Botswana Ministry of Health

Management of Sexually Transmitted Infections

STI Management Course - Facilitator's Guide

June 2005

I-TECH
The International Training and Education Center on HIV (I-TECH) was established in 2002 by the Health Resources and Services Administration (HRSA) in collaboration with the Centers for Disease Control and Prevention (CDC). I-TECH supports the ongoing development of health-care provider training systems that are locally determined, optimally resourced, highly responsive, and self-sustaining in countries and regions hardest hit by the AIDS epidemic.

BOTUSA
The BOTUSA Project is a collaboration of the Botswana government and the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services, existing to provide technical assistance, consultation, and funding; implement programs; and conduct research with the Botswana government and other local and international partners for the prevention, care and support, and surveillance of HIV/AIDS, tuberculosis, and sexually transmitted infections (STIs).

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Welcome to the STI Syndromic Management Training!

Thank you for being a facilitator for the Comprehensive STI Management 3-Day Training Course. This Facilitator's Guide and Training-of-Trainers course includes important information and skills that will guide you as you teach the 3-day course. Below you will find a table of contents that will help familiarise you with the contents of this Guide.

Table of Contents

	Page
Part I. About this Guide	
Introduction	**3**
Course Schedule	**5**
Course Evaluation Form	**7**
Part II. Teaching the 3-Day STI Management Course	
Part II Contents	**13**
Aim, Learning Objectives, and Key Points	**14**
Handouts and Worksheets	**15**
References	**71**
Part III. Resources for Teaching the 3-Day STI Management Course	
Part III. Contents	**73**
Aim, Learning Objectives, and Key Points	**74**
Handouts and Worksheets	**75**
References	**92**
Appendix: STI Course Slides and Lecture Notes (optional)	**93**

COMPREHENSIVE STI MANAGEMENT
3-DAY TRAINING COURSE

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Part I:
About This Course

About This Guide

Introduction

What you will learn

This guide provides information that will help you teach the STI 3-Day Training Course. The STI 3-Day course covers the basic elements of comprehensive STI care in a primary health-care setting and is based on the newly revised STI Reference Manual for Botswana published by the Botswana Ministry of Health. This guide includes trainer's notes, helpful hints for using different training methods, and exercises to help prepare you to teach the 3-day course.

Topics covered in the 3-day course include the syndromic management of STIs and updated treatment protocols, patient-centred care, behaviour-change counselling, and STI/HIV risk reduction. Participants will also learn about the new national policy for routine HIV testing and how it fits within the context of STI care and treatment. This guide was developed to help prepare you to teach each of these subjects effectively in the 3-day course.

Why this guide is important

Before facilitating a new course, trainers need to be very familiar with the content and adequately prepared to teach the course effectively. The 3-day STI course is an important course for health-care providers to enable them to provide the very best STI care, counselling, and support to their patients. This guide will help prepare you to train health-care providers so that they receive the highest quality training as participants in the 3-day STI course.

Who this guide is designed for

This guide is designed for health-care providers who have been identified to teach the 3-day STI Training Course for health-care professionals. Some previous STI training is recommended. The trainers who teach the 3-day course should be very familiar with the new *Management of Sexually Transmitted Infections Reference Manual* and have a desire to assist other health-care providers to learn about STI diagnosis and treatment.

Course ground rules

During the 3-day STI Management course that you will be facilitating, participants will be asked to customize their own list of ground rules for the training. Although these lists may be different across the groups that you train, there are some basic ground rules to consider:

1. Show respect for opinions and voices of others in the training group.
2. Do not interrupt.
3. Do not use cell phones during the training (opportunities to make and return calls will be available during breaks).
4. Personal disclosures shared during the training sessions should remain confidential and not be shared outside of the training group.

Learning assessment and course evaluation

Assessment and evaluation in the 3-day course. At the beginning of the 3-day STI Management course, participants will be asked to take a brief **pre-test** to assess their level of knowledge in certain areas covered during the course. This test will help you as the facilitator for the course to assess the knowledge level of each participant. At the completion of the course, participants will then be asked to complete the same test again as a **post-test**. The post-test is used to measure how much knowledge participants gained during the course. When you teach the 3-day course, you should allow approximately 15 minutes at the beginning and the end of the course for participants to complete the pre- and post-tests.

Participants will also complete a **course evaluation** form at the end of the course. This form is used to collect their comments and suggestions so that the course may be improved for future participants. Make sure to allow 10 to 15 minutes at the end of the theoretical portion of the course for participants to complete this course evaluation.

How to use the Participant's Handbook and this Facilitator's Guide

Participant's Handbook. Participants will receive a Participant's Handbook, which serves as a supplemental resource to the 2005 edition of the STI Reference Manual for Botswana, the primary textbook for this course. While the reference manual contains the majority of the information that will be covered during the 3-day district training, the Participant's Handbook provides participants and facilitators with an overview of each session that includes learning objectives, key points, and a description of session activities with accompanying worksheets. At the beginning of each session description, there are also references to the corresponding chapters of the STI reference manual so that participants and facilitators can prepare and follow along accordingly. The Participant's Handbook and corresponding STI Reference Manual make up the training materials for the 3-day STI Management course and all facilitators are expected to follow both carefully when they train.

Facilitator's Guide. This Facilitator's Guide is intended for use by facilitators who will be teaching the 3-day STI Management course. This Guide includes information about how to teach the course effectively.

Comprehensive STI Syndromic Management 3-Day Course Schedule

The following schedule is provided as a guide only. The actual order of events may differ according to time available and facilitator preferences.

Day 1: Theoretical Training		
Time	**Session**	**Topics Covered**
8:00 – 8:20	Course Opening	Registration Opening Prayer Welcome remarks
8:20 – 9:30	Session 1	Course training objectives Agenda review Pre-test Course overview and background
9:30 – 10:00	Session 2	Patient-centred care • Video 1 and 2
10:00 – 10:40	Session 3	Gathering Information: History Taking and Assessing STI/HIV Risk • Role-play
10:40 – 10:55	TEA BREAK	
10:55 – 11:10	Session 4	Integrating Routine HIV Testing into the Primary-Care Visit
11:10 – 11:40	Session 5	Physical Exam • Video 3
11:40 – 12:40	Session 6	Diagnosis and Management of STI-Related Syndromes: *GUD*
12:40 – 13:40	LUNCH	
13:40 – 14:25	Session 6 (Cont'd)	Diagnosis and Management of STI-Related Syndromes: *Vaginal Discharge*
14:25 – 14:55	Session 6 (Cont'd)	Diagnosis and Management of STI-Related Syndromes: *Urethral Discharge*
14:55 – 15:15	Session 6 (Cont'd)	Diagnosis and Management of STI-Related Syndromes: *Inguinal Bubo*
15:15 – 15:40	Session 7	Risk-Reduction Counselling • Video 4
15:40 – 16:10	Session 8	HIV Post-Test Counselling • Video 5 • Role-play
Evening	Homework	Review Reference Manual and Flowcharts

Day 2: Practical & Theoretical Training		
Time	**Session**	**Topics Covered**
7:30 – 12:45	Morning practical training	Clinical practice of STI Syndromic Management
12:45 – 13:45	LUNCH	
13:45 – 14:15	Session 6 (Cont'd)	Diagnosis and Management of STI-Related Syndromes: Review of Flowcharts for *Balanitis* and *Acute Scrotal Swelling*
14:15 – 15:00	Practical Training	Clinical encounters or case-study discussion
15:00 – 16:30	Applied Theoretical Training	Pre-prepared case-study discussion

Day 3: Practical Training		
Time	**Session**	**Topics Covered**
7:30 – 12:45	Morning practical training	Clinical practice of STI Syndromic Management
12:45 – 13:45	LUNCH	
13:45 – 14:15	Session 6 (Cont'd)	Diagnosis and Management of STI-Related Syndromes: Review of Flowcharts for • Management of RPR/VDRL-positive cases • Ophthalmia Neonaturum
14:15 – 16:00	Practical Training Theoretical Training	Clinical encounters or case-study discussion Prepared case-study discussion
16:00 – 16:30	Closure of Course	Post-test and course evaluation

Participant Course Evaluation Form

The course evaluation form contained on the following pages is provided here for your use as an instructor. These forms can be handed out to course participants at the completion of training to gain important feedback on the overall content and effectiveness of the course. You can use this information to make improvements to the course for future trainings.

STI Case-Management Course Evaluation

Date _____

Designation/Title (i.e., registered nurse, pharmacy technician) _____

1. Please complete the following by ticking the column of your choice.

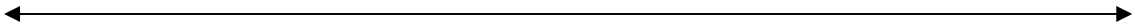
PLEASE RATE THE QUALITY OF THE FOLLOWING…	**POOR**	**FAIR**	**GOOD**	**VERY GOOD**	**EXCELLENT**
Overall Content of Course					
Participant's Handbook					
Reference Manual					
Presentation of Material by Trainers					
Group Activities and Exercises					
Facilitation of Activities by Trainers					

Training Methodology / Facilitation Skills (for trainers only)

2. Think about what you *already knew before* this training and what you *learned during* this training about **your ability to facilitate training**.

   Then evaluate your knowledge and ability in each of the following topic areas related to training methods and facilitation skills ***Before*** and ***After*** this training.

1 = No knowledge or skills **3 = Some knowledge or skills** **5 = A lot of knowledge or skills**



BEFORE TRAINING					***SELF-ASSESSMENT OF YOUR KNOWLEDGE AND SKILLS RELATED TO:***	**AFTER TRAINING**				
1	**2**	**3**	**4**	**5**	*Giving presentations/lecturing*	**1**	**2**	**3**	**4**	**5**
1	**2**	**3**	**4**	**5**	*Leading a discussion*	**1**	**2**	**3**	**4**	**5**
1	**2**	**3**	**4**	**5**	*Applying adult learning principles*	**1**	**2**	**3**	**4**	**5**
1	**2**	**3**	**4**	**5**	*Facilitating a role-play*	**1**	**2**	**3**	**4**	**5**
1	**2**	**3**	**4**	**5**	*Using visual aids*	**1**	**2**	**3**	**4**	**5**
1	**2**	**3**	**4**	**5**	*Using clinical case studies*	**1**	**2**	**3**	**4**	**5**

Knowledge of STI Management

3. Think about what you *already knew before* this training and what you *learned during* this training about **managing sexually transmitted Infections**.

   Then evaluate your knowledge in each of the following topic areas related to managing STIs ***before*** and ***after*** this training.

1 = No knowledge **3 = Some knowledge** **5 = A lot of knowledge**

BEFORE TRAINING					*SELF-ASSESSMENT OF YOUR KNOWLEDGE RELATED TO:*	AFTER TRAINING				
1	2	3	4	5	*Patient-centred care*	1	2	3	4	5
1	2	3	4	5	*Integrating STI risk assessment, risk-reduction discussions, and routine HIV testing in a primary-care setting*	1	2	3	4	5
1	2	3	4	5	*History taking and risk assessment*	1	2	3	4	5
1	2	3	4	5	*Physical exam*	1	2	3	4	5
1	2	3	4	5	*Diagnosis and management of STI-related syndromes*	1	2	3	4	5
1	2	3	4	5	*Risk-reduction discussion and planning*	1	2	3	4	5
1	2	3	4	5	*HIV post-test counselling*	1	2	3	4	5

Clinical Skills Related to STI Management

4. Think about *your* clinical skills and abilities *before this training* and the clinical skills and abilities that you *learned during* this training related to **diagnosing and treating sexually transmitted infections**.

   Then evaluate your ability in each of the following skill areas related to clinically managing STIs ***before*** and ***after*** this training.

1 = No skills **3 = Some skills** **5 = A lot of skills**

BEFORE TRAINING					*SELF-ASSESSMENT OF YOUR CLINICAL SKILLS RELATED TO:*	AFTER TRAINING				
1	2	3	4	5	*Conducting a patient-centred-care visit*	1	2	3	4	5
1	2	3	4	5	*Assessing a patient's STI risk in a primary-care setting*	1	2	3	4	5
1	2	3	4	5	*Discussing risk reduction with your patient in a primary-care setting*	1	2	3	4	5
1	2	3	4	5	*Conducting routine HIV testing in a primary-care setting*	1	2	3	4	5
1	2	3	4	5	*Taking a patient's medical history*	1	2	3	4	5
1	2	3	4	5	*Conducting a female physical exam*	1	2	3	4	5
1	2	3	4	5	*Conducting a male physical exam*	1	2	3	4	5
1	2	3	4	5	*Diagnosing STI-related syndromes*	1	2	3	4	5
1	2	3	4	5	*Creating a risk-reduction plan with a patient*	1	2	3	4	5
1	2	3	4	5	*Counselling a patient after they receive their HIV test*	1	2	3	4	5

Potential Open-Ended Questions

1. What are the 3 most important *things* you learned during this training?

2. Using the scale below, please rate the course in terms of its impact and usefulness in the following areas.

1 = Not useful at all **5 = Very useful**

Area	1	2	3	4	5
Useful in your daily work	1	2	3	4	5
Increasing your **willingness** to train and mentor others	1	2	3	4	5
Increasing your **ability** to train and mentor others	1	2	3	4	5

3. To what extent do you feel prepared to **perform** job tasks related to STI management?

1	2	3
Not at all prepared	Somewhat prepared	Well prepared

If you do NOT feel prepared to perform job tasks related to STI management, please explain briefly why you do not.

4. To what extent do you feel prepared to **train others** on job tasks related to STI management?

1	2	3
Not at all prepared	Somewhat prepared	Well prepared

If you do NOT feel prepared to train others on job tasks related to STI management, please explain briefly why you do not.

5. What topic areas related to STI management and training would you like **more information** on, if any?

6. If you were given the task of redesigning this course, what would you ***change***?

7. Please share any other comments you have that would help us ***strengthen*** or ***improve*** this course.

8. What was the **most valuable** part of this training? Why was it valuable for you?

9. What was the **least valuable** part of this training? What wasn't it valuable for you?

Thank you for completing this evaluation!

COMPREHENSIVE STI MANAGEMENT
3-DAY TRAINING COURSE

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Part II:
Teaching the
3-Day STI Management
Training Course

Part II: Teaching the 3-Day STI Management Training Course

	Page Number
Part II Contents	13
Aim, Learning Objectives, and Key Points	14
Handouts and Worksheets	
Teaching with Case Studies	15
HSV	18
Syphilis	20
Vaginal Discharge and Lower Abdominal Pain	24
Bubo	33
Warts	38
Acute Scrotal Swelling	41
Neonatal Conjunctivitis	45
Balanitis	48
Genital Ulcer Disease	51
Urethral Discharge	54
STI and Pregnancy	56
Miscellaneous Case Study Questions	59
Teaching with Trigger Films (Trigger Tapes)	61
Patient-Centred vs. Provider-Centred Care (Segments 1& 2)	62
Sensitive Physical Exam	63
Risk-Reduction Counselling	64
HIV Post-Test Counselling	66
Teaching with Role-Plays	67
HIV Post-Test Counselling	68
Interactive Lecture Assignment Worksheet	69
References	71

Part II. Teaching the 3-Day STI Management Training Course

Aim
The aim of Part II of this guide is to learn about specific training methods that can be used effectively to teach the STI Management Training Course.

Learning Objectives
By the end of Part II on teaching the STI Management training course, you will be able to:

- Use appropriate methods skillfully to train participants in the 3-day STI Management course
- Use case studies to generate discussion and analytical thinking about diagnosing syndromes and treating patients
- Use trigger films to create a discussion about medical content and diagnostic thinking, patient-provider communication, ethics, and other related topics
- Use role-plays that provide an opportunity for participants to practice new skills and reflect on their work
- Teach an algorithm from the STI Reference Manual to your colleagues correctly and effectively

Key Points

- Good trainers use a variety of techniques to reach the greatest number of participants
- Adults must be able to apply what they learn
- Different training methods should be used to teach different skills
- The more varied your training methods are, the more interesting and interactive your training course will be
- Trigger films and case studies are two effective ways to generate discussion and teach important skills related to diagnosing syndromes and treating patients

Handouts and Worksheets

Teaching with Case Studies

A case study is a written scenario of a professional situation that includes details about a problem that must be analysed and solved. A case study provides participants with an opportunity to analyse typical, sometimes difficult, professional scenarios and to discuss different approaches for responding to the situation.

Case studies are more interesting for learners than completely didactic material. Learners can apply new knowledge and skills to challenging situations, giving them the opportunity to develop their analytical and problem-solving skills. Case studies represent actual patient encounters and demonstrate clinical decision-making.

The Anatomy of a Case Study
A case study is divided into five different types of activities.

Case Activity	Example
1. Clear learning objectives based on clinical skill needs.	To be able to diagnose GUD in a male patient.
2. Describe detailed features of the patient and case.	Peter, a 35-year-old male, has come in to the clinic complaining of pain in his genitals and sores on his penis. He has been experiencing these symptoms for about one week. He has had a few casual partners since he met his girlfriend. He says that he tries to use condoms. Upon examination, you find multiple small, round ulcers on his penis and some swelling in the groin.
3. Identify first decision point.	What is your syndromic diagnosis?
4. Discuss options and determine “best” answer.	Patient has a genital ulcer disease, most likely herpes.
5. Conclude and move to the next decision point.	How would you manage this patient’s infection?

Based on Developing Clinical Case Studies: A Guide for Teaching, A. Downer and S. Swindells, 2003.

Creating a Case Study Based on Clear Learning Objectives

- Learning objectives are words, pictures, or diagrams that tell others what you intend for your students to learn.
- Objectives should be specific, measurable, and achievable.
- A case study should have more than one objective; often a series of objectives are addressed as the case unfolds.
- The clinical decision points of the case focus on the issues identified in the objectives.

Describing Features of Patient and Case Detail

- The patient and case detail provide baseline information about the patient and move the learner toward the first clinical decision point.
- The number of elements included in the case description depends on the complexity of the case and the information needed to stage the decision point.

  Sample Baseline Information

  - age
  - sex
  - STI/HIV infection status
  - reported symptoms at presentation
  - recent medical history
  - relevant social history
  - findings from physical examination
  - results of laboratory studies
  - findings of diagnostic workup

Developing Decision Points in Case Studies

- Decision points focus learners' attention on distinct opportunities for informed decision-making and problem solving in a clinical setting.
- It is important to develop well-defined questions that address learning objectives.
- Don’t focus attention on issues irrelevant to primary learning goals.

Discussing Options

- Responses to decision points should not be obvious and may be varied.
- While there is often no "right" answer, there should be clearly "preferred" or “best practice” answer(s).
- The case can provide options to participants (i.e., multiple choice), or ask them to discuss possible options on their own and then choose. There are advantages and disadvantages to each method. Multiple-choice questions allow for large-group discussion and can be done more quickly. Group discussion with no options provided allows for more discussion and potential alternative answers.

Potential Problems with Case Studies

- Not enough detail provided on patients or overall context.
- Too many details that may give away the answer(s).
- Answers to decision points are too obvious.
- Case is not representative of common patient population.
- Case is too simple or rudimentary.
- Participants lack knowledge or experience needed to respond to decision point(s).

- Decision point, problem to solve, or question is unclear.
- Questions do not focus on the most pertinent, “critical incident” aspects of case.

Importance of Discussion in Case Studies

Discussions are central to case studies.

- Case studies are not intended to be a lecture where the right answer is immediately provided by a trainer.
- Problem-solving and critical thinking about decisive clinical moments require participants to contribute.
- The conversation must focus on the problem and ask participants to consider details, identify options, and determine best responses.
- This conversation cannot be created unless participants TALK.

Characteristics of an Effective Case Study Facilitator

- Asks questions, and then asks more questions.
- Considers and analyses possible responses.
- Probes student responses with supportive questions (i.e., “That’s an interesting idea...why would you choose that treatment option?”).
- Explores pros and cons of alternative responses.
- Requires participants to consider all details in case.
- Provides additional illustrative information to make case clearer and more instructive.

Worksheet B.1

Case Study 1: HSV

Instructions: This case study is a practical companion to the Genital Ulcer Disease (GUD) section of **Session 5: Diagnosis and management of STI-related syndromes.** Read the case description below. Use the GUD flowchart in this handbook or the *Clinical Guide* to answer the questions. For multiple choice questions, circle the correct answers. For other questions, fill in the answer in the space provided. Be prepared to discuss the case during training.

Case Study 1: HSV

Description of Case 1:

A 32-year-old woman presents with a crop of small painful superficial unilateral skin ulcers on the external genitalia. She states that the ulcers were vesicles at the beginning. There is no history of a similar disease and she denies any systemic symptoms.

On physical examination, the patient is afebrile and there is no systemic or localised lymphadenopathy or neuropathy. There is no mucosal involvement.

Questions:

1. What is your diagnosis? Why?
   a. Non-Primary Initial HSV Infection
   b. First symptomatic chronic HSV infection
   c. Primary HSV infection
   d. First or second
2. What is the most likely cause of her genital herpes infection?
   a. HSV1
   b. HSV2
   c. Either HSV1 *or* HSV2
3. A patient with **recurrent** oral herpes most likely has:
   a. Only HSV1
   b. Only HSV2
   c. Either HSV1 *or* HSV2
4. A woman has type-specific antibody to HSV-1.
   - How has she acquired the infection?

5. A woman has type-specific antibody to HSV-2.
   - How has she acquired the infection?

Answers to HSV Case Study

Answers: HSV Case 1

Answer 1: a

- Her herpes is mild and unilateral without any evidence of mucosal involvement. There are no systemic signs or symptoms.
- All of the above are inconsistent with primary HSV, a severe form of the disease in a host who has never been exposed to HSV-1 or HSV-2.
- Her signs and symptoms are consistent with non-primary initial or relapsing HSV infection.

Answer 2: b

- Most cases of genital herpes are caused by herpes simplex virus 2 (HSV-2), but some cases may be caused by an infection with herpes simplex virus 1 (HSV-1), the usual cause of orolabial herpes.
- HSV-1 causes a **substantial minority** of genital infections, but systematic recurrences and sub-clinical viral shedding are less frequent than with HSV-2 infection.

Answer 3: a

- This patient has HSV-1.
- HSV-2 almost exclusively infects the genitals, anus, or surrounding areas.
- Oral infection with HSV-2 is uncommon except in the presence of primary genital herpes.
- Recurrent oral herpes is almost never due to HSV-2.

Answer 4

- Type-specific antibody to HSV-1 reflects either genital or oral infection.

Answer 5

- Type-specific antibody to HSV-2 almost always indicates sexually acquired anogenital infection.

Worksheet B.2

Case Studies 2 – 4: Syphilis

Instructions:	This case study is a practical companion to the Genital Ulcer Disease (GUD) section of **Session 5: Diagnosis and management of STI-related syndromes.** Read the case description below. Use the GUD flowchart (Session 5.2) and RPR/VDRL flowchart (Appendix C) in this handbook or in the *Clinical Guide* to answer the questions. To answer questions, fill in the answer in the space provided. Be prepared to discuss the case during training.
Case Study 2: Syphilis	
Description of Case 2:	A pregnant woman has positive RPR.
Questions:	1. What questions would you like to ask this patient? 2. What does RPR stand for? 3. What is the difference between RPR and VDRL?
Case2 Cont'd:	You learn that she has never been treated for syphilis in the past, and there is no other RPR test result available. In your history and PE, there are no signs or symptoms suggestive of syphilis.
Questions:	4. What are your plans for this patient?
Case 2 Cont'd:	In a follow-up 3 months later, you find the patient's RPR titre has increased.
Questions:	5. What is your plan now?

Case Study 3: Syphilis	
Description of Case 3	A 55-year-old man has a positive RPR and no signs or symptoms suggestive of active syphilis. He had been tested and treated 6 months ago for syphilis. RPR was positive with titre of 1/8. Now RPR is 1/2.
Questions:	1. What is your plan for this patient?

Case Study 4: Syphilis	
Description of Case 4	Syphilis in pregnancy is associated with: • Congenital syphilis • Spontaneous abortion • Stillbirth
Questions:	1. What is the appropriate treatment for syphilis during pregnancy if the mother is allergic to penicillin?

Answers to Syphilis Case Studies

Answers: Syphilis Case 2

Answer 1

- History of syphilis and treatment for syphilis in the past? When and how?
- Any signs or symptoms suggestive of active syphilis?
- Is this latent syphilis?
- If she has been tested in the past, is the report available?
- Any allergies. If allergic to penicillin, arrange for the newborn to be given procaine penicillin.

Answer 2

- RPR stands for Rapid Plasma Reagin.
- Reagin is IgG targeting cardiolipin.

Answer 3

- RPR and VDRL look for the same antigen against cardiolipin. To interpret the result of VDRL, you need a microscope. For RPR, a microscope is not necessary.

Answer 4

- There are two possibilities:
- She has asymptomatic syphilis.
- RPR is Biological False Positive (BFP), which may happen in pregnancy.
- Treat for syphilis.
- 2.4 IU IM weekly for 3 weeks.
- Review after 3 months.

Answer 5

- Treatment has failed or re-infection has occurred.
- Repeat the treatment with close follow-up.
- Reinforce the education. Elaborate on the consequences of syphilis on pregnancy (stillbirth, premature delivery, congenital syphilis, etc.).
- The patient may have HIV. Treatment failure is not infrequent in a patient with HIV. Repeat the treatment and follow carefully.

Answers: Syphilis Case 3

Answer 1

- This patient should be followed with additional RPRs in 6 and 12 months.
- There is no active syphilis, and the RPR has dropped 4-fold, which means syphilis has been treated appropriately and he has not been re-exposed to syphilis recently.

Answers: Syphilis Case 4

Answer 1

- If possible, she should be desensitised and treated with penicillin. Doxycycline is contraindicated during pregnancy and erythromycin should not be used because it does not reliably cure an infected fetus.
- If desensitisation is not possible, then treat with erythromycin. Immediately after the delivery, the newborn must be treated with penicillin.

Worksheet B.3

Case Studies 5 – 11: Vaginal Discharge and/or Lower Abdominal Pain Syndrome

Instructions: These case studies are a practical companion to the Vaginal Discharge Syndrome section of **Session 5: Diagnosis and management of STI related syndromes.** Read the case description below. Use the flowcharts in this handbook or the *Clinical Guide* to answer the questions. Fill in the answers to questions in the space provided. Be prepared to discuss the case during training.

Case Study 5: **Vaginal Discharge and/or Lower Abdominal Pain Syndrome**

Description of Case 5:

A 25-year-old woman comes to you for evaluation of lower abdominal pain of 2 days duration. She denies vaginal discharge, yellow discharge, or fever. She has no history of missed or overdue periods, recent delivery or abortion, or abnormal vaginal bleeding.

On physical examination her temperature is 37 C. There is no abdominal mass, abdominal tenderness, or rebound tenderness. There is no cervical mucopus or vaginal discharge. There is no cervical motion tenderness. There is no vulval erythema, excoriation, or curd-like discharge. There is no evidence of any other STI.

Questions:

1. What is the syndromic diagnosis?

2. What would you do?

Case Study 6: **Vaginal Discharge and/or Lower Abdominal Pain Syndrome**

Description of Case 6:

An 18-year-old woman, recently married, comes to you for evaluation of her lower abdominal pain of 2 days duration. She denies vaginal discharge, yellow discharge, or fever. She has no history of missed or overdue periods, recent delivery or abortion, or abnormal vaginal bleeding.

On physical examination her temperature is 37 C. There is no abdominal mass, abdominal tenderness, or rebound tenderness. There is no cervical mucopus or vaginal discharge. There is no cervical motion tenderness. There is no vulval erythema, excoriation, or curd-like discharge. There is no evidence for any other STI.

Questions:

1. What is the syndromic diagnosis?

2. What would you do?

Case 6 Cont'd:	Another 18-year-old woman presents with LAP of 3 days duration.
Questions:	3. What else do you want to know? 4. What is meant by Risk-Factor Assessment in the setting of vaginal discharge/LAP?
Case 6 Cont'd:	The patient thinks she is pregnant. She has married recently. She has missed her period. She denies fever or vaginal discharge. Her abdomen is tender, and there is guarding.
Questions:	5. What should you do?
Case Study 7: **Vaginal Discharge and/or Lower Abdominal Pain Syndrome**	
Description of Case 7:	A 25-year-old woman presents to you for evaluation of her LAP of 2 days duration. She is not complaining of fever or abnormal discharge. There is no history of missed or overdue periods, recent delivery or abortion, or abnormal vaginal bleeding. On physical examination, temperature is 37 C. There is lower abdominal tenderness and guarding. Pelvic examination shows no vaginal ulcer, or discharge. There is no evidence for VVC. Speculum examination reveals no cervical mucopus or erosion, but during pelvic examination she is very uncomfortable. There is cervical motion tenderness.
Questions:	1. What are your thoughts? (Consult the Vaginal Discharge and/or Lower Abdominal Pain Flowchart.) 2. What are your recommendations?

Case 7 Cont'd:	Immediate transfer is not possible. You decide to treat her for PID as you are trying to make the arrangements to transfer, but her situation is getting worse quickly and now she has nausea and vomiting.
Questions:	3. What are the possibilities? 4. What are you going to do?
Case Study 8: **Vaginal Discharge and/or Lower Abdominal Pain Syndrome**	
Description of Case 8:	An 18-year-old woman is complaining of vulval pruritis and irritation associated with external dysuria. She denies fever, yellow discharge, or abdominal pain. She has not missed her period, and she is not postpartum and there is no history of abortion. On PE, there is no abdominal tenderness or guarding. On pelvic examination there is no discharge, no yellow discharge, no cervical mucopus, and no cervical motion tenderness. The vagina and endocervix are normal. There is vulval erythema and excoriation.
Questions:	1. What are your thoughts and plans? 2. What is the syndromic diagnosis?

Case Study 9: **Vaginal Discharge and/or Lower Abdominal Pain Syndrome**	
Description of Case 9:	A 24-year-old sexually active woman is complaining of non-yellowish vaginal discharge of a few days duration. There is no abdominal pain. On physical examination, there is no fever. There is no abdominal tenderness. There is no adenopathy. On pelvic examination, there is no ulcer. There is no vaginal discharge. Cervix looks normal. There is vulval erythema and excoriations.
Questions:	1. What is your syndromic diagnosis and approach?

Case Study 10: **Vaginal Discharge and/or Lower Abdominal Pain Syndrome**	
Description of Case 10:	A 19-year-old sexually active woman is complaining of non-yellowish vaginal discharge of a few days duration. There is no abdominal pain. On physical examination, there is no fever. There is no abdominal tenderness. There is no adenopathy. On pelvic examination, there is no ulcer. There is no vaginal discharge. Cervix looks normal. There is vulval erythema and excoriations.
Questions:	1. What is your syndromic diagnosis and approach?

Case Study 11: **Vaginal Discharge and/or Lower Abdominal Pain Syndrome**	
Description of Case 11:	A 12-year-old girl is brought to you by her mother with a chief complaint of vaginal discharge, vulvovaginal discomfort, and pruritis. She is not sexually active, and her mother is very concerned regarding her complaints.
Questions:	1. What are your thoughts and what are you going to do? 2. What questions would you like to ask?

Case 11 Cont'd:	**Health History** • You ask her mother to step out. You make the girl comfortable and ask about her school and education first. Then you gradually ask her if she is sexually active or if anyone has abused her. • The patient insists that she is not sexually active. She says that she acquired the illness from sitting too long and too frequently in the bathtub. • She denies fever and abdominal pain. **Physical Examination** • On physical examination, the abdomen is soft. • There is bilateral tender inguinal adenopathy. The vulvovagina is swollen and inflamed. It is covered with curd-like, whitish discharge. • There are many superficial and painful ulcers on the labia minor. There are a few blisters on the labia major. On speculum examination, there are several erosions on the cervix. There is copious yellowish endocervical discharge. There are several superficial ulcers on the vaginal wall bilaterally. There is vaginal thrush. There is no cervical motion tenderness.
Questions:	3. What are your thoughts? What is the syndromic diagnosis? 4. What are the possible etiological agents? 5. Consult the appropriate flowcharts and come up with a treatment plan.
Case 11 Cont'd:	**Remarks:** Cervical mucus production and humoral immunity are absent until ovulation begins. The risk of complications of STI is higher in immature adolescents exposed to infection as compared to physically mature women. In addition, susceptibility to STI and ascending infection and subsequent PID are more frequent in sexually active prepubescent adolescents.
Questions:	6. What are the major issues? 7. How do you handle the situation? How do you deal with her partner or partners? What do you say to her mother?

Answers to Vaginal Discharge and Lower Abdominal Pain Case Studies

Answers: Vaginal Discharge and Lower Abdominal Pain Case 5

Answer 1

- The syndromic diagnosis is vaginal discharge and/or LAP syndrome.

Answer 2

- Referring to the flowchart, she does not have an STI.
- Her abdominal pain is most likely unrelated to STI.
- She should be followed carefully.

Answers: Vaginal Discharge and Lower Abdominal Pain Case 6

Answer 1

- The syndromic diagnosis is vaginal discharge and/or LAP syndrome.
- Referring to the flowchart, she has one risk factor for cervicitis: Age less than 21 years.
- Although she has no vaginal discharge or cervical discharge, there is a possibility for cervicitis.
- There is no evidence of PID.

Answer 2

- Treat for CT/GC and TV/BV.
- This approach definitely errs toward over-treatment, particularly for vaginal discharge, since she neither complains of nor has clinical evidence of vaginal discharge.

Answer 3

- You would like to know answers to the following questions:
- History of vaginal discharge?
- Missed or overdue periods, abnormal vaginal bleeding, recent delivery or abortion, fever, abdominal mass, tenderness, rebound tenderness or guarding, vaginal discharge, cervical mucopus or yellow discharge, cervical motion tenderness.

Answer 4

- Risk-Factor Assessment in this setting means the predictors of endocervicitis in the absence of objective evidence for vaginal discharge.
    - Age less than 21 years
    - Patient complains of yellow discharge

Answer 5

- She must be referred immediately. She may have one of the many serious complications of pregnancy.
- Evaluation for possibility of STI has to be deferred. An immediate and thorough OB/GYN evaluation is mandatory.

Answers: Vaginal Discharge and Lower Abdominal Pain Case 7

Answer 1

- The possibility of PID or other surgical conditions is high.

Answer 2

- Refer immediately.
- If immediate referral is not possible, treat for PID while you are arranging for the referral.

Answer 3

- You have to be very concerned. There is much overlap between clinical presentations of PID and many other diseases.
- She may have appendicitis, or rupture of ovarian cysts.
- Despite not missing a period, she may have pregnancy-related complications.

Answer 4

- Refer her immediately. Call for help!

Answers: Vaginal Discharge and Lower Abdominal Pain Case 8

Answer 1

- This is VVC and should be treated accordingly.

Answer 2

- This is not a syndrome.
- It is similar to diagnosing warts. There is no syndromic approach to warts. Warts is a very specific disease.

Answers: Vaginal Discharge and Lower Abdominal Pain Case 9

Answer 1

- She has vaginal discharge and/or lower abdominal pain syndrome.
- Consulting the flowchart, we see that she needs to be treated only for VVC. This is because there is no vaginal discharge on physical examination, and there is no risk factor for endocervicitis.

Answers: Vaginal Discharge and Lower Abdominal Pain Case 10

Answer 1

- She has vaginal discharge and/or lower abdominal pain syndrome.
- Referring to the flowchart, she is younger than 21, and the probability of asymptomatic endocervicitis is high.
- Despite a normal pelvic examination, she should be treated for endocervicitis.
- In addition, she has VVC and should be treated for that.
- Although she complains of vaginal discharge, none was seen during the physical examination. As a result, you will not treat her for this symptom. You will follow her carefully, however.

Answers: Vaginal Discharge and Lower Abdominal Pain Case 11

Answer 1

- There are many possible explanations for her symptoms, including hypersensitivity reaction and candidiasis. Even some worms may get into the vulvovagina and cause irritation.
- You also are concerned about the possibility of STI in thispatient. The girl is young and probably would not reveal the true story in front of her mother. You would like to interview and examine her in the presence of just a chaperon.

Answer 2

- You would like to ask about her sexual activities.
- Before asking any sensitive questions, emphasise that the information will remain confidential. Explain that the information helps you to make the right diagnosis and provide the appropriate treatment.
- Ask about her sexual partner's health history.
- Ask if she has had fever, abdominal pain, or any other complaint.

Answer 3

- She has vaginal discharge with VVC and genital ulcer disease.
- The endocervix is involved.
- Possibility of PID is low.

Answer 4

- Vaginal Discharge: TV, BV, VVC.
- Endocervical Discharge: GC, Chlamydia.
- Genital Ulcer Disease: Chancre, Chancroid, HSV.
- HPV?

Answer 5

- The patient needs ceftriaxone, doxycycline, metronidazole, cotrimazole, and acyclovir.
- She needs a Pap smear.
- She needs to be tested for pregnancy.
- She must be followed very carefully.
- She needs appropriate counselling and education.

Answer 6

- Her HIV status
- How to handle the issue of confidentiality
- Counseling

Answer 7

- There are no general answers for these culturally, socially, and ethically sensitive issues. You have to come up with a practical plan.

Worksheet B.4

Case Study 12: Bubo

Instructions:	This case study is a practical companion to **Session 6: Diagnosis and management of STI-related syndromes.** Read the case description below. Use the flowcharts in this handbook or in the *Clinical Guide* to answer the questions. Fill in the answers to questions in the space provided. Be prepared to discuss the case during training.
Case Study 12: **Bubo**	
Description of Case 12:	A young man has a tender mass in his groin, with history of fever and weight loss of several weeks duration. He is a truck driver and has multiple sexual partners. On physical examination, there is a very tender, matted, non-fluctuant group of lymph nodes in the right groin and the skin over the mass is tender and inflamed, and not moving over the mass.
Questions:	1. What is your syndromic diagnosis? 2. What are the etiological possibilities? 3. Before you proceed, what else would you like to know?
Case 12 Cont'd:	He is febrile, has thrush, poor dentition, no systemic adenopathy, no genital ulcer, no urethral discharge. No testicular mass. No foot or thigh infection.
Questions:	4. What are your thoughts about this case? 5. What is the syndromic diagnosis? 6. Do you want to order any specific test? Which ones? 7. What is your therapeutic plan?

Case 12 Cont'd:	You think he has bubo without genital ulcer and treat him for LGV according to the algorithm. You also ask him for HIV testing. HIV testing is a routine procedure. In this particular case, you are suspecting immunodeficiency (AIDS).
Questions:	8. What are the clinical findings in this case that are suggestive of AIDS? 9. Give 4 reasons why someone may have thrush but not have AIDS. 10. Give 4 reasons why someone may have lost weight and not have AIDS.
Case 12 Cont'd:	The patient comes back in 5 days to report that his pain is intolerable and he has not improved. You see him in your consultation room. He has been adherent and has had no sexual encounters since last visit. The mass is bigger and it is fluctuant again.
Questions:	11. What is your plan?
Case 12 Cont'd:	After 3 weeks of treatment and repeated aspiration, he is getting worse. He has closely adhered to your recommendations.
Questions:	12. What are your thoughts and plans now for this patient?

Case 12 Cont'd:	His HIV test result comes to your consultation room and he is HIV positive.
Questions:	13. Was there any evidence in the patient's history or PE suggestive of immunodeficiency? 14. What are your thoughts and plans for this patient?
Follow-Up:	In hospital, a biopsy of one of the lymph nodes showed tuberculosis. A chest X-ray also showed pulmonary infiltrate consistent with TB.

Answers: Bubo Case Study

Answers: Bubo Case 12

Answer 1

- Bubo

Answer 2

- Infectious
  - STI-related: Chancre, chancroid, LGV
  - Not STI-related: TB, fungi, cat scratch disease
  - Infection in foot or other area related to the lymphatics of the groin
- Non-infectious
  - Cancer, lymphoma, Kaposi's sarcoma

Answer 3

- Any history of STI in the past?
- Any evidence of a new STI?
- Any history of trauma to the leg, foot infection, or infection close to the groin?
- Systemic adenopathy?
- Other questions?

Answer 4

- You think he has bubo without a genital ulcer.

Answer 5

- Inguinal bubo.

Answer 6

- You also ask him about HIV testing.
  - HIV testing is a routine procedure.
  - In this case, you suspect immunodeficiency (AIDS).

Answer 7

- Treat him for LGV according to the algorithm.

Answer 8

- Weight loss
- Thrush

Answer 9

Causes of Candidiasis

- Broad-spectrum antibiotics, including doxycycline therapy
- Steroid therapy
- Diabetes
- Cancer and chemotherapy
- Newborns and infants younger than 6 months

Answer 10

Causes of Weight Loss

- TB
- Malnutrition
- Cancer
- Anorexia
- Chronic diseases

Answer 11

- According to the flowchart, you tap the bubo again and ask him to continue his antibiotics and call if he is not improving.
- Or you may have another suggestion?

Question 12

- Discussion.

Answer 13

- He has AIDS, and the etiology of the bubo could be one of several opportunistic infections.

Answer 14

- You refer him with a comprehensive summary of your findings and treatment.

Worksheet B.5

Case Studies 13-15: Warts

Instructions: This case study is a practical companion to the Genital Warts section of **Session 5: Diagnosis and management of STI-related syndromes.** Read the case description below. Use the flowcharts in this handbook or in the *Clinical Guide* to answer the questions. Fill in the answers to questions in the space provided. Be prepared to discuss the case during training.

Case Study 13: **Warts**

Description of Case 13: A 3-year-old girl has genital warts.

Questions:

1. Do you think she has been sexually abused?
   - Why?
   - What are the other explanations?
   - What is her chance of developing squamous cell carcinoma?
   - What is your plan?

Case Study 14: **Warts**

Description of Case 14: A young woman, a patient of yours, with previously completely treatment of anogenital warts, is in your consultation room with a mild overgrowth on her vulva that is suggestive of warts.

Questions:

1. How do you explain the situation?

Case Study 15: **Warts**

Description of Case 15: A 20-year-old woman who has a new boyfriend comes to you with new cervical lesions suggestive of warts. She denies any previous experience with warts and thinks she has acquired the disease from her new boyfriend.

Questions:

1. What would be your explanation?

Warts: Additional Questions

Questions:

Question Set 1

- Is there any situation in which anogenital warts caused by strains 6 or 11 may lead to squamous cell carcinoma?

- What are the most common HPV strains in cutaneous warts?

- What is Buschke Loewenstein tumour?

- What do LSIL and HSIL mean?

- Which of the following solutions is very toxic?
  - Podophyllin in 15 to 20 % tincture of benzoin
  - Podophyllotoxin

Question Set 2

The safety of which of the following therapies has not been established during pregnancy?

- Cryotherapy
- Surgery
- 90% trichloroacetic acid
- Podophyllotoxin
- Imiquimod

Remarks: Genital warts can enlarge considerably or may appear for the first time during pregnancy. Spontaneous regression after delivery is known to occur. This happens because pregnant women are immunosuppressed even in the absence of HIV infection.

Answers to Warts Case Studies

Answers: Warts Case 13

Answer 1

Obviously, sexual abuse has to be considered, but there are many other possible explanations:

- Reactivation of latent infection acquired at birth.
- Close contact with the family, if parents have active genital warts.
- Auto inoculation: Transfer of HPV 1, 2, 3, or 4 from hand warts of the child to the anogenital area.

Answers: Warts Case 14

Answer 1

- She may have a relapse, or she may have acquired a new strain of anogenital HPV.

Answers: Warts Case 15

Answer 1

- Warts are common among sexually active adults.
- The incubation period, likelihood of transmission to future partners, and duration of infectivity are unknown.
- The current sex partner may not be the source of infection.

Answers: Warts Additional Questions

Answer Set 1

- Malignant transformation into squamous carcinoma is known to occur in Buschke Loewenstein tumour.
- Strains HPV 1, 2, 3, and 4.
- Giant condylomas.
- Low- and High-grade Squamous Intraepithelial Lesions.
- Podophyllotoxin is a purified and non-toxic formulation.

Answer Set 2

- The safety of both podophyllotoxin and imiquimod during pregnancy has not been established.

Worksheet B.6

Case Studies 16 and 17: Acute Scrotal Swelling

Instructions:	This case study is a practical companion to the Acute Scrotal Swelling section of **Session 5: Diagnosis and management of STI-related syndromes.** Read the case description below. Use the flowcharts in this handbook or in the *Clinical Guide* to answer the questions. Fill in the answers to questions in the space provided. Be prepared to discuss the case during training.
Case Study 16: **Acute Scrotal Swelling**	
Description of Case 16:	A 22-year-old man with many previous episodes of STI is in your consultation room with a chief complaint of sudden onset of right-sided scrotal tenderness of one-hour duration.
Questions:	1. What is your syndromic diagnosis? 2. Refer to the flowchart - what questions would you like to ask?
Case 16 Cont'd:	He denies any urethral discharge, fever, dysuria, and genital ulcer. His last sexual activity was with a new partner several weeks ago and he did not use a condom and did not let his partner use a condom. His partner looked healthy and did not have any obvious discharge or genital lesion.
Questions:	3. What does "His partner looked healthy" mean?
Case 16 Cont'd:	On physical examination he is in severe pain and he is afebrile. There is no inguinal adenopathy. There is no genital ulcer, no urethral discharge even with penile milking. The right scrotum is mildly swollen, not red, no bruises, no sign of trauma or injury.
Questions:	4. Based on the information presented to you, do you have any other questions?

Case 16 Cont'd:	There is no history of trauma, no history of inguinal hernia.
Questions:	5. On your physical examination of the genitalia, is there any particular area that you would like to focus on? 6. How do you check for testicular torsion?
Case 16 Cont'd:	On further PE you see that the right testis is elevated and extremely tender.
Questions:	7. What are your thoughts and plans for this patient now? 8. What part of the patient's history is inconsistent with STI? 9. What parts of the clinical findings are worrisome?

Case Study 17: **Acute Scrotal Swelling**

Description of Case 17:	A 44-year-old man with history of renal stone and multiple STIs comes to visit you for fever, and progressive painful swelling of scrotum of 4 days duration. In addition, he is complaining of right flank pain and dysuria. He has sexual encounters 2 to 3 times a week with his wife, who is healthy. On PE, you find him in pain and febrile. He looks very toxic. There is no urethral discharge, no inguinal adenopathy, and no genital ulcer. The entire scrotal tissue is red and swollen, very tender to the touch, and you even feel some fluctuation.
Questions:	1. What are your thoughts and what are you going to do?

Answers to Acute Scrotal Swelling Case Studies

Answers: Acute Scrotal Swelling Case 16

Answer 1

- Acute scrotal swelling

Answer 2

- Recent sexual activities?
- Is he using condoms?
- Any urethral discharge?
- Any genital ulcers?

Answer 3

- Many STIs, particularly in women, are asymptomatic. The partner may look healthy, but be carrying one or several agents of STI.

Answer 4

- History of inguinal hernia?
- History of trauma?

Answer 5

- Check for hernia.
- Check for torsion of testis.
- Check for epididymitis.
- Check for orchitis or testicular abscess.

Answer 6

- Look for unilateral elevation of testis.

Answer 7

- Discussion.

Answer 8

- The sudden onset of severe pain is not consistent with STI. There are other inconsistencies, including lack of a recent sexual contact, genital ulcer, or urethral discharge.

Answer 9

- The most significant finding is the elevation of the right testis, which is highly suggestive of torsion.
- Refer him to a urologist immediately.

Answers to Acute Scrotal Swelling Case 17

Answer 1

The patient has infectious epididymitis and orchitis with a possibility of testicular abscess. Refer him immediately:

- There is the possibility of an abscess that needs to be drained by a urologist.
- The history of renal stone and flank pain suggest epididymitis and orchitis, which are complications of a urinary-tract infection.
- The possibility of an STI is less likely.

Worksheet B.7

Case Studies 18 and 19: Neonatal Conjunctivitis

Instructions: This case study is a practical companion to the Neonatal Conjunctivitis section of **Session 6: Diagnosis and management of STI-related syndromes.** Read the case description below. Use the flowcharts in this handbook and in the Clinical Guide to answer the questions. Fill in the answers to questions in the space provided. Use lines to connect the answers in the matching columns. Be prepared to discuss the case during training.

Case Study 18: **Neonatal Conjunctivitis**

Description of Case 18: A 5-day-old newborn has nonpurulent and mild conjunctivitis, despite receiving tetracycline ointment at birth.

Questions:

1. Match the conditions with the onset times below:

   A) Chemical conjunctivitis
   B) Gonococcal conjunctivitis
   C) Chlamydial conjunctivitis
   D) Herpetic conjunctivitis

   1. *5 to 14 days after birth*
   2. *First day of birth*
   3. *3 to 5 days after birth*
   4. *Within the first 2 weeks after birth*

2. When do you suspect HSV conjunctivitis or Keratitis in a newborn?

3. The neonatal conjunctivitis is a serious eyesight-threatening situation with very specific clinical features, including dilatation of conjunctival blood vessels (chemosis), excessive secretion, severe edema, and a destructive course. Why is this disease more severe in neonates than older children?

Case Study 19: Neonatal Conjunctivitis	
Description of Case 19:	A newborn female has conjunctivitis 10 days after birth. Her mother is healthy and is not complaining of any anogenital lesions or discomfort. The newborn has fever and a few blisters on the face, around the conjunctiva. She looks a little drowsy and yellow. The corneas show opacification.
Questions:	1. What are your thoughts and plans for this patient?

Answers to Neonatal Conjunctivitis Case Studies

Answers: Neonatal Conjunctivitis Case 18

Answer 1

- Shortest IP; first day of life
- Longest IP; within the first 2 wks
- 5 to 14 days of IP
- 3 to 5 days of IP

- Chemical
- HSV
- Chlamydia
- GC

Answers

- A and 2
- B and 3
- C and 1
- D and 4

Answer 2

- Mother has had active genital HSV during delivery
- Mother has acquired primary HSV close to delivery
- Baby has blisters on conjunctiva, face, or any other part of the body
- Newborn is systemically sick
- There is corneal opacification
- Conjunctivitis is not responding to treatment

Answer 3

- Immunity is in a developmental stage
- Absence of lymphoid tissue in the conjunctiva of the newborn
- Absence of tears at birth

Answers: Neonatal Conjunctivitis Case 19

Answer 1

- She must be referred immediately. She has all of the manifestations of disseminated HSV.
- Pregnant women without signs or symptoms of HSV and with only serological evidence of the virus may pass the virus to the newborn.

Worksheet B.8

Case Studies 20 & 21: Balanitis

Instructions:	This case study is a practical companion to **Session 5: Diagnosis and management of STI-related syndromes.** Read the case description below. Use the flowcharts in this handbook and in the *Clinical Guide* to answer the questions. Fill in the answers to questions in the space provided. Be prepared to discuss the case during training.
Case Study 20: **Balanitis**	
Description of Case 20:	A 25-year-old man complaining of itching and discharge from the glans of the penis for 3 days. No history of dysuria. He is not circumcised. On PE he is afebrile and there is no finding except that on retraction foreskin and glans have erythema and excoriations. On penile milking there is no discharge.
Questions:	1. What are your diagnosis and plans for this patient?
Case 20 Cont'd:	After taking medication, he reports that he has not improved, and your examination confirms this.
Questions:	2. What are your plans for this patient now? 3. How do you treat his partner(s)?
Case Study 21: **Balanitis**	
Description of Case 21:	A 20-year-old man is complaining of itching and discharge of a few days duration on glans penis. There is no other complaint. PE is unremarkable except the tip of glands is red, but you cannot retract the foreskin to complete your examination.
Questions:	1. What are your thoughts and plans?

Case 21 Cont'd:	At a follow-up visit, he has not improved. He has adhered to the therapeutic regimen and not sexually active.
Questions:	2. What are your thoughts and plans for this patient now?
Case 21 Cont'd:	A week later he is in your consultation room for follow-up. He has improved considerably, but you have his HIV test results back. Unfortunately, it is positive. A confirmatory test is not a requirement.
Questions:	3. What are your plans now?

Answers to Balanitis Case Studies

Answers: Balanitis Case 20

Answer 1

- He has balanoposthitis, which is a fungal and occasionally trichomonas infection.
- Treat with gentian violet or clotrimazole cream.
- Local hygiene is essential for both treatment and prevention. Refer to the Balanitis Flowchart for details.

Answer 2

- He may have trichomoniasis.
- Treat with metronidazole 400 mg BID for 7 days, and review in 7 days.

Answer 3

- Treat with metronidazole and clotrimazole for trichomoniasis and candidiasis.
- Refer to the flowchart.

Answers: Balanitis Case 21

Answer 1

- Since you cannot examine him for GUD, assume he has GUD. GUD has more patient- and public-health consequences than balanitis.
- Treat him for GUD with close follow-ups.
- Refer to the GUD Flowchart.

Answer 2

- Now treat him for the causes of balanitis without genital ulcers. Refer to flowchart and the previous case.
- Recommend antifungal cream.

Answer 3

- Refer to Routine HIV Testing Flowchart.
- He needs:
    - Emotional support
    - Education about prevention of transmission
    - Evaluation for ARV eligibility
        - CD4, VL
    - Partner testing

Worksheet B.9

Case Studies 22 and 23: Genital Ulcer Disease

Instructions: This case study is a practical companion to **Session 5: Diagnosis and management of STI-related syndromes.** Read the case description below. Use the flowcharts in this handbook and in the *Clinical Guide* to answer the questions. Fill in the answers to questions in the space provided. Be prepared to discuss the case during training.

Case Study 22: **Genital Ulcer Disease**

Description of Case 22:

A 30-year-old female with 2 children comes to you complaining of itchiness of the vulva. She also complains of genital ulcers that come and go, usually appearing before her menses. She has never been treated for this sore before. She denies dysuria and has no history of PV discharge. She has a steady boyfriend, though she says that she was not faithful at first. She admits to unprotected sex. She does not want an HIV test. Her last normal menstrual period was three weeks ago.

Physical Exam

- Temp: 39.5, BP: 110/80
- Open ulcer on the right labia

Questions:

1. What is the syndromic diagnosis?

2. How do you manage this patient?

3. How do you treat her partner?

Case Study 23: **Genital Ulcer Disease**	
Description of Case 23:	A 19-year-old male comes to you complaining of painful sores on the penis. It started two days ago. First there was itching, followed by rash around the penile shaft. He tested HIV-negative last month. **Physical examination** The patient's head, chest, and abdomen are unremarkable. On his genitalia, you find small crops of vesicles around the penile shaft and glans penis. You observe no open ulcers. The glans penis is retractable. The anal area is unremarkable.
Questions:	1. What is the syndromic diagnosis? 2. How are going to manage the patient? 3. How are you going to manage the partner?

Answers to Genital Ulcer Disease Case Studies

Answers: Genital Ulcer Disease Case 22

Answer 1

- The diagnosis is genital ulcer disease (open ulcers).

Answer 2

Manage the GUD as follows:

- Benzathine Pen 2.4 mu IM stat
- Ceftriazone 250 mg IM Stat (already prescribed for PID)
- Acyclovir 400 mg TID for 7 days

In addition:

- Issue contact slip(s)
- Risk-reduction plan: use of condoms
- Review in 7 days

Answer 3

Treat her partner for GUD:

- Benzathine Pen 2.4 mu IM stat
- Ceftriazone 250 mg IM

Answers: Genital Ulcer Disease Case 23

Answer 1

- The diagnosis is genital ulcer disease (genital herpes).

Answer 2

Manage the patient as follows:

- Acyclovir 400 mg TID for 7days.
- Advise him on the use of condoms.
- Educate him about genital herpes.

Answer 3

Treat his partner as follows:

- Assess for genital ulcer disease and other STIs.
- Provide education about disease transmission, prevention, treatment, and signs and symptoms.
- Discharge home if you find no ulcers.

Worksheet B.10

Case Study 24: Urethral Discharge

Instructions:	This case study is a practical companion to **Session 6: Diagnosis and management of STI-related syndromes.** Read the case description below. Use the flowcharts in this handbook and in the *Clinical Guide* to answer the questions. Fill in the answers to questions in the space provided. Be prepared to discuss the case during training.
Case Study 24: **Urethral Discharge**	
Description of Case 24:	A 24-year-old man comes to you complaining of a mildly bothersome "drip" from the tip of his penis that began about 3 days ago. He says it's also "a bit itchy" when he urinates. On physical examination, you see no discharge on milking of the urethra.
Questions:	1. How would you treat his condition using the syndromic management flowchart?

Answers to Urethral Discharge Case Study

Answers: Urethral Discharge Case 24

Answer 1

- Risk-factor assessment: Burning at urination or itchy when urinating.
- Treat for chlamydia and gonorrhoea.

Worksheet B.11

Case Study 25: STI and Pregnancy

Instructions: This case study is a practical companion to **Session 5: Diagnosis and management of STI related syndromes.** Read the case description below. Use the flowcharts in this handbook and in the *Clinical Guide* to answer the questions. Fill in the answers to questions in the space provided. Be prepared to discuss the case during training.

Case Study 25: STI and Pregnancy

Description of Case 25:

Trichomoniasis
Trichomoniasis is associated with:

- Premature rupture of the membranes
- Pre-term delivery
- Low birth weight

Bacterial Vaginosis
Bacterial vaginosis is associated with:

- Premature rupture of the membranes
- Chorioamnionitis
- Pre-term labour
- Postpartum endometritis
- Post-Cesarean wound infection

Syphilis
Syphilis in pregnancy is associated with

- Congenital syphilis
- Spontaneous abortion
- Stillbirth

Questions:

1. What is the appropriate treatment for syphilis during pregnancy if the mother is allergic to penicillin?

2. What is appropriate treatment for LGV or granuloma inguinale during pregnancy?

3. What is appropriate treatment for chancroid during pregnancy if mother is allergic to ceftriaxone?

Case 25 Cont'd:

- Ciprofloxacin and tetracyclines are absolutely contraindicated during all stages of pregnancy.
- Metronidazole may be used at any time during pregnancy, but many pregnant women do not tolerate the usual dose. The dose has to be reduced to the minimum and given 3 times daily.

Questions:

4. How do you treat vaginal trichomoniasis during pregnancy?

5. Which of the following therapies has not been established as safe during pregnancy?
   - Cryotherapy
   - Surgery
   - 90% trichloroacetic acid
   - Podophyllotoxin
   - Imiquimod

Case 25 Cont'd:

Genital Warts

Genital warts can enlarge considerably or may appear for the first time during pregnancy. Spontaneous regression after delivery is known to occur. This happens because pregnant women are immunosuppressed even in the absence of HIV infection.

Answers to STI and Pregnancy Case Study

Answers: STI and Pregnancy Case 25

Answer 1

Part 1

- If possible, she should be desensitised and treated with penicillin. Doxycycline is contraindicated during pregnancy, and erythromycin should not be used because it does not reliably cure an infected fetus.
- If desensitization is not possible, then treat with erythromycin. Immediately after delivery, treat the newborn with penicillin.

Part 2

- Erythromycin 500 mg orally QID for 10 days
- Erythromycin does not cross the placenta, so the newborn must be treated for syphilis.

Answer 2

- Erythromycin 500 mg orally, QID for at 14 days for LGV and until all lesions have completely epithelialised for granuloma inguinale.

Answer 3

- Erythromycin 500 mg orally QID for 7 days.

Answer 4

- Metronidazole 2 Gm orally, in a single dose.

Answer 5

- The safety of both podophyllotoxin and imiquimod during pregnancy has not been established.

Worksheet B.12

Case Study 26: Miscellaneous Case Study Questions

Instructions: This case study is a practical companion to **Session 5: Diagnosis and management of STI-related syndromes.** Read the case description below. Use the flowcharts in this handbook and in the *Clinical Guide* to answer the questions. Fill in the answers to questions in the space provided. Be prepared to discuss the case during training.

Case Study 26: Miscellaneous Questions

Questions:

1. Name at least one disease for each of the following organisms.
   - Mycoplasma homonis
   - Mycoplasma genitalium

2. In sexually mature women, GC and Chlamydia are not etiological agents of vaginitis, but in pre-pubertal girls they may be. What is the biological explanation for this difference?

Answers to Case Study: Miscellaneous Questions

Answers: Miscellaneous Questions Case 26

Answer 1

- Mycoplasma homonis: Vaginitis
- Mycoplasma genitalium: Urethral discharge in men

Answer 2

- Gonococcus usually invades columnar rather than squamous epithelium. Adult women have squamous epithelium lining the vagina. In pre-pubertal girls the columnar epithelium covers the vagina so they may get gonococcal vulvovaginitis.

Teaching with Trigger Films (Trigger Tapes)

Rosalie Ber, M.D., DSc.
Gideon Alroy, M.D.

A typical trigger film (TF) teaching session begins with the tutor describing the main theme of the TF to be viewed. Students may jot down points of interest for discussion. We generally view the entire trigger film, but occasionally pause it after a specific important issue is raised and ask the students for alternative techniques/approaches to what they've just viewed. In the latter case, the students are asked to make suggestions as to how they predict the encounter may unfold both diagnostically and interpersonally. The setting and the medical content of each TF must be clarified before these and other aspects can be discussed. Often it is necessary to replay parts of a TF or to view the entire film again if students' attention to detail wanes. Tutors must also be sensitive to biases students may have that can lead to a "halo" effect, where students identify so closely with particular TF characters that they can view the TF only from those characters' perspectives.

The tutor/facilitator's role includes:

- Making sure that the medical setting and basic facts of the TF situation are clear to all participants.
- Ensuring that all students are active participants and enabling them to express their views in a fair and "democratic" manner.
- Being able to identify and describe "halo" effects.
- Legitimising different genuine approaches.
- Encouraging participants to be critical of the events that are portrayed in the TFs.

Discussions of the TFs should include the following topics:

- The participants and the setting and what may have happened prior to the event depicted (e.g., is the event valid, realistic?).
- The medical content and diagnostic thinking.
- Patient-physician communication.
- Ethics, etiquette, and professional behaviour.
- Personal points of view—the students' and tutors' personal views of the interaction overall or particular aspects of it. *Note: The facilitator should express his or her personal view only after all of the students have shared their thoughts and with the explicit understanding that the tutor's view is equal to that of any other and is not authoritative.*

Adapted from "Twenty Years of Experience Using Trigger Films as a Teaching Tool," by Rosalie Ber and Gideon Alroy, both of the Department of Medical Education at B. Rappaport Faculty of Medicine, Technion-Israel Institute of Technology in Haifa, Israel. Published in *Academic Medicine*, 2001; 76: 656-658.

Worksheet 2.1

Viewing of Video Segments 1 and 2: Patient- vs. Provider-Centred Care	
Objective:	Be able to recognise the differences between patient-centred and provider-centred care
Description:	A nurse welcomes a young woman and questions her about her reasons for coming into the clinic.
Instructions:	While you watch the videos, pay close attention to how the nurse is interacting with her patient. Reflect on what you know about patient-centred care and, in the spaces provided below, write down the ways in which she does or does not follow these principles in each video segment.
Questions:	Specific questions to think about as you watch the video include: • Does the provider take time to build rapport at the beginning of the visit? • Does the provider actively listen to the patient's concerns and answer her questions in an appropriate and thoughtful manner? • Does the provider respond to the patient in a non-judgmental way? • What should the provider have done differently/what would you do differently in this situation?
Segment #1	What the nurse did that was patient-centred: What the nurse did that was **not** patient-centred:
Segment #2	What the nurse did that was patient-centred: What the nurse did that was not patient-centred:

Worksheet 4.1

Viewing of Video Segment: Sensitive Physical Exam	
Objective:	Understand the steps involved in a physical exam and how it can be performed in a way that is more "sensitive" to the patient.
Description:	A nurse performs a physical exam on an 18-year-old girl who is complaining of vaginal discharge.
Instructions:	While you watch the video, pay close attention to how the nurse is interacting with her patient and the different steps she follows in performing the exam. Reflect on what you know about performing physical exams and, in the space provided below, write down the ways in which she does or does not follow what you believe to be the correct protocol.
Questions:	Specific questions to keep in mind while you are watching the video include: • Does the nurse help the patient to feel relaxed and comfortable? • Does the nurse do a good job of explaining to the patient beforehand what will happen during the exam? • Does the nurse explain what she is doing as she performs the exam? • Does the nurse perform a thorough exam? • How could the nurse have done a better job/what would you have done differently?

Observations:

Worksheet 6.1

Viewing of Video Segment: Risk Reduction Counselling	
Objective:	Observe the steps involved in an effective risk-reduction counselling session and use the rating instrument provided to rate the performance of the counsellor.
Description:	A nurse counsels Peter, a 35-year-old man, on how to reduce his risk of acquiring and transmitting STI/HIV.
Instructions:	While you watch the video, pay close attention to how the nurse is interacting with her patient and the different techniques she employs to discuss sensitive issues. Fill in the observation checklist below according to your observations.

Scoring Guide:

0= not observed
1= observed with beginning learner communication skills or partially completed tasks
2= observed with expert patient-centred communication skills* and completed all tasks

Determining Stage of Change				
Explored knowledge about HIV/STI risk behaviours	**0 1 2**			
Clarify misperceptions in words patient can understand	**0 1 2**			
Assessed patient's perception of importance of changing target behaviour	**0 1 2**			
Explored recent risk incidents and previous risk-reduction attempts	**0 1 2**			
Assessed, summarised, and reflected back patient's motivators and concerns around behaviour change	**0 1 2**			
Counselling for Risk Reduction and Behaviour Change				
Gathered adequate information to assess initial stage of change for condom use and partner discussions about HIV/STI: [ ] precontemplation [ ] contemplation [ ] ready for action/preparation [ ] action [ ] maintenance	**0 1 2**			
Precontemplation counselling strategies: [ ] inquired about pros and cons of behaviour [ ] discussed impact of behaviour [ ] used empathic and summary reflections [ ] asked if patient wanted information about health risks associated with target behaviour [ ] storytelling	**0 1 2**			
Contemplation counselling strategies: [ ] explored cons for behaviour change using reflection and summarisation [ ] explored pros for behaviour change using reflection and summarisation [ ] demonstrated empathy and respect for patient's beliefs and feelings	**0 1 2**			

Ready for action/Preparation counselling strategies: [ ] asked patient to brainstorm specific steps, and [ ] skills required for carrying out a behaviour-change plan [ ] helped patient create realistic plan based on resources, time, and support [ ] rehearsed behaviour [ ] predicted barriers [ ] assessed confidence	**0 1 2**			
Action counselling strategies: [ ] discussed initial experience with behaviour change plan [ ] celebrated successes [ ] refined skills (role-plays or practice) [ ] explored potential triggers for relapse [ ] assessed confidence	**0 1 2**			
Maintenance counselling strategies: [ ] assessed patient experiences [ ] celebrated successes [ ] explored triggers for relapse [ ] assessed confidence	**0 1 2**			
Reaching Common Ground - STI Treatment, Partner Management, and Risk-Reduction Planning				
Reached agreement with patient on specific steps to distribute and discuss contact slip(s) with sexual partner(s)	**0 1 2**			
Agreed upon risk-reduction plan matching patient's readiness for change	**0 1 2**			
Reinforced skills to carry out: [ ] partner management plan, using [ ] role play [ ] problem-solving [ ] risk-reduction plan, using [ ] role play [ ] problem-solving	**0 1 2**			

*** Expert Communication Skills**

- Maintained good eye contact
- Used active listening – non-verbal cues
- Had warm, accepting body language
- Mainly used open-ended questions
- Avoided interrupting
- Used summaries and reflections

Worksheet 8.1

Viewing of Video Segment: HIV Post-Test Counselling	
Objective:	Observe the steps involved in an effective post-test counselling session.
Description:	A nurse counsels Peter, a 35-year-old man, after his HIV test result comes back positive.
Instructions:	While you watch the video, pay close attention to how the nurse is interacting with her patient and the different techniques she employs to discuss sensitive issues. Reflect on what you know about post-test counselling and, in the space provided below, write down the ways in which she does or does not follow what you believe to be the correct protocol.
Questions:	Specific questions to keep in mind while you are watching the video include: • Does the nurse clearly explain the test results? • Does the nurse address all of the patient's main concerns? • Does the nurse take steps to guide the patient towards proper management of his condition? • How could the nurse have done a better job/what would you have done differently?

Observations:

Teaching with Role-Plays

Role-plays simulate situations that learners are likely to encounter in their work. They give participants the opportunity to apply techniques, strategies, and knowledge learned during the class. Role play is an opportunity to learn while doing.

Benefits of Role-Plays
Role-plays are an active form of learning, providing a balance to more passive activities such as lectures. During a role play, participants can develop skills that they have learned during the class. It is an opportunity for participants to practise what they have learned and to reflect on their own work. Some role-plays may include giving and receiving feedback on the techniques used during the role play.

Types of Role-Plays

Scripted—For a scripted role play, the trainer asks volunteers to perform the roles by reading parts from a prepared script. After the volunteers perform the script, the whole group discusses the role play. This type of role play is instructive: It helps participants identify what they should or should not do.

Coaching—During a coaching role play, the trainer takes the role of the person learning, and asks for a participant to play the other role. For example, the trainer would play the health-care provider, and the participant would play a patient. The trainer stops from time to time to ask the group how to proceed next. The trainer follows up the role play with a discussion.

Spontaneous—During a group discussion, a trainer may ask a participant to help demonstrate a certain technique. Because it is spontaneous and part of a larger discussion, participants might not think of it as a role play.

Rotating Trio—A rotating trio role play gives all participants a chance to try out their skills. The trainer divides the class into groups of three, and the participants take turns playing the different roles. One participant observes, while the others do the role play. Then the participants change places until each has done each role. For example, in a role play about a health-care provider counseling a patient, each participant would have the opportunity to play the roles of health-care provider, patient, and observer.

Adapted from "The Trainer's Handbook,", by Karen Lawson. Jossey-Bass Pfeiffer, San Francisco, 1998.

Worksheet 8.2

Role Play: HIV Post-Test Counselling	
Objective:	Be able to employ the counselling strategies outlined during this session to have an effective discussion with a patient who has tested positive for HIV.
Scenario:	Lekwalo, a young woman who has come to the clinic complaining of vaginal discharge, has tested positive for HIV. She becomes very upset when she hears the result but does not clearly understand what it means. The health-care provider tries to console her and counsel her about what steps she can take to manage her infection and cope emotionally.
Instructions:	• You have 5 minutes for the role play and 5 minutes for debriefing. • Divide into groups of 3 consisting of the patient, a provider, and an observer. • Remember that the focus of this activity is on giving the HIV test result and providing post-test counselling. • You do not need to cover management of Lekwalo's vaginal discharge during this role play. • The observer can use Worksheet 8.3 in noting strengths and weaknesses in the health provider's approach. • During your 5-minute debriefing, allow the health-care provider to comment first on what was effective and what could have been more effective. Then the patient and observer can offer comments. • If there is time, you will also have an opportunity for a brief discussion with other groups, to share your thoughts about the role play.
Characters:	***Lekwalo*** You are an 18-year-old woman who has come in because you are concerned about what you think may be an STI. You agree to have a routine HIV test, expecting it to be negative since your test 2 years ago came back negative and you have been with the same partner ever since. Now that you are being told you are infected with HIV, you feel like there is nothing you can do and you are very shocked and upset. The only person you have had sex with is your steady boyfriend but you think he may have other casual partners. Up to now, your boyfriend has not been tested for HIV – you have wanted to ask him but were too afraid of how he would react. You are afraid to tell your boyfriend about your result because you think he may leave you and are worried that your family will blame you for becoming infected. You know that HIV is not curable and it can kill you, but you do not understand how the disease affects people or what can be done to treat it. ***Health-Care Provider*** You want to give Lekwalo time to absorb the meaning of her result. You also want to support her to seek the proper treatment, to take steps for "positive living," and to prevent passing HIV to others. Remember to: • Explain in simple language what a positive test result means. • Explore your patient's feelings about the result and make her feel that you are there to support her. • Encourage her to discuss the result with trusted friends and/or family and discuss the concept of "positive living." ***Observer*** Closely watch the interaction between the patient and provider, looking for use of appropriate counselling strategies. After the role play, comment on the effectiveness of the health-care provider's approach and make suggestions for improvement based on your observations.

Worksheet
Interactive Lecture Assignment

Assignment Instructions

Select two or three other people and form a training team. Your team will be assigned one of the algorithms included in the *STI Reference Manual.* Your group is to develop an 8 to 10 minute interactive lecture that will help us learn the algorithm.

You may use the PowerPoint slides as visual aids, and/or make other visual aids. Deliver your lecture in an engaging way to your workshop colleagues and receive feedback from them. Be ready to ask and answer questions of and from the group.

Date: All interactive lectures will be presented on Wednesday afternoon, August 18.

Members of your training team: _____

Algorithm to teach:
_____

What training methods will you use? What visual aids will you use?

What questions will you ask?

What questions are you likely to be asked by participants?

Notes

References

Ber, Rosalie and Gideon Alroy. “Twenty Years of Experience Using Trigger Films as a Teaching Tool,” *Academic Medicine*, 2001; 76: 656-658.

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COMPREHENSIVE STI MANAGEMENT 3-DAY TRAINING COURSE

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Part III: Resources for Teaching the 3-Day STI Management Training Course

Part III: Resources for Teaching the 3-Day STI Management Training Course

	Page Number
Part III Contents	**73**
Aim, Learning Objectives, and Key Points	**74**
Handouts and Worksheets	
Training Ice Breaker Activities	**75**
The Calm and Competent Trainer: Characteristics of Effective Trainers	**78**
Four Learning Styles	**80**
Advantages and Disadvantages of Training Methods	**81**
The Calm and Competent Trainer: How to Facilitate Effectively	**83**
Becoming an Effective Communicator	**85**
Lecturing Creatively	**88**
Presentation Skills Checklist	**90**
References	**92**
Appendix: STI Course Slides and Lecture Notes	**93**

Part III. Resources for Teaching the 3-Day STI Management Training Course

Aim
The aim of Part III of this guide is to provide trainers with resources about teaching methods, learning styles, and activities that can be used effectively to teach the STI Management Training Course.

Learning Objectives
By the end of Part III on teaching the STI Management training course, you will be able to:

- Apply basic principles of adult learning to teach health-care providers effectively.
- Use a variety of training methods to effectively teach participants with a variety of learning styles.
- Use appropriate methods skillfully to train participants in the 3-day STI Management course.

Key Points

- Effective teachers are good verbal and non-verbal communicators.
- Goal in training is to choose a variety of learning styles to reach the greatest number of participants.
- Adults learn best in environments where they feel respected and confident.
- Trainers need to allow participants to use their experience and knowledge in the learning environment.
- Adults must be able to apply what they learn.
- Adults are busy people who expect their time during training to be used carefully.
- Different training methods should be used to teach different skills.
- The more varied your training methods are, the more interesting and interactive a training course will be.

Training Icebreaker Activities

Icebreakers are reproduced by permission of Results Through Training, Inc., www.rttworks.com. Guidance about how to use them in training is provided by I-TECH.

The following icebreakers are optional activities that can help you get to know the course participants, help the participants relax with each other, or provide a change of pace during the day. These helpful tools can be used during a course to accomplish several different learning objectives:

- Energise a class when participants are tired.
- Refocus a group when they are overwhelmed by course information.
- Help participants be more comfortable with each other by sharing information.
- Normalise concerns about participating in the training (hear that others have similar concerns).
- Gather information to help the trainer learn more about participants' hopes and concerns, abilities, history, or other information

Read through the list for activities that you might like to use. If you find some you like, choose one or two that you want to add to your course. Depending on your training style and the needs of the participants, one activity may be more appropriate than another.

Learn About the Participants
As a trainer, it is important for you to know about the concerns and hopes your participants have for the training. The more you know, the more you can adjust your training according to your participants' needs. To learn about your participants' concerns and learning needs, try these icebreakers:

Challenges and Objectives
Divide the class into small teams. Instruct teams to identify their challenges in the topic and their objectives for the training. Post work on flip charts. Have them introduce their team and share their work with the rest of the class.

Questions
Have each person write a question they want answered in the training on a Post-It (sticky) note or piece of paper. Have them introduce themselves and their question. Then post all questions on a wall chart. During the training, or at the end, ask the group to answer the questions.

Hopes and Concerns
Ask each person to share his or her greatest hopes and concerns about participating in the training (for example, "Everyone else will know more than I do."). Post hopes and concerns on two different flip charts. At the end of the session, revisit the lists and ask the group to share whether their hopes and/or concerns were realised.

Participants Learn from Each Other
Adults bring a great deal of experience and knowledge to the course. They also enjoy learning from each other. To bring the participants' collective experience and wisdom about the topic out in to the training, try:

Learning from Experience
Have participants introduce themselves and explain one thing they have learned the hard way about the topic you are covering. Post the information on a flip chart and refer to them throughout the class.

Dos and Don'ts
Have participants introduce themselves, sharing their name, hospital or clinic, and either a "Do" or a "Don't" tip related to STI Management. Post tips on a flip chart.

Collective Knowledge
Have participants work in teams to identify five rules for dealing with challenging patients. Write the rules on flip-chart paper.

Quick Change of Pace
If energy in the class drops, participants are tired, or you just completed a long, didactic session and everyone needs a mental break, try this quick sharing activity:

Dinner Plans
Have each person complete the following sentence:

"If I could have dinner with any person, living or dead, it would be _____ because _____."

Reflect on Learning
It can help adults learn to have them reflect on what they are learning that is important to them. To encourage the participants to share with each other and re-enforce what they are learning, try:

Good or New
Ask each person to share something good or new that they have experienced in the last 24 hours.

I Noticed
As an icebreaker for the second or third day of a training session, have each individual share one thing he or she has learned since the last session that they know they will use in their clinical practice.

Most Important
At the end of each day of the course, ask participants to share with the class the most important new thing they learned during the day.

Participants Comfortable with Each Other
To get participants more comfortable about learning together, it can help to have them share things about themselves with each other. To get participants to share more about themselves, try:

I'm Unique
Ask each person to share one thing that makes him or her unique.

Three Truths and a Lie
Give each individual a 3x5 card and instruct them to write 4 statements about themselves: One of the statements should be false, while 3 should be true. Explain that the goal is to fool people about which statement is the lie. Allow 5 minutes to write statements, then have each person read the 4 statements and have the group guess the lie. Award a prize to the individual who makes the most correct guesses.

I'm like a…?
Have each person develop a simile for themselves when they are in a particular mood or experiencing difficulty. (A simile is a comparison to something that is very different, but shares some characteristics.) For example: "When I get busy and have too much to do, I'm like a car with a little bit of gas – I usually have just enough energy for one more task but eventually I run out and just completely stop." Emphasise that people have different ways of dealing with stress and challenges because people experience them differently.

Guess Who
Prior to the session have each participant complete and return to you a survey that answers 5 to 7 questions about himself or herself. For example:

- Favorite type of food
- Last movie you saw
- Last book you read
- Where you would love to visit
- Favorite activity

During the session, read the clues and have the rest of the class guess which person is being described.

The Calm and Competent Trainer: Characteristics of Effective Trainers

Effective trainers:

- Know their subject matter. They have researched their topic and are well-informed and perceived as credible by learners.
- Take the time to get to know their audience. They demonstrate respect for and listen to the learners. They call learners by name, if possible.
- Are nonjudgmental. They validate everyone's experience and their right to their own perspective.
- They respect differences of opinion and life choices.
- Are culturally sensitive. They are aware that their views and beliefs are shaped by their cultural background, just as the perspectives of learners are shaped by their own culture and life experiences.
- Are self-aware. They recognise their own biases and act in a professional manner when their "hot buttons" are pushed.
- Are inclusive. They encourage all learners to share their experiences and contribute to the group-learning process in their unique ways.
- Are lively, enthusiastic, and original. They use humor, contrasts, metaphors, and suspense. They keep their listeners interested and challenge their thinking.
- Use a variety of vocal qualities. They vary their pitch, speaking rate, and volume. They avoid speaking in a monotone.
- Use "body language" effectively. Their body posture, gestures, and facial expressions are natural and meaningful, reinforcing their subject matter.
- Make their remarks clear and easy to remember. They present one idea at a time and show relationships between ideas. They summarise when necessary.
- Illustrate their points. They use examples, charts, and visual and audio aids to illustrate subject matter.
- Understand group dynamics and are comfortable managing groups. They are comfortable with conflict resolution.
- Are flexible. They read and interpret learners' responses — verbal and non-verbal — and adapt training plans to meet their needs. They are "in charge" without being overly controlling.
- Are open to new ideas and perspectives. They are aware that they do not know all the answers. They recognise that they can learn from course participants, as well as offering them new knowledge or perspectives.

- Are compassionate. They understand that the topics addressed during training may have an emotional impact on learners. They are empathetic and understanding about learners' emotional reactions.

- Are receptive to feedback. They encourage co-trainers and learners to give feedback, both informally and through formal evaluation. When they receive negative feedback about their performance, they critically analyse this feedback instead of becoming defensive.

- Continuously work to improve their performance. Even the most experienced trainers can improve their training skills. Effective trainers seek out opportunities to learn new skills and use negative feedback as an opportunity to improve.

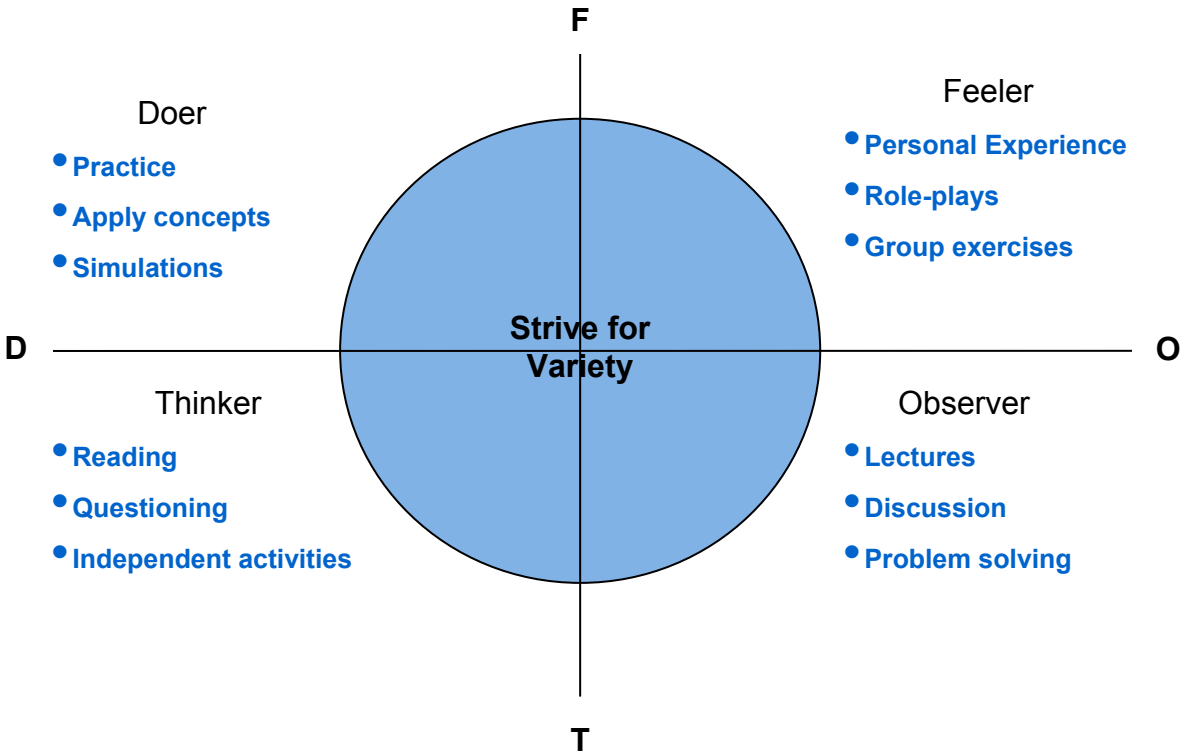
Four Learning Styles

From Lawson, K., The Trainer's Handbook, 1998, San Francisco, CA: Jossey-Bass.

Four Categories of Learning Experiences or Styles

- **Doer**: Likes to be actively involved in the learning process, wants to know how he or she will apply learning in real world, likes information presented clearly and concisely.
- **Feeler**: People-oriented, expressive, focuses on feelings and emotions, thrives in open, unstructured learning environment.
- **Thinker**: Relies on logic and reason, likes to share ideas and concepts, analyses and evaluates, enjoys independent work.
- **Observer**: Likes to watch and listen, tends to be reserved, will take his or her time before participating, and thrives on learning through discovery.

Training Methods & Learning Styles



Advantages and Disadvantages of Training Methods

Methods	Description	Advantages	Disadvantages
Presentation/ Lecture	Trainer orally presents new information to the group.	Keeps group together and on the same point. Time control is easier. Useful for large group size (20 or more).	Can be dull if used too long without trainees' participation. Difficult to measure if people are learning. Retention is limited.
Small Group Discussion	Trainer divides large group into small groups of 6 or less. Small group has a short time to discuss a topic or solve a problem.	Keeps participants interested and involved. Resources can be discovered and shared. Learning can be observed.	Learning points can be confusing or lost. A few participants may dominate the discussion. Time control is more difficult.
Brainstorming	For idea generation and creative group thinking, all participants rapidly present as many ideas as possible on a problem or issue. Group then organises list into categories for further discussion.	Can get all participants involved in collecting a lot of information. Quickly generate ideas.	The problem/issue must be clearly defined. Time control is more difficult.
Demonstration	Participants are shown the correct steps for completing a task or are shown an example of a correctly completed task.	Aids comprehension and retention. Stimulates participants' interest. Can give participants model to follow.	Must be accurate and relevant to participants. Written examples can require lengthy preparation time. Trainer demonstrations may be difficult for all participants to see well.

Methods	Description	Advantages	Disadvantages
Role-Plays	Participants act out problem-solving situations similar to those they will encounter in their workplace.	Helps retention. Allows practice of new skills in a controlled environment. Participants are actively involved.	Requires preparation time. May be difficult to tailor to all situations. Needs sufficient class time for exercise completion and feedback.
Case Study	Participants are given information about a situation and directed to come to a decision or solve a problem concerning the situation.	Requires active participant involvement. Can simulate performance required after training. Learning can be observed.	Information must be precise and kept up-to-date. Needs sufficient class time for participants to complete the case. Participants can become too interested in the case content.
Reading	Written material is used to present new information to participants.	Saves time (trainees can read faster than trainer can talk). Material can be kept for later use. Insures consistency of information.	Can be boring if used too long without interruption. Participants read at different paces. Difficult to measure if people are learning.

The Calm and Competent Trainer:
How to Facilitate Effectively

Create an Effective Learning Atmosphere

There are three important things that you as the facilitator can do to help create an effective learning atmosphere for the course participants.

1. **Support the participant group by building an atmosphere of trust and modelling a positive attitude**. One of the most important tasks of a good facilitator is to build an atmosphere of trust. An accepting and non-threatening atmosphere will encourage the expression of ideas, beliefs, and attitudes by all participants. Below are some ways to build trust among participants:
   - *Assure that confidentiality will be maintained*. Establish a group rule on the first day that everyone's confidentiality will be protected so that people can talk freely without fear that their comments will be shared outside the course.
   - *Provide constructive and supportive feedback*. Let participants know when they've contributed something useful and interesting to the group. For example, you can say, "That's a good example of the concept we are discussing."
   - *Model a positive attitude*. Participants will probably get tired as the course progresses and they will need encouragement. Call upon the person appointed as the energiser and maintain a positive attitude yourself. If there are difficult moments during the course, address them with honesty and a constructive comment. For example, "This topic brings up difficult feelings, but if we explore our own feelings we can better assist our clients to do the same."

2. **Ensure that the entire course content is covered.** It is important to stay on schedule and help participants see how each session follows logically from the previous session.
   - If participants deviate from the topic, offer to address their comments during a break.
   - Write additional topics identified by participants on flip-chart paper as a reminder of topics to be covered if there is time remaining at the end of the session. Keep this list visible to participants throughout the workshop.
   - The lesson plans for each session include key summary points. Referring to these key points and reviewing them at the end of a session will help you to know if you have covered all of the main content for each session.

3. **Model effective facilitation skills.** Try to remember these basic facilitation strategies throughout the course:
   - Ask open-ended questions. For example, you can say, "What did you learn from the role-play on counselling?" instead of "Did you learn how to counsel a client during the role-play?".
   - Listen carefully to both the words being spoken and for any feelings that may accompany the words.
   - Rephrase participants' communications accurately and without judgment.
   - Respect every participant's feelings, perspectives, and contributions.
   - Adhere to time schedule.

- Focus on developing skills and not only on knowledge.
- Make the learning process active.
- Make the course material clear by speaking slowly and using language that is understood by all participants.

Prepare Clear, Well-Structured Handouts

When preparing your own handouts (i.e., additional group exercise worksheets, articles, handouts from PowerPoint slides or acetates, etc.) follow the guidelines below:

- **Create handouts with a clear learning goal**. Be discerning in the handouts you choose to distribute to participants. The handouts should be central to participants' learning and contribute significantly to their understanding of the session's content.
- **Organise the handout in an easy-to-read format**. Refrain from putting too much text on a page. Use appropriate spacing and a clear font style (e.g., Times New Roman – 12 point, Arial – 11 point, Comic Sans – 11 point for group worksheets, etc.).
- **Only photocopy originals**. It's common for handouts to be copies of copies. This can be problematic when copying articles or book chapters. Use the original source when making copies.

Becoming an Effective Communicator

Whether you are giving a speech, leading a workshop, or talking one-to-one with a patient or family, your goal is to be a clear and effective communicator. The secret of good communication is to remember that the audience is more important than the topic. People want you to care about them, and most of them hunger for honest information from someone who tells the truth in plain language. All communication is really one-to-one. Even speaking to an audience means speaking to a collection of individuals. Show people that you care by helping them to see the meaning and value of the information you are sharing and how it affects their daily lives.

The information below will help you as you **plan**, **prepare**, and **present** a lecture.

Plan

1. Audience	**2. Message**	**3. Visual Aids**
• Who is in the audience? • What do they have in common? You with them? • What are their wants, worries, and questions? • How long do you have? • What is your own purpose? What response do you want from them when you finish?	• In 25 words or less, what is the most important thing you want the audience to remember or do as a result of your communication?	• Will you use visual aids? • What kind? (PowerPoint, flip chart, acetates, chalkboard, other) • Will you use props or printed handouts?

Prepare

4. Opening	**5. Body**	**6. Conclusion**
• Greet people warmly. • Get the attention of your audience – state a question or share a personal experience. • Preview what is coming – promise people what they will get from listening to you or talking with you. • Give your name after the question or promise. • Offer people some information about your professional and personal qualifications. • Let people know if you want to hear questions during or after your presentation.	You can build your presentation around different organising themes such as: • the questions your audience is likely to have; or • a time structure (past, present, future); or • a problem / solution approach (your subject today, the problem, solution(s), benefits); or • a decision-making approach (state an opinion or suggestion, offer an opposite view, give evidence to support the first opinion or suggestion, and restate it in a new way). If you use statistics: • don't overuse them; • give a source; • use up-to-date information; • round up or down; • present numbers visually if over four figures long; and • turn facts into pictures when possible.	• Summarise the main points. • Invite or encourage people to act. • State the next steps. • Write a strong final line that alerts people that you are finished and ends on a positive note of hope. • End on time.

Present

7. Delivery	**8. Body Language**	**9. Visual Aids**
• Speak in short phrases in terms understood by your audience. • Emphasise key ideas. • Define and translate technical terms and statistics. • Use a conversational tone of voice. • Control the volume of your voice. • Involve your audience with questions, requests, handouts, or interactive exercises. • Show respect for each person during the question and answer period. • Be courteous to hostile or difficult individuals. • Repeat all questions before answering them in a large group. • Transition from one main idea to another using words ("therefore"), phrases ("As I explained earlier," …"On the one hand", "according to"), and sentences ("Now let's look at another point of view." or "Here is another way of looking at this.")	• Stand rather than sit when you are speaking. • Plant your feet firmly on the floor and stand tall. • Stand at ease and show a friendly face. • If you are sitting when you speak, lean forward slightly, from the waist with a straight back. • Use your hands to communicate. • Look at the people in the audience when you speak to them. • Convey energy and enthusiasm for the topic. • Wear clothing that makes you feel comfortable and effective and shows respect for your audience. • Use verbal focusing techniques such as signposting (showing with your hands the number of points or ideas you want to highlight) or the inserted question ("So, what does all this tell us about adherence to treatment?").	• Use lettering large enough to see. • Place visual aids where they can be seen. • Display key words rather than sentences. • Use graphic devices for clarity (borders, bullets, boxes). • Add images as well as words (images at top or left and text to the right). • Write large on flip charts and white boards. • Display visual aids only when ready to discuss them. • Use a pointer. • Locate and test equipment and lights in advance. • Talk to the group, not the screen. • Show slide for 5 to 10 seconds before you speak. • Don't sacrifice learning through discussion to passive learning through technology.

Lecturing Creatively

from *The Skillful Teacher.* Brookfield, SD. (1990). San Francisco: Jossey-Bass.

The author discusses how to enhance lecturing as a means of communicating information and ideas. The author challenges teachers to make lectures "enlivening and critically stimulating" for students and offers the following advice.

1) **Be Clear About Why You Choose to Lecture** – don't just lecture out of habit, but be clear on why you are choosing to lecture. Common reasons for lecturing include:
    - *To establish the broad outlines of a body of material* – such as presenting a group of conflicting opinions or different schools of thought related to a particular topic.
    - *To set guidelines for independent study* – highlight key questions and encourage curiosity for follow-up study.
    - *To model attitudes you hope to encourage in students* – encourage students' critical thinking and open discussion by supporting their arguments with evidence (where possible) and explore alternative perspectives and interpretations.
    - *To encourage learners' interest in a topic* – use of personal animation or passion for the topic of discussion.
    - *To set the moral culture for discussions* – be focused, rigorous, and respectful, especially in early lectures; explore opinions that oppose your own; wrap up with concise, final conclusions.

2) **Research Your Audience** – "…find out beforehand something about the culture and concerns of your audience." If you are unable to find out about your audience before a lecture, spend some time at the beginning asking questions and allowing each individual to express opinions (ask for show of hands for large groups). This can include suggestions of possible themes (from you or the group), a discussion of common professional roles, or a discussion of their perception of the day's learning objectives.

3) **Pace Your Presentation** – "The average attention span for listening to an uninterrupted lecture has been estimated at somewhere between 12 and 20 minutes." If a session is scheduled for a longer period of time, break up the lecture into 15 to 20 minute sections and either offer breaks in between or incorporate discussions, question–and-answer sessions, or group exercises (large or small groups).

4) **Personalise Your Presentation** – Try to personalise the topic by using personal examples from your life, anecdotes from current events or popular culture, or by connecting concepts by using analogies and metaphors that are familiar to people. Personalising lectures serves 3 functions:
    i) It helps to provide familiar, accessible points of entry for complex ideas.
    ii) It captures the attention of an audience to see someone speaking from personal experience.
    II) Talking publicly about aspects of your life outside of your role as an educator helps to create credibility.

5) **Speak from Notes** – versus speaking from, and strictly adhering to, pre-written scripts. *Skeleton notes* are carefully drawn up and give an ordered, systematic progression of ideas and allow you freedom to digress. Give yourself room to incorporate audience questions and discussion without feeling overwhelmed from having strayed from the script. Assumption: You have thorough knowledge of the topic so that a word or phrase from your notes will trigger ideas and associations.

6) **Use Visual Aids** – Use graphic depictions of main points to demonstrate the connection between them in an appealing way. Distribute copies of visual aids *at the end* of a lecture – be sure to tell an audience this so members don't spend time trying to copy your words verbatim.

7) **Use Critical Incidents** – "Critical incidents are brief written (or spoken) depictions of vividly remembered events." This exercise calls for audience members to identify an influential or memorable incident in their lives and connect it to the topic at hand. Avoid this technique if the audience has no knowledge or experience with the topic.

8) **Leave with a Question** – End with questions about the topic you've just discussed. Don't be afraid to play the devil's advocate on some of your own points. This will encourage your audience to explore the topic further.

9) **See Yourself as Your Audience Sees You** – Find ways to observe, and improve upon, your own lecturing. This can be done by audience evaluation, informal discussion with audience members, or by videotaping yourself and watching for behaviours that may be distracting for the audience. You can also audiotape yourself and make improvements in pacing, pitch, and delivery. Another option is to have a friend or colleague observe you.

Presentation Skills Checklist

Presenter: _____ Topic: _____

As you listen to the presenter, put an X where you agree with the statement.

Delivery	Content
❑ The speaker greeted the audience warmly.	❑ The opening got my attention.
❑ I could hear the speaker.	❑ The introduction told me what to expect from the presentation.
❑ I could understand the speaker.	❑ The purpose of the talk was clear.
❑ The talk was delivered with warmth and feeling.	❑ The talk was designed in a logical way from beginning to middle and end.
❑ The talk was delivered with personal conviction from both the mind and heart.	❑ The presentation was well suited to the audience.
❑ The presentation seemed practised.	❑ The content was interesting to me.
❑ The presenter involved the audience.	❑ The presenter summarised the main points before finishing.
❑ The presenter handled questions and comments with calm courtesy.	❑ The presenter let us know when the talk was over.
❑ The talk contained effective examples and illustrations.	❑ The talk ended on a strong final line or idea.
❑ The presenter defined technical terms and statistics for us.	❑ The presenter ended on time.
Body Language	**Visual Aids**
❑ The speaker stood during the presentation.	❑ The speaker used visual aids.
❑ The speaker had good eye contact with the audience.	❑ I could read the material from where I was sitting.
❑ The speaker showed no distracting movements or gestures.	❑ The visual aids got the point across in a clear and simple way.
❑ The speaker smiled.	❑ The speaker did not block the screen or flip chart.
❑ The presenter used his or her hands to help communicate ideas visually.	❑ The speaker talked to the audience rather than to the screen or flip chart.
❑ The speaker tried to use verbal focusing techniques.	❑ The visual aids used key words rather than sentences.

Notes

References

Results through Training, www.RTTWorks.com.

Lawson, K., The Trainer's Handbook, 1998, San Francisco, CA: Jossey-Bass.

Brookfield, SD., The Skillful Teacher, 1990, San Francisco, CA. Jossey-Bass.