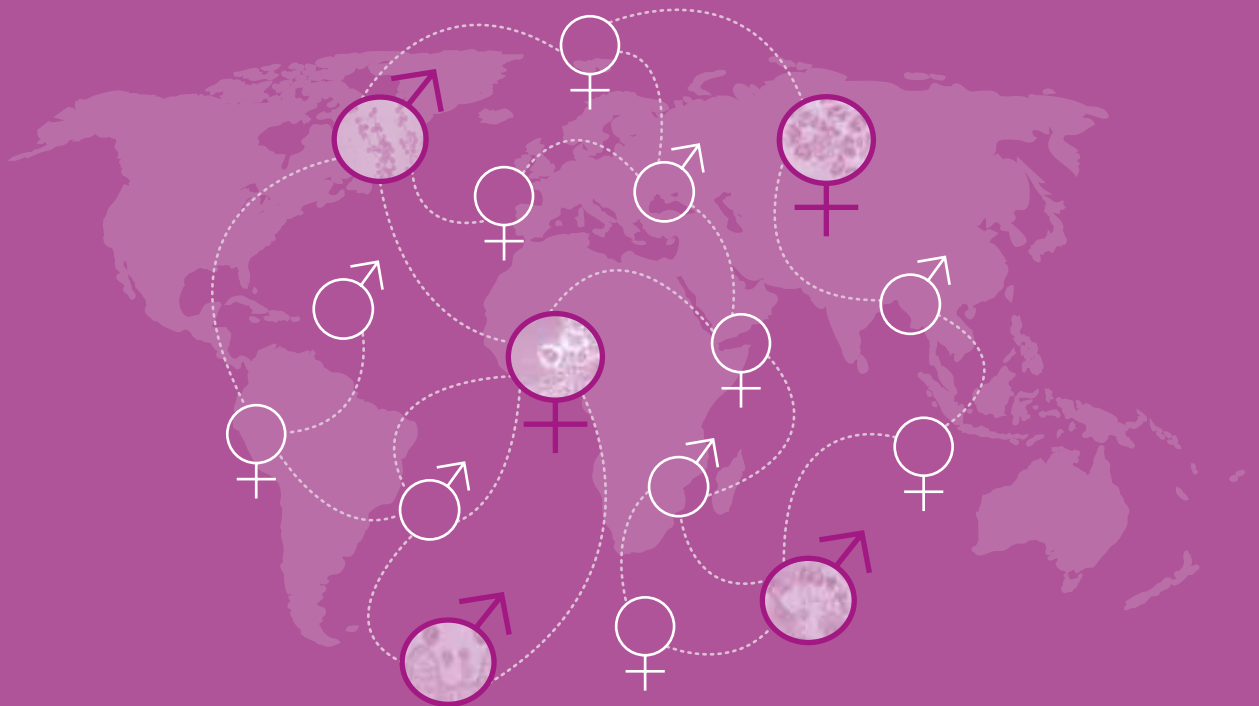


Training Modules for the Syndromic Management of Sexually Transmitted Infections 2nd Edition

Module 7 Recording and Development Plan

Breaking the chain of transmission

Breaking the chain of transmission



Module 7

Recording and Development Plan

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Introduction

This final module is about data collection. It also offers a development plan to help you apply all the skills and knowledge you have acquired while studying syndromic case management of sexually transmitted infections (STIs).

By "data collection", we mean keeping a record of the number of patients or diseases we see and treat. As we hope to show, effective recording gives important benefits, both for your national ministry of health and your health centre and health district or region.

This module will help you understand how to integrate reporting of STI syndromes into an Integrated Disease Surveillance system and how the knowledge gained may help in planning.

Your learning objectives

Study of recording will enable you to:

- explore the benefits of reporting and understand the overall plan of an effective surveillance system;
- examine and learn about clinic-based tally sheets;
- examine an Integrated Disease Surveillance form;
- list the data that should be notified;
- review any reporting system currently in use at your own health centre;
- plan how to make STI reporting a regular routine in your work with patients.

Your development plan will help you to:

- assess your understanding of syndromic case management;
- review your performance in day-to-day work;
- decide on goals for self-development.

PART 1: RECORDING

1: Recording as part of a surveillance system

In this first section we look at **recording**, not just as an aid for your centre but as an essential contribution you can make to a wider STI and other diseases surveillance system. Such surveillance shows up trends in disease patterns and is of vital importance in the battle to control disease.

“The strengthening of STI surveillance systems should be viewed as a central component of the global effort to strengthen all countries’ STI/HIV prevention programmes.”

UNAIDS/WHO Working Group on Global HIV/AIDS/STI Surveillance, 1999.

By "recording" we mean keeping a simple record of numbers. We look at the type of data you should record and how. We then discuss what these data can (and cannot) show, how other components of a surveillance system enrich our picture of STI trends and how that knowledge can be put to use.

Once established in the daily routine of a health centre, recording is not at all difficult. It involves a simple tally sheet and is something all service providers can easily incorporate into their working day.

This section will enable you to:

- recognize the need for universal recording and reporting;
- identify the appropriate data you should collect and how to do so;
- review some limitations of data interpretation;
- outline components of a surveillance system that supplement the data you provide;
- analyse how surveillance findings could benefit health services locally as well as nationally and regionally;
- define your responsibilities as a recorder.

The importance of universal reporting

Clearly, to be successful, any surveillance system must have accurate data. This can be achieved only if *all* health centres submit records. We call this "universal" reporting.

In the past, and in some areas still, reports were received from certain "sentinel" sites only. The problem with this was that such better-equipped sites were often not representative.

Reports need to come from all service providers; ministries of health should monitor that this happens.

It is generally expected and accepted that case reporting of STIs gives a slower figure than the true picture. This is due in part to underreporting. At the clinic, underreporting may be due to health-care workers not remembering to tally every person consulting for STIs. This will happen if there is no set system for tallying. On a broader scale the total burden of STIs, even of symptomatic ones, is underestimated at the clinic level. This is because many patients do not seek care; others go to the private sector or self-medicate: all are missed.

To determine the burden of infection/disease that approaches the truth, one simple method is to conduct a community-based survey, establish the proportion of people with STIs and compare it with a clinic population. The deficit may give the approximate factor by which there is underreporting.

Using a tally sheet

Centres can only supply quality data if expectations are realistic. If too much is asked for, recording systems break down because people are too busy to maintain them. So it is important to keep recording simple.

All that service providers need do is complete a tally sheet for STI cases and submit the data. In the tally sheet, scores are kept by marking a stroke for each case that needs recording. For example, the following would indicate three cases seen:

OOOOO
OOOOO

Many centres keep tally sheets to notify new cases of a whole range of diseases. Tally sheets are quick and simple to maintain. There is never any breach of confidentiality in such recording.

The data to collect

A simple, undifferentiated "STI" entry on a general tally of diseases does not yield enough information for surveillance. We need a sheet showing numbers for each syndrome.

An important function of the tally is to show trends. So:

- cases reported should be restricted to new episodes;
- there must be a breakdown into sex and age groups.

A tally like this must be distinguished from a tally showing simple numbers of people treated. In a tally showing people numbers, each person is recorded once. But when syndromes are recorded, the same person may yield two (or more) entries – for example, a patient may have a discharge *and* a genital ulcer.

What can the data show?

Module 1 asked you to consider the value of STI statistics, both internationally and locally in your region.

To remind yourself of the limitations of interpreting recorded data, please answer these four questions.



Questions

1. Among women, the most common symptom is lower abdominal pain. What can you conclude from this?
2. Data collected over the last two years show there has been a significant increase in the number of patients treated for genital ulcers. What can we interpret this to mean?

3. Figures for the number of STI cases treated are much lower in Region A than in all other regions. What might this mean?

4. Figures show a national decrease in the total number of STI cases treated over the last two months. What might this mean?

Please turn to our answers starting on page 25.

As the answers to these questions show, we must be very careful about drawing conclusions from any reporting that is not backed by reliable information on the context. But this does not mean that your recording reveals nothing. Studied with other records, your figures may show:

- the numbers of patients treated for probable STIs and what proportion they are of all patients treated;
- the proportion of patients with particular syndromes (as we noted in the answer to Question 1, the syndromes that are the most definite indicators of STIs are urethral discharge in men and genital ulcers in men and women);
- (from recorded new episodes of STI syndromes) incidence of STI syndromes in the clinic population;
- (from recorded new episodes and follow-up treatment) an indication of prevalence of STIs in the clinic population;
- (if you know the clinic attendance pattern of the population) an approximate idea of the STI disease burden in your catchment population;
- (from this information) the workload due to STI syndromes at your clinic and some clues to the possible future workload.

Finally, your lists of contact slips issued and contact slips received give you a simple record of partner notification – a vital step in our programme.

How STI surveillance components enrich the overall picture

Your recording is likely to be only one component in a much larger surveillance programme and it can add a lot more to our knowledge.

In the first place, your country or region may have a number of "sentinel" clinics with more developed facilities and these can gather more detailed information – for example, results of syphilis serology and other laboratory tests, other life-threatening diseases, etc.

In the second place, a national (or wide-area) surveillance system should have four more major components to supplement case reporting. The additional components are as follows.

- **Prevalence assessment and monitoring.** Prevalence assessment attempts to show the full extent of a disease. One of its main purposes is to identify the subgroups who are most at risk. (This could include subgroups with a high risk of STIs, HIV infection, malaria, etc.)
- **Assessment of STI syndrome etiologies.** Specialized STI clinics and laboratories work to determine the causative agents of STI syndromes. There are trends in disease, so syndrome etiologies need to be reassessed at regular intervals (at least every 2 or 3 years). Meanwhile a number of new tests are being developed.
- **Antimicrobial resistance monitoring.** As you know, all over the world, gonococcal (and other) infections are developing resistance to drugs. This makes it essential to keep testing the efficacy of drugs regularly, so that effective drugs are identified and used at all times.
- **Special surveys.** Special surveys are often needed to enhance routine assessments. For example, they may be set up when there are particular outbreaks of infection. At about 3-year intervals there should be a routine review of methods of syndromic management.

With STI components supplementing national disease reporting, health authorities can construct a fairly accurate picture of disease patterns and of which treatments will work. They can then use this knowledge as a basis for planning.

To make recording systematic and complementary, the World Health Organization (WHO) recommends use of an Integrated Disease Surveillance (IDS) form. You can see an example of this form on page 35.

When all the components of surveillance work together in a national or regional scheme, central health care planners may be empowered to:

- keep you informed of disease trends as shown in the incidence of recently acquired infections;
- advise you of new treatments;
- provide other information required for managing patients;
- assist you in drawing up a practical management plan to control spread of disease;
- assist your centre in getting its appropriate share of service providers and drugs.

(Of course, what is practically possible can often fall short of what we all would like.)

Your responsibilities

Now let us return to your own task of recording. Whatever your exact reporting format, your entries must be complete and accurate: you must maintain data quality. The key to this is timing. Your records will be reliable if you always record **at the time** of consultation. The tally sheet format makes this easy. A sheet can be kept so that it is always to hand. Once you have made recording a habit, the keeping of a tally is efficient, quick and easy.

Submitting reports at the **correct intervals** is essential. Only with this regular reporting can central records be reliable. Analysis of trends is often based on comparisons of time spans (for example a period in one year against the same period in another). The best way to achieve regularity is to allot someone the specific responsibility of collecting tally sheets at the appropriate times (usually the end of the month). The task would involve copying, completing totals and then sending off the forms.

We hope we have demonstrated that none of the tasks needed for recording is either time consuming or difficult. In Section 2 we ask you to review your own practice.

Summary

Recording numbers of STI patients and syndromes that you treat can help your health centre identify trends in disease patterns. It can also contribute to a larger STI surveillance system. The knowledge gained may play an important role in planning strategies of disease prevention and control, not only at national level but at global level as well.

Service providers should keep a tally of new episodes treated for each syndrome, and the tally should be broken down into sex and age groups. There should also be a simple record of partner notification. The use of IDS forms helps bring together local, regional and national disease surveillance for planning purposes.

We hope that, by the end of Section 2, you will agree that tallying data is simple and easy to incorporate into your own work. We hope you will be committed to keeping accurate and complete records.

2: Using a tally sheet

Having considered how recording can help us, we now turn to our main recording tool – the tally sheet.

This section will enable you to:

- familiarize yourself with data tallying using a simple tally sheet;
- read and complete it;
- review your own working practices.

On the next page you will see an example of a tally sheet on which you can record STIs.

Please note the following points:

- this tally sheet is simple to complete;
- it is used to record new episodes of probable STIs;
- it records male and female cases separately;
- for each sex, it lists six clinical syndromes;
- records are broken down into five spans of age range;
- there are rows and columns for totals;
- there are boxes in which to record contact slips issued and contact slips received.

To help you focus, we follow up with some simple questions.

TALLY SHEET 1 – SEXUALLY TRANSMITTED INFECTIONS

CLINIC: _____	NAME OF OFFICER: _____
DISTRICT: _____	POSITION: _____
MONTH: _____	SIGNATURE: _____

CLINICAL SYNDROME	MALE – NEW EPISODE					TOTAL CASES
	0-9 YRS	10-19 YRS	20-29 YRS	30-39 YRS	40+ YRS	
Urethral discharge	OOOOO OOOOO	OOOOO OOOOO	ØØØØØ OOOOO	ØOOOO OOOOO	ØOOOO OOOOO	
Genital ulcer	OOOOO OOOOO	ØØOOO OOOOO	ØOOOO OOOOO	ØOOOO OOOOO	ØØOOO OOOOO	
Inguinal bubo without ulcer	OOOOO OOOOO	OOOOO OOOOO	ØOOOO OOOOO	OOOOO OOOOO	ØOOOO OOOOO	
Scrotal swelling	OOOOO OOOOO	ØØOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	
Genital warts	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	
Other STIs	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	
TOTAL MALES						

CLINICAL SYNDROME	FEMALE – NEW EPISODE					TOTAL CASES
	0-9 YRS	10-19 YRS	20-29 YRS	30-39 YRS	40+ YRS	
Vaginal discharge	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	ØØØØØ OOOOO	ØØOOO OOOOO	
Genital ulcer	OOOOO OOOOO	OOOOO OOOOO	ØOOOO OOOOO	ØØOOO OOOOO	OOOOO OOOOO	
Lower abdominal pain	OOOOO OOOOO	ØOOOO OOOOO	ØØØØØ OOOOO	ØØOOO OOOOO	ØØOOO OOOOO	
Inguinal bubo without ulcer	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	ØOOOO OOOOO	OOOOO OOOOO	
Genital warts	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	
Other STIs	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	OOOOO OOOOO	
TOTAL FEMALES						

Contact slips issued	
Contact slips received	



Question

6. To help you practise reading tally sheets, answer the questions below by referring to Tally Sheet 1 (page 12).
- During the period shown on the tally sheet, how many new cases of genital ulcer were seen among men?
 - How many of these new cases of genital ulcers in males fall within the age group 10–19 years?
 - How many new cases of genital ulcer were seen among women?
 - For women with new cases of genital ulcer, which (so far) is the age group most affected?
 - How many cases of urethral discharge in men are recorded?
 - What are the total numbers of new STI syndromes recorded (i) for men and (ii) for women?

Please turn to our comments on page 26.

Now look at Tally Sheet 2 and turn to Question 7.

TALLY SHEET 2 – SEXUALLY TRANSMITTED INFECTIONS

CLINIC: _____	NAME OF OFFICER: _____
DISTRICT: _____	POSITION: _____
MONTH: _____	SIGNATURE: _____

CLINICAL SYNDROME	MALE – NEW EPISODE					TOTAL CASES
	0-9YRS	10-19 YRS	20-29 YRS	30-39 YRS	40+ YRS	
Urethral discharge	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Genital ulcer	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Inguinal bubo without ulcer	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Scrotal swelling	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Genital warts	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Other STIs	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
TOTAL MALES						

CLINICAL SYNDROME	FEMALE – NEW EPISODE					TOTAL CASES
	0-9YRS	10-19 YRS	20-29 YRS	30-39 YRS	40+ YRS	
Vaginal discharge	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Genital ulcer	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Lower abdominal pain	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Inguinal bubo without ulcer	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Genital warts	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Other STIs	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
TOTAL FEMALES						

Contact slips issued	
Contact slips received	



Question

7. To help you practise recording on tally sheets, please look at Tally Sheet 2 (page 14) and imagine the following scenario.

During a period you see a series of new cases which could be STIs. They are:

- a young man aged 18 who complains of urethral discharge;
- a girl aged 15 who has a large genital ulcer;
- a 30-year-old woman with vaginal discharge and confirmed risk behaviour;
- a young man aged 25 with a genital ulcer;
- another man, in his 40s, who has scrotal swelling;
- a woman aged 22 with genital ulcer;
- a woman aged 31 with vaginal discharge which you believe to be the result of an STI;
- a woman, aged 35 or 36, who has a genital ulcer.

Record this on Tally Sheet 2.

Add up the totals (so far).

Compare your completed tally with the one on page 27.

A typical recording procedure

To conclude this section, here is an outline of a typical recording procedure within a health centre:

1. At the start of a week or month, each service provider starts a fresh tally sheet, recording each patient or episode treated for STIs as the tally sheet requires.
2. At the end of the week or month, a designated provider or clerk collects the tally sheets and collates the data.
3. The data are interpreted, then made available to staff at the centre. Information is then extracted to complete the Integrated Disease Surveillance (IDS) form to send to the next level. It may also be sent to the ministry of health's epidemiology unit.
4. At the epidemiology unit, all data received are compiled and distributed in periodic reports.

Plan A on pages 17–20 will ask you to check what happens to any data collected by your own health centre.

Review

We hope you now understand why recording is so important and how easy it will be to incorporate an STI tally sheet into your working routine.

Without accurate records, your country, region or even your health centre will be unable to monitor trends in the STI epidemic. More importantly, it may not be possible to plan sufficient facilities and drugs for future treatment. Nor will you have enough data to decide whether your treatment, education or partner management techniques are effective.

You have seen how our Integrated Disease Surveillance (IDS) form gives details of STI syndromes as part of an overall disease surveillance and monitoring for the whole country. In your own region it may need some modification – but this is the model we suggest.

Your role in recording is a vital one. Always use the tally sheets carefully and accurately to help your clinic make its STI care as effective as possible.

To conclude this workbook, please turn to the Action Plan on the next page. It will help you to review your own recording practice.

Action plan

Plan A: Reviewing working practice

Please complete this plan if your health centre has established reporting methods. You may need to work with colleagues or a supervisor/trainer.

Method
What reporting methods does your health centre use?
Were these methods laid down by your ministry or controlling body?
Are data on syndromic STI cases kept separately from data on other notifiable diseases?
If so, how do you make sure there is not confusion or duplication?
What syndromic STI cases do you report on your tally sheet?

Recording and Development Plan

How is your tally broken down into age groups (if at all)?

How does your centre monitor and follow up on the partners of patients found to have an STI? Are partner notification cards issued, and how do you check on responses and treatment?

Who do you send your tally or IDS forms to?

At what time intervals do you send tallies or IDS forms?

Administration

Where are your tally sheets stored?

Who collects them and when?

Where are tally sheets kept while you are working? (They should be accessible and visible so you remember to complete them.)

How are new members of your health team informed about reporting?

Your assessment

From what you have learnt of syndromic case management, how appropriate do you think your methods of recording are?

How can your own reports assist you with management of STI patients locally?

What other data might you usefully collect (if this is practicable)?

What information and guidance do you get back from your ministry of health or controlling body?

Are there any practical changes or improvements you would like to suggest for your own reporting system? If so, what are they?

Plan B: Developing a method and routine

Please complete this plan if your health centre needs to develop a method and routine for reporting.

If possible, work with colleagues or a supervisor/trainer. Of course, your method will depend on the reporting requirements in your country or region.

Working out ideas for a method

What does your ministry of health or controlling body ask you to report?

Do the authorities provide guidance?

Do you report other notifiable diseases? How?

For your locality, do you have any reporting objectives beyond those set out earlier in this module?

Referring back to the example on pages 12 and 14, design a simple tally sheet that health workers in your centre could comfortably use.

How would you best manage partner notification?

At what time intervals should you send your tally reports?

Planning administration

As far as you can say, what process would be needed to get a reporting system agreed and established at your health centre?

Where could you keep tally sheets?

Who would complete them?

Recording and Development Plan

How would all relevant members of your team be informed?

Who would collect the sheets and compile data?

Who would the tallies be sent to?

Your hopes

What guidance or supplies would you, in turn, hope for from your ministry of health or controlling body?

Answers

The aim of the first four questions is to explore the limitations of interpreting STI data. We must apologize for question 2 because, in fact, it is misleading – for reasons we will explain in a moment.

1. Lower abdominal pain is a common symptom of many conditions – not just STIs – you would have to be very careful in making conclusions from such data. Any conclusions need to be supported with other evidence.

In fact, the only syndromes that can be taken as really trustworthy indicators of STIs are urethral discharge in men and genital ulcers in men or women.

2. At face value, a significant increase in the number of patients treated for STIs seems to suggest there has been an equal increase in the general population. But the data *cannot be interpreted* in such a way because these patients may not be a representative sample of the population. To find out the *size* of the STI epidemic would require research of a different nature. The only sure interpretation of these data would be that more patients have been treated for genital ulcers. Otherwise, we can only suggest *possible* interpretations based on informed guesses. To name just two:
 - Introducing quality care for patients with STIs should itself have encouraged a significant increase in the number of people who come for treatment – including for treatment of genital ulcers.
 - New or improved recording techniques might have led to more accurate data collection than in the past.

You might like to discuss other *possible* causes of such an increase with your colleagues or trainer. (By the way, have you worked out why our question was misleading? We asked "What can we interpret this to mean?" when our question should have been "What *might* this mean?")

3. Again, comparison of any variation between regions is difficult because there can be so many possible reasons for the variation. For example, it could be that Region A has fewer health facilities than other regions or that the region is more rural, so that fewer people have access to a facility. Alternatively, the population of Region A might rely more on traditional healers, so that STI patients do not appear in their statistics. You could probably identify a number of equally plausible explanations. Remember that we cannot automatically assume fewer cases treated in Region A to mean there is less STI in the population of Region A than elsewhere.

4. Once again, we cannot infer an automatic explanation for the decrease in the number of patients treated. Variations over time might be caused by seasonal patterns such as heavy rains which make travel difficult, or harvesting, which draws people away from villages. They may be caused by other events, such as a new health facility which has attracted patients with STIs. If monthly recording data are available, over several years it would be possible to identify any regular seasonal variations in cases treated for STIs. Economic factors may also play a role in the decrease – for example, introduction of user fees or increase in cost of clinic fees in a poorly paid population.

- 5a) We can use data on the frequency and incidence of STIs to assess *trends* in the numbers of STI cases we treat. This could help the centre better to plan its human and material resources, such as drugs and, if applicable, condoms. Knowing trends and anticipating seasonal variations may also enable the health centre to plan more relevant campaigns and research projects, perhaps with other services such as community and education centres.

- 5b) Regional and national health services could also use the data to help plan resources – financial as well as human and material. Equally, they might be able to plan more effective health education campaigns and liaise with other services that could help in the fight against STIs. Also, although we have stressed that we cannot draw conclusions about *why* variations occur between or within regions or countries, such variations do suggest possible issues that could be researched in more detail. So recording also helps to identify useful research that would add to the understanding of STI epidemiology.

6. The tally sheet readings are:

(a) New cases of male genital ulcer	6
(b) Male genital ulcer cases in the 10–19 age group	2
(c) New cases of female genital ulcer	3
(d) Age group most affected for female genital ulcer	30–39
(e) New cases of urethral discharge in men	5
(f) Total numbers for new STI episodes	men: 15 women: 19

7. Please see the tally sheet on the next page.

COMPLETED TALLY SHEET 2 – SEXUALLY TRANSMITTED INFECTIONS

CLINIC: _____ DISTRICT: _____ MONTH: _____	NAME OF OFFICER: _____ POSITION: _____ SIGNATURE: _____
---	--

CLINICAL SYNDROME	MALE – NEW EPISODE					TOTAL CASES
	0-9 YRS	10-19 YRS	20-29 YRS	30-39 YRS	40+ YRS	
Urethral discharge	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	1
Genital ulcer	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	1
Inguinal bubo without ulcer	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	0
Scrotal swelling	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	1
Genital warts	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	0
Other STIs	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	0
TOTAL MALES	0	1	1	0	1	3

CLINICAL SYNDROME	FEMALE – NEW EPISODE					TOTAL CASES
	0-9 YRS	10-19 YRS	20-29 YRS	30-39 YRS	40+ YRS	
Vaginal discharge	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	2
Genital ulcer	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	3
Lower abdominal pain	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	0
Inguinal bubo without ulcer	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	0
Genital warts	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	0
Other STIs	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	0
TOTAL FEMALES	0	1	1	3	0	5

Contact slips issued	
Contact slips received	

PART 2: YOUR DEVELOPMENT PLAN

1: Introduction

This development plan is for you to work through once you have completed your training in STI case management. It is important for you to reflect on your skills and the services you offer. Such reflection will enable you to see ways of progressing further.

The plan is in clear parts – none of them lengthy. You may work through the parts with your supervisor or trainer.

- You are first invited to reflect on what you have learnt in these modules. You should try to identify what you have learnt well and can now put into practice. Equally, you should identify any aspects you still need to improve and learn more about.
- Putting your knowledge into practice is the thing that matters most. So you should next seek to find out how your service appears to patients and colleagues.
- After obtaining a picture of your possible strengths and weaknesses, you should make a plan for developing your skills further.
- Finally – after at least a month of STI case management – we ask you to review your progress. It takes time to get proficient with a new set of complex skills, so it pays to give some time to self-examination.

2: Reflecting on your learning

Please flip back through each of the modules you have studied on STI case management, paying particular attention to the objectives and action plans.



Now answer these questions:

What skills do you feel confident you have learnt well and can now perform effectively? (Think too about things you may have achieved in practice.)

Are there any skills you feel you have not understood or not learnt sufficiently? (Again, think of occasions in your practice – this time, occasions when you may not have performed at your best.) If you recognize some weaknesses, please note them below.

3: Assessing your performance

You should examine not just what you have learnt but also what others think of your service.

Think of three patients you have worked with recently. What would you **like** them to say about you?

What do you think these patients would actually say about your service?
If this is different, why?

What might a colleague observing you with these patients have to say?

Discuss what you have noted above with your supervisor/trainer. Record any extra points that he/she makes about your performance.

4: Planning your skills development

Now the important part. We suggest you set yourself development objectives to increase your proficiency. You might wish to think of this as a "learning contract".

You should not concentrate on difficulties alone. Include objectives enabling you to continue and strengthen the skills you have already mastered well.

After thinking about your strengths and about activities you enjoy, complete the box below.

I will continue to work to the same high standard at the skills below and strengthen them:

5: Review

Reviews are important, so take the trouble to study this stage.

Before attempting a review on your progress, wait until you have been working in STI case management for at least a month. Make sure you have had the chance to work through at least half of your development plan.

Go back over the notes you made in Parts 2 and 3 of this development plan. Now note down how you feel you have progressed in both your strengths and possible weaknesses.

Recording and Development Plan

By now you are in a good position to comment on ways you might improve STI management practices at your centre. You may have come across issues or problems you did not anticipate during your training. There may be difficulties with resources, administration or teamwork – and you may have found working with STI patients more stressful or upsetting than you expected.

Please note down any problems you can resolve or improve personally.

Note any issues or problems that require the attention of your supervisor or the team.

It is essential to have a service that works efficiently, so be sure to raise any problems you have noted.

This completes this development plan.

However, it is unlikely to be the end of your self-development. So urgent is the need to counter the STI epidemic that we will always find new challenges to our skills and understanding. The size of the task may seem overwhelming, but you are part of a strategy that has been carefully planned, is working and has the greatest chance of controlling the spread of infections.

We wish you success in your work.

Sample integrated disease surveillance (IDS) form

DISTRICT IDS MONTHLY SUMMARY OF OUTPATIENT AND INPATIENT SURVEILLANCE REPORTS (district to next level)

Year _____ Month _____ District _____ Province _____

Record below the total number of cases and total number of deaths for each disease/condition. Report these totals to the next level. Complete the column for the current month for all disease/conditions

	Outpatient		Inpatient	
	Cases		Cases	Deaths
Malaria < 5 years	Uncomplicated			
	Severe			
Malaria > 5 years	Uncomplicated			
	Severe			
Inpatient malaria with severe anaemia (< 5 years)				
Uncomplicated malaria < 5 years, lab-confirmed				
Uncomplicated malaria 5+ years, lab-confirmed				
Pneumonia (< 5 years)				
Severe pneumonia (< 5 years)				
Diarrhoea with some dehydration (< 5 years)				
Diarrhoea with severe dehydration (< 5 years)				
New AIDS cases				
Male urethral discharge				
Male non-vesicular genital ulcer				
Female non-vesicular genital ulcer				
Diarrhoea with blood				

Number of sites that reported on time _____

Number of outpatient sites that are supposed to report _____ Number of sites that reported late _____

Zero reporting for immediately reported, case-based disease/conditions: Total cases previously reported this month on case forms or line lists

AFP		Measles		Plague	
Cholera		Meningitis		Yellow fever	
Dracunculiasis		Neonatal tetanus		Viral haemorrhagic fever	

Note: Official counts of immediately notified cases come only from case forms or line lists. The counts from the zero-reporting boxes are not official counts.

Analysis, interpretations, comments, and recommendations on both outpatient and inpatient data

Other information:

Look at the trends in the *District Analysis Book*. Comments on observed trends? Abnormal increase in cases, deaths, or case fatality ratios? Lack of decrease of previous increasing trends? Improving trends

Conclusions, actions taken, and recommendations

Sent _____ Date: _____ Received _____ Date: _____
report Person: _____ report Person: _____

Some dehydration, severe dehydration, pneumonia, and severe pneumonia are defined according to WHO Integrated Management of Childhood Illness (IMCI) definitions. TB and leprosy data reported quarterly on separate forms. Update District Analysis Book if reports from health facilities are received late. If late reports are received from health facilities from previous months, send a separate sheet to the next level to update numbers.

Glossary

AIDS	Acquired immunodeficiency syndrome caused by the human immunodeficiency virus (HIV)
Epidemiology	The study of the incidence , distribution and causes of an infection or disease in a population
Frequency	The number of infections over a given time period
Incidence	The frequency of new infections, expressed as a percentage of the population at risk
Prevalence	The proportion of a given population that has a disease or infection at a certain time
Tally sheet	A chart on which the numbers of patients, events or episodes can be recorded quickly and accurately. The sheet is then used to summarize and collate the data collected
Universal reporting	A system of data collection in which all health facilities document and report the number of patients or episodes treated

Abbreviations

IDS	integrated disease surveillance
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization