to unique pressures and situations
- Many are removed from their normal socio-cultural safety nets and families (or community members) for extended periods of time
- For men who are mobile for economic reasons, e.g. truck drivers, having unprotected sex with sex workers is a common high risk behaviour

Contd.

- The socio-economic vulnerability of female mobile populations may force them into transactional sex (sex for money or favour)
- This increases their vulnerability to sexual violence thereby placing them at increased risk of HIV and STI infection

Group work

- Brainstorm on:
 - **Counselling issues for Mobile Population**
 - **Strategies for counselling or important points to remember**
- Group Presentation

Issues and Points to Consider while Counselling

Mobile population clients are removed from their families for extended periods of time leading to unsafe sexual behaviours

- Counsellors must never assume that a mobile client only has sex with the opposite sex
- Counsellors need to give their mobile clients an opportunity to talk about their sexual activities
- If required, counsellors must ask whether their client's sexual partners are male, female, transgender (or some or all of the above)

Contd.

Mobile populations may not be able to access preventive information and services due to socio-economic, cultural and language barriers

- Counsellors must identify common misconceptions relating to STI, HIV and prevention and clarify the same

Mobile clients are difficult to follow up with

- Provide appropriate health education in available contact time

Contd.

Fear (e.g., of police harassment) and secrecy may lead to hurried and unprotected sexual encounters increasing the risk of HIV transmission

- Counsellors must accept their clients' fears and limitations and must exhibit a non-judgemental attitude
- Counsellors must explore clients' barriers to safer sex behaviour
- Counsellors must explore options for safer sex practices and practical solutions to HIV and STI risk reduction

DAY NINE

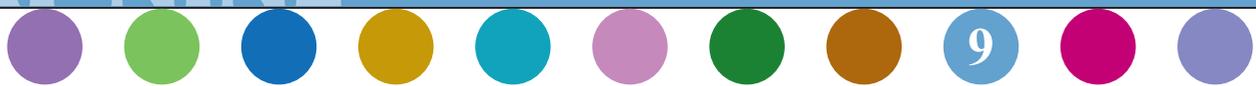


DAY NINE



Session 1
Counselling for Adolescents

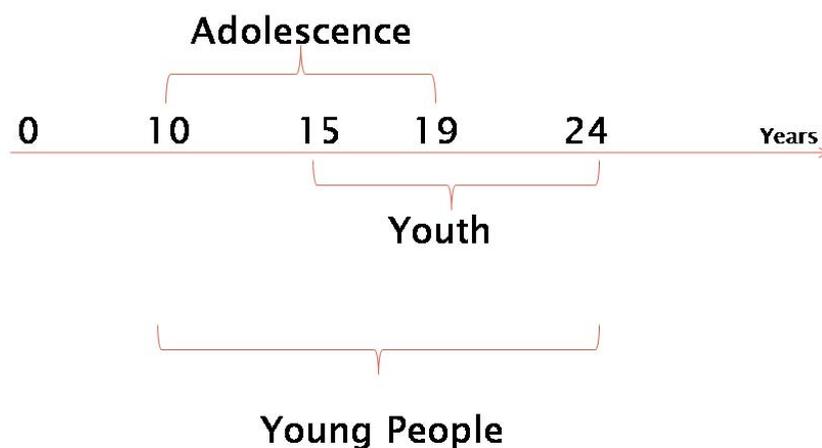




Understanding Adolescence

- ▶ "Adolescence" covers ages 10–19 years in the RCH-II programme
- ▶ Government of India (GoI) in the National Youth Policy defines adolescence as 13–19 years
- ▶ GoI defines youth as 15–35 years
- ▶ "Young people" covers ages 10–24 years
- ▶ "Young adults" covers ages 20–24 years

Definition as per WHO



Facts about Adolescents in India

- ▶ Adolescents comprise about 22% of India's population
- ▶ Girls make up 47% of adolescent population
- ▶ Anemia and Stunting are widely prevalent, especially in girls
- ▶ 44.5% girls are married by 18 years (NFHS 3)
- ▶ Adolescents (15–19 years) contribute 19% of TFR (NFHS 3)
- ▶ High maternal mortality among adolescent mothers
- ▶ Unmet need for contraception (15–19 years) 27% (NFHS 3)
- ▶ Contraceptive use is 8% and contraceptive use of modern methods is 5%

Contd.

- ▶ Premarital sexual relations are increasing
- ▶ Trafficking and prostitution has increased
- ▶ RTI are common in young women
- ▶ Misconceptions about HIV/AIDS are wide spread
- ▶ 40% start taking drugs and are prey to substance abuse between 15–20 years (UNODC, 2002)
- ▶ Nearly one out of three in 15–19 years is working



Development in Adolescents



Brainstorming

► Changes in adolescents:

- Physical
- Sexual
- Emotional

Physical Development – BOYS

- ▶ Growth spurt occurs
- ▶ Muscles develop
- ▶ Skin becomes oily
- ▶ Shoulders broaden
- ▶ Voice cracks
- ▶ Underarm and chest hair appears
- ▶ Pubic hair appears
- ▶ Facial hair appears
- ▶ Penis and testes enlarge

Physical Development – GIRLS

- ▶ Growth spurt occurs
- ▶ Breasts develop
- ▶ Skin becomes oily
- ▶ Hips widen
- ▶ Underarm hair appears
- ▶ Pubic hair appears
- ▶ External genitals enlarge
- ▶ Uterus and ovaries enlarge



Sexual Development

- ▶ Sexual organs enlarge and mature
- ▶ Erections in boys
- ▶ Sexual desire
- ▶ Sexual attraction
- ▶ Menarche, Ovulation
- ▶ Sperm Production, Ejaculation
- ▶ Initiation of sexual behaviours

Emotional and Social Development

- ▶ Preoccupied with body image
- ▶ Want to establish own identity
- ▶ Fantasy/daydreaming
- ▶ Rapid mood changes, Emotional instability
- ▶ Attention seeking behaviour
- ▶ Sexual attraction
- ▶ Curious, Inquisitive

Contd.

- ▶ Full of energy, restless
- ▶ Self exploration and evaluation
- ▶ Conflicts with family over control
- ▶ Peer group defines behavioural code
- ▶ Formation of new relationships

Co-relation to Health
and Development





Group Work – 3 groups

- ▶ Health implications to changes/development
- ▶ Presentation

Health Implications

Changes in Adolescence - Physical

- Normal growing-up
- Increase in height and weight
- Breasts development
- Skin becomes oily
- Desire to be thin, have a good figure

Health Implications

- Undue anxiety and tension
- Increased nutrition requirement – if inadequate, under nourished and anemic
- Stooping of shoulders, poor posture, back pain
- Acne
- Protein-energy malnutrition, anemia

Contd.

Changes in Adolescence – Sexual

- Desire to have sex
- Ejaculation
- Menstruation

Health Implications

- Unsafe sex leading to unwanted pregnancy, STI, HIV; Need of health education and services
- Fear, guilt, myths – emotional problems
- Dysmenorrhoea (pain during menstruation), Menorrhagia (excessive bleeding) – Anemia, Poor menstrual hygiene may lead to RTI

Contd.

Changes in Adolescence - Emotional and Social

- Development of Identity
- Very curious
- Peer pressure

Health Implications

- Confusion, moodiness, irritation
- Experimentation, risk taking behaviour
- Effect on life styles
- Unhealthy eating habits leading to obesity
- Smoking and alcohol use leading to ill health
- Speed driving, accidents

Contd.

Consequences of unsafe sexual behaviour in Adolescents:

- ▶ Early Pregnancy and Parenthood (within and outside marriage); Higher MMR
- ▶ Unsafe abortions and its related complications
- ▶ Higher percentage of low birth weight (LBW) babies and increased infant morbidity and mortality
- ▶ STI including HIV/AIDS

Contd.

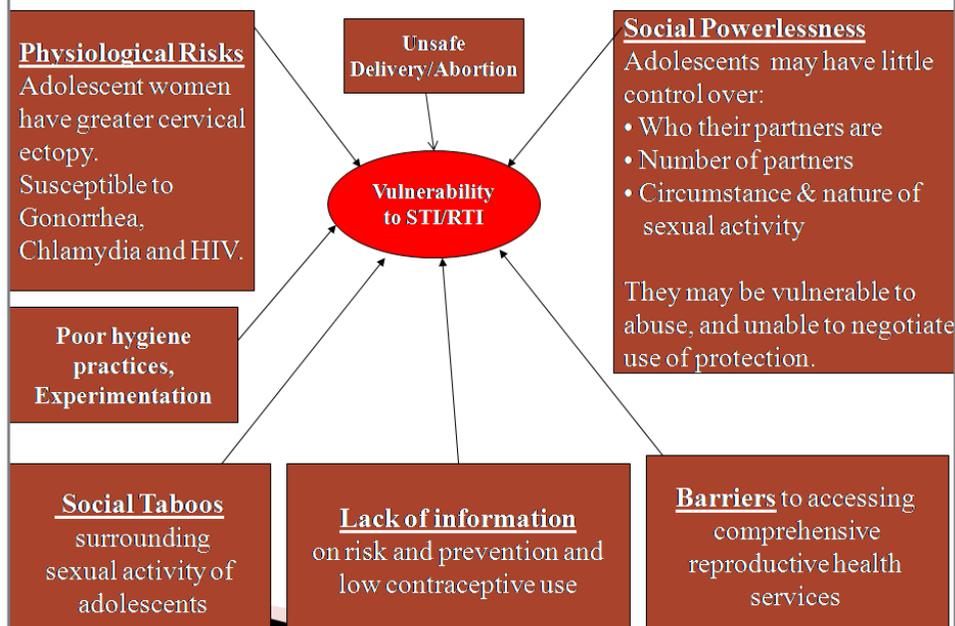
Consequences heightened in adolescents even if it has been 'safer sex'

- ▶ Economic impact – Hindrance to academic and career progression because of pregnancy
- ▶ Emotional impact – Guilt, stress, anxiety, suicide
- ▶ Social impact – Stigma (especially if unmarried)

Adolescents and STI/RTI

- ▶ STI one of the most common infections among sexually active adolescents
- ▶ STI/RTI an important health problem – rise to considerable morbidity
- ▶ STI/RTI, including HIV, most common among young people aged 15–24 and more so in young women of that age group
- ▶ Adolescents face enhanced vulnerability to HIV/AIDS

ADOLESCENTS VULNERABLE TO STI/RTI



Benefits of Investing in Adolescent Health

- ▶ **Health benefits** for the individual adolescent: In terms of her/his current and future health, and in terms of the intergenerational effects
- ▶ **Economic benefits:** Improved productivity, return on investments, avert future health cost
- ▶ **As a human right:** Adolescents (like other age groups) have a right to achieve the highest attainable level of health

Contd.

Adolescent sexuality impacts, among others, the following health indicators

- ▶ Increased Total Fertility Rate (TFR)
- ▶ Low Contraceptive Prevalence Rate (CPR)
- ▶ Increased Maternal Mortality Rate (MMR)
- ▶ Increased Infant Mortality Ratio (IMR)
- ▶ Increased under-5 Mortality rate
- ▶ High abortion rate
- ▶ High STI incidence/prevalence rate
- ▶ High HIV incidence/prevalence rate

Barriers from client and service provider perspective



Group Work – 3 groups

- ▶ **Group 1:** What are the barriers related to clients (adolescents)?
- ▶ **Group 2:** What are barriers related to health provider and policy?
- ▶ **Group 3:** What are the barriers related to health facility?

Group Presentation

Barriers related to clients (Adolescents)

- ▶ Discomfort with real or perceived clinic conditions
- ▶ Discomfort with real or perceived attitudes of providers
- ▶ Concern that the staff will be hostile or judgmental
- ▶ Belief that the services are not intended for them
- ▶ Concern over lack of privacy and confidentiality
- ▶ Embarrassment at needing or wanting RH services

Contd.

- ▶ Shame, especially if the visit follows coercion or abuse
- ▶ Fear of being examined by provider of opposite sex
- ▶ Fear of medical procedures
- ▶ Ignorance or lack of information about health risk and services available:
 - ▶ Poor understanding of their changing bodies and needs
 - ▶ Insufficient awareness of pregnancy and STI or HIV risks
 - ▶ Lack of information of what services are available and location of services

Barriers related to health providers and policy

Provider Factors:

- ▶ Untrained providers and staff for adolescent health issues
- ▶ Providers and staff not sensitive to adolescents' needs
- ▶ Judgmental and/or non empathetic attitude of providers and staff
- ▶ Providers and/or staff refuse services to adolescents
- ▶ Providers unwilling to provide sufficient time to the adolescent client for interpersonal communication
- ▶ Provider attitude biased towards boys versus girls

Contd.

Policy factors

- ▶ Discrimination against adolescents, sometimes by requiring minimum age or parental consent
- ▶ Unclear laws and policies regarding adolescents, both married/unmarried and boys/girls
- ▶ Not involving adolescents during formulation of policies related to their needs and concerns
- ▶ Cost of services is high and unaffordable by adolescents



Barriers related to health facility

Provider factors:

- Lack of designated or special health services for adolescents at the facility
- Lack of privacy and confidentiality
- Unfriendly environment
- Timings are not suitable and convenient to the adolescents
- Lack of services that adolescents want
- Distance

Characteristics of
adolescent-friendly
reproductive and sexual
health services



Adolescent-friendly Policies

- ▶ Sensitive and caters to adolescent needs
- ▶ Affordable and acceptable services
- ▶ Respect for both boys and girls (married and single)
- ▶ Publicity of adolescent programmes and facilities
- ▶ Adolescent programmes to include comprehensive services

Contd.

- ▶ Linkages with other institutions to promote publicity and encourage utilization of services
- ▶ Informative material for adolescent growth, development and health issues and concerns
- ▶ Promotion of trained peer counsellor
- ▶ Service provided is free of cost or affordable

Adolescent–friendly Providers

- ▶ Trained provider aware of adolescent issues
- ▶ Provides correct and complete information
- ▶ Is respectful towards adolescents' needs and concerns
- ▶ Increases self–confidence in adolescents
- ▶ Ensures privacy and confidentiality
- ▶ Non–judgmental, friendly attitude
- ▶ Good communication and counselling skills
- ▶ Helps develop life skills

Adolescent–friendly Facility

- ▶ Non–threatening and comfortable environment
- ▶ Maintaining privacy and confidentiality
- ▶ Accessible and approachable (close to adolescents or where they gather)
- ▶ Counselling and curative services available
- ▶ Convenient timing
- ▶ Adequate space

Communicating with Adolescent

- ▶ Break the ice to gain her/his trust
- ▶ Consider the age and sexual experience
- ▶ Demonstrate patience and understanding of the difficulty adolescents have in talking about sex
- ▶ Assure privacy and confidentiality
- ▶ Respect her/his feelings, choices, and decisions
- ▶ Ensure a comfort level for the adolescent to ask questions and communicate concerns and needs

Contd.

- ▶ **Use language and terms the adolescent uses and can understand**
- ▶ **Impart the basic knowledge**
- ▶ **Respond to expressed needs for information in understandable and honest ways**
- ▶ **Explore feelings as well as facts**
- ▶ **Encourage the adolescent to identify options**
- ▶ **Lead an analytical discussion of consequences of options**
- ▶ **Assist her/him in making an informed decision**
- ▶ **Help the adolescent plan how to implement her/his choice**



Session 2 Counselling Prisoners



Why are prisoners at risk?

- ▶ Prisoners may have unprotected sex
- ▶ They may share infected injecting equipment
- ▶ They are often found to have various psychiatric and mental disorders
- ▶ Prisoners may already have been practicing high risk behaviours prior to being imprisoned

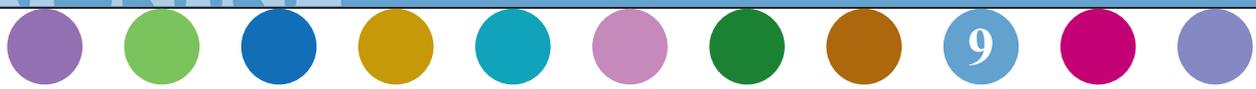
As a result, there may be an increased risk of transmission of HIV and other blood-borne viruses.

Group Work

- ▶ Brainstorming on issues to consider while counselling prisoners

Risk Assessment of Prisoners

- ▶ Explore sexual behaviours and possible non-sexual exposure such as sharing of needle and syringes
- ▶ Provide the client with appropriate IEC materials explain routes of STI/RTI and HIV transmission and prevention techniques



Counselling on HIV testing in Prisons

- ▶ Compulsory testing of prisoners for HIV is unethical and ineffective, and should be prohibited
- ▶ The counsellor needs to review the existing policy and practice within the facility with regard to HIV testing, and work with the facility's management to develop a testing policy that incorporates as many best practice features as possible

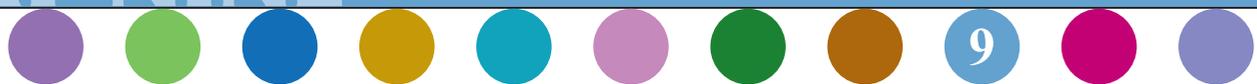
Counselling on substance abuse in Prisons

- ▶ Because of the relationship between crime and both legal and illegal drug use, many prisoners may have drug-related problems
- ▶ These can include addiction to drugs such as heroin, amphetamines and alcohol, and physical or mental problems as a result of drug use
- ▶ Counselling should explore strategies to respond to drug-related problems (e.g. treatment for mood disorders, motivational interviewing, information on safe injecting)

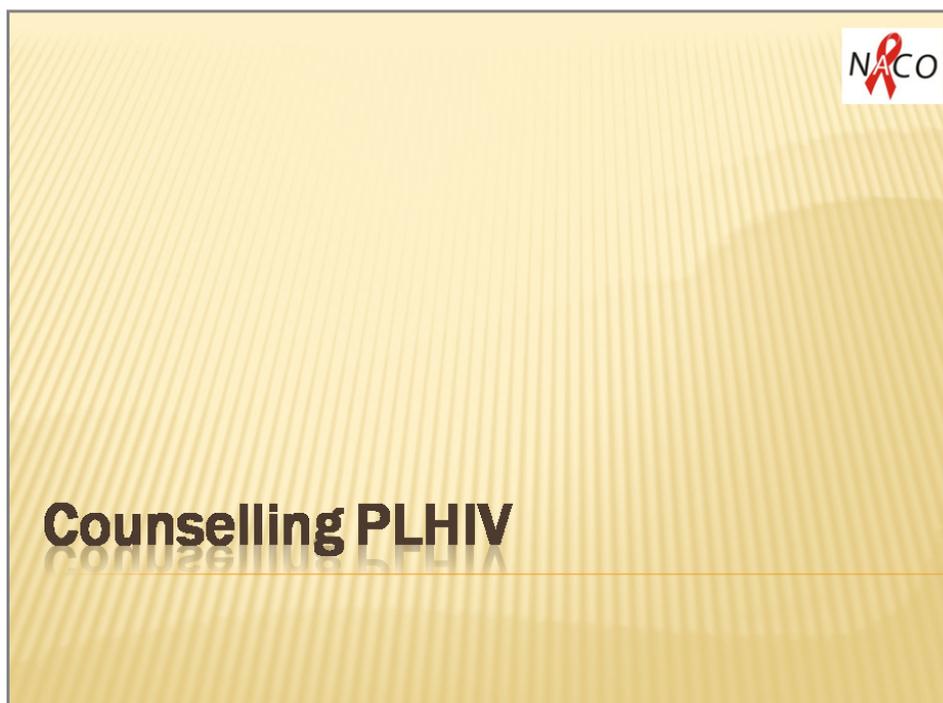
Other Counselling Issues for Prisoners

Counselling for prisoners may also address several other issues:

- ▶ **Pre-release counselling for risk reduction**
- ▶ **Partner disclosure and treatment**
- ▶ **Demonstration of the use of condoms and safe injecting practices**
- ▶ **Suicide risk reduction and psychological referral**
- ▶ **Use of prison health services**



Session 3 Counselling for PLHIV



Importance of Counselling PLHIV

PLHIV may experience:

- ❖ A sense of loss – of dreams and future
- ❖ A sense of limitation – will it be possible to have a life partner? Children?
- ❖ A sense of self-blame – of not being able to avoid HIV
- ❖ A sense of depression/helplessness
- ❖ A sense of fear – of telling partner? Of stigma that they will face?

Role of Counsellors

- ❖ Help client deal with spoken and unspoken feelings
- ❖ Assist client overcome difficulties of adjusting to her/his situation
- ❖ Provide referrals for practical needs

Group Work

- ❖ Identify vulnerabilities of a specific PLHIV group (positive youth, positive IDU, positive FSW, positive MSM, positive migrant worker) to STI
- ❖ Brainstorm on possible consequences (physical, mental, social, emotional, treatment-related etc.)
- ❖ Discuss effective counselling strategies to deal with them
- ❖ Group Presentation



What should counselling cover?

- ❖ Assessing needs – psycho-social and medical
- ❖ Providing information and referrals – healthy living, support, nutrition
- ❖ Providing information and referrals – medical care
- ❖ Explaining options for 'positive prevention'

Assessing Needs

A counsellor should be able to assess the following:

- ❖ Current health status of client at the time
- ❖ Availability of appropriate, non-stigmatizing health care
- ❖ Support from family and community
- ❖ Mental health status

Providing Information and Referrals – Healthy Living

Specific Issues for counselling:

- ❖ Avoid stress
- ❖ Exercise
- ❖ Keep up daily personal hygiene
- ❖ Prevent infections (drink clean water, wash hands, practice safer sex and prevent STI, clean and cover wounds)

Providing Information and Referrals – Support

Specific Issues for counselling:

- ❖ Find people to talk to for emotional support
- ❖ Become part of PLHIV support groups and positive networks



Providing Information and Referrals – Nutrition

Specific Issues for counselling:

- ❖ Devise healthy eating plan
- ❖ Avoid spicy, oily food
- ❖ Include pulses, vegetables, egg, milk, fish in diet
- ❖ Take small frequent meals

Providing Information and Referrals – Medical Care

Specific Issues for counselling:

- ❖ Take medications as prescribed
- ❖ Visit the nearest ART centre
- ❖ Monitor general health

Positive Prevention

Specific Issues for counselling:

- ◆ Fear of infecting someone
- ◆ Fear of not being able to find an intimate partner
- ◆ Medication side effects that affect sexual function
- ◆ Desire for pregnancy
- ◆ Correct and consistent condom use

Experience Sharing by Positive Speaker!

DAY TEN



DAY TEN

Session 1 Referrals and Networking

Referrals and Networking

Referrals

- Clients have needs that cannot be provided by a single facility and may need referral to other facilities in the same or in different hospitals
- Thus, many services need to be provided through making referral agreements with other providers

Networking

- Networking refers to the process of strengthening relationships with organizations that provide support services
- Networking is necessary to comprehensively cover needs of clients

Group Work

- Each group assigned a set of referral needs (e.g., ICTC/ART/TB-HIV/PPTCT)
- Brainstorm on
 - Steps required to set up an effective referral network
 - Factors that would facilitate smooth referrals from the service perspective; and
 - Actions that a counsellor can take to ensure the referral is effective from the client perspective
- Group Presentation

Effective Referrals

When making referrals the counsellor will need to:

- Work with clients to determine what their priority needs are
- Explain which needs can be met by the clinic and which will need to be met by outside resource
- Explain how the referral system works

Contd.

Clients should be referred to services that are:

- Responsive to their priority needs
- Appropriate to their culture, language, sex, sexual orientation, age, and developmental level

Clients should receive help accessing and completing referrals, and completion of referrals should be verified.

Maintaining Referrals

Counsellors should maintain working relationships with managers of services in the referral network to ensure referrals can continue smoothly.

This may be done formally through regular meetings held to discuss and solve problems, or informally through phone calls or visits.

Tools

Various tools are used to facilitate the referral process:

- Directory of Referral services
- Referral forms

Directory of Referral Services

Referral agreements should be documented in a directory of referral services

This directory will:

- List and describe the service
- Give the location/s
- The service hours and name and contact details of the service provider
- Who may use the service (any criteria)
- Any costs and other information that is needed by the counsellor or client

**Let's understand & practice -
Directory of Referral Services
(see format)**

Referral Form

- This form needs to be filled every time a patient is referred outside the clinic for any service, especially health care
- The form has two parts:
 - The top part is filled by the Doctor or the Counsellor
 - The lower part is filled by the in-charge (mostly the Doctor) of the referred agency
- The lower part is retained at the referral site so as to be collected by the STI Counsellor weekly

(see format)

**Let's understand & practice -
Referral Form
(see format)**

Directory of Referral Services					
Sr. No.	Service	Location	Working Hours	Name and phone no. of Contact Person	Others (like cost, etc)



STI/RTI Referral Form

To be filled and handed to the client by STI Counsellor

Referral to:

ICTC/Chest&TB/Laboratory _____

The patient with the following details is being referred to your center:

Name: _____ Age: _____ Sex: _____

STI-PID No: _____

Kindly do the needful

Referring Provider:

Name: _____ Designation: _____

Contact Phone: _____ Date of referral: _____

To be filled and retained at referral site so as to be collected by STI counsellor weekly

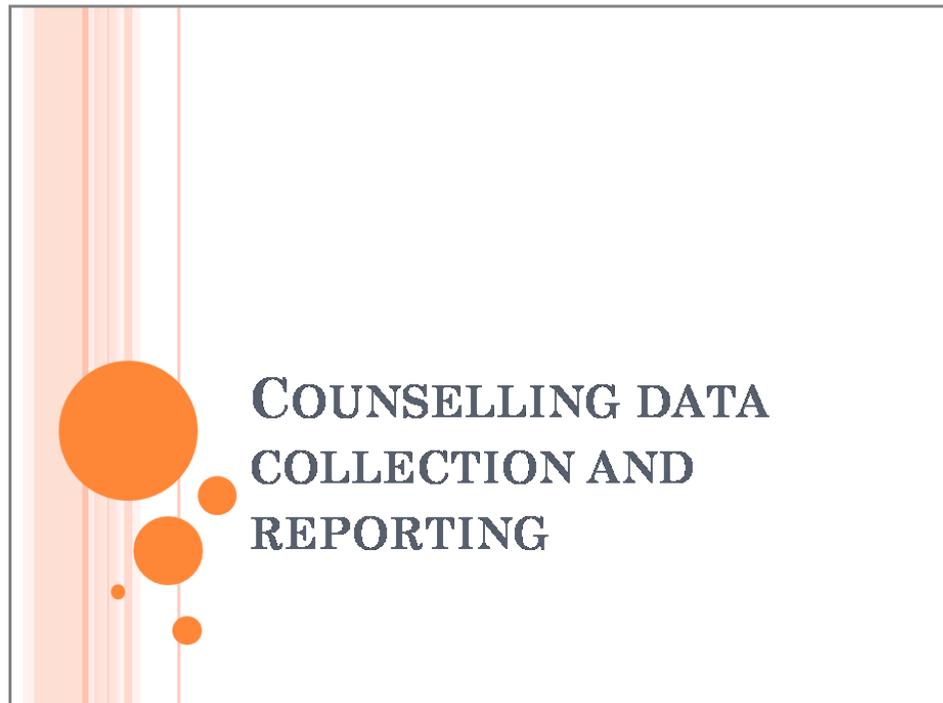
The above patient referred has been provided ICTC/TB/RPR/VDRL/TPHA/ _____ services and the patient has been tested/diagnosed/treated for _____

The test/s results of RPR/VDRL/TPHA is/are _____

Signature of the Medical Officer/Counsellor/Lab In-charge

Session 2

Counselling Data Collection and Reporting

**CLIENT DATA**

- Quantitative information that is collected about
 - Service or a patient/client
 - Numbers of clients
 - Numbers of different services provided
 - Whether it is a new client or if the client has received services earlier
 - Type of service

- Usually used for monitoring and evaluating a service in relation to the outputs or indicators agreed upon

CLIENT RECORD

- Includes the following details of the client:
 - Name or identifier
 - Information covering demographic/personal details, sex/gender, age, location (how to reach)
 - Date of first visit
 - Medical and the counselling record

COUNSELLING RECORD FORM

- Uniform format filled by counsellors
- Describes the interactions the counsellor has with the client
- Records as much data as needed to maintain a detailed record of the service provided and needed follow up
- Intended to document enough information about the counselling session to help the counsellor provide ongoing quality counselling

Let's see each one (handout/sample):

- Counsellor's Patient Diary
- STI/RTI Patient Wise Record

EXERCISE

- Practice forms
 - Counsellor's Patient Diary
 - STI/RTI Patient Wise Record
- Present experience

Game of Confidentiality and Trust!

Let's see some more formats (handout/sample):

- Master Register for Doctors at STI and Gyne&Obs Clinic

EXERCISE

- Practice forms
 - Master Register for Doctors at STI and Gyne&Obs Clinic
- Present experience

IMPORTANCE OF CLIENT RECORDS

- Client records are intended to ensure continuity and quality of service delivery
- Benefits of maintaining client records, include availability of information to different counsellors and healthcare workers within the team to ensure emotional support and follow up management

IMPORTANCE OF ANALYSIS AND REPORTING

- Necessary to enter client and clinic data into a system so as to ensure proper analysis and reporting
- Reporting reflects the overall service provided by the counsellor/s during a specified period
- Reporting helps to make decisions on the effectiveness and efficacy of services provided

BARRIERS TO DATA RECORDING PRACTICES

- **Individual barriers**
 - Leave data field in the data collection form blank
- **Occupational barriers**
 - Non-availability of forms
 - Power breakdown etc

Counsellor's Patient Diary										
Date	STI-PID No.	New/ Repeat	Age	Sex	Occupation	Education	Patient Complaints	Imp. Points in Sexual & Personal History	Interventions by Counsellor	Other Remarks

Guidelines for filling Counsellor's Patient Diary

This form/register has to be filled after every counselling session.

This not only helps know the number of counselling sessions held but also the type of counselling provided.

It also provides details of each patient including the STI-PID No., age, sex, occupation, education, complaints and sexual and personal history.

Using the form the counsellor also keeps track whether the patient is new or is a repeat case of counselling.



STI/RTI Patient Wise Record

NATIONAL AIDS CONTROL ORGANIZATION STI / RTI PATIENT WISE RECORD			
Provider Name Clinic Name Clinic Unique ID Number:		Patient ID Number: Patient OP Number	
Date		STI / RTI syndrome diagnosis	
Patient Detail		STI / RTI Risk Assessment	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	Age New Client <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical History taken <input type="checkbox"/> Sexual History taken <input type="checkbox"/> Physical examination conducted <input type="checkbox"/> Speculum and/or Proctoscopic exam conducted <input type="checkbox"/> Significant points in bullets	Vaginal Cervical Discharge <input type="checkbox"/> Genital pediculosis <input type="checkbox"/> Genital warts <input type="checkbox"/> Lower Abdominal Pain <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Presumptive treatment <input type="checkbox"/> Others (specify)-
Type of visit <input type="checkbox"/> New STI/RTI <input type="checkbox"/> Repeat STI/RTI <input type="checkbox"/> Asymptomatic <input type="checkbox"/> General		STI / RTI syndromes UD <input type="checkbox"/> GUD - Herpetic <input type="checkbox"/> GUD - Non herpetic <input type="checkbox"/> Scrotal swelling <input type="checkbox"/> Inguinal Bubo <input type="checkbox"/> Genital scabies <input type="checkbox"/> Anorectal discharge <input type="checkbox"/> Genital molluscum Examination findings:	
Patient flow <input type="checkbox"/> Referred <input type="checkbox"/> Direct walkin		Lab Test Performed RPR <input type="checkbox"/> Reactive <input type="checkbox"/> Titre <input type="checkbox"/> Confirmed with TPHA Gram Stain <input type="checkbox"/> ICDC <input type="checkbox"/> WBC <input type="checkbox"/> None <input type="checkbox"/> Nugent's score +ve KOH <input type="checkbox"/> Whiff test +ve <input type="checkbox"/> Pseudohyphal/Spores <input type="checkbox"/> None Wet Mount <input type="checkbox"/> Motile Trichomonads <input type="checkbox"/> Clue Cells <input type="checkbox"/> None HIV <input type="checkbox"/> Reactive <input type="checkbox"/> Non reactive <input type="checkbox"/> If reactive, write clinical stage	
Details of STI/RTI treatment given			
Kits (if available) <input type="checkbox"/> Kit 1 (Grey) <input type="checkbox"/> Kit 2 (Green) <input type="checkbox"/> Kit 3 (White) <input type="checkbox"/> Kit 4 (Blue) <input type="checkbox"/> Kit 5 (Red) <input type="checkbox"/> Kit 6 (Yellow) <input type="checkbox"/> Kit 7 (Black)		Drugs used (if KITS are not available) <input type="checkbox"/> Acyclovir 400 mg <input type="checkbox"/> Amoxicillin 500 mg <input type="checkbox"/> Azithromycin 1 gm <input type="checkbox"/> Benz. Penicillin 2.4MU <input type="checkbox"/> Benzyl benzoate 25% <input type="checkbox"/> Cefixime 400 mg <input type="checkbox"/> Ceftriaxone 250 mg & 1 gm <input type="checkbox"/> Ciprofloxacin 500 mg <input type="checkbox"/> Clotrimazole 500 mg <input type="checkbox"/> Doxycycline 100 mg <input type="checkbox"/> Erythromycin 500 mg <input type="checkbox"/> Fluconazole 150 mg <input type="checkbox"/> Metronidazole 400 mg <input type="checkbox"/> Secnidazole 500 mg	
General Medicines <input type="checkbox"/> Adrenaline <input type="checkbox"/> Antihistamines <input type="checkbox"/> Hydrocortisone <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Metoclopramide <input type="checkbox"/> Ranitidine		Others <input type="checkbox"/> Permethrin 5% and 1% <input type="checkbox"/> Podophyllin 20% <input type="checkbox"/> Trichloroacetic acid 30%	
Other services provided			
Patient education <input type="checkbox"/> Partner treatment <input type="checkbox"/> Condom Usage <input type="checkbox"/> Other risk reduction		Referrals <input type="checkbox"/> ICTC <input type="checkbox"/> PPTCT <input type="checkbox"/> Designated Microscopy centre <input type="checkbox"/> Care and Support ARV centre <input type="checkbox"/> PLHA network <input type="checkbox"/> Others (specify)	
Partner treatment <input type="checkbox"/> Prescription written <input type="checkbox"/> Medication given		Condoms <input type="checkbox"/> Given free <input type="checkbox"/> Sold / Social Marketted <input type="checkbox"/> Prescribed <input type="checkbox"/> Demonstrated	
<input type="checkbox"/> IEC material given <input type="checkbox"/> Append results if any other tests performed			

Guidelines for Filling the STI/RTI Patient Wise Record

General Instructions:

Write the name of the service provider, name and unique ID number of clinic. As name and number of facility remains constant,

1. SACS may print the name and unique ID number of STI/RTI clinic on cards before dispatching them to individual clinics.
2. Write the name of service provider
3. Write the patient ID number
 - a. Write the patient ID number starting from 00001 and write consecutive numbers from April to March.
 - b. Repeat the same for each financial year
4. Write the patient general out-patient number (wherever applicable/available).

Who should fill the cards?

The STI/RTI patient wise card should be filled by STI/RTI service providers (doctors/counsellors) for each new STI/RTI episode treated. The cards should be stored securely.

The monthly reporting format should be filled by using the consolidated data from these cards. The filled cards should be available at clinic during supervisory visits.

The STI/RTI service providers include:

- a) Providers at all designated STI/RTI and Ob Gyn clinics (sentinel sites like area/district hospitals, teaching hospitals attached to medical colleges etc)
- b) Providers at targeted interventions providing STI/RTI services for high risk groups
- c) All franchised private providers with memorandum of understanding with NACO/SACS/DAPCU/Implementing Agency for providing STI/RTI services

Specific instructions:

1. Write the date of visit under date column
2. Note the patient details
 - Tick the box for - Male or Female or Transgender accordingly
 - Age - Write the completed years as told by patient
 - New Client
 - Tick **“Yes”** if the patient is a new client i.e. attending that particular STI/RTI clinic for first time
 - Tick **“No”** if the patient has visited that particular STI/RTI clinic previously
3. Note the type of visit **ONLY** after examination is completed
 - Tick type of visit as **“New STI/RTI”** if the patient is attending with a fresh episode of STI/RTI.
An STI/RTI patient visit includes individual visits where:
 - Patients present with STI/RTI symptoms, and confirmed to have STI/RTI on physical and internal examination.
 - STI/RTI signs are elicited by internal examinations, and/or
 - STI/RTI etiology diagnosed using laboratory method, and/or
 - If a known herpes patients visits with recurrent infection, tick this box
 - Include all those who are tested positive for syphilis by laboratory test
 - Tick type of visit as **“Repeat visit”** if the patient repeated the visit for the previously documented complaints. This includes STI/RTI follow up (when the visit happens within 14 days following treatment).

- Tick type of visit as “**Asymptomatic**” if patient reports no STI/RTI symptoms and no signs are elicited during examination.
- Tick type of visit as “**General**” if the patient attended for a general (non STI/RTI related) complaint.

[For STI/RTI Clinics with Targeted Intervention “only”]:

- Tick type of visit as “New STI/RTI” if the HRB Groups individual is attending the STI clinic for the first time. The HRB Groups may be having STI or may not be having STI. Any HRB Groups attending the STI clinic, subsequently are “Old” A New STI/RTI visit includes individual HRB Groups visits where:
 - Patients present with STI/RTI symptoms, and confirmed to have STI/RTI on physical and internal examination.
 - STI/RTI signs are elicited by Speculum or proctoscope examinations,
 - STI /RTI etiology diagnosed using laboratory method
 - If a known herpes patients visits with recurrent infection
 - Speculum or proctoscope exam is carried out to detect STI/RTI but no STI/RTI detected and provided with presumptive treatment
- Tick type of visit as “**Repeat visit**” if the HRB Groups individual repeated the visit for the previously documented complaints. This includes STI/RTI follow up (when the visit happens within 14 days following treatment).
- Tick type of visit as “**Asymptomatic**” if HRB Groups individual reports no STI/RTI symptoms and no signs are elicited during examination
- Tick type of visit as “**General**” if the HRB Groups individual attended for a general (Non STI/RTI related) complaint]

4. Note the Patient flow

- a. Tick “**Referred by**” if the patient is referred by some other facility (such as ICTC/PPTCT/ART centre, other OPDs in the institute where the clinic is located, NGOs/STI clinics with targeted interventions, Peer Educator/Outreach worker etc)
- b. Tick the “**Direct walk in**” if the patient attended the clinic directly

5. STI/RTI risk assessment - Done by Medical Practitioner

- a. Tick the box after taking detailed “**Medical history**” from the patient.
- b. Tick the box after taking detailed “**Sexual history**” from the patient
- c. Tick the box after conducting detailed “**Physical examination**” of the patient
- d. Tick the box after conducting detailed “**Internal examination**” of the patient
- e. Write the key points of significance from history in the box provided.

6. STI/RTI syndrome diagnosis - Done by Medical Practitioner

- a. Tick the appropriate box as per the diagnosis made
- b. While making the syndrome diagnosis, the standardized definitions given ONLY to be followed.
- c. Should be filled in for first clinic visit for the index STI/RTI complaint only
- d. Should be filled in even if the diagnosis is made on clinical or etiological basis
- e. If the patient has more than one syndrome or condition, tick all the appropriate syndromes and/or conditions diagnosed.
 - **VCD, Vaginal/cervical discharge:** Includes (1) woman with symptomatic vaginal discharge, (2) asymptomatic patient with vaginal discharge seen on examination, and (3) cervical discharge seen on speculum examination (all etiological and clinical STI diagnosis relating to vaginal or cervical discharge should be included here)
 - **GUD-non-herpetic, Genital ulcer disease-non-herpetic:** Tick if female or male, with genital or ano-rectal

- ulceration and with no blisters (vesicles) (all STI clinical or etiological diagnosis relating to genital ulcers, except herpes simplex 2, and LGV should be included here)
- **GUD-herpetic, Genital ulcer disease-herpetic:** Tick if female or male, with genital or ano-rectal blisters (vesicles) with no ulcers

Note: If both ulcers and blisters are present, tick on both GUD and GUD herpetic

- **LAP, Lower abdominal pain:** Tick if patient has lower abdominal pain or tenderness, or cervical motion tenderness
- **UD, Urethral discharge:** Tick if male with urethral discharge with or without dysuria or other symptoms
- **ARD, Ano-rectal discharge:** Tick if male with symptoms of tenesmus or if anorectal discharge seen on examination
- **IB, Inguinal bubo:** Tick if the person has inguinal bubo and no genital ulcer (Clinical diagnosis of LGV should be included here)
- **SS, Painful scrotal swelling:** Tick if person has painful scrotal swelling
- **Genital warts:** Tick if patient has genital warts
- **Genital scabies:** Tick if patient is diagnosed as having genital scabies.
- **Genital Pediculosis:** Tick if patient is diagnosed as having genital pediculosis.
- **Genital molluscum:** Tick the box if the patient is suffering with molluscum lesions over the genitalia
- **Other (specify):** Write if any other STI/RTI is diagnosed and specify the condition (e.g., secondary, Late, Congenital syphilis; oral and or anal warts etc.)
- **Asymptomatic:** This box to be ticked ONLY by STI/RTI clinics functioning under Targeted Intervention

7. Examination findings - Done by Medical Practitioner

Summarize the salient findings of physical including internal examination in the box provided.

8. Laboratory tests performed -

■ RPR/VDRL test:

- Tick if Rapid Plasma Reagin (RPR) /VDRL test is conducted and found reactive
- Write the highest titers reactive
- Tick if RPR/VDRL result is confirmed with TPHA

■ Gram stain:

- Tick the box for "ICDC" if urethral and endo-cervical smears demonstrates >5 PMN/hpf and intracellular gram-negative diplococci inside polymorph nuclear cells
- Tick the box for "WBC" if urethral and endo cervical smears demonstrates >5 PMN/hpf and no intracellular gram-negative diplococci inside polymorph nuclear cells
- Tick the box for "None" if urethral smears demonstrates <5 PMN/hpf and no intracellular gram-negative diplococci inside polymorph nuclear cells
- Tick the box for "None" if endo cervical smears demonstrates <10 PMN/hpf and no intracellular gram-negative diplococci inside polymorph nuclear cells
- Tick the box for "Nugent's score Positive" - if the score is between 7 and 10 of vaginal discharge smear (refer the National guidelines for managing reproductive tract infections including sexually transmitted infections, August 2007).

■ KOH:

- Tick the box for "Whiff test" - If a drop of 10% potassium hydroxide on vaginal secretion on a glass slide releases fishy odors of amines
- Tick the box for "Pseudohypha" - If budding yeast/hypha is seen under light microscope
- Tick the box "None" - if negative for whiff test and pseudohypha

■ Wet mount:

- Tick the box for “Trichomonads” - if Motile trichomonads seen under light microscope (10x)
- Tick the box for “Clue cells” - if Clue cells comprise more than 20% of all epithelial cells in any view under light microscope
- **HIV:**
 - Tick the box for “Reactive” - if an HIV test is performed as per national HIV testing guidelines and declared as reactive
 - Tick the box for “Non Reactive” - if an HIV test is performed as per national HIV testing guidelines and declared as non reactive
 - Write the clinical stage in the box for “Clinical stage” - for all patients tested reactive for HIV

9. Details of STI/RTI treatment given -

This section has ‘four’ components:

- Pre specified colour coded kits starting from No 1 to 7
 - Tick the box against the kit administered to the patient
 - If more than one kit is given to same patient due to multiple syndromes then tick the relevant boxes
- General medicines administered to the patient
 - Tick the relevant box, if any of these medicines were administered
 - If drugs for anaphylaxis are checked, detail the entire management of anaphylaxis including the outcome on a separate sheet and append to the card.

All drug allergies, idiosyncratic reactions to be marked with “red ink” on the card

- If kits are not in supply or in addition to kits loose drugs were prescribed/administered then tick the relevant boxes. Treatment regimens should be in accordance to National Technical Guidelines for Managing RTI including STI, August 2007.
- Write any other drug administered or prescribed to patient which doesn’t fall in any of the above mentioned categories.

10. Other services provided

This section has five components and is basically concerned with what additional value-added services are provided to patient.

- a. Patient education: tick the relevant box if individual patient is provided with STI counselling on:
 - Partner’s treatment
 - Condom usage and disposal
 - Other risk reduction communication
- b. **Partner treatment:** tick the relevant box if individual patient is provided with:
 - Written Prescription
 - Medications
- c. **Condoms:** tick the relevant box if individual patient is provided with:
 - Condoms (free)
 - Condoms (Social marketed)
 - Demonstration of condoms (all clinics should have a penis model for demonstration purpose)
- d. **Referrals:** tick all the relevant boxes:
 - **ICTC:** tick the box if STI/RTI patient referred to the ICTC
 - **PPTCT:** tick the box if a pregnant STI/RTI patient referred to PPTCT
 - **DMC:** tick the box if STI/RTI patient who has suspected to be chest symptomatic referred to DMC
 - Care and support centre: tick this box if a referral is done (List of care and support centres with contact details should be available at all clinics and displayed at waiting hall)

- **ART centre:** tick this box if a referral is done (List of ART centres with contact details should be available at all clinics and displayed at waiting hall).

All individuals who are tested reactive for HIV are to be referred for nearest ART centre, for registration and subsequent follow up. This ART registration number should be written over the card for future references)

- **PLHIV networks:** tick this box if a referral is done (List of PLHIV networks with contact details should be available at all clinics and displayed at waiting hall)
- **Others (specify):** if a referral other than those mentioned above is done then specify the place/centre to which patient is referred.

Counsellors should get the feedback of referral and document them in the card. As there is no name over the card, the information will remain confidential and this fact should be emphasized to PLHIV and HRB Group individuals.

- e. **IEC material given:** tick this box if take-home IEC material is provided to attendee (The clinic should keep a stock of simple hand bills on STI/RTI for patient self education. SACS should ensure availability of such IEC material at all STI/RTI clinics)

11. Append with results if any other tests performed:

Tick this box if any other additional tests performed. Append the copies of test/s performed along with their results.



Master Register for Doctors at STI and Gyne & Obs Clinic

Name of the Hospital: _____																			
Clinic Unique ID number: _____																			
ST/RTI Syndromic Coding: 1=UD, 2=GUD-herpetic, 3=GUD-Non-Herpetic, 4=Vaginal-cervical discharge, 5=Vaginal Bubo, 6=Genital Scabies, 7=Ano-rectal Discharge, 8=Genital Molluscum, 9=Scrotal Swelling, 10=Genital pediculosis, 11=Genital Warts, 12=Lower Abdominal Pain, 13=Asymptomatic, 14=Presumptive treatment, 15=Others (Specify)																			
Sr. No.	Date	Patient OPD Number	Patient ID Number	Name	Age	Sex	Referred (R/W) Walk in (W) (if Referred then specify)		ST/RTI syndrome diagnosis	Treatment provided Kit (if available)- Specify Kit Number	Drugs Prescribed	Counseling Done: 1=Yes, 2=No	Condoms Number of pieces provided	Partner management Partner Notification: 1=Yes, 2=No	Referred to 1-CTC, 2-TB, 3-ART, 4-RPR/VDRL/TPHA, 5-Others	Lab Investigations		Wet mount	
							WR	Referred from								RPR test	TPHA test		
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
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23																			

Guidelines for Filling the Master Register for Doctors at STI and Gyne&Obs Clinic**General Instructions:**

Write the name and unique ID number of clinic/hospital

Who should fill the cards?

The Master Register for Doctors at STI and Gyne&Obs Clinic should be filled by counsellors for each new STI/RTI episode treated. The cards should be stored securely.

This also acts as a consolidated report and should be filled by using the STI/RTI Patient Wise Card.

Specific instructions:

While filling this form the counsellor should keep the STI/RTI Patient Wise Record handy. Ideally, the counsellor should fill the master register after each patient or at the end of the day for all patients seen that day.



DAY ELEVEN

Session 1
Reporting and Documentation



Reporting and Documentation

Let's understand and practice -

Monthly Report Format for STI/RTI Clinics (handout/sample)



Exercise

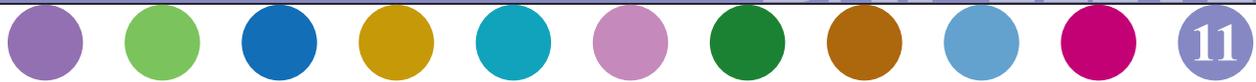
- Practice form
- Present experience



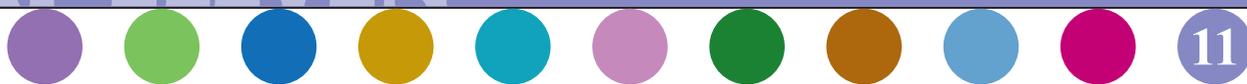
													Monthly	STI/RTI	
Unique ID. No. of STI/RTI Clinic /Gynecology OPD /TI NGO															
MONTHLY REPORT FORMAT FOR STI/RTI SERVICES															
Name of STI/RTI Clinic/Hospital to which the Gynecology OPD is Attached/TI NGO															
Sub Type			Category						Location						
Address :															
District :						Block :			City :						
Reporting Period :			Month(MM) :			Year(YYYY) :									
Name of Officer In - charge :															
Phone no. of Officer In - charge :															
Name of Centre/service provider :															
Section 1 : No. of Patients Aailed STI/RTI services in this month															
Type of Patients	Age Group & Sex												Total		
	< 20			20-24			25 - 44			> 44					
	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG	Male	Female	TS/TG
Clinic visit with STI/RTI complaint and were diagnosed with an STI/RTI													0	0	0
<ul style="list-style-type: none"> Clinic visit with STI/RTI complaint but were NOT diagnosed with an STI/RTI. Clinic visit for Syphilis Screening (Excluding ANC) For TI-NGOs-RMC,PT, Syphilis Screening(whichever applicable) 													0	0	0
Follow up visit for the index STI/RTI complaint													0	0	0
Total No of visits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Section 2 : STI/RTI syndromic diagnosis				
(Should be filled by all STI/RTI service providers for clinic visit for STI/RTI complaint only)				
Age Group & Sex				
Diagnosis	Male	Female	TS/TG	Total
1.Vaginal/ Cervical Discharge (VCD)				0
2.Genital Ulcer (GUD) - non herpetic				0
3.Genital ulcer (GUD) - herpetic				0
4.Lower abdominal pain (LAP)				0
5.Urethral discharge (UD)				0
6.Ano-rectal discharge (ARD)				0
7.Inguinal Bubo (IB)				0
8.Painful scrotal swelling (SS)				0
9.Genital warts				0
10.Other STI				0
11. Serologically +ve for syphilis				0
Total No of cases	0	0	0	0
No of people living with HIV/AIDS (PLHAs) who attended with STI/RTI complain during the month				
Section 3. Details of other services provided to patients attending STI/RTI clinics in this month				
To be filled in by all STI/RTI Service Providers				
Service	Male	Female	TS/TG	Total
1. Number of patients counseled				0
2. Number of condoms provided				0
3. Number of RPR/VDRL tests conducted				0
4. Number of patients found reactive				0
5. Number of partner notification undertaken				0
6. Number of partners managed				0
7. Number of patients referred to ICTC				0
8. Number of patients found HIV-infected (of above)				0
9. Number of patients referred to other services				0



		Monthly	STI/RTI		
Unique ID. No. of STI/RTI Clinic/Gynecology OPD/ TI NGO					
Section 4 : STI/RTI service for HRGs in the month (To be filled in by TI NGO)					
	Male	Female	TS/TG	Total	
Number of new individuals visited the clinic				0	
Number of Presumptive Treatments(PT) provided for gonococcus and Chlamydia infection				0	
Number of regular STI check-ups(RMC) conducted (check-up including internal examination of HRGs once in a quarter)				0	
Section 5 : ANC syphilis screening in this month					
Should be filled by all service providers with ANC service provision					Total
Number of ANC first visits in the month (Registration)					
Number of pregnant woman previously registered but screened in current month					
Number of rapid plasma reagin (RPR/VDRL) tests performed					
Number of RPR/VDRL reactive (Qualitative)					
Number of RPR/VDRL reactive above $\geq 1:8$ (Quantitative)					
Number of RPR/VDRL reactive confirmed with TPHA					
Number of pregnant women treated for syphilis					
Section 6 : Laboratory diagnosis of STI/RTI					
Laboratory diagnosis/Tests	Male	Female	TS/TG	Total	
1. Total RPR/VDRL tests performed				0	
RPR tests reactive $\geq 1:8$				0	
Number of RPR reactive confirmed with TPHA				0	
2. Total Gram stain performed				0	
Gonococcus + (gram negative intracellular diplococci +)				0	
Non-Gonococcus urethritis (NGU)-Pus cells +ve				0	



Non-Gonococcus cervicitis (NGC)-Pus cells +ve						0
None						0
Nugents score +ve						0
3. Wet mount test performed						0
Motile Trichomonads +ve						0
Whiff test +ve						0
Clues cells +						0
None						0
4. KOH test performed						0
5. Availability of consumables (Yes=1,No=2)						
Do you have STI pre-packed kits?						
Functional Computer						
AMC of Computer						
Section 7 : Drugs & Consumables						
Drugs & Consumables	Opening stock	Number received this month	Consumed	Damage/Wastage	Closing stock	Stock Sufficient for approx months
RPR tests						
TPHA kits (wherever applicable) (Tests)						
Pre packed STI Kit 1						
Pre packed STI Kit 2						
Pre packed STI Kit 3						
Pre packed STI Kit 4						
Pre packed STI Kit 5						
Pre packed STI Kit 6						
Pre packed STI Kit 7						
Condom Pieces						

Reagent for gram stain						
Reagents wet mount and KOH test						
Others						
					Monthly	STI/RTI
Unique ID. No. of STI/RTI Clinic/Gynecologic OPD/TI NGO			0			

Section 8 : Details of Staff at the STI/RTI or Gynecology clinics					
Human resource details at STI/RTI and /or Gynecology clinics (Should be filled by all STI/RTI clinics)					
Staff	Number Sanctioned	Number in place	Number of Person Trained during month		
			Induction	Refresher	Others
Medical Officer					
Staff Nurse					
Laboratory Technicians					
Laboratory Attendant					
Counsellor					



Guidelines for filling Monthly Report Format for STI/RTI Clinics

General Instructions:

Who should fill this?

This reporting format should be filled by all STI/RTI service providers and sent to the corresponding reporting authority by the 5th of next month. The STI/RTI service providers include:

- Providers at all designated STI/RTI and Obstetrics and Gynaecologic clinics (sentinel sites like area/district hospitals, teaching hospitals attached to medical colleges etc)
- Targeted Interventions providing STI/RTI services for High Risk Behaviour Groups

What should be reported?

- Section 1, 2, 3 and 7 should be reported by all STI/RTI service providers
- Additional Section 4 should be filled by all Targeted Interventions for High Risk Behaviour Groups
- Additional Section 5 should be filled by all service providers providing antenatal checkups of pregnant women and STI/RTI services
- Additional Section 6 should be filled up by NACO designated STI/RTI clinics (sentinel sites) with laboratory services (Laboratory may be located in the clinic or Clinic may be utilizing the general pathological lab in the hospital), section 8 should be filled by the NACO designated STI/RTI clinics or gynaecologic clinic .Write Clinic Unique ID No, name of the Centre, Address, Block, District, Reporting period (months and years to be put in numbers), Name and Phone no. of service provider.

Specific Instructions:

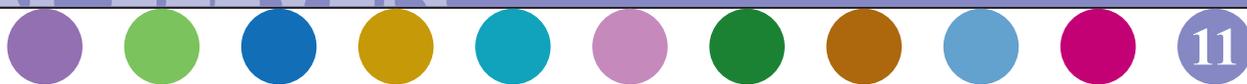
Section 1 should be reported by all STI/RTI service providers

Clinic visit with STI/RTI complaints and were diagnosed with STI/RTI	Fill the number of individuals visited with the particular STI/RTI complaints as per STI/RTI patient wise card. This indicates new STI/RTI episodes.
Clinic visit with STI/RTI complaint but were NOT diagnosed with STI/RTI	Fill the number of individuals visited for complaints of STI/RTI, but were not diagnosed with STI/RTI as per patient wise card.
Clinic visit for syphilis screening (exclude ANC)	Include the patients who came for syphilis screening to Designated STI/RTI clinics. Do not include ANC attendees.
For TI NGOs, RMC, PT, Syphilis screening (whichever is applicable)	For TI NGOs, fill all those HRG attending the STI clinic for Regular Medical Check up, Presumptive Treatment Syphilis screening.
Follow up visits index STI/RTI complaint	Fill the number of patients who have come for a repeat visit for a previously documented complaint. This includes STI/RTI follow-ups for any reasons.
Age Group and Sex	Fill the number of individuals who have availed STI/RTI services under appropriate age and sex category.
Total no. of visits	Fill in the total number of STI/RTI visits under the specific category

Section 2

- Should be reported by all STI/RTI service providers
- Should be filled for clinic visit for the index STI/RTI complaint only
- Should be filled even if the diagnosis is made on clinical or etiological basis

Diagnosis	Fill up consolidated number of STI/RTI patients diagnosed with following syndromes
1. VCD - Vaginal/Cervical Discharge	a) Woman with symptomatic vaginal discharge b) Asymptomatic patient with vaginal discharge seen on examination c) Cervical discharge seen on speculum examination. (All etiological and clinical STI/RTI diagnosis relating to vaginal or cervical discharge should be included here)
2. GUD - Non Herpetic - Genital ulcer disease- Non Herpetic	Female or male or transgender with genital or ano-rectal ulceration and with NO blisters (vesicles) (All STI clinical or etiological diagnosis relating to genital ulcers except herpes simplex 2, and LGV should be included here)
3. GUD - Herpetic - Genital Ulcer Disease – Herpetic	Female or male or transgender with genital or ano-rectal blisters (vesicles) with ulcers or recurrence. Note: Write the no. of individuals presented with ulcers and blisters under both GUD Non Herpetic and GUD Herpetic.
4. LAP - Lower Abdominal Pain	Female with Lower Abdominal Pain or tenderness, or Cervical motion tenderness
5. UD - Urethral Discharge	Male or transgender with intact genitalia with Urethral Discharge with or without dysuria or other symptoms
6. ARD - Ano-Rectal Discharge	Male, Female or Transgender with symptoms of tenesmus or if Ano-Rectal Discharge seen on exam
7. IB - Inguinal Bubo	Individuals with inguinal bubo and NO Genital Ulcer. (Clinical diagnosis of LGV should be included here)
8. SS - Painful Scrotal Swelling	Male or Transgender (with intact genitalia) with painful scrotal Swelling
9. Genital Warts	Individuals with genital warts including wart in anal region
10. Other STI's	Individuals attending with any other STI/RTI related condition (eg. Genital Scabies, pubic lice, Molluscum Contagiosum etc)
11. Serologically Positive for Syphilis	Individuals treated for serological Syphilis.



Total No. of episodes	Fill in the total number of STI/RTI diagnosis made during the month.
People living with HIV attended with STI/RTI	People living with HIV and attended STI/RTI clinic for STI/RTI related complaints and management.

Section 3 should be reported by all STI/RTI service providers	
<p>Details of other services provided</p> <ol style="list-style-type: none"> 1. Number of counselling provided 2. Number of condoms provided 3. Number of RPR/VDRL tests conducted 4. Number found to be reactive 5. Number of partner notifications undertaken 6. Number of partners managed 7. Number of individuals referred to ICTC 8. Number found HIV infected 9. Number of individuals referred for other 	<p>Fill total number of individuals provided with STI/RTI counselling</p> <p>Fill total number of condoms provided to all STI/RTI patients</p> <p>Fill total number of RPR/VDRL tests conducted*</p> <p>Fill the number detected reactive for RPR/VDRL test*</p> <p>Fill the total number of partner notifications undertaken of index STI/RTI patients treated</p> <p>Fill the total number of partners of index STI/RTI patients attended the clinic and managed</p> <p>Fill the number of STI/RTI clinic attendees referred to ICTC</p> <p>Fill the number detected as HIV reactive, of the referred individuals</p> <p>Fill in the number of STI/RTI clinic attendees referred for any services other services like care and support, tuberculosis screening etc</p>

Section 4 Should be filled by TI NGO providing services to High Risk Behaviour Groups (HRG).

Number of new individuals visited the clinic	Fill in total number of High Risk Behaviour Group individuals visiting the clinic for the first time for any clinical services. This has no relationship with what complaints they have. This number can be arrived by summing up “new clients” checked as “Yes” in patient wise card.
Number of presumptive treatments (PT) provided for Gonococcus and Chlamydia	Fill in total number of individuals (Sex Worker) provided with treatment for Gonococcus and Chlamydia without any STI signs and symptoms as per NACO STI/RTI technical guidelines August 2007.
Number of regular STI check-ups (RMC) conducted (Check up including internal examination of HRG once in a quarter).	Fill in the number of individuals (who attended this clinic at least once in the past) attended for STI/RTI services and received genital examination, which may include speculum or proctoscope examination and found to be not having STI/RTI.

Section 5

- Should be filled by all service providers with ANC service provision
- Should fill information for women making first visit for ANC only

Number of ANC first visits in the month (Registration)	Write the number of pregnant women registered for first time with the clinic during the month
Number of pregnant women previously registered but screen in current month	Write the number of pregnant women registered in previous month but got tested for RPR/VDRL in this month.
Number of RPR/VDRL performed	Write the number of registered pregnant women undergone RPR/VDRL test during the month*
Number of RPR/VDRL reactive (qualitative)	Write the number of pregnant women found reactive for RPR/VDRL test*
Number of RPR/VDRL reactive \geq 1:8 (quantitative)	Write the number of pregnant women found reactive for RPR/VDRL test*
Number of RPR/VDRL reactive confirmed with TPHA	Write the number of RPR/VDRL reactive samples confirmed confirmed with TPHA test with TPHA test
Number of pregnant women treated for syphilis	Write the number of pregnant women diagnosed having syphilis undergone treatment



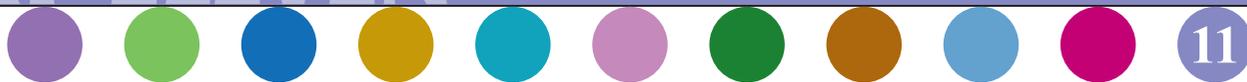
Section 6 should be filled by all NACO designated STI/RTI clinics with laboratory facilities

<p>Total RPR/VDRL test performed</p>	<p>Fill in the total number of RPR or VDRL qualitative tests conducted among men, women, and others during the reporting month* (sum of the data recorded in section C)</p>
<p>RPR test reactive \geq 1:8</p>	<p>Fill in the number of RPR/VDRL tests reactive at or above 1:8 titres among men, women and others*</p>
<p>No. of RPR/VDRL reactive confirmed with TPHA confirmed with TPHA test*</p>	<p>Fill in the number of sera reactive with RPR/VDRL tests</p>
<p>Total Gram stain performed</p>	<p>Fill in total number of gram stain performed among men (urethral smear) and women (endo-cervical smear and vaginal discharge smear)*</p>
<p>Number of Smears +ve for Gonococcus</p>	<p>Fill in number of smears positive for gonococcus</p>
<p><i>Criteria for urethral smear</i></p>	<p>> 5 PMN/hpf and intracellular gram negative diplococci inside polymorphonuclear cells</p>
<p><i>Criteria for endocervical smear</i></p>	<p>Numerous PMN/hpf and intracellular gram negative diplococci inside polymorphonuclear cells</p>
<p>Non Gonococcal Urethritis/cervicitis-Pus cells +</p>	<p>Fill in number of smears positive for non-gonococcal Urethritis/cervicitis</p>
<p><i>Criteria for urethral smear</i></p>	<p>> 5 PMN/hpf and NO intracellular gram negative diplococci inside polymorphonuclear cells</p>
<p><i>Criteria for endocervical smears</i></p>	<p>>10 PMN/hpf and NO gram negative diplococci inside polymorphonuclear cells</p>
<p>None</p>	<p>Fill in number of smears negative for both</p>
<p><i>Criteria for urethral smear</i></p>	<p>< 5PMN/hpf and NO intracellular gram negative diplococci inside polymorphonuclear cells</p>
<p><i>Criteria for endocervical smear</i></p>	<p><10 PMN/hpf and NO gram negative diplococci inside polymorphonuclear cells</p>
<p>Number of smears +ve for Nugent's score</p>	<p>Fill in the number of smears +ve for Nugent's score. Nugent's score is +ve when the score is between 7 to 10</p>
<p>Wet mount tests performed</p>	<p>Fill in the total number of wet mounts performed among women</p>
<p>Motile trichomonads +</p>	<p>Fill in the number of wet mounts demonstrated Motile trichomonads seen under light microscope (10x)</p>

Clues cells +	Fill in the number of wet mounts demonstrated Clue cells more than 20% of all epithelial cells in any view under light microscope
Whiff test +	Fill in the number of wet mounts released fishy odours of amines, when a drop of 10% potassium hydroxide is placed on vaginal secretion on a glass slide
None	None of the above tests are positive
KOH test performed	Fill in total number of KOH tests performed among women
Candidiasis+	Fill in the number of wet mounts demonstrated budding yeast/hypea under light microscope
None	Fill in the number of wet mounts not demonstrated budding yeast/hype under light microscope
Availability of consumables, functional computers and AMC of Computers.	TPHA testing - check yes or no as per kits availability Check yes or no for availability of the STI/RTI colour coded drug kits, functional computers and its AMC.

**The information on number of test conducted and /or results may or may not be available with facility providing clinical services. The providers are to ensure collection of the laboratory data from the concerned providers/departments/or facilities (microbiology/pathology/general lab).*

Section 7	
<ul style="list-style-type: none"> - Should be filled by all service providers at STI/RTI clinic - Provide details of stock of RPR test, TPHA tests kits, Per-packed STI kit 1, kit 2, kit 3, kit 4, kit 5, kit 6 and kit 7, condom pieces, reagents for gram stain, wet mount and KOH test and others if any 	
Opening Stock	Write the number of STI/RTI drug kits/ reagent/RPR, TPHA test kits available on the first day of the month.
Number received in this month	Write the number of STI/RTI drug kits/ reagent/RPR, TPHA test kits received during the month.
Number consumed	Write the number of STI/RTI drug kits/ reagent/RPR, TPHA test kits were utilised or distributed during the month.
Damage/Wastage	Write the number of STI/RTI drug kits/ reagent/RPR, TPHA test kits were wasted or damaged during the month.
Closing stock	Write the number of STI/RTI drug kits/ reagent/RPR, TPHA test kits available on the last day of the month.
Stock sufficient for approximate month	This indicator will be automatically calculated by the software. (closing stock/drugs consumed plus damaged /wasted) Every clinic to ensure one quarter (3 months) drug/testing kits/ reagent supply for the clinic.



Section 8 should be filled by all STI/RTI clinics and contains human resource details at STI/RTI clinics.

<p>Details of staff</p> <p>Medical Officer/s</p>	<p>Number of doctors posts sanctioned, Number in place</p> <p>Number of the doctors trained (Induction/Refresher/Other)</p>
<p>Staff Nurse</p>	<p>Number of Staff Nurse posts sanctioned, Number in place</p> <p>Number of the staff nurse trained (Induction/Refresher/Other)</p>
<p>Lab Technician</p>	<p>Number of Lab Technician posts sanctioned, Number in place</p> <p>Number of the Lab Technician trained (Induction/Refresher/Other)</p>
<p>Lab Attendant</p>	<p>Number of Lab Attendant posts sanctioned, Number in place</p> <p>Number of the Lab Attendant trained (Induction/Refresher/Other)</p>
<p>Counsellor</p>	<p>Number of Counsellor posts sanctioned, Number in place</p> <p>Number of the Counsellor trained (Induction/Refresher/Other)</p>

Session 2
Legal and Ethical Issues



**Legal and Ethical Issues in
Counselling**

Legal Issues

- Issues that have some legal repercussions/standings as per the law of the country
- Some examples:
 - Women above 18 years have the right to terminate pregnancy that meets the legal criteria
 - Homosexuality in India was illegal till a 2009 Delhi high court decision

Ethical Issues

- Issues that represent the ideal standards set and enforced by professional associations
- Some examples:
 - Every client has the right to know any information that relates to her/him
 - Every client has the right to receive equal treatment and healthcare

Group Work

- “Legal and ethical discussion question bank”
- Brainstorm on the questions raised
- Presentation

Group 1

- What are some of the ethical principles that guide or will guide your counselling practice regarding confidentiality and consent?
- What do these terms mean to you for your counselling activities?
- Do you make exceptions?
- What are the exceptions that you make?
- In what circumstances do you think an exception would be acceptable?

Group 2

- What human rights injustices are happening in your locality/community and/or in any clinic where you have worked or are working?
- How have these affected the vulnerability of your clients to STI or HIV infection or the impact of infection?
- What can counsellors do about these injustices or abuses, in your opinion, given the roles and responsibilities of counsellors?

Group 3

- What are some of the ethical principles that guide or will guide your counselling practice regarding personal conduct (professional behaviour) and integrity (regarding sexual relationships with clients)?
- What types of codes of conduct and disciplinary procedures/measures are in place where you work?

Case Studies

- 3 groups
- Counselling Situation – related questions
- Presentation

Group 1

You are conducting a counselling session and the client is extremely depressed and expresses an intention to commit suicide. The client has been accompanied by a friend.

1. How do you respond?
2. What are the ethical issues in this case?
3. What are the rights of the client?
4. What are your obligations as the counsellor?

Group 2

You are conducting a counselling session with an FSW client who has been treated with an STI. She is returning for her follow up and you are helping her to develop a risk reduction plan. She says that she has been forced to have sex with the ORW in her area and is unable to refuse out of fear of losing her benefits at the clinic. The ORW has connections with the local community and she is afraid of losing his 'protection' and 'good will'.

1. What are the ethical and/or legal issues in this case?
2. What are her rights?
3. What are your obligations as her counsellor?
4. How do you handle this case?

Group 3

You are supervising a counselling session of a counsellor under training. It is a female client who is eager to have a baby with her regular partner. She feels that she can hold onto him if she gives him a son. The counsellor feels that it is stupid to expect such favours from a relationship that is not “legal” (a non-marital relationship). The counsellor is advising the client and is very judgmental in her/his comments. She is now 4 months pregnant and is planning on having an ultra-sound and pregnancy termination if it is not a boy. On observing the sessions, you are very concerned about the counsellors’ abilities and attitudes towards the client.

- 1. What are the ethical and/or legal issues in this case?
- 2. How do you respond?

Common ethical problems include:

- Rights of individual versus rights of society
- Confidentiality
- Right to refuse blood tests/diagnostic procedures
- Right to refuse treatment
- Right to receive treatment
- Right to receive information

Some basic ethical considerations include:

- **Beneficence:** i.e., act in the client's best interest
- **Non-maleficance:** i.e., do no harm to the client or the situation
- **Justice:** i.e., non-biased, fair to the client and situation
- **Autonomy:** i.e., facilitate client's right

Conclusion

- **Counsellors must be aware of their own personality and needs in counselling situations**
- **They need to be sensitive to the client's needs and not resort to aggressiveness to deal with frustrating situations**
- **Counsellors must adhere to professional standards for ethical practice**
- **Counsellors will be faced with dilemmas while counselling and must always be aware of and understand their ethical responsibilities**

The relationship between the counsellor and the client is very important in building rapport, trust and confidence and is a critical ethical consideration



Session 3 Other Issues for Counselling

NACO

Other Issues for Counselling

Introduction

- STI/RTI Counsellor may get clients who need more than STI/RTI or HIV/AIDS counselling
- This may include counselling on sexual violence or rape

Sexual Violence

Any sexual act, attempt to obtain sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force.

This also includes rape.

Brainstorm – Support required for victims of sexual violence or rape

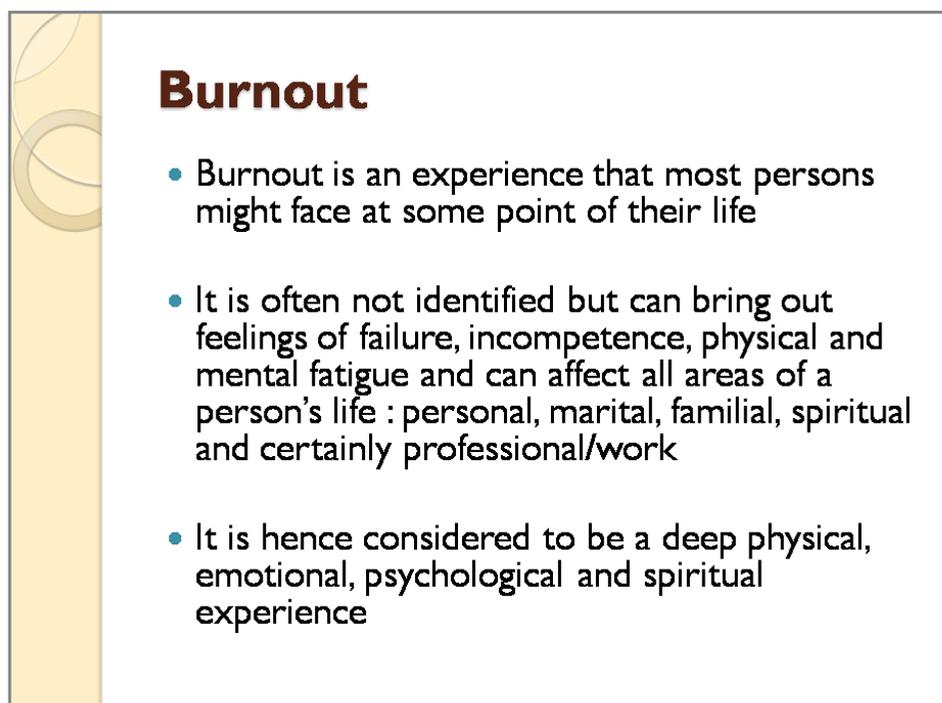
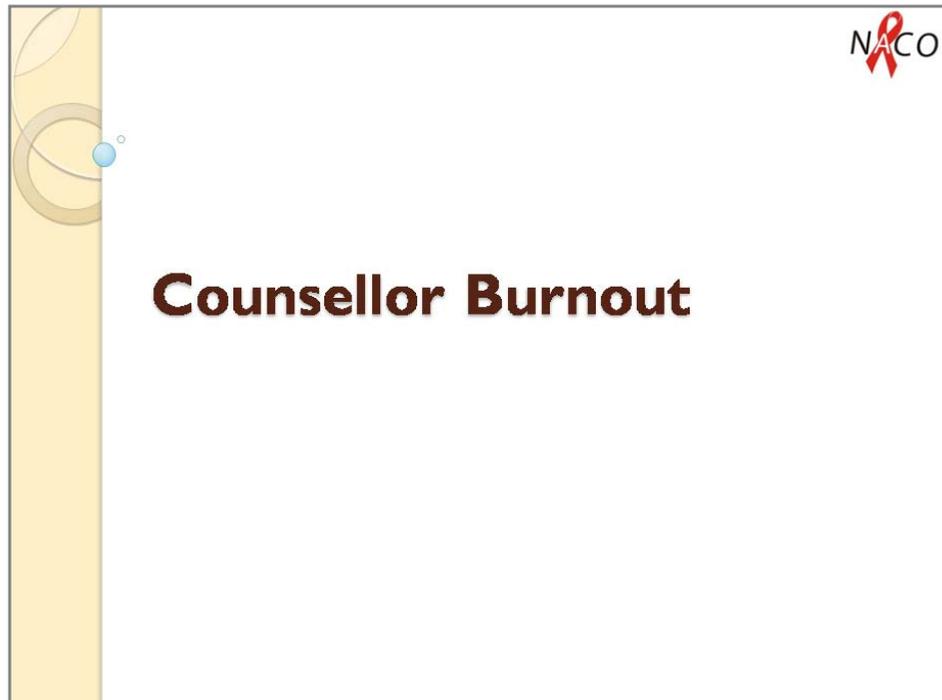
Support Required – Sexual Violence or Rape

- Medical services
- Psychological services
- Legal assistance
- Counselling

Remember!

- Victims of sexual violence or rape need sensitive handling and counselling to be able to cope with their physical and psychological trauma
- Encourage clients to take help of professional psychologist also
- Explain that client should assist and cooperate with legal authorities to document facts
- Assist clients to contact appropriate legal services or support institution for follow-up support

Session 4
Counsellor Burnout



Stages of Burnout

- Stage 1: Physical, mental and emotional exhaustion
- Stage 2: Shame and doubt
- Stage 3: Cynicism and callousness
- Stage 4: Sense of failure, helplessness and crisis

Group Work

- 3 groups
- Brainstorming Exercise & Group Presentation

Group 1 brainstorms about the causes of burnout - Who (what personality traits/characteristics) typically experience burnout? What contributes to burn out among counsellors?

Contd.

Group 2 brainstorms about the signs and symptoms of burnout - What feelings does the person with burnout experience? (these could be feelings of failure, incompetence, mental or physical fatigue, etc). What areas of the person's life are affected by this experience of burnout? (e.g. personal, professional, spiritual, marital, familial, etc)

Group 3 brainstorms about coping with burnout – How does or might counsellor burnout affect the quality of counselling or what might be the effects of counsellor burnout on their counselling? What can counsellors do to manage and prevent burnout?

Situations that may contribute to burnout and options for prevention

Client overload: client records readily available for reference, smooth client flow, health education sessions undertaken by support staff during wait time

Handling emotional issues over a period of time: staff recreation activities arranged by management, sending counsellors to workshops/meetings, positive feedback by supervisors

Contd.

Lack of supervision and support: regular review of case records, supervisor to observe counselling session and provide constructive feedback

Inadequate skills or excessive expectations: revise expectations, build capacity (training, refreshers)

Lack of support from team/colleagues: team building exercises, clarity of roles and responsibilities of all team members

Personal Burnout Prevention and Management Plan

Working in pairs:

- Identifying signs and symptoms
- Identifying strategies and making plans for adopting a healthy life style

Design & Developed by

