

THE UNITED REPUBLIC OF TANZANIA



MINISTRY OF HEALTH AND SOCIAL WELFARE

SEXUALLY TRANSMITTED AND REPRODUCTIVE TRACT INFECTIONS

**A MANUAL
FOR SERVICE PROVIDERS**

National AIDS Control Programme (NACP) &
Reproductive and Child Health Section

JANUARY 2008

**SEXUALLY TRANSMITTED
AND
REPRODUCTIVE TRACT INFECTIONS**

A MANUAL
FOR SERVICE PROVIDERS

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National AIDS Control Programme
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DAR ES SALAAM

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome	PMCTC	Prevention Mother to Child Transmission
ARV	Anti-Retroviral drug	MTUHA	Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya
CTC	Care and Treatment Clinic	MOHSW	Ministry of Health and Social Welfare
BCC	Behavioural Change Communication	MSD	Medical Store Department
EC	Emergency Contraception	NACP	National AIDS Control Programme
FGM	Female Genital Mutilation	NC	Neonata Conjunctivitis
FP	Family Planning	PSS	Painful Scrotal Swelling
GRN	Goods Received Note	PAP	Papanicolaou
GUD	Genital Ulcer Disease	PEP	Post Exposure Prophylaxis
HMIS	Health Information Management System	PID	Pelvic Inflammatory Disease
HIV	Human Immunodeficiency Virus	PITC	Provider Initiated Testing and Counselling
H/W	Health Worker	RTI	Reproductive Tract Infection
HCP	Health Care provider	STI	Sexually Transmitted Infection
HTA	High Transmission Areas	UDS	Urethral Discharge Syndrome
IB	Inguinal Bubo	UNFPA	United Nations Population Fund
IDC	Infectious Disease Centre	VDS	Vaginal Discharge Syndrome
IEC	Information, Education and Communication	VCT	Voluntary Counselling and Testing
IUCD	Intrauterine Contraceptive Device	WHO	World Health Organization
IB	Inguino Bubo		
JICA	Japan International Cooperation Agency		

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PREFACE

The need for comprehensive and standardized services for Sexually Transmitted infections (STIs) and Reproductive Tract Infections (RTIs) and a package for training have been felt for a long time. This became obvious after the Ministry of Health and Social Welfare (MOHSW) adapted the WHO guidelines into National Guidelines for Management of STIs/RTIs in March 2007.

The training of service providers for STI/RTI management has been conducted in this country for more than a decade by MOHSW in collaboration with other public and non-governmental organizations. However, there were no standardized guidelines and the focus was mainly on STIs with little emphasis on RTIs.

The preparation of this manual included reviewing the prevailing STI management manuals and developing a comprehensive STI/RTI management trainer's guide and a guidance for service providers.

The reviewed STI/RTI management trainer's guide and the Service Provider manual will be of significant help in several ways. Firstly, they will provide standardization in the training and provision of STI/RTI services in Tanzania. Secondly, these guidelines will lead to good coverage of the population that seriously needs these services including mothers who attend reproductive and child health, and family planning services. Thirdly, adolescents, youth and men who do not usually access these services will also be targeted. Fourthly, sexual violence an area that has for long time been neglected in STI/RTI services has now received adequate attention to help rape survivors get adequate medical and psychological care.

A chapter on ordering, receiving, storing and dispensing of medicines and other related supplies will ensure constant availability of these commodities at the facility and proper record keeping.

It is thus expected that this service provider manual will be effectively utilized in the efforts to scale up prevention and control of STIs/RTIs in the country.



Wilson C. Mukama

Permanent Secretary

Ministry of Health and Social Welfare

INTRODUCTION

This manual is intended to be one of the tools to guide trainers in enabling trainees to acquire appropriate knowledge and skills in the management of STIs/RTIs, particularly using the Syndromic Approach.

Following the development of the new National Guidelines for Management of Sexually Transmitted and Reproductive Tract Infections, March 2007, there was a need for revising the current manuals for Management of STIs and developing a new STI/RTI training management package.

Rationale of reviewing previous manuals for STI management

WHO periodically revises and issues generic STI control guidelines and training materials to guide countries to update theirs in line with changing knowledge and locally generated evidence.

The Ministry of Health and Social Welfare (MOHSW) of Tanzania has recently revised its guidelines for the management of STIs/ RTIs in line with current WHO guidelines. These new guidelines which replace those developed before (in 2003), put more emphasis on the differentiation of STIs which are predominantly sexually transmitted from RTIs which may not be sexually transmitted.

The other emphasis of the new guidelines is the integration of STI/RTI services into regular reproductive health services as an approach that uses special skills to reach more clients who need them.

Moreover, the manuals in current use have shown to have a number of gaps such as:

- Logistics for drugs, laboratory reagents and other STI/RTI related supplies was not adequately addressed.
- Previous manuals developed in 2003 had several components on HIV/AIDS while HIV/AIDS has its own package. For example basic facts about HIV/AIDS
- Sexual Violence which is currently a public social and health concern was neglected
- Components on detecting, preventing and promoting prevention of

STI/RTI and use of services were not given due weight. Further more, men involvement in STI/RTI services was not emphasized.

- Inclusion of the component of organizing STI services makes the STI/RTI services to be more vertical rather than integrated services.

Having newly revised training manuals which address the above gaps will provide comprehensive information for STI/RTI management.

Aim and Purpose of the manual for service provider

The aim of this manual is to enable service providers to implement effectively and efficiently the new comprehensive package of STI/RTI management.

The purpose is to standardize the management of STIs/RTIs in the country.

- The trainers will use this manual in orienting themselves before during and after conducting the training.
- The trainees will use it as a reference material during and after training in management of STIs/RTIs.
- The supervisor will use it as a standard tool to measure the extent of success of implementation.
- Service providers will use it as an immediate resource/reference material in the clinical settings.

Goal and Objectives of the manual

The goal is to enable the service providers to plan, conduct, monitor and evaluate the STI/RTI services in accordance with National STIs/RTIs guidelines.

General Objectives

The STIs/RTIs service providers should be able to;

- Establish and maintain positive inter-personal relationship with clients in need of STI/RTI services
- Provide conducive environment for STI/RTI management
- Manage clients with STIs/RTIs using syndromic management approach
- Create a user-friendly environment whereby marginalized groups can seek for STI/RTI information and services

- Integrate STI/RTI services within the general health care services.
- Mobilize the community for STI/RTI prevention and behaviour change
- Recognize the strategies of the national STI/RTI and HIV/AIDS programme
- Integrate STIs/RTIs into regular reproductive health services
- Manage effectively logistics for medicines, laboratory reagents and STI/ RTI related supplies
- Manage effectively STI/RTI complications related to pregnancy, abortion and the postpartum period and post sexual violence.

RESPONSIBILITIES AND TASKS OF THE STI/RTI SERVICE PROVIDER

The STI/RTI Service Provider will do the following:

RESPONSIBILITY 1:

Establish and maintain interpersonal communication ensuring positive relationship with the Client, Community and Co-workers.

TASKS:

1. Establish and maintain provider/provider and client/provider relationship.
2. Establish and maintain services that promote the client's and Community's rights during service delivery.

RESPONSIBILITY 2:

Promoting STI/RTI education to individuals, couples, groups and community.

TASKS:

1. Planning, conducting and evaluation STI/RTI educational session for target groups specified in the national guidelines for management of STI/RTI service delivery and training.

The task involves the following:

- Promoting health care seeking behaviour in women and men.

- Promoting sexual reproductive health among adolescents and youths.
- Conducting sessions on prevention of STIs/RTIs.
- Promoting antepartum, Partum and post-partum care.

RESPONSIBILITY 3:

Counselling individuals, couples and groups for and during STI/RTI Services

TASKS:

1. Using counselling skills to:
 - Prevent re-infection and spread to others
 - Ensure compliance to treatment.
 - Identify and notify sexual contacts.
 - Promote safer sex practices including condom use among groups at high risk i.e. adolescents, youth and commercial sex workers.
1. Counsel and refer cases that cannot be managed at the level.
2. Counsel and manage survivors of rape.

RESPONSIBILITY 4:

Managing STI/RTI Client

TASKS

1. Taking proper history.
2. Performing thorough physical examination.
3. Making accurate decision
4. Taking proper action.
5. Conduct follow-up to determine drug compliance, treatment outcome and partner notification.
6. In case of treatment failure, refer for further appropriate management. e.g. change to third line treatment, laboratory investigation or upper level of service delivery.

7. Establish linkage of STI/RTI Management of adolescents and youths with other RH Services.
8. Offer PITC to a client.
9. Providing health education on STIs/RTIs using Behavioural Change Communication (BCC), IEC materials.
10. Promoting and teaching on proper condom use and negotiation.

RESPONSIBILITY 5:

Organizing the STI/RTI clinic to offer quality, accessible and equitable services.

TASKS

1. Establish conducive environment for youth friendly services.
2. Organize the STI/RTI clinic in a way that enhances acceptance and continuity of the services.
3. Ensure availability of medicines, medical supplies and equipment for use in the STIs/RTIs at the facility.
4. Preventing nosocomial infections in health service providers and clients.
5. Maintaining records according to the Health Management Information System (HMIS)/"MTUHA"
6. Compiling and using data for the quality of STI/RTI service.

RESPONSIBILITY 6:

Mobilizing Individuals, Couples, Groups and community for STI/RTI Prevention and Behaviour Change.

TASKS

1. Conducting advocacy activities.
2. Promote health-seeking behaviour among the community.
3. Screen pregnant women for STIs/RTIs and HIV/AIDS.

4. Promote relevant IEC materials and utilize them appropriately.
5. Advocate for Voluntary Counselling and Testing for HIV/AIDS
6. Promote the use of condoms and other services among individuals, couples, youth and adolescents.

RESPONSIBILITY 7:

Recognize the STI/RTI management strategies

TASKS

1. Apply National STI/RTI and HIV/AIDS Prevention strategies during service provision.
2. Adhere to National STI/RTI treatment guidelines.
3. Offer PITC
4. Sensitize the community to actively participate in home-based care
5. Participate in the implementation of STI/RTI research activities.

RESPONSIBILITY 8:

Manage effectively logistics for medicine, laboratory reagents and other related supplies

TASKS

1. Establish monthly requirements
2. Order medicine and other medical supplies and equipment for STIs/RTIs timely maintain inventory/records according to Health Management Information System (HMIS)/“MTUHA”

Introduction to STI/RTI/HIV/AIDS

The Importance of STI/RTI on public health

Sexually Transmitted Infections and Reproductive Tract Infections (STIs/RTIs) remain a public health problem of major significance in many countries of the world. WHO statistics indicate that Over 340 million curable and many more incurable STIs occur each year among women worldwide and that Non-sexually-transmitted RTIs are even more common. Failure to diagnose and treat STIs/RTIs at an early stage may result into serious complications and consequences including infertility, foetal wastage, ectopic pregnancy, anogenital cancer, premature delivery, as well as neonatal and infant infections. Proper management of STIs/RTIs also reduce the maternal and infant mortality. STIs are also known to enhance the spread of HIV infection in communities. STIs/ RTIs also have negative socio economic impact that include, increase cost for health service, relationship/ marriage problems etc.

To reduce the burden of STIs/RTIs, efforts are needed in both health care facilities and in the community. Effective prevention and case management practiced by health care providers can reduce the STI/RTI burden in several ways. For example, effective treatment reduces STI transmission in the community; safe and appropriate clinical procedures mean fewer iatrogenic infections. Community education and outreach are important to promote prevention of infection and use of health care services and thus further reduce disease transmission within the community.

Factors that facilitate STI/RTI transmission in the community

There are many factors which facilitate STI/RTI transmission in the community including:

- Risky sexual behaviours such as: having multiple partners or not practicing safe sex

- Socio-economic factors such as transactional sex or lack of information on STIs/RTIs
- Cultural factors such as societal rituals of cleansing or widow inheritance.
- Biologically, adolescents/youth are at most risk because of immature sexual organs and females are more likely to be infected compared to men because of their anatomical make up.
- War and political instability in the country create mobility and migration that adversely influence changes in sexual behaviour
- Iatrogenic infections are more common where there are many STIs, and where health care providers do not have the training or supplies to perform procedures safely, Post-partum and post-abortion infections are more common where safe services and follow up care are not available.
- Endogenous yeast infection and bacterial vaginosis are common worldwide and are influenced by environmental, hygienic, hormonal and other factors.

Relationship between STI/RTI and HIV/AIDS

The reason that STI/RTI and HIV/AIDS are related is that these diseases have many things in common. For example,

- HIV and STIs/RTIs share the same major modes of transmission route such as unprotected penetrative sex and mother to child transmission
- The same risk behaviour predispose to infection of HIV and STIs/RTIs
- Having STIs/RTIs increases the risk of acquiring and transmitting HIV infection.
- Effective treatment of STIs/RTIs decreases the amount of HIV in the genital secretions and makes HIV transmission less likely.
- Being HIV infected can change the clinical presentation and treatment outcome of the STIs/RTIs.

Important information on STIs/RTIs

Definition

Sexually Transmitted Infections (STIs) are a group of infections that are predominantly transmitted through unprotected sexual contact with an infected person.

Reproductive Tract Infections (RTIs) are infections of the genital tract. Not all sexually transmitted infections are reproductive tract infections; and not all reproductive tract infections are sexually transmitted; STI refers to the way of transmission whereas RTI refers to the site where the infections develop.

How do people acquire STIs/RTIs?

There are basically five modes of STI/RTI transmission

- *Endogenous infection:* causative organisms are found in the vagina. It is usually not transmitted from person to person but immuno compromising factors can cause overgrowth which may lead to symptoms. For example, yeast infection, bacterial vaginosis.
- *Sexually transmitted infections:* usually caused by unprotected sexual contact with infected person. For example, gonorrhoea, Chlamydia, syphilis, HIV infection, scabies, trichomoniasis, genital warts
- *Latrogenic infections:* causing organisms may be found inside or outside the body such as STI in the vagina or contaminated medical procedures or instruments. For example, Pelvic inflammatory disease following abortion or trans-cervical procedures.
- *Vertical transmission:* from mother to child during pregnancy e.g., congenital syphilis, HIV infection, during delivery or breast feeding. e.g., Neonatal conjunctivitis (NC), HIV infection
- *Through blood transfusion and/or its products* in this case organisms are found in the blood or blood products. Any contact with infected blood or blood products may cause the spread of disease. For example, HIV infection, syphilis, hepatitis B and hepatitis C.

What is the clinical presentation of STIs/RTIs?

Some STIs/RTIs are asymptomatic while others are symptomatic.

Common symptoms of STIs/RTIs are painful micturition, abnormal vaginal discharge, urethral discharge, genital ulcerations, genital itching, swelling of inguinal lymphnodes, scrotal swelling, lower abdominal pains and pains during sexual act.

It is important to note here that a number of individuals can be infected without symptoms. This applies to both women and men.

It is important to note that infected but asymptomatic individuals can also infect their sexual partner(s).

Can STIs/RTIs be prevented?

Most of STIs/RTIs and their complications are preventable. Communities with good access to effective prevention and treatment services have lower rates of STI/RTI.

Common approaches within reproductive health services include: abstinence, fidelity, correct and consistent use of condom, early treatment, medicine compliance, screening and treating of asymptomatic cases.

Important information on HIV/AIDS Definitions

Many people are confused about the difference between HIV and AIDS. There fore, it is very important that as a service provider you are able to explain the difference to your patients.

HIV infection is the state of being infected by the Human Immuno Deficiency Virus (HIV) type 1 and 2 without symptoms and signs whereas AIDS is the state of being HIV infected with presentation of symptoms and signs.

To be infected with HIV virus means that:

- You have virus in your body
- You can always pass the virus to others
- You can look healthy and feel well until you become sick with AIDS and that might take years

How do people acquire HIV?

Mode of transmission of HIV infection is through unprotected penetrative sexual intercourse, contact with infected blood and/or its products, vertical transmission (mother to child) and contact with infected body fluids such as vomitus, faecal matters and ascitic fluid.

Pathogenesis of HIV/AIDS

Pathogenesis of HIV/AIDS follows a pattern where HIV starts by infecting lymphocytes called T- helper lymphocytes or CD4+ cells (CD4+ Cells assist in maintaining normal body immunity). Multiplication of HIV in CD4+ cells kills them. When many CD4+ are killed the body immunity decreases. Decreased body immunity results into being vulnerable to opportunistic infections and cancers (AIDS).

What is the clinical presentation of HIV/AIDS?

Most of the symptoms and signs of HIV/AIDS encountered are due to opportunistic infections. You as a service provider you need to know the most common symptoms and signs, and stages of the progression of HIV infection. It will help you to guide and advise your patients effectively. Symptoms and signs such as fever, cough of more than one month duration and usually persistent, dysphagia, odynophagia, weight loss, diarrhea, generalized lymphadenopathy, skin rash, generalized pruritis, altered mental status or on-and-off severe headaches are common. Other possible causes of the above symptoms and signs should be ruled out.

What are the available tools for Diagnosis of HIV/AIDS?

The diagnosis of HIV infection is mainly based on laboratory tests. The tests that are currently available in Tanzania include various forms of ELISA, western blot and rapid tests such as Determine, SD-Bioline and Unigold.

Can HIV/AIDS be prevented?

Prevention and control measures of HIV/AIDS include abstinence, fidelity, correct and consistent condom use, voluntary counselling and testing, PITC, screening of blood before transfusion, prevention of mother to child transmission, proper management and control of STIs/RTIs and adhering to standard precautions of infection control.

National HIV/AIDS Policy And STI/RTI Guidelines And Strategies

National HIV/AIDS policy

The national policy on HIV/AIDS which was launched in October 2001, put emphasis on prevention of the transmission of HIV/AIDS. Among the specific objectives of the policy are:

- Creating and sustaining an increased awareness of HIV/AIDS through
- targeted advocacy, information, education and communication for
- behaviour change
- Promoting safer sex practices e.g. use of condoms, non-penetrative sex, faithfulness to partners and abstinence.
- Prevention and management of STIs/RTIs particularly early diagnosis, treatment, prevention and control because of their role in facilitating HIV/AIDS transmission.
- Prevention of mother to child transmission

National STI/RTI guidelines

There are a number of guidelines (national and international) developed or adapted by the Ministry of Health and Social Welfare to guide the implementation of STI/RTI strategies. Among the current guidelines are:

- MOHSW (2007) National guidelines for management of sexually transmitted and reproductive tract infections.
- MOHSW (2005) National guidelines for voluntary testing and counselling
- MOHSW (2004) National guidelines for screening and treatment of syphilis during pregnancy
- MOHSW (2003) National policy guidelines for reproductive health services
- WHO (2003) Guidelines for the management of sexually transmitted infections
- National Guideline for the clinical management of HIV and AIDS

STI/RTI intervention strategies

For effective management and control of STI/RTI interventions national strategies are directed towards:

- Training of service providers
- Effective primary prevention of STIs/RTIs
- Promotion of appropriate STI/RTI care seeking behaviour
- Effective case management
- Contact management
- Routine prevention of Neonatal conjunctivitis
- Availability and affordability of drugs
- STI/RTI case finding and screening
- Monitoring and evaluation

Your role as a service provider in reducing the burden of STIs/RTIs

There are a number of challenges to providing effective STI/RTI services to the people who need them. A significant proportion of people with STIs/RTIs do not seek treatment because they are asymptomatic or have mild symptoms. Others who have symptoms may prefer to treat themselves or seek treatment at pharmacies or from traditional healers. Even those who come to a clinic may not be properly diagnosed and treated. In the end, only a small proportion of people with STIs/RTIs may be cured and avoid re-infection. Service providers have a major role in responding to these challenges.

Many of these challenges can be addressed by making the most of opportunities to promote prevention, improve health care-seeking behaviour, and detect and manage existing infections. Other roles of service providers have been outlined in the National Guideline for management of STIs/RTIs chapter one page 10.

Detection (Diagnosis) of STIs/RTIs

General screening for STIs/RTIs

It has been researched and reported that a significant proportion of women and men with STIs/RTIs, do not have symptoms. Even those with mild symptoms may not complain when they come for other care services. Asymptomatic infections may equally cause complications as symptomatic ones.

It is the role of the service provider to utilize every opportunity to screen patients/ clients for STIs/RTIs both clinically and/or by laboratory investigation when they come for other services.

What you need to remember on detection of STIs/RTIs

Detecting asymptomatic infection is important to an individual as well as community since it interrupts transmission.

- Health care provider should have adequate skills and knowledge on common signs and symptoms of STIs/RTIs.
- All STI/RTI patients should be encouraged to take a HIV test.
- Provider Initiated Testing and Counselling should be encouraged
- Symptom suspicion and early care seeking behaviour should be promoted.
- Screening clients who come for Reproductive Health Services such as pregnant women, is an effective strategy for prevention of RTIs/RTIs such as congenital syphilis.

- Speculum examination is essential and should be performed carefully to detect any sign and Papanicolaou smear should be taken to detect early cervical cancer.

What are the challenges?

There are several barriers in the detection and control of STIs/RTIs in a community: Firstly, not all who are infected seek for care and some are asymptomatic. Secondly, those who seek for care not all are properly managed or get cured and finally, partner notification and management is another snag. Barrier cascades and some strategies for detecting STIs/RTIs in patients who come for other services have been summaries in figure 2.1 and tables 2.1 and 2.2 of the National Guidelines for management of STIs/RTIs chapter 2 on page 11, 12, and 13.

What you need to remember on challenges

It is important to remember that some issues may come up when screening or presumptively treating for STIs/RTIs.

- Clients who come to clinic or health facility for other reasons may not be prepared to hear that they may have STI/RTI
- These clients may be more upset if they are told that they have to inform their sexual partners
- Such situations must be handled carefully to avoid losing patients' trust and damaging the reputation of the facility
- The fact that no screening test is 100% accurate clients should be given clear explanation and the possibility of error
- All the time health providers should avoid labelling problems as sexually transmitted when it is uncertain because of the stigma.

Screening for specific STIs/RTIs and HIV infections

Recommendations for screening in specific STIs/RTIs and HIV including indications for screening and the available tools have been adequately discussed in the National Guidelines for management of STIs/RTIs chapter 2 on pages 14 to 18.

One of the strategies in STI/RTI/HIV screening is adoption of Provider Initiated Testing and counselling (PITC). PITC components aim at providing correct information, encouraging every client to be tested, assisting a decision making and testing for any client who comes for other health services.

What a service provider should observe

Standard precautions during screening

Laboratory screening involves handling of blood and other body fluids. Standard precautions should be observed at all times when dealing with invasive procedures such as drawing blood. All body fluids should be considered infectious.

Precautions are aimed at protecting the service provider and client. They also aim at protecting against nosocomial infections.

Standard precautions include:

Safe personal behaviour

- Wash hands with soap and water before and after every procedure
- Wear protective clothing such as aprons and gloves and remove them
- after testing
- Cover any wound or broken skin with plaster
- Work tidily and avoid contaminating your work place
- Don't bite finger nails or chew pencils

Safe handling of specimen

- Explain the client what is to be done to gain cooperation and trust of client
- Disposable specimen collecting materials should be used
- Avoid needlestick injuries
- Cap infected fluids before centrifuging
- Disinfection should be carried out using appropriate disinfectant such as 0.5% hypochlorite
- Antiseptic recommended for skin decontamination is 70% alcohol (methanol)

- All disposable items should be burnt or incinerated (where possible)

Laboratory testing for Syphilis screening

There are two major categories of serological testing for syphilis namely; Non-Treponemal and Treponemal tests. Procedures for laboratory testing are discussed in National Guidelines for Management of STI/RTI and the National guideline chapter 3 on page 18 and Trainers Guide on PITC .

Remember that:

- Indications for screening in some conditions such as cervical cancer screening depend on availability of resources
- Pre-testing counselling should always be done by a well trained service provider
- All laboratory investigations should be done by a trained health personnel
- RPR tests may remain positive for about six months to one year even after successful treatment, thus results must always be recorded
- Treponemal specific tests remain positive for the rest of one's life
- Serum/plasma should be tested on the same day and haemolysed blood should never be used
- Clients should preferably be informed about the test results on the same day.
- For positive syphilis result treatment should be given on the same day

Provider Initiated Testing and Counselling (PITC)

HIV counselling and testing approaches

- Client Initiated Voluntary Counselling and testing (VCT)
- This is a client – initiated Voluntary HIV Counselling and Testing
- Provider – Initiated HIV testing and Counselling (PITC)

Health care practitioners will have the role of initiating HIV testing and counselling for all patients attending health care facilities in

order to make specific clinical decisions that require knowledge of the patient's HIV status

- **Mandatory HIV screening**
This refers to routine screening for HIV and other blood borne viruses of all blood for blood transfusion or transfer of bodily fluids or parts
- **HIV Testing in medical research and surveillance**
In Tanzania this is performed according to specific guidelines and regulations approved by the appropriate scientific and review boards.

PITC concepts

PITC refers to HIV testing and counselling which is recommended by health care providers to persons attending health care facilities as a standard component of medical care. The major purpose of such testing and counselling is to enable specific clinical decisions to be made and/or specific medical services to be offered that will not be possible without knowledge of the person's HIV status.

PITC also aims to identify unrecognized or unsuspected HIV infection in persons attending health facilities. Health care providers may therefore recommend HIV testing and counselling to patients in some settings even if they do not have obvious HIV-related symptoms or signs. Such patients may nevertheless have HIV and may benefit from knowing their HIV-positive status in order to receive specific preventive and/or therapeutic services. In such circumstances HIV testing and counselling is recommended by the health care provider as part of a package of services provided to all patients during all clinical interactions in a health facility.

It is emphasized that, the principles of informed consent, counselling, and confidentiality must be observed. Persons retain the right to decline the HIV test without being denied any services to which they are entitled to at the health facility.

Rationale for PITC

- Integrating HIV testing into service provision for all patients to normalizes as other chronic disease.
- Majority of people in Tanzania do not know their status. PITC increases the individual's access to HIV testing hence number of individuals that know their status.
- People tend to prefer being tested within the context of a regular health service visit. A visit to a specialized facility just for an HIV test can be time consuming, inconvenient and stigmatizing.
- PITC takes less time it focuses more on post – test counselling and referral to appropriate services.
- Rates of HIV infection are higher among TB and other patients, with signs and symptoms of HIV and AIDS, than among the general population. It is therefore important to test these groups of patients for HIV.

Importance of PITC in Tanzania

- HIV counselling and testing in Tanzania done in the past has occurred at VCT sites only.
- The number of people in Tanzania who have been tested and know their HIV status has been very low, around 15% of the population.
- UNAIDS and WHO point out the critical need for increasing the number of people who have received HIV counselling and testing and know their status, and are able to access care, treatment, prevention, and support services.
- In Tanzania, the national policy calls for recommending HIV testing to every person who comes to a health facility, regardless of their malady.

Similarities and differences between VCT and PITC

Both VCT and PITC:

- Are voluntary
- Require the consent of the client/patient
- Test for the benefit of the client/patient
- Require that the result be given to the client/patient
- Are preferably done using a rapid test with a same day result

However VCT and PITC have following differences:

	VCT	PITC
Setting	<ul style="list-style-type: none"> • Stand alone • Mobile • Health facilities 	Health facilities
Clients/ Patients	<ul style="list-style-type: none"> • Come for HIV test • Expect to get tested for HIV • More likely asymptomatic 	<ul style="list-style-type: none"> • Come for other services • Not expecting HIV test • Symptomatic
Initiated by	Client	Provider
Providers	Trained counsellors, not necessarily a HCP	HCP trained to provide counselling
Results	Anonymous	Linked
Aim	Preventing HIV transmission through risk assessment, risk reduction plan	For appropriate management, referral for HIV care, and treatment
Pre-test Counselling	<ul style="list-style-type: none"> • Client centred • Long discussion about need for HIV testing • Explore whether they wish to be tested for HIV • Discuss the results with negatives and positives clients because of the focus on prevention 	<ul style="list-style-type: none"> • Counsellor centred • Limited discussion about need for HIV testing • Provider recommending HIV test to patients • Focus on those who test positive with emphasis on their medical care
Duration	Long: 1- 2hrs	Short: 20 -30 min

PITC steps

Pre-test information in PITC

During the PITC pre-test information session, the provider shall explain to the person(s) the following:

- The reasons why HIV testing and counselling is being recommended
- The clinical and prevention benefits of HIV testing
- The services that are available in the case of either an HIV-negative or an HIV-positive test result, including availability of antiretroviral treatment
- That the test result will be treated confidentially
- That the patient has the right to decline the test.
- That declining an HIV test will not affect the patient's access to services that do not depend upon knowledge of HIV status
- In the event of an HIV-positive test result, encouragement of disclosure to other persons who may be at risk of exposure to HIV
- That the patient has an opportunity to ask the health care practitioners questions

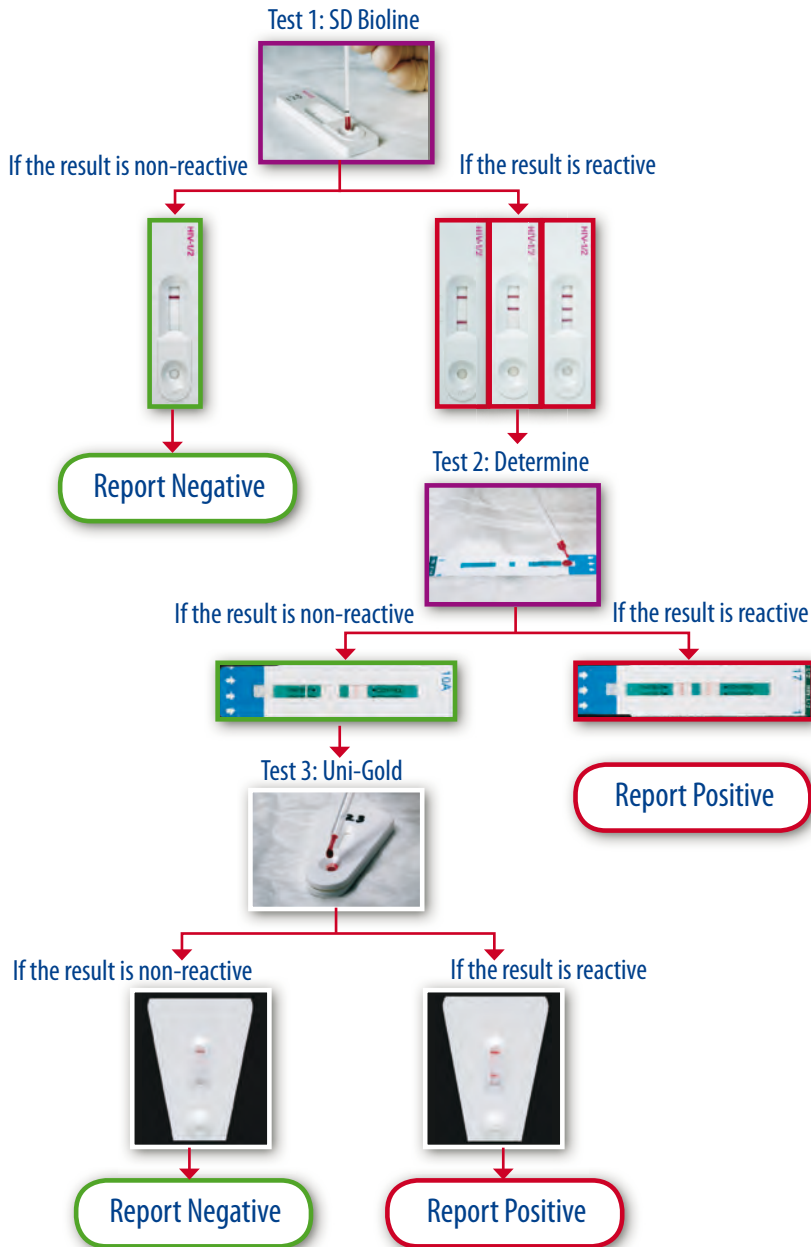
HIV testing algorithm in Tanzania

HIV testing in Tanzania is done according to the national testing algorithm and is based on serial testing. A testing algorithm refers to the combination of tests and the sequence of use in HIV testing to provide maximum sensitivity and specificity.

With 'serial testing' a blood sample is taken and tested using the "first" test. If the result is reactive the test result is given to the client as HIV negative. If the test result is reactive the blood sample is tested using a "second" different HIV test. If the second test is also reactive the result is given to the client as HIV positive. If the second test is negative, (first test is positive and second test is negative), a "third" test (also called a tie-breaker) is used. The final test result of the sample is determined by the result of the tie-breaker. In a situation where there is no tiebreaker for rapid testing, discordant samples should be referred to the laboratory for ELISA testing.

Health care practitioners shall follow the MOHSW approved testing algorithm.

Figure 1: National HIV Rapid Testing Algorithm (2007)



Post test counselling

During the post-test counselling session, health care practitioners should:

- Assess patient's readiness to receive HIV test results
- Communicate HIV test results simply and clearly and give the patient time to consider the results
- Dispel any false beliefs regarding invulnerability or immunity to HIV
- Explain how to remain negative and/or how to prevent re-infection (condoms)
- Discuss prevention, disclosure and options for partner referral to HIV testing and counselling services
- Arrange referral for additional counselling and support

Post test counselling for negative patients

- Explain about the window period and the importance to repeat the test within 3 months
- Basic advice on methods to prevent HIV transmission
- Provision of male and female condoms and guidance on their use.

Post test counselling for positive patients

Individuals whose test result is HIV-positive, the health care provider shall provide the following information:

- Inform the patient of the result simply and clearly, and give the patient time to consider it
- Ensure that the patient understands the result
- Allow the patient to ask questions
- Help the patient cope with emotions arising from the test result
- Discuss any immediate concerns and assist the patient to determine who in her/his social network may be available and acceptable to offer immediate support

- Describe follow-up services that are available in the health facility and in the community, with special attention to the available treatment, PMTCT, and care and support services
- Provide information on how to prevent transmission of HIV, including provision of male and female condoms and guidance on their use
- Provide information on other relevant preventive health measures such as good nutrition, use of co-trimoxazole and, in malarious areas, insecticide-treated bed nets
- Discuss possible disclosure of his/her result, when and how this may happen and to whom
- Encourage and offer referral for testing and counselling of partners and children.
- Assess the risk of violence or suicide and discuss possible steps to ensure the physical safety of patients, particularly women who are diagnosed HIV-positive
- Arrange for follow-up visits or referrals for treatment, care, counselling, support and other services as appropriate (e.g. tuberculosis screening and treatment, prophylaxis for opportunistic infections, STI treatment, family planning, antenatal care)

Ethical and legal issues in PITC

Testing and counselling services are very sensitive. Health care providers are expected to be aware of the below mentioned ethical and legal implications while providing these services. This is necessary due to sensitive nature of HIV and AIDS associated stigma and vulnerability of clients.

Informed consent

- Always obtain informed consent of the client (no coercion)
- Verbal consent is adequate (written consent not prerequisite)
- **Privacy and confidentiality**
- All records should be kept confidential out of reach of unauthorized persons

- Ensure space provides for privacy

Shared confidentiality

- Only client will allow disclosure of HIV results to a third party
- Health providers may access the results for purposes of providing care to the client

Access to services

- Client who declines to undergo HIV testing should not be denied other services
- Provide or refer the client to appropriate services after HIV results

Children < 1

- Consent provided by parents/legal guardians
- If married and/or sexually active may give own consent

Mentally challenged

- Get consent from parent/legal guardian

STI/RTI Health Education, Counselling, Contact Referral And Management

Chapter

3

Health Education

What is health education?

Health Education is the provision of essential information related health to individuals or groups to promote health and health behaviour.

How to deliver health messages to the public

Health education on STIs/RTIs can be done alongside other health education activities in the community or at a facility by using available opportunities and various media. Use of relevant Information, Education, Communication (IEC) and Behaviour Change Communication (BBC) materials produced and distributed by the MOHSW and other reputable organizations are highly recommended.

Service providers are also encouraged to use other public meetings to deliver this important message on STIs/RTIs. Use of local and religious leaders and other influential people is likely to be effective. Dissemination of local STI/RTI prevalence data obtained from clinic and providing leaflets on consequences of STIs/RTIs on the person can also be used for advocacy.

Health Education on various health related issues is a routine activity done at a health facility either in groups or on individual basis.

What the public needs to know about STIs/RTIs

The public should be educated on the following:

- Definition, cause, mode of transmission, symptoms and signs of

STIs/RTIs, their complications and importance of seeking early and appropriate treatment

- Adverse outcome of STIs/RTIs particularly in pregnancy
- Presence of asymptomatic STIs/RTIs and their consequences particularly in Pregnancy
- Availability of services and importance of early screening and treatment of STIs/RTIs in reducing HIV transmission
- The role of men in STI/RTI control and utilization of services.
- Importance of partner management

What to observe when planning for health education

The following should be observed when preparing for health education sessions:

- Prepare the session in advance
- The content is what you want the audience to hear
- Main points should be stressed IEC/BCC materials, which relate to the session have to be prepared in advance
- Have a clear understanding of the content and how to make the presentation understood
- The presentation is given in an attractive and enjoyable manner
- Rehearse the presentation and make sure there is enough time for the content to be covered

How to make a good presentation

Greet the audience, introduce yourself and your topic and objectives

- Present content factually and clearly
- Maintain an engagement with the audience. For example make presentation while standing, maintain eye contact so that clients/ audience maintain their interest
- Make sure your voice is audible
- Give time to audience to ask questions, clarify and summarize

Counselling

What is counselling?

Counselling is a (Confidential) dialogue between a counsellor and a client aimed at helping the client cope with a difficult situation through informed decision making.

Counselling is not:

- Giving advice
- Telling someone what to do
- Interrogating someone
- Finding solutions to someone's problem

Basic skills of counselling

- Relationship building
- Exploration
- Understanding
- Action plan

Factors that promote successful counselling

- Privacy and confidentiality
- Empathy as an ability to enter someone else's world as if it was yours
- Willingness to help
- Accuracy of information
- Respect
- Use of understandable language
- Use of visual aids
- Use of good listening skills throughout the process

What you need to remember when doing counselling

- There is no direct answer in counselling
- Do not be judgmental towards the client
- The client and not the counsellor make the final decision
- It is not advisable to counsel your relative, a friend or someone who is very close to you. In such a situation refer the client to your colleague
- Do not give results to any other person other than the client

Counselling in special situation (Couple counselling)

- Counselling a man and a woman together may need empowering them with additional negotiation skills.
- The provider needs to assess the individual's situation, coach him/her on appropriate negotiation skills, offer to meet with partner and offer continued follow-up support.

Differences between counselling and health education

Counselling

- Confidential
- Usually one to one or couple
- Evolves strong emotions in both Client and counsellor
- Focused, specific and goal targeted information used to change attitudes
- Issue – oriented
- Based on needs of client

Health education

- Not usually confidential
- Small or large groups of people
- Emotionally neutral
- Generalized

- Content oriented
- Based on public health needs

Contact Notification, Referral and Management

Contact notification, referral and management in STI/RTI control involve the process of counselling STI/RTI clients (index case) to notify and refer his/ her sexual contact(s) to the facility for management.

What is index case?

The first STI client reported for management

What is contact case?

Sexual partner/s referred to the clinic by the index client for management

Purpose of contact management

The purpose of notifying and treating sexual partner(s) is to break the chain of transmission and prevent possible eventual re-infections.

It is therefore important to include all contacts that the client might have had sexual contact with during the past three months.

What are the steps for contact notification and referral?

- The service provider counsels the client who has an STI/RTI and provides treatment. A referral card (or slip) known as TAARIFA MUHIMU (important notice) is given to the index case requesting contacts to report to the mentioned facility/clinic. The referral card contains the registration number of the index case only and not the name
- The client who has an STI/RTI informs the contact by handing them the referral slip and explaining the importance for the partner to attend the mentioned facility or clinic.
- The contact presents the referral card to the facility service provider for appropriate care

How to manage the contact?

- Contact with STI/RTI syndrome is treated according to the found syndrome and of the index case
- Cont without signs or symptoms is treated to equivalent syndrome of the index case (epidemiological treatment)
- The service provider should show appreciation to the contact for responding positively to the request to attend the clinic and explain/counsel on the reason for the notice
- During counselling the contacts should be asked and educated on the importance of treating other partners
- Other contact management measures are discussed in the National Guideline for management of STIs/RTIs chapter 3 on page 26
- Before discharging the client, health education is provided. Contacts with an STI/RTI syndrome are regarded as contact index cases. They should therefore be asked to refer their own further contacts

Preventing STIs/RTIs

Introduction

The provision of STI/RTI clinical care at the various levels of the health care delivery system in Tanzania offers a unique opportunity to deliver prevention messages and interventions. People in need of care who have established a trust relationship with a health care provider are motivated and are likely to accept the need for behaviour change and adopt practices necessary to stop further transmission of STIs/RTIs.

A comprehensive approach to management of STIs/RTIs includes prevention of sexually transmitted, iatrogenic and endogenous infections.

Important points to note in STI/RTI prevention

- Since STIs/RTIs are known as being co-factors for HIV transmission. Health care provider should ensure provision of quality STI/RTI services in all health facilities through syndromic approach. Training, provision of adequate supplies and supportive supervision should be undertaken
- Condom, both male and females, constitute an effective protection measure against many STI/RTI and HIV infection transmission. Easy access to condoms for those who need them within the health care setting should be ensured and scaled up. Education on consistent and proper condom use should be provided by all health care staff.
- Some STIs/RTIs are transmitted by contaminated blood e.g. HIV infection and syphilis. An effective and well functioning national blood transfusion services including screening of blood before transfusion will ensure the regular availability of adequate amount of safe blood in all transfusion centres.

- Sex workers and their clients, homosexuals and drug users have disproportionately high prevalence of STIs/RTIs and HIV compared to general population. Increasing access to services and interventions for these groups will reduce transmission of STIs/RTIs and HIV among these groups and in the general population.
- The priority health sector intervention for vulnerable groups including youths, men and pregnant women, include the expansion of youth friendly services and outreach services for men and integration of STIs/RTIs into reproductive and child health services. If these programmes are well implemented they can reduce risk of transmission.
- Voluntary Counselling and Testing as well as Provider Initiative Testing and Counselling have been shown to be effective in influencing change in sexual behaviour and practices. They also need to be accessible and user friendly.
- Minimal infection control measures and adherence to standard precautions for prevention of infection during invasive procedures and during childbirth can help to prevent many iatrogenic RTIs

Promoting Prevention of STIs/RTIs and use of services

Chapter 5

Promotion of STI/RTI prevention and the use of services remain to be among the top agenda of health care providers in order to ensure wide utilization of the services by the people in need. However, it has been noted that providing STI/RTI services does not mean that they will be used by all particularly the poor and vulnerable groups.

What are the barriers?

Utilization of STI/RTI services in Tanzania is affected by a number of factors such as;

- Unskilled health care providers
- De-motivated health care providers
- Negative attitude of health care providers
- Lack of equipment, medicine and supplies
- Inability to meet the cost
- Lack of awareness
- Lack of community involvement and support
- Unfriendly clinic/facility settings e.g. opening hours, lack of privacy
- Inadequate STI/RTI services for special groups e.g. youth friendly services
- Stigma attached to STI/RTI services For further information on barriers in utilization of STI/RTI services refer to chapter 5 on page 42 and 43 of the National Guideline for Management of STIs/RTIs.

What needs to be done?

It is important to remove the barriers that prevent people from using STI/RTI services by:

- Training of health service providers in STIs/RTIs and customer care
- Integrating STI/RTI services into routine facility/clinic services
- Introducing mobile and outreach STI/RTI services for special /vulnerable groups
- Adequate access to correct information on STIs/RTIs
- Addressing clinic/facility delivery barriers such as opening hours, availability of medicines
- Gender sensitive services
- Affordable services
- Community participation and ownership
- Health workers need to be targeted with measures to reduce stigma and discrimination within the health service delivery setting.
- Health workers need also to be appropriately informed and sensitized on the issues surrounding STIs/RTIs so that they can transfer this knowledge and measures to reduce stigma within the general population

Can community participation help?

Community can promote prevention and utilization of STI/RTI services through the following:

- Advocacy through community forums
- Promotion of peer education
- Supporting and participating outreach services
- Referring clients to the services

NB. *Issues related to reaching groups that do not normally use reproductive health services including adolescent/ youth and other vulnerable groups have been extensively discussed in the National Guidelines for management of STI/RTI services chapter 5 on Page 44 to 50.*

Integrating STI/RTI services into routine reproductive health services

Chapter

6

Why integrating STI/RTI services into routine RH services?

People who are supposed to benefit from reproductive health services form a greater part of the country population. The RH services are intended to cater for both men and women from childhood to adulthood. Yet, for many years routine RH services have not been addressing STI/RTI management adequately.

The reasons for integrating the services include:

- Prevention of STIs/RTIs and their complications require a common approach within reproductive health services because, the clinical appearance of different STIs/RTIs overlaps especially in women.
- In reproductive health settings such as antenatal and family planning clinics, non-sexually transmitted Infection (RTIs) are usually commoner than STIs.
- Failure to diagnose and treat STIs/RTIs at early stage of pregnancy may result into adverse outcomes including foetal wastage, premature delivery
- Other serious complications are infertility, ectopic pregnancy as well as neonatal infections (Neonatal conjunctivitis, neonatal pneumonia, congenital syphilis).
- Reproductive health services provide an opportunity for assessing, diagnosing and treating STIs/RTIs
- Integrating STIs/RTIs into routine reproductive health services is an innovative approach that uses special skills to reach more clients who need them.

STI/RTI assessment during Family Planning visits

What service providers need to remember?

- Women attending Family Planning clinic have usually come for family planning methods and not for STIs/RTIs. They may not be prepared to hear that they have an STI/RTI
- Introducing the topic of STIs/RTIs should be done with greater care. If the topic is brought too early, the woman may feel that her family planning needs have been ignored and if brought too late, the choice of method may need to be re-considered.
- Service provider should use appropriate communication skills when introducing the topic of STIs/RTIs.
- Open ended and personalized questions such as “please tell me what your concerns are in relation to infection that are spread by sex” can yield better results than closed questions requiring ‘YES or NO’ answer.
- Do not lose this opportunity for STI/RTI screening, education and counselling, and providing appropriate treatment
- STI/RTI prevention and concerns should be discussed with all family planning clients at each visit. Dual protection against pregnancy and STIs/RTIs should be promoted at every opportunity.

What you need to do when the client visits the facility

Step one: Discuss the method

- Contraceptive needs
- STI protection needs
- Options of methods
- Help client select method

Step two: Assess for STIs/RTIs

- Find out if your client has a STI/RTI
- Assess the need for STI/RTI screening and treatment
- Assess medical eligibility for the preferred method

Step three: Provide the method

- Counsel the client as per counselling guidelines

- Demonstrate use of condom
- Consider STI/RTI risk for the preferred contraceptive method

NB. *Procedures for integrating STIs/RTIs in routine FP services and provision of dual protection and emergency contraception are adequately discussed in the National guidelines for management of STIs/RTIs chapter 6 on page 52 to 60.*

STI/RTI assessment in pregnancy, child birth and the postpartum period

Why STI/RTI assessment in pregnancy and childbirth?

STI/RTI prevention and management are important during pregnancy, child birth and the postpartum period due the seriousness of the associated complications. For example, upper genital tract infections may lead to spontaneous abortion or preterm rupture of membranes. Complications of untreated STIs/RTIs following delivery may be life threatening. Service provider must utilize antenatal clinic visit to detect and treat STIs/RTIs.

What you need to do

At first antenatal visit

- Detect and manage STIs/RTIs
- Offer syphilis testing and treatment
- Screen for bacterial vaginosis and trichomoniasis
- Provide PITC for HIV
- Discuss plans for delivery and post partum care

During follow up antenatal visit

- Assess for symptoms of STIs/RTIs in themselves and their partners
- Repeat syphilis testing if the initial test was negative
- If the mother is HIV positive manage or refer according to PMCTC protocols
- Review birth plans, options for infant feeding and postpartum contraception
- Insist on STI/RTI prevention and condom use

During labour and delivery

- Look for signs of STIs/RTIs
- Carefully manage ruptured membranes using aseptic procedures
- In case genital herpes and or warts is suspected refer to hospital for caesarean section.
- Observe standard precautions against infection throughout the process of labour and delivery
- Provide prophylaxis against neonatal conjunctivitis
- Observe baby for signs of syphilis and treat
- Treat for syphilis in babies born to syphilis positive mothers even if the mother was treated

During postpartum period

- Assess for STI/RTI and provide treatment during the follow-up visits

Management of STI/RTI complications related to pregnancy, abortion and the postpartum period

Infections in pregnancy, following miscarriage, induced abortion or in the post partum can be life threatening. They must be managed aggressively, efficiently and without delays. Serious complications include endometritis and septic abortions in case of induced abortion and endometritis and puerperal sepsis in case of postpartum infections.

Management of infections in early pregnancy

Infections in early pregnancy usually lead to abortions, therefore;

- Perform rapid assessment to rule out early signs of abortion
- Provide antibiotics intramuscularly or intravenously(IM or IV)
- Perform safe evacuation of the uterine content if possible
- Refer to appropriate hospital for further management

Management of infections during rupture of membranes

- Assess for the existence of infections
- Provide antibiotics I.V or IM ÿ Avoid unnecessary vaginal examination
- Manage according to appropriate flow chart chapter 9 on page 99 of the National guideline
- Refer to appropriate facility for further management

Management of infections following childbirth

Infections following child birth are associated with postpartum endometritis and puerperal sepsis. The health care provider should do the following:

- Assess for STIs/RTIs
- Provide antibiotics IM or IV
- Manage according to flow chart chapter 9 on page 100 in the National guideline
- Refer immediately to appropriate facility

The following tables show various regimens for the above mentioned infections

Table 6.1 Antibiotic regimens for treatment of infection following miscarriage, induced abortion or delivery (septic abortion, postpartum, endometritis)

OPTION 1	OPTION 2	OPTION 3	OPTION 4
Commonly available, least expensive. Give all 3 drugs	Choose one drug from each box (=3 drugs)	Give both drugs	Choose one drug from each box (=3 drugs)
ampicillin 2g intravenously or intramuscularly, then 1g every 6 hours	ceftriaxone 250mg by intramuscular injection, every 8 hours	clindamycin 900mg by intravenous injection, every 8 hours	ciprofloxacin^b 500mg orally, twice a day, or spectinomycin 1g by intramuscular injection, 4 times a day
gentamycin 80mg intramuscularly every 8 hours	doxycycline 100mg orally or intravenous injection, twice a day, or tetracycline 500mg orally 4 times a day	gentamycin 1.5mg/kg of body weight by intravenous injection every 8 hours	doxycycline 100mg orally or by intravenous injection twice a day, or tetracycline , 500mg orally, 4 times a day
metronidazole^a 500mg orally or intravenous infusion every 8 hours	metronidazole^a 400-500mg orally or by intravenous injection, twice a day, or chloramphenicol 500mg orally or intravenous injection, 4 times a day		metronidazole^a 400-500mg orally or by intravenous injection, twice a day, or chloramphenicol 500mg orally or by intravenous injection, 4 times a day

a. Patients taking metronidazole should be counselled to avoid alcohol.

b. The use of quinolones should take into consideration the patterns of *Neisseria gonorrhoeae* resistance

NOTE: For all regimens, therapy should be continued for 2 days after the patient is fever free

Table 6.2 Antibiotic regimens for treatment of infectious complications with viable pregnancy (chorioamnionitis, rupture of membranes)

<p>OPTION 1 – Safest for fetus when there are no signs of material infection</p>	<p>OPTION 2 – Best coverage when material signs of infection (fever, foul smelling discharge) are present</p>
<p>Oral/intramuscular combination that is safe in pregnancy. Choose one from each box (=3 drugs)</p>	<p>Commonly available. least expensive. Give all 3 drugs until delivery. If woman delivers vaginally discontinue all antibiotic after delivery. If delivery is by Caesarean section, continue antibiotics until she is fever free for 48 hours</p>
<p>cefixime 400mg orally as a single dose, or ceftriaxone 125-250mg by intramuscular injection</p>	<p>ampicillin 2g intravenously or intramuscularly, then 1g every 6 hours</p>
<p>Erythromycin^a 500mg orally 4 times a day for 7 days, or azithromycin 1g orally as a single dose</p>	<p>gentamycin 80mg intramuscularly every 8 hours</p>
<p>Metronidazole^b 2g orally as a single dose</p>	<p>metronidazole^b 500mg orally or by intravenous infusion every 8 hours</p>

a. Erythromycin estolate is contraindicated in pregnancy because of drug-related hepatotoxicity; only erythromycin base or erythromycin ethylsuccinate should be used.

b. Patients taking metronidazole should be counselled to avoid alcohol.

Table 6.3 Recommended treatments for vaginal infection in pregnancy

<ul style="list-style-type: none"> • Therapy for bacterial vaginosis and trichomoniasis PLUS • Therapy for yeast infection if curd-like white discharge, vulvo-vaginal redness, and itching are present 			
Coverage	First choice Choose one from BV/TV box below, or one from each box if yeast infection is suspected Bacterial vaginosis Metronidazole ^a 2 g orally in a single dose, or Metronidazole 400 or 500 mg orally twice a day for 7 days Trichomoniasis	Effective substitutes Clindamycin cream 2%, one full applicator (5 g) intravaginally at bedtime for 7 days, or Clindamycin 300 mg orally twice a day for 7 days tinidazole ^a 2 g orally in a single dose, or tinidazole 500 mg orally twice a day for 5 days nystatin 100,000 unit vaginal tablet, one a day for 14 days	If woman is pregnant or breastfeeding Choose one from BV/TV box below, or one from each box if yeast infection is suspected Metronidazole 200 or 250 mg orally 3 times a day for 7 days, or Metronidazole gel 0.75%, one full applicator (5 g) intravaginally twice a day for 5 days, or clindamycin 300 mg orally twice a day for 7 days miconazole 200 mg vaginal suppository, one a day for 3 days, or clotrimazole ^b 100 mg vaginal tablet, two tablets a day for 3 days, or nystatin 100,000 unit vaginal tablet, one a day for 14 days.

a. Patients taking metronidazole or tinidazole should be cautioned to avoid alcohol. Use of metronidazole is not recommended in the first trimester of pregnancy.

b. Single-dose clotrimazole (500 mg) available in some places is also effective for yeast infection (CA).

Management of Symptomatic STIS/RTIS

What you need to know?

This refers to management of STIs/RTIs in people who seek for care because they have symptoms, or when a health care provider detects signs of possible infection while providing other health care services

A symptom is something that the patient notices, while a sign is something observed by the health care provider.

Four clinical situations are common:

- A person comes to the clinic with a spontaneous complaint of STI/RTI symptoms
- A patient admits to symptoms when asked by the health care provider (elicited symptoms).
- The health care provider detects signs of STIs/RTIs when examining a patient for other reasons
- A person comes to the clinic as a contact to STI/RTI index case with or without symptoms and signs.

What a service provider need to note

- Health care providers should be able to recognize STI/RTI symptoms and signs in these different clinical situations.
- They should know when it is possible to tell the difference between STIs and non-sexually transmitted conditions. Women with genital tract symptoms may be concerned about STI even though most symptomatic RTIs in women are not sexually transmitted.

- Providers and patients should also understand that STIs/RTIs are often asymptomatic, and that the absence of symptoms does not necessarily exclude infection. Screening for asymptomatic STI/RTI should be done where possible.

STIs/RTIs can be managed through the following approaches:

Aetiological laboratory approach: Identification of causative agents through laboratory methods followed by disease specific treatment.

Aetiological clinical approach: Targeting treatment of disease based on suspected causative agents diagnosed clinically.

Syndromic approach: Identification of clinical syndromes (Symptoms and signs) followed by syndrome specific treatment targeting causative agents which can cause the syndrome.

NB 1: *Advantages and disadvantages of each approach are discussed fully in the National Guideline for STI/RTI management chapter 8 on page 73 and 74.*

NB 2: *Syndromic management approach entails the service provider to follow laid down steps in a flow chart which guides him or her in making rational management decision. These flow charts are sometimes known as treatment algorithms, treatment protocols or treatment decision tree. Instructions on how to use flow charts are discussed in the National Guideline chapter 8, page 75 to 76.*

Steps in using the flow charts:

- Start by asking the patient for his/her symptoms
- Find the appropriate flow chart as stated in the clinical problem box with "Patient Complaints of..."
- The clinical problem box usually leads to an action box, which asks you to take the history and or examine the patient.
- Next, move to the decision box. After taking the history and examining the patient you should have the necessary information to choose Yes or No accurately.

- Depending on your choice, there may be further decision and action boxes.

NB. *History taking and physical examination are part and parcel of STI/RTI syndromic management. It is essential to carry out speculum and bimanual examination when attending female client and the procedure involved is illustrated below. However for history taking and other physical examination refer to Annex 1 on pages 121 to 125 in the National Guideline for management of STIs/RTIs.*

Procedure for speculum examination

- Be sure the speculum has been properly disinfected or sterilized before you use it. Wet the speculum with clean warm water or a lubricant, if available, before inserting it.(refer to Annex 2 on pages 129 to 131 in National Guideline for management of STIs/RTIs)
- Insert the first finger of your gloved hand in the opening of the vagina (some clinicians use the tip of the speculum instead of a finger for this step). As you put your finger in, push gently downward on the muscle surrounding the vagina. Proceed slowly, waiting for the woman to relax her muscles.
- With the other hand, hold the speculum blades together between the pointing finger and the middle finger. Turn the blades sideways and slip them into the vagina. Be careful not to press on the urethra or clitoris because these areas are very sensitive. When the speculum is halfway in, turn it so the handle is down. Note: on some examination couches, there is not enough room to insert the speculum handle down — in this case, turn it handle up.
- Gently open the blades a little and look for the cervix. Move the speculum slowly and gently until you can see the cervix between the blades. Tighten the screw (or otherwise lock on the speculum) so it will stay in place.
- Check the cervix, which should look pink, round and smooth. There may be small yellowish cysts, areas of redness around the opening (cervical os) or a clear mucoid discharge; these are normal findings. Look for signs of cervical infection by checking for yellowish discharge or easy bleeding when the cervix is touched with a swab. Note any abnormal growths or sores.

- Notice if the cervical os is open or closed, and whether there is any discharge or bleeding. If you are examining the woman because she is bleeding from the vagina after birth, induced abortion or miscarriage, look for tissue coming from the opening of the cervix.
- To remove the speculum, gently pull it towards you until the blades are clear of the cervix. Then bring the blades together and gently pull back, turning the speculum gently to look at the walls of the vagina.
- Be sure to disinfect your speculum after each examination.

Signs to look for during speculum Examination

Signs to look for during speculum Examination

- Vaginal discharge and redness of the vaginal walls are common signs of vaginitis. When the discharge is white and curd-like, yeast infection is likely.
- Ulcers, sores or blisters.
- If the cervix bleeds easily when touched or the discharge appears mucopurulent with discoloration, cervical infection is likely.
- If you are examining the woman after birth, induced abortion or miscarriage, look for bleeding from the vagina or tissue fragments and check whether the cervix is normal.
- Tumours or other abnormal-looking tissue on the cervix.

How to feel the reproductive parts inside the abdomen: Bimanual examination

- Test for cervical motion tenderness. Put the pointing finger of your gloved hand in the woman's vagina. As you put your finger in, push gently downward on the muscles surrounding the vagina. When the muscles relax, put the middle finger in too. Turn the palm of your hand up.

- Feel the opening of her womb (cervix) to see if it is firm and round. Then put one finger on either side of the cervix and move the cervix gently while watching the woman’s facial expression. It should move easily without causing pain. If it does cause pain (you may see her grimace), this sign is called cervical motion tenderness, and she may have an infection of the womb, tubes or ovaries. If her cervix feels soft, she may be pregnant.
- Feel the womb by gently pushing on her lower abdomen with your outside hand. This moves the inside parts (womb, tubes and ovaries) closer to your inside hand. The womb may be tipped forward or backward. If you do not feel it in front of the cervix, gently lift the cervix and feel around it for the body of the womb. If you feel it under the cervix, it is pointed back.
- When you find the womb, feel for its size and shape. Do this by moving your inside fingers to the sides of the cervix, and then “walk” your outside fingers around the womb. It should feel firm, smooth and smaller than a lemon.
 - If the womb feels soft and large, she is probably pregnant.
 - If it feels lumpy and hard, she may have a fibroid or other growth.
 - If it hurts when you touch it, she may have an infection inside.
 - If it does not move freely, she could have scars from an old infection.
- Feel the tubes and ovaries. If these are normal, they will be hard to feel. If you feel any lumps that are bigger than an almond or that cause severe pain, she could have an infection or other emergency. If she has a painful lump, and her period is late, she could have an ectopic pregnancy and needs medical help right away.
- Move your finger and feel along the inside of the vagina. Make sure there are no unusual lumps, tears or sores.
- Have the woman cough or push down as if she were passing stool. Watch to see if something bulges out of the vagina. If it does, she could have a fallen womb or fallen bladder (prolapse).
- When you are finished, dispose glove appropriately. Wash your hands well with soap and water.

Signs to note during bimanual examination

SIGNS TO LOOK FOR WHEN DOING A BIMANUAL EXAMINATION

- Lower abdominal tenderness when pressing down over the uterus with the outside hand.
- Cervical motion tenderness (often evident from facial expression) when the cervix is moved from side to side with the fingers of the gloved hand in the vagina. Uterine or adnexal tenderness when pressing the outside and inside hands together over the uterus (centre) and adnexa (each side of uterus).
- Any abnormal growth or hardness to the touch.

Management of common STI syndromes

URETHRAL DISCHARGE SYNDROME (UDS) Definition

It is the presence of abnormal secretions in distal portion of urethra in males usually accompanied by symptoms and signs.

Common signs and symptoms include:

Urethral discharge, burning sensation or painful micturition, itchy urethra and increased frequency of micturition.

Aetiologies

Common organisms responsible are *Neisseria gonorrhoeae*, *Chlamydia trachomatis* and *Trichomonas vaginalis*.

Common complications include:

Orchitis, epididymitis, urethral stricture and infertility



Figure 1: Urethral discharge in a male patient

Management

Take history

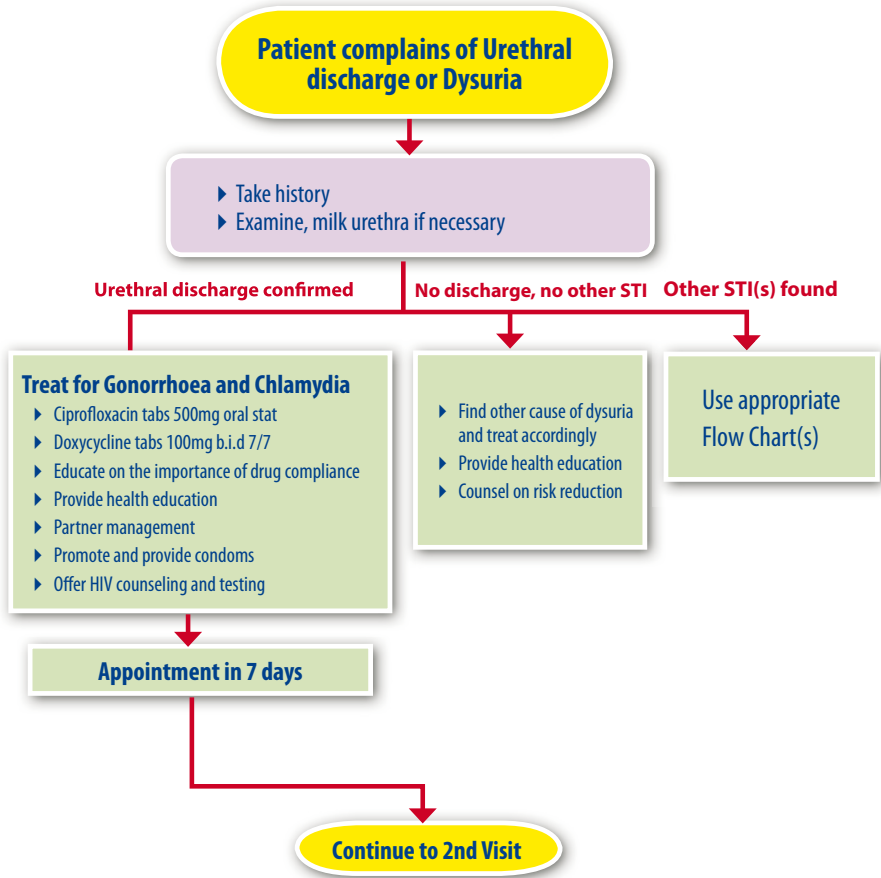
Proper physical examination

- Ask the client to milk urethra if necessary
- Treat according to flow chart
- Educate on the importance of drug compliance
- Provide health education and counselling on risk reduction
- Record number of contacts and initiate contact referral
- Promote and provide condoms
- Offer PITC
- Advise to return after 7 days for follow up or as need arise

Preventive and control measures

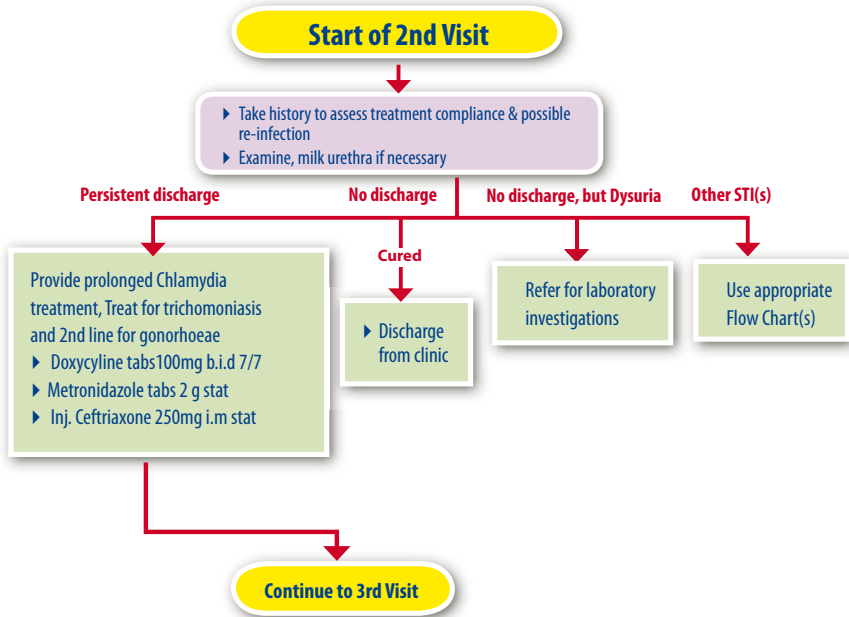
- Abstinence
- Fidelity
- Correct and consistent use of condoms
- Screening for STI/RTI
- Health education
- Counselling
- Drug compliance
- Partner notification, referral and management

Flow Chart 1.1 Management of Urethral Discharge Syndrome (UDS), First Visit

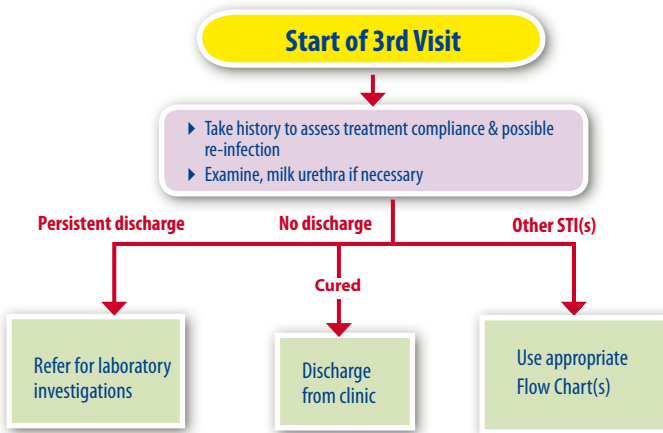


- ▶ Other option for secondline treatment of Neisseria Gonorrhoea is Spectinomycin Inj. 2g i.m. stat
- ▶ This flowchart assumes effective therapy for gonorrhoea to have been received and taken by the patient prior to this visit

Flow Chart 1.2 Management of Urethral Discharge Syndrome (UDS), Second Visit



Flow Chart 1.3 Management of Urethral Discharge Syndrome (UDS), Third Visit



Vaginal Discharge Syndrome (VDS)

Definition

It is a change of colour, odour, and amount of vaginal secretions usually accompanied with symptoms and signs.

Common symptoms and signs include:

Abnormal vaginal discharge, burning or painful micturition, itchy vulva, increased frequency and urgency of micturition and painful coitus

Aetiologies

Common organisms responsible are Neisseria gonorrhoeae, Chlamydia trachomatis, Trichomonas vaginalis, Candida albicans and anaerobic bacteria

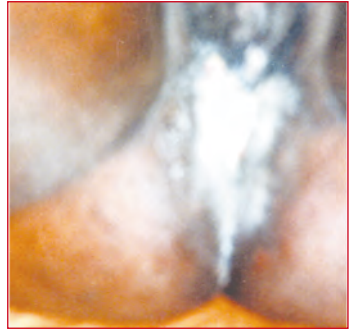


Figure 2: Vaginal discharge

Common complications include:

Endometritis, salpingitis, oophoritis, ectopic pregnancy and infertility

Management

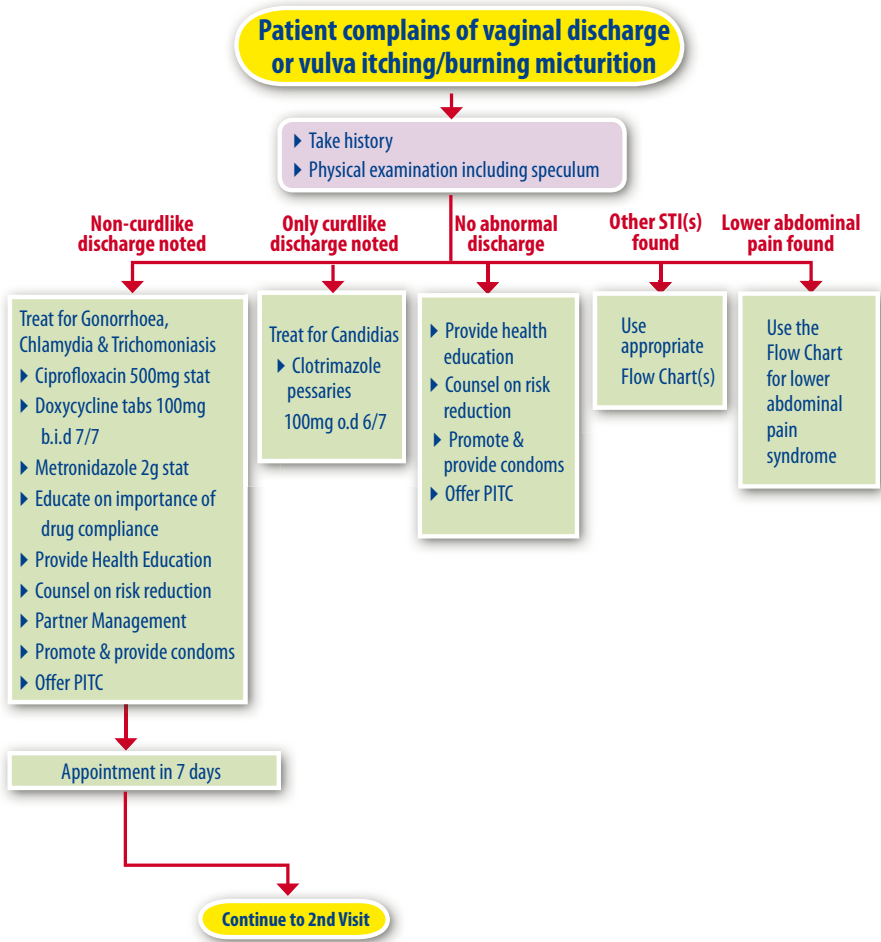
- Take history
- Proper physical examination including speculum
- Treat according to appropriate flow
- Educate on importance of drug compliance
- Provide health education
- Counsel on risk reduction
- Record number of contacts and initiate contact referral
- Promote and provide condom
- Offer PITC

- Advise to return after 7 days or as the need arises

Preventive and control measures

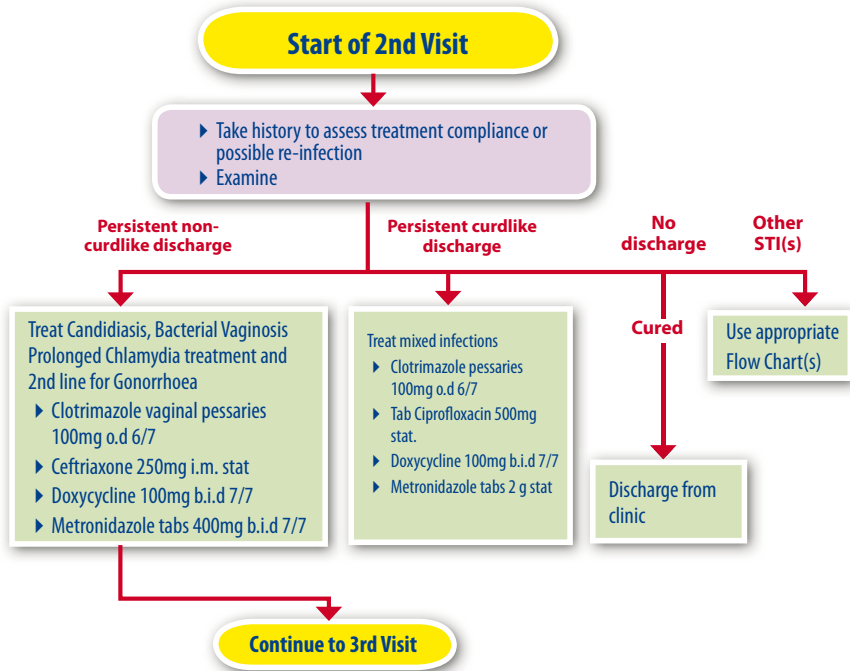
- Abstinence
- Fidelity
- Correct and consistent use of condom
- Screening for STI/RTI
- Health education
- Counselling
- Drug compliance
- Partner notification, referral and management

Flow Chart 2.1 Management of Vaginal Discharge Syndrome (VDS), First Visit

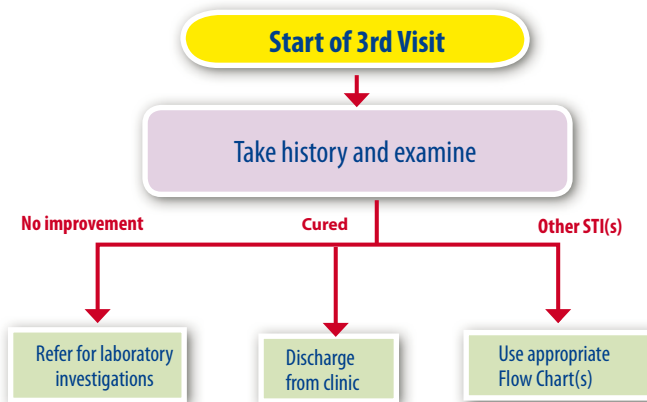


- ▶ Do not give Metronidazole in 1st trimester of pregnancy;
- ▶ Do not give Doxycycline or Ciprofloxacin in pregnancy or to lactating mother: substitute with Erythromycin 500 mg t.i.d 7/7 and Ceftriaxone 250 mg i.m. stat.

Flow Chart 2.2 **Management of Vaginal Discharge Syndrome (VDS),
Second visit**



Flow Chart 2.3 **Management of Vaginal Discharge Syndrome (VDS), Third Visit**



PELVIC INFLAMMATORY DISEASE (PID) OR LOWER ABDOMINAL PAIN SYNDROME

Definition

It is an inflammation of the uterus and / or fallopian tubes, ovaries and pelvic peritoneum

Common symptoms and signs include:

Lower abdominal pains and tenderness, painful micturition, painful coitus, abnormal vaginal discharge, menometrorrhagia, fever and sometimes nausea and vomiting

Common complications include:

Infertility, ectopic pregnancy, chronic lower abdominal pains, dysmenorrhea and pelvic abscess

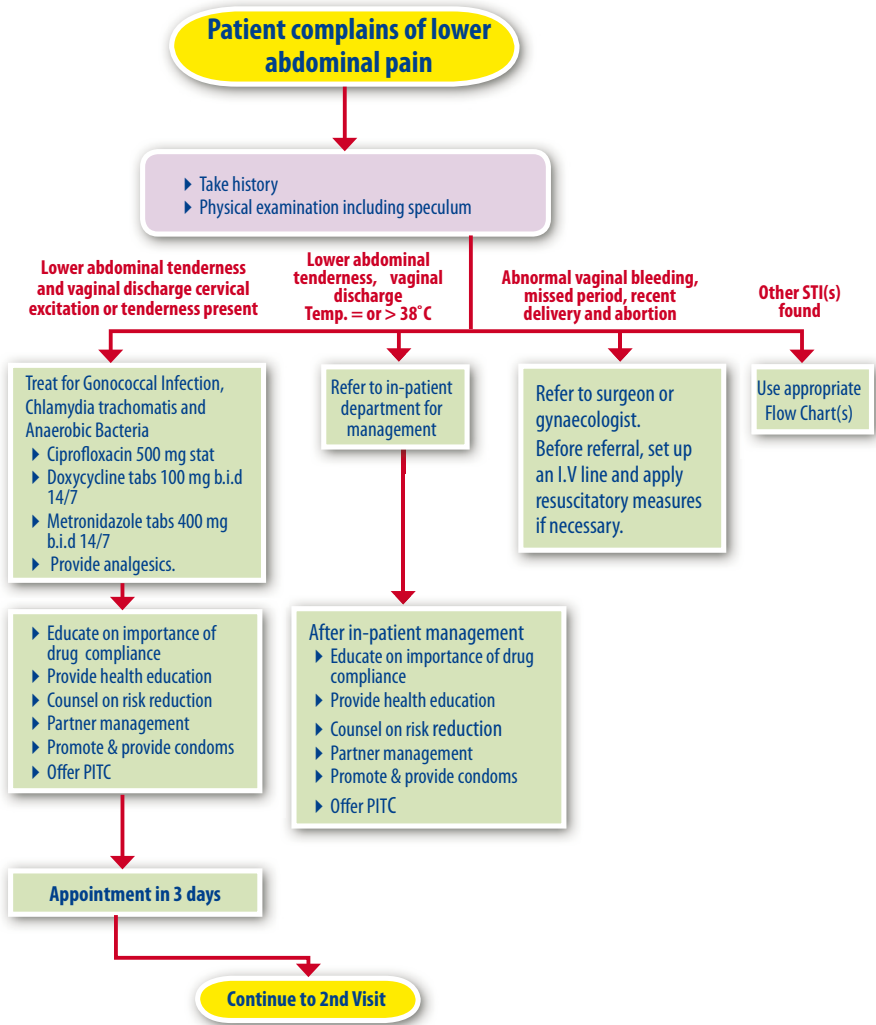
Management

- Take history
- Proper physical Examination
- Treat according to appropriate flow chart
- Educate on importance of drug compliance
- Provide health education
- Counsel on risk reduction
- Record number of contacts and initiate contact referral
- Offer PITC
- Advise to return after 3 days or as the need arise

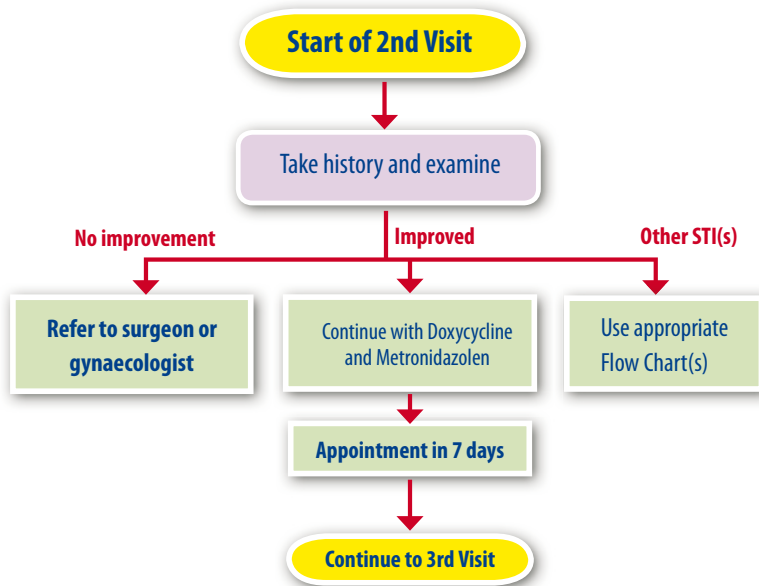
Preventive and control measures

- Abstinence
- Fidelity
- Early treatment of VDS
- Screening for VDS
- Correct and consistent use of condom
- Aseptic technique in pelvic examination and invasive procedure

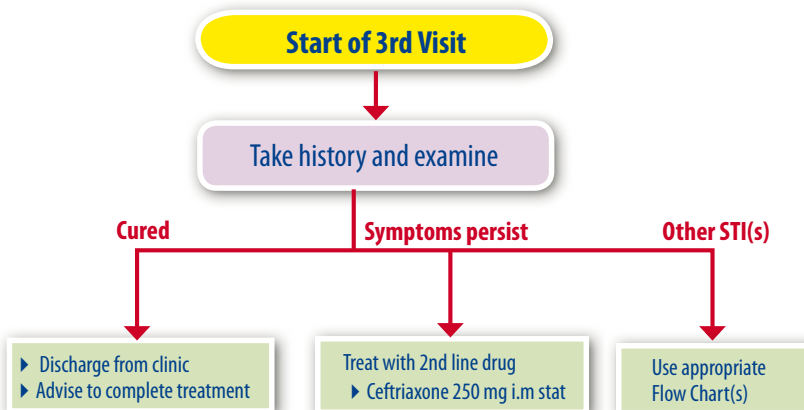
Flow Chart 3.1 **Management of Pelvic Inflammatory Disease (PID), First Visit**



Flow Chart 3.2 **Management of Pelvic Inflammatory Disease (PID),
Second Visit**



Flow Chart 3.3 **Management of Pelvic Inflammatory Disease (PID),
Third Visit**



In patient treatment of PID

All patients with PID who have fever of body temperature = or > 38°C should

be admitted for closer care. The recommended in-patient treatment options for PID are as follows:

Regimen 1

Ciprofloxacin 500 mg orally, twice daily or spectinomycin 1 g by intramuscular injection, 4 times daily

PLUS Doxycycline 100 mg orally or by intravenous injection, twice daily, or tetracycline 500mg orally, 4 times daily

PLUS Metronidazole, 400-500mg orally or by intravenous injection, twice daily, or chloramphenicol 500 mg orally or by intravenous injection, 4 times daily.

Regimen 2

Ceftriaxone, 250mg by intramuscular injection, once daily

PLUS

Doxycycline, 100mg orally or by intravenous injection, twice daily or tetracycline 500mg orally 4 times daily.

PLUS

Metronidazole, 400-500mg orally or by intravenous injection, twice daily or chloramphenicol, 500 mg orally or by intravenous injection, 4 times daily.

Regimen 3

Clindamycin, 900 mg by intravenous injection, every 8 hours

PLUS

Gentamycin, 1.5 mg/kg by intravenous injection, every 8 hours

Note

For all three regimens, therapy should be continued until at least two days after the patient has improved and should then be followed by either doxycycline, 100mg orally, twice daily for 14 days, or tetracycline, 500mg orally, 4 times daily, for 14 days.

Patients taking metronidazole should be cautioned to avoid alcohol. Tetracyclines are contraindicated in pregnancy.

PAINFUL SCROTAL SWELLING (PSS)

Definition

It is an inflammation of the epididymis and testis often accompanied with scrotal pains.

Common symptoms and signs include:

Scrotal pains, swelling, tenderness, and fever.

Aetiology

Common organisms responsible are Neisseria gonorrhoea and Chlamydia trachomatis.

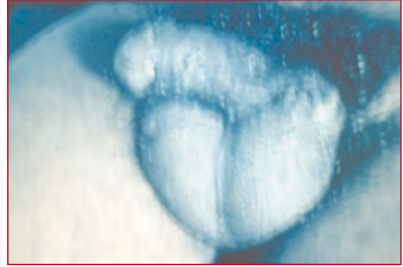


Figure 3: Left Scrotal Swelling

Common complications include:

Infertility and scrotal abscess

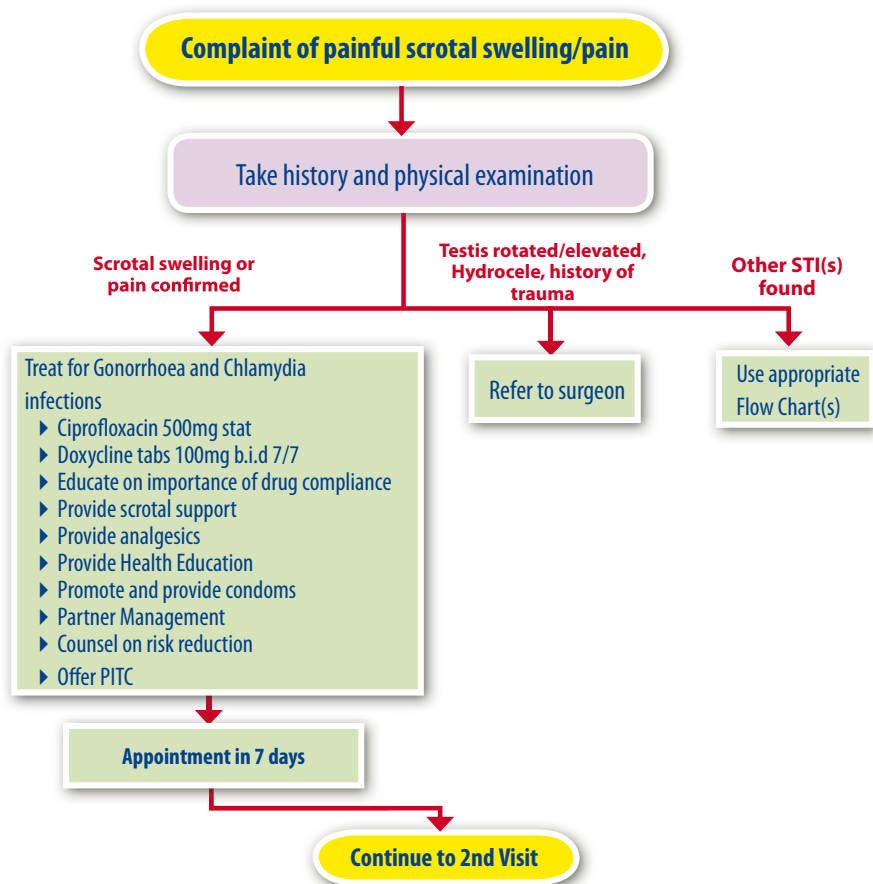
Management

- Take history
- Proper physical Examination
- Treat according to appropriate flow chart
- Educate on importance of drug compliance
- Provide health education
- Counsel on risk reduction
- Record number of contacts and initiate contact referral
- Promote and provide condoms
- Offer PITC
- Advise to return after 7 days for follow up or as need arises

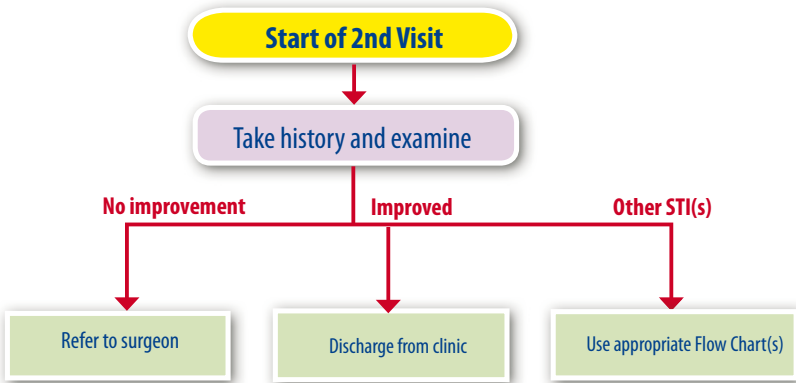
Preventive and control measures

- Abstinence
- Fidelity
- Correct and consistent use of condom
- Screening for UDS
- Early treatment of urethral discharge

Flow Chart 4.1 Management of Painful Scrotal Swelling (PSS), First Visit



Flow Chart 4.2 **Management of Painful Scrotal Swelling (PSS), Second Visit**



NEONATAL CONJUNCTIVITIS (NC)

Definition

It is an inflammation of the conjunctiva of a new born baby (less than one month of age)

Common symptoms and signs include:

Reddish conjunctiva, swelling/oedema of eyelids and purulent eye discharge

NB. Chlamydial pneumonia is a possibility.

Aetiology

Common organisms responsible are Neisseria gonorrhoea and Chlamydia trachomatis

Common complications include:

Blindness and chlamydial pneumonia

Management

- Take history of the neonate
- Proper physical examination



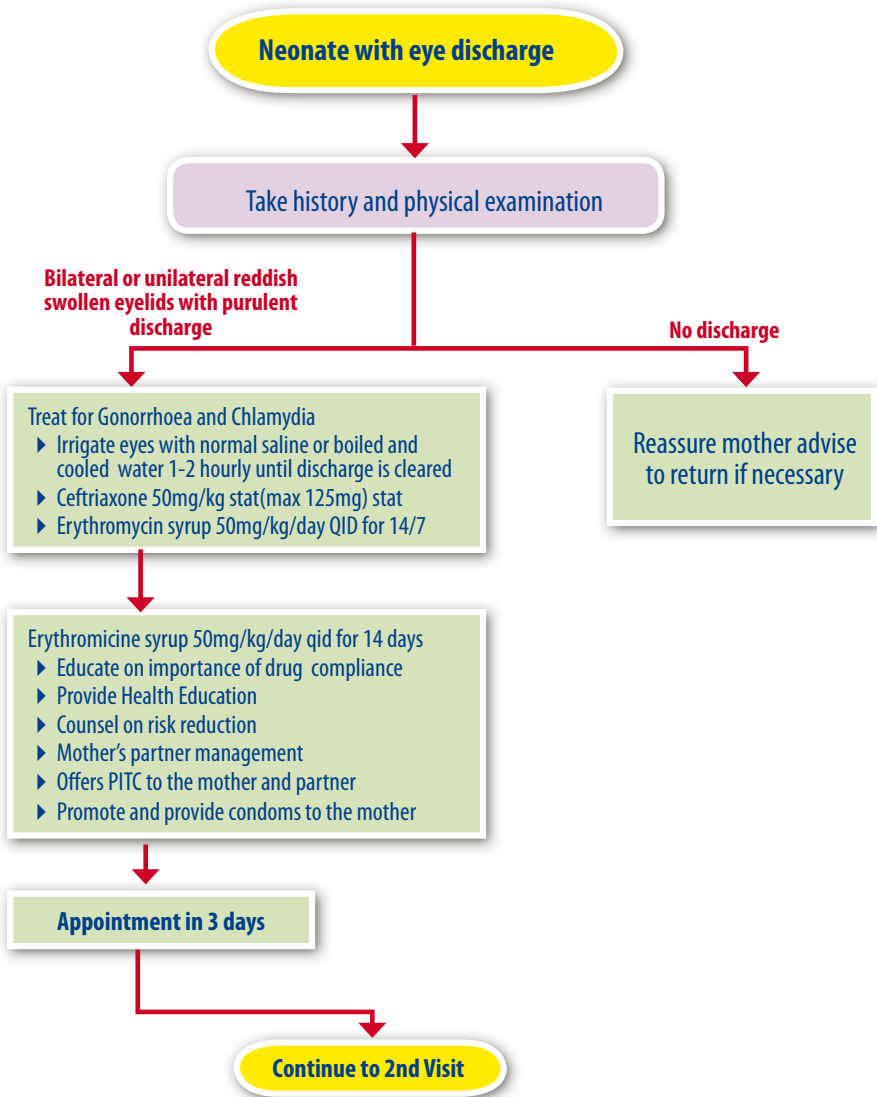
Figure 4: Neonatal conjunctivitis

- Treat neonate according to appropriate flow chart
- Educate mother on the importance of drug compliance
- Initiate contact referral (mother and her sexual partners)
- Provide health education
- Counsel the mother
- Offer PITC to the mother and her partner or refer
- Advise to return after 3 days for follow up or early as the need arises

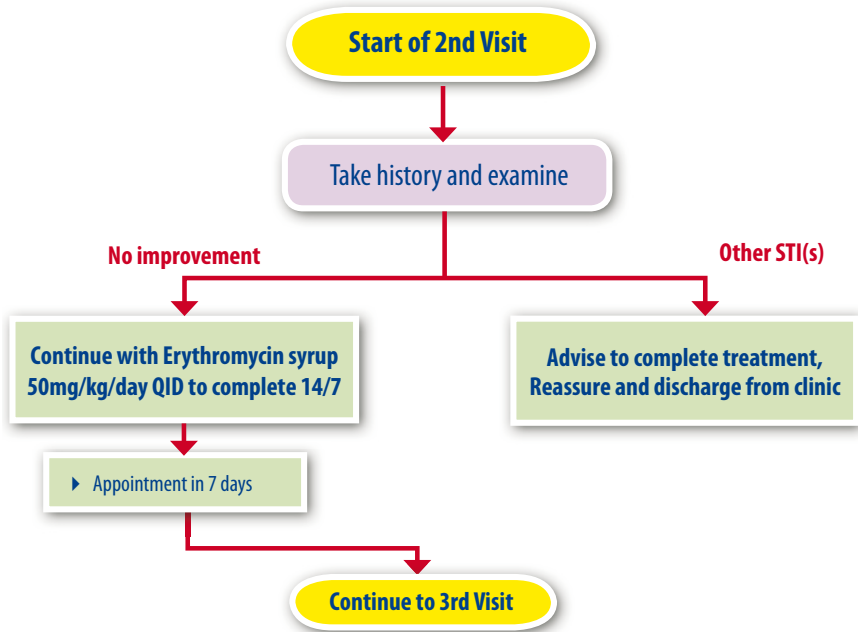
Preventive and control measures

- Screening of pregnant mothers for VDS
- Early treatment of VDS in pregnant women
- Routine eye chemoprophylaxis for all newborns immediately after birth
- by providing 0.1% of tetracycline eye ointment

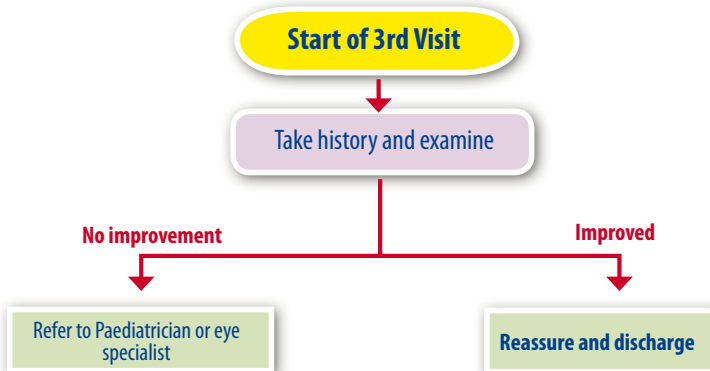
Flow Chart 5.1 **Management of Neonatal Conjunctivitis (NC), First Visit**



Flow Chart 5.2 **Management of Neonatal Conjunctivitis (NC), Second Visit**



Flow Chart 5.3 **Management of Neonatal Conjunctivitis (NC), Third Visit**



- ▶ Both parents should be examined and treated as per flow chart for genital discharge syndrome.

GENITAL ULCER DISEASE (GUD)

Definition

It is a loss of skin or mucous membrane continuity producing one or more lesions in genitalia

Common symptoms include:

Genital ulcerations that may be painful or painless sometimes accompanied with lymphadenopathy. Some of these lesions are purulent and dirty, while others have rough edges. Painful coitus and painful micturition

Aetiologies

Common organisms responsible are *Treponema pallidum*, *Haemophilus ducreyi*, *Chlamydia trachomatis*, Herpes simplex type 2, *Klebsiella granulomatis*

Common complications include:

Congenital syphilis, Inguinal bubo, urethral fistula in males, phimosis and paraphimosis.

Management

- Take history
- Proper physical examination
- Treat according to appropriate flow chart
- Educate on importance of drug compliance
- provide health education
- Record number of contacts and initiate contact referral
- Promote and provide condoms
- Offer PITC or refer
- Advise to return after 7 days or early as the need arises

Preventive measures

- Abstinence
- Fidelity



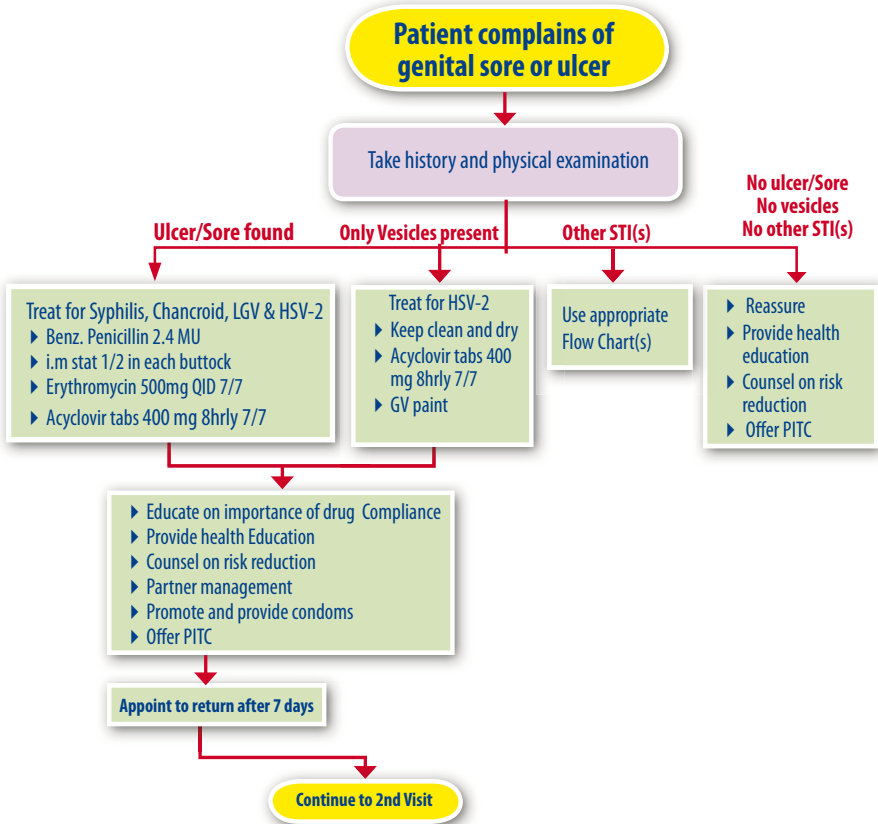
Figure 5.2: Multiple genital ulcer in female patient



Figure 5.1: Penile Ulcer

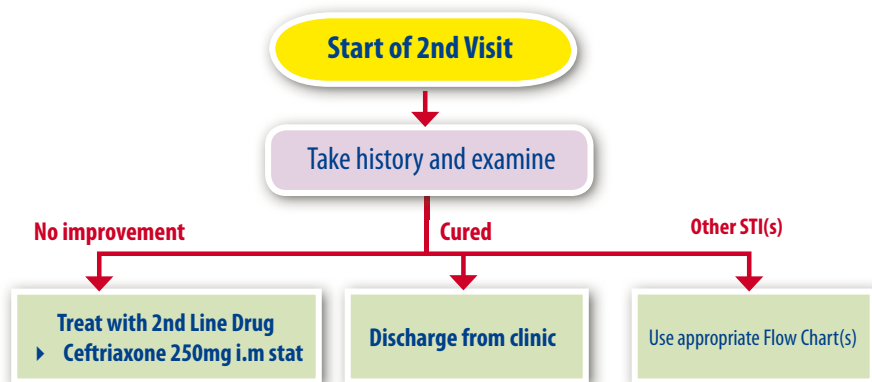
- Correct and consistent use of condom
- Screening for STI/RTI
- Medicine compliance
- Partner notification and management
- Health education

Flow Chart 6.1 **Management of Genital Ulcer Disease (GUD), First Visit**



- ▶ Patients allergic to penicillin substitute with Erythromycin tabs 500mg QID for 15 days
- ▶ Do not give Acyclovir during pregnancy and breast feeding.

Flow Chart 6.2 Management of Genital Ulcer Disease (GUD), Second Visit



INGUINAL BUBO (IB)

Definition

It is a painful swelling of the inguinal lymph nodes and usually with pus formation.

Common symptoms and signs include:

Swelling of inguinal lymph nodes often fluctuant, fever, pains and tenderness

Aetiologies

Common organisms responsible are *Chlamydia trachomatis* and *Haemophilus ducreyi*.

NB: Sometimes infections in the lower limbs may cause swelling of inguinal lymph nodes.

Common complications include:

Chronic ulcers, fistula/ sinus formation, scar formation and genital elephantoid swelling.



Figure 6.1: Right inguinal bubo in a male patient

Management

- Take history
- Proper physical examination
- If the Bubo becomes fluctuant aspirate through normal skin
- Treat according to appropriate flow chart.
- Educate on the importance of drug compliance
- Provide health education
- Counsel
- Record number of contacts and initiate contact referral
- Promote and provide condoms
- Offer PITC or refer
- Advise to return after 7 days or early as the need arises

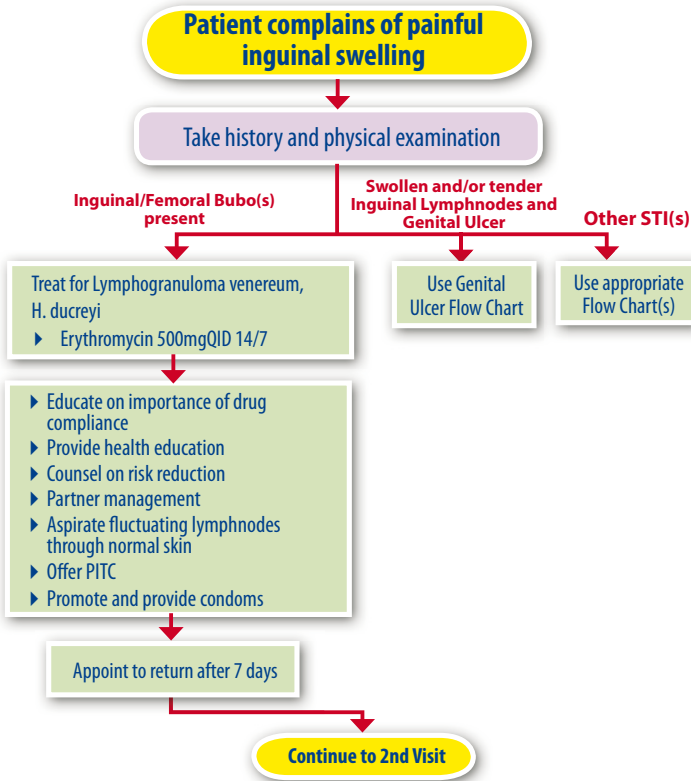


Figure 6.2: "Groove sign" of lymphogranuloma venereum

Preventive and control measures

- Abstinence
- Fidelity
- Correctly and consistently use of condom
- Early treatment of
- Screening
- Partner notification and management
- Health education

Flow Chart 7.1 **Management of Inguinal Bubo (IB), First Visit**



Flow Chart 7.2 **Management of Inguinal Bubo (IB), Second Visit**



- ▶ Alternative treatment for Chancroid is Ciprofloxacin 500mg orally twice daily for 3 days and Doxycycline 100mg b.i.d 14/7.
- ▶ Do not incise the BUBO.

Management of Non Syndromic STIS/RTIS

These are conditions that commonly affect genitalia. However other parts of the body may also be affected. Some of these conditions are transmitted through penetrative sexual contact e.g. genital warts and syphilis while some are transmitted through intimacy and may not affect genital parts e.g. epiclesis, scabies.

Early Syphilis

This refers to primary, secondary or latent syphilis of not more than two years duration. In this case it is recommended to treat by giving:

Benzathine Benzyl Penicillin

- 2.4 I.U I.M single dose given as two injections at separate sites or
- Alternative regimen for penicillin allergic non-pregnant patients
- Doxycycline 100 mg orally twice daily for 15 days or
- Tetracycline, 500 mg orally, 4 times daily for 15 days

Late Syphilis

This refers to Syphilis infection of more than 2 years.

Recommended regimen is Benzathine Benzyl Penicillin 2.4 mm I.U. once weekly for 3 consecutive weeks.

Syphilis In Pregnancy

Pregnant women should be regarded as a separate group requiring close surveillance, in particular, to detect possible re-infection after treatment has been given. It is also important to treat the sexual partner(s).

Pregnant women with syphilis at all stages of pregnancy, who are not allergic to penicillin, should be treated with penicillin according to the dosage schedules recommended for the treatment of non-pregnant patients at a similar stage of the disease, that is Benzathine Benzyl penicillin 2.4 mm I.M single dose. However, if there are clinical reasons to suspect that the client has late syphilis provide 3 dose of Benzathine Benzyl Penicillin.

Congenital Syphilis

Definition

- Congenital syphilis is infection by *Treponema pallidum* acquired by the foetus through the placenta from an infected mother.
- It is classified as early congenital syphilis when it manifests in the first two years of life and late when it manifests later in life

Clinical Presentation of Early Congenital Syphilis

- Bullous skin eruption (syphilitic pemphigus) at birth
- Skin lesions appearing 2-8 weeks after birth
- Mucous membrane lesions
- Mucous patches in throat
- Nasal discharge
- Failure to thrive
- Bone lesions
- Generalized lymphadenopathy
- Hepatosplenomegaly



Fig. 7.1: Hepatosplenomegaly



Figure 7.2: Condylomata lata

Clinical Presentation of Late Congenital Syphilis

- Gummata
- Neurological symptoms and signs (rare)
- Cardiovascular manifestations (rare)
- Clutton's joints
- Interstitial keratitis
- Hutchison's "peg" teeth & mulberry molars
- Perforation of hard palate
- Saddle nose
- Corneal opacity



Figure 7.3: Cleft palate

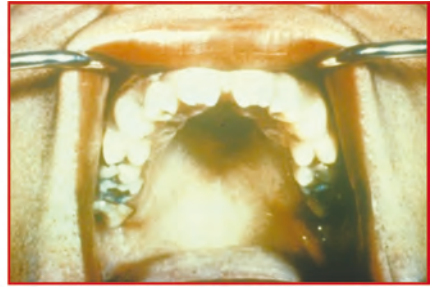


Figure 7.4: Mulberry molars of congenital syphilis

Management of congenital syphilis

- Crystalline penicillin 50,000 IU/kg 12 hrly for 10 days or Procaine penicillin 50,000 IU/kg OD for 10 days
- Babies allergic to penicillin: Erythromycin syrup 7.5-12.5mg/kg 6 hrly for 30 days
- Tetracyclines are contradicted in babies

Prevention of Congenital Syphilis

- Prevention of STIs in the general population
- Routine syphilis screening and treatment of mothers during pregnancy
- All infants born to mothers who tested positive for syphilis during pregnancy should be treated with single dose benzathine penicillin 50,000 IU/kg IM regardless of whether the mother had treatment during pregnancy or not



Figure 8.1: Penile warts

Genital Warts

Definition

Painless growths on genital skin or mucous membrane caused by the Human Papilloma Virus (HPV) which is predominantly sexually transmitted

Clinical Presentation

- Painless growths often occur in moist mucocutaneous areas of genitalia and anus (may be fungating)
- May be hidden in inner parts of genitalia
- e.g. urethra, vagina or anus



Figure 8.2: genital warts in female patient

Chemical Treatment

- Patient applied Podophyllotoxin 0.5% solution/gel
OR
- Patient applied Imiquimod 5% cream
OR
- Provider applied Podophyllin in compound tincture of benzoin
OR

- Trichloroacetic acid (TCA) 80-90%

NB: For cervical and vaginal warts keep speculum until the drug has dried out

Physical treatment

- Cryotherapy with liquid nitrogen

OR

- Electrosurgery

OR

- Surgical removal

Complications

- Cancer of cervix
- Penile cancer

NB: During pregnancy it is safer for the baby to be delivered by caesarian section

Balanoposthitis

Definition & Aetiology

- Inflammation involving the glands, penis and foreskin (prepuce)
- Not sexually transmitted – commonly caused by *Candida albicans*
- Associated with immunosuppression or uncontrolled Diabetes mellitus
- More common in uncircumcised with poor hygiene

Treatment

Advise to wash with soap and safe water and apply

- Gentian violet 0.5% twice daily for 7 days

OR

- Clotrimazole 1% cream, twice daily for 7 days

OR

- Miconazole 2% cream twice daily for 7 days

OR

- Nystatin cream, twice daily for 7 days

Pediculosis

Definition, Aetiology and Clinical Presentation

- Pediculosis is a skin infestation by the louse *Phthirus pubis* transmitted through intimate contact e.g. during sexual intercourse
- Commonly affects the pubis and rarely the eyelashes
- Patient present with pruritus
- Typical lice and eggs seen on pubic hair and/or eyelashes

Prevention and Treatment

- Basic prevention is keeping personal body hygiene
- Treatment includes
 - Shaving and washing with water and soap followed by topical application of one of:
 - Lindane 1% lotion or cream,
 - Pyrethrins plus peperonyl butoxide
 - Permethrin 1%
 - BBE
 - Washing and ironing of clothes and bed linen

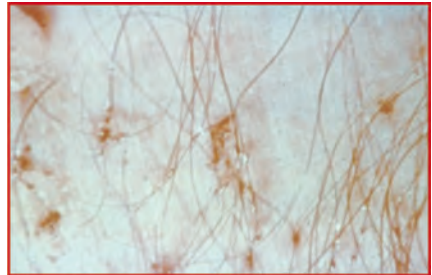


Figure 9: Genital pediculosis showing lice and nits

Scabies

Definition, Aetiology and Clinical Presentation

- Scabies is a skin infestation caused by a mite *Sarcoptes scabiei* acquired through skin to skin contact e.g. during sexual intercourse

- Closely associated with poor hygiene and overcrowding
- Patient present with a pruritic erythematous skin rash
- Secondary bacterial infection and eczema are common



Figure 10: Scabies on the hand

Prevention and Treatment

Body washing with soap and water followed by application of one of:

- Benzyl benzoate emulsion (BBE)
 - Gamma benzene hexachloride
 - Crotonitron
- Prevention is mainly by:
 - Personal hygiene
 - Environmental hygiene in congregate settings
 - Treatment of sexual contacts

NB: *Further management of these conditions is discussed on chapter 8 on page 90 to 94 in the National guideline*

Sexual Violence/ Abuse

Sexual violence/abuse pose a public concern as it is associated with many risks such as unwanted pregnancy, stigma, acquisition of STI/RTI/HIV as well as physical and psychological trauma to both survivors and families.

Sexual abuse happens to both males and females particularly in children and the youth. The service provider needs to be prepared to diagnose symptoms of sexual abuse, provide both medical and psychological care.

Sexual abuse is a broad subject but for the purpose of medical care and in particular dealing with STIs/RTIs/ HIV this document will focus mainly on rape

Definition of rape

Rape is defined as the use of physical and/or emotional coercion, or threats to use coercion, in order to penetrate a child, adolescent, or adult vaginally, orally, or anally against her/his wishes.

Type of rape

There are many types of rape including

- Acquaintance rape – when the survivor knows assailant
- Marital rape – when one spouse forces the other to have sexual intercourse.
- Stranger rape – when the attacker is not known by the person who is attacked.
- Gang rape – when two or more people sexually assault another person.

- Incest rape – when a person is raped by his or her own relative.

Why is rape a health problem?

Rape can impact a survivor's health through:

- Laceration and internal injuries
- Unwanted pregnancy and its consequences (unsafe abortion, bad pregnant outcome, etc)
- STI/RTI including HIV
- Abortion- related injuries
- Gynaecological problems
- Sexual dysfunction
- Psychological trauma
- Rape can also cause fear, depression and suicide

What you need to remember

- Rape acts are so common and frequently happen but they are seldom reported
- Survivors of rape may need shelter and legal protection
- In most instances the assailant is a member of immediate family or a relative or someone well known to the survivor
- In addition to medical and psychological care, the survivor may need emergency contraception and STI/RTI/HIV prophylaxis
- The family members may need psychological care

What you should do

- Ensure your facility has the capacity to provide essential and basic services to the survivors of rape such as care for any injury, evaluation of STI/RTI/HIV, collection of forensic evidence, evaluation of pregnancy or refer
- Perform initial assessment after obtaining informed consent. This will include taking history and doing physical examination

- Collect and document forensic evidence such as date and time of rape, patient statement, and results of clinical examination
- Manage injuries sustained in the assault and provide counselling to both survivors and family members
- Offer emergency contraception, presumptive treatment for STIs/RTIs and post exposure prophylaxis for HIV (PEP) as per treatment algorithm.
- Refer to appropriate health facility for subsequent management if necessary e.g. for forensic examination or specialized treatment
- Arrange for follow - up care of the survivor and significant others

Table 8.1 STI presumptive treatment options for adults

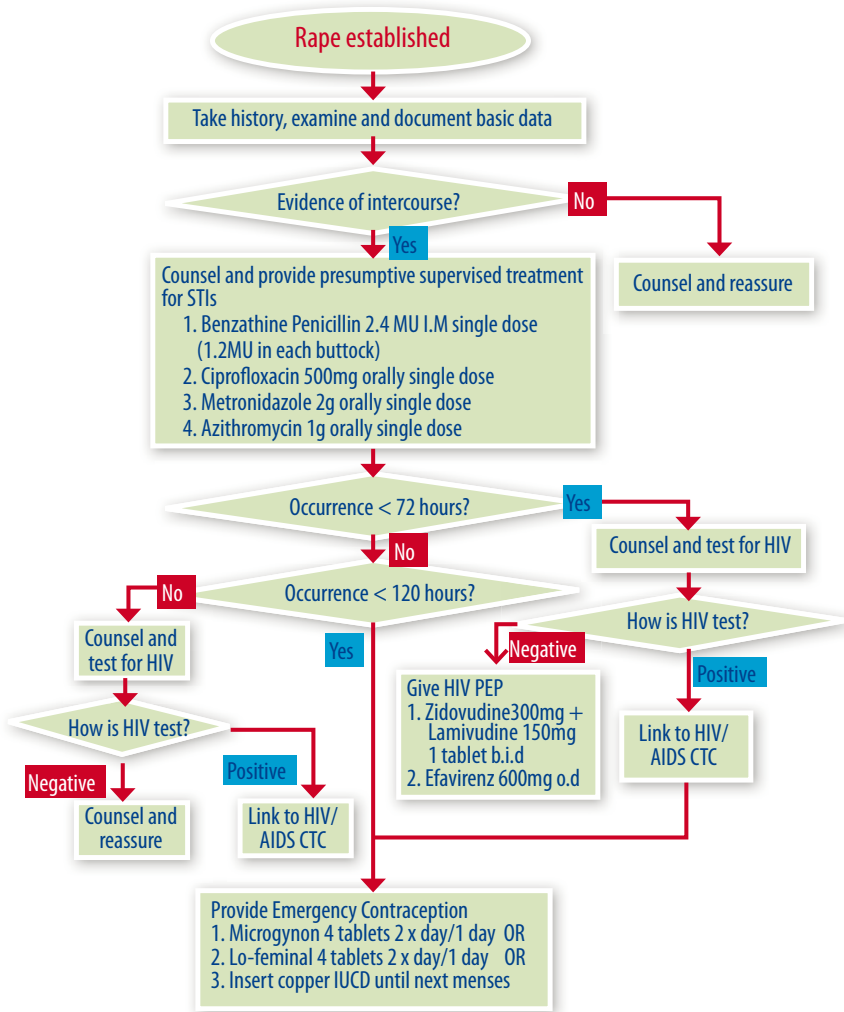
	Option 1	Option 2	Option 3
Coverage	All single dose, highly effective. Choose one from each box (= 3 or 4 drugs) ^a	Effective substitutes – possible resistance in some areas, or require multiple dosage	If patient is pregnant, breast-feeding or under 16 years old Choose one from each box (= 3 or 4 drugs) ^b
Syphilis	Benzathine penicillin 2.4 Mega units by intramuscular injection	doxycycline ^c 100 mg orally twice a day for 14 days (in case of penicillin allergy only)	Benzathine penicillin 2.4 MU by single intramuscular injection
Gonorrhoea/ chancroid	cefixime 400 mg orally as a single dose, or ceftriaxone 125 mg by intramuscular injection	ciprofloxacin ^d 500 mg orally as a single dose, or spectinomycin 2 g by intramuscular injection	cefixime 400 mg orally as a single dose, or ceftriaxone 125 mg by intramuscular injection
Chlamydia/ lymphogranuloma venereum	azithromycin 1 g orally as single dose	doxycycline ^e 100 mg orally twice a day for 7 days, or tetracycline 500 mg orally 4 times a day for 7 days	azithromycin 1 g orally as single dose, or erythromycin 500 mg orally 4 times a day for 7 days
Trichomoniasis	metronidazole ^b 2 g orally as a single dose	tinidazole ^e 2 g orally as a single dose	metronidazole ^b 2 g orally as a single dose, or 400–500 mg 3 times a day for 7 days

- a. Benzathine penicillin can be omitted if treatment includes either azithromycin 1 g or 14 days of doxycycline, tetracycline or erythromycin, all of which are effective against incubating syphilis.
- b. Metronidazole should be avoided in the first trimester of pregnancy. Patients taking metronidazole should be cautioned to avoid alcohol.
- c. These drugs are contraindicated for pregnant or breastfeeding women.
- d. The use of quinolones should take into consideration the patterns of *Neisseria gonorrhoeae* resistance.
- e. Patients taking tinidazole should be cautioned to avoid alcohol.

Table 8.2 STI presumptive treatment options for children

Coverage	All single-dose antibiotics are highly effective. Choose one from each box (= 3 or 4 drugs)	Older children and adolescents
Syphilis	benzathine penicillin 50,000 units/kg of body weight by single intramuscular injection, or erythromycin 12.5 mg/kg of body weight orally 4 times a day for 14 days	>45 kg, use adult protocol
Gonorrhoea/ chancroid	cefixime 8 mg/kg of body weight as a single dose, or ceftriaxone 125 mg by intramuscular injection, or spectinomycin 40 mg/kg of body weight (maximum 2 g) by intramuscular injection	>45 kg, use adult protocol
Chlamydia/ lymphogranuloma venereum	erythromycin 12.5 mg/kg of body weight orally 4 times a day for 7 days	12 years or older, use adult protocol
Trichomoniasis	metronidazole 5 mg/kg of body weight orally 3 times a day for 7 days	12 years or older, use adult protocol

Flow Chart 8: Clinical Management of Survivors of Rape



- ▶ Always treat injuries including provision of TT
- ▶ Advice for legal protection issues
- ▶ Psychological support (both at time of crisis and long-term)
- ▶ Immunization against Hepatitis B (1 and 6 months)
- ▶ Re-evaluate after 3 months (genital examination) HIV and syphilis testing)

Ordering Medicines, Laboratory Reagents and Supplies

Chapter

9

What is Ordering

It is a process for requesting medicines, lab. Reagents and related supplies in order to provide services

Why do you order?

You order to avoid interruption of service provision. Adequate availability of medicines, laboratory reagents and related STI/RTI supplies is an essential component in the management and control of STIs/RTIs. . Management and control of STIs/RTIs is based on syndromes, however, laboratory still has a role depending on the setting and availability of resources. Laboratory investigations is essential in syphilis screening of pregnant women, screening for HIV, culture and sensitivity for admitted patients, Papanicolaou (PAP) smear for early detection of cervical cancer and research.

What do you need to know before ordering?

Proper data collection and record keeping is a corner stone in ordering medicines, laboratory reagents and related supplies. Data and record keeping will assist you to determine prevalence of syndromes, calculating monthly consumption and estimating minimum and maximum stock levels, it also helps in determining the buffer/security stock level for lead time. Ordering should be done timely to avoid stock out of medicine and other supplies

What is the procedure for ordering?

Determine the need based on the available data, identify and fill the forms and forward according to laid down procedures.

What is the procedure for receiving and storage?

Receive the delivery note from the supplies, inspect the quantity and quality of delivered goods, raise goods received note (GRN), put received goods in the store and sign GRN and then enter goods into ledger and bin card.

What is the procedure for issuing/ dispensing?

Enter the total number of units dispensed/issued from the appropriate register, enter the total number of units removed from inventory for any reason other than dispensing, enter the total number received into the inventory for any reason other than delivered from MSD/NACP, enter the total number of units removed from inventory to land and then enter the total number of units added/removed from inventory after item counting of the products.

Monitoring and Evaluation

Overview

Monitoring and evaluation ensure delivery of quality services and eventually assessing the impact. The process involves recording using standardized tool, analysis and interpretation. The results obtained from analysis should be used in decision-making and improvement of STI/RTI services.

Definition of Terms

Monitoring:

A systematic recording of various steps and events in implementing an intervention

Evaluation:

The system of assessing the success or failure of an activity in order to ensure proper re-planning or implementation of activities

Objectives for Monitoring and Evaluation of STI/RTI Services

- To provide essential information for clients' follow up
- To provide information on prevention and management of STIs/RTIs, drug consumption and demand.
- To assess the effectiveness of the programme through quantitative and qualitative methods.
- To improve the management of STI/RTI services as necessary and inform the policy-makers.

- To gather and analyze services statistics and use the information for planning, prevention and control.

Purpose for Monitoring STI/ RTI Services

To determine whether:

- Work progresses according to schedule
- Standards are maintained
- Resources are used rationally, properly and as planned
- Required infrastructure is available and used

Process of Monitoring STI Services

The process includes:

- Daily registering of STI clients attended at health care facility using daily STI register
- Monthly compilation of the data captured in the daily STI register at the facility
- Monthly compilation of the report from each facility at district level
- Monthly compilation of the report from all districts at the regional level
- Monthly compilation of the report from all regions at the NACP level
- Using information gathered to track trends, strengths and weaknesses.
- Using collected information to assist decision making and management.

Explain the Process of Reporting and Dissemination

To whom should the report be submitted:

- At the health facility forms are completed in duplicate by 7th day of next month and one copy sent to DMO and second copy remains at the facility.

- At district level DMO aggregates the reports and sends one copy to RMO by 14th day of next month and second copy remains at the facility.
- RMO aggregates the reports and send both aggregated and individual district reports to NACP epidemiology unit by 21st day of next month.

When the report should be submitted

- At facility level – monthly
- At district level – monthly
- At regional level – monthly
- At MOHSW – quarterly for MTUHA and monthly for NACP

Describe methods of data collection, analysis and presentation

- Data collection is done manually or computerized where possible
- Analysis is done manually or by using soft ware programme
- Presentation is done by graphs charts, oral, written reports.

NB. *An STI/RTI service provider should be able to collect data, keep records, evaluate, process, analyse, make interpretation and use them*

Process of Evaluating STI/RTI Services

Purpose

- Determine whether the objectives were achieved
- Determine whether the services can be extended else where

When to conduct evaluation

- Annually at the facility, district and regional levels
- Two yearly at the national level

Aspects to Evaluate

- Actual services delivery
- Occurrence of STI/RTI episodes

- Staff performance
- Adequacy of staffing levels
- Client satisfaction and response
- Material needs and allocation
- Techniques

Methods of Evaluating STI/RTI Services

- Review of records
- Questionnaire
- Interviews
- Observations
- Focus group discussion
- Client exit interview

How to record and report information on STI/RTI information is available in the National Guideline chapter 11 on page 116 to 120.

ANNEX: LIST OF REFERENCE MATERIALS

1. *Ministry of Health and Social Welfare, Tanzania (2007): Guidelines for HIV Testing and Counselling in Clinical Settings (Draft 0)*
2. *Ministry of Health and Social Welfare, Tanzania (2007): National Guideline for Management of Sexually Transmitted and Reproductive Tract Infections*
3. *Ministry of Health and Social Welfare, Tanzania (2007): Provider Initiated Testing and Counselling*
4. *Ministry of Health and Social Welfare, Tanzania (2007): Trainer's Presentation Guide for Management of Sexually Transmitted and Reproductive Tract Infections*
5. *Ministry of Health and Social Welfare, Tanzania (2007): Trainer's Guide for Management of Sexually Transmitted and Reproductive Tract Infections (Final Draft)*
6. *Ministry of Health and Social Welfare, Tanzania (2006): Surveillance of HIV and Syphilis Infections among Antenatal Clinic Attendees 2005/6*
7. *Ministry of Health, Tanzania (2004): National AIDS Control Programme, HIV/AIDS/STI Surveillance Report*
8. *Ministry of Health, Tanzania (2005): National Guidelines for the Clinical Management of HIV and AIDS (second edition)*
9. *Ministry of Health, Tanzania (2004): National Guidelines for Screening and Treatment of Syphilis during Pregnancy (first edition)*
10. *Ministry of Health, Tanzania (2003): Sexually Transmitted Infections: A Manual for Service Providers (first edition)*
11. *World Health Organization (2005): Development of Reproductive Health and Research: A Guide to Essential Practice on Sexually Transmitted and other Reproductive Tract Infections.*
12. *World Health Organization (2005): Multi-Country Study on Women's Health and Domestic Violence against Women, Initial Results on Prevalence, Health Outcomes and Women's Responses.*

