# STI CLINIC HANDBOOK

Comprehensive STI services for Sex Workers in Avahan-Supported Clinics in India

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# List of Abbreviations

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ARD | Ano-rectal discharge |
| AZT | Azidothymidine (Zidovudine) |
| BD | Two times per day |
| BP | Blood pressure |
| COGS | Clinic Operational Guidelines and Standards |
| CPR | Cardio-pulmonary resuscitation |
| DIC | Drop-in center |
| DOTS | Directly Observed Therapy Short-term |
| FEFO | First expires, first out |
| GUD | Genital Ulcer Disease |
| HIV | Human Immuno-deficiency Virus |
| HLD | High level disinfection |
| HSV | Herpes Simplex Virus |
| ICTC | Integrated counseling and testing center |
| IM | Intramuscular |
| IV | Intravenous |
| NGO | Non-government organization |
| PEP | Post Exposure Prophylaxis |
| PID | Pelvic Inflammatory Disease |
| RPR | Rapid Plasma Reagin |
| SCM | Syndromic case management |
| SLP | State Lead Partner |

SOP Standard Operating Procedure

STI Sexually transmitted infection

SW Sex Worker

TB Tuberculosis

TDS Three times per day

TPHA *Treponema pallidum* Hemagglutination Assay

UD Urethral discharge

VDRL Venereal Disease Laboratory test

VCT Voluntary counseling and testing

WBC White blood cell

WHO World Health Organization

3TC Lamivudine

## Units of Measurements

° C degree Celsius

mg milligram

ml milliliter

# Introduction

This handbook has been developed by Family Health International [FHI] with technical support from World Health Organization [WHO], under Avahan, the India HIV/AIDS initiative of the Bill & Melinda Gates Foundation.

## Section One : Clinic Management

This section of the handbook is for clinic managers to use as a reference guide for the day-to-day management of state-lead partner (SLP) supported clinics. However, clinic managers must refer to the *Clinic Operational Guidelines and Standards* (COGS) for more detailed information on clinic management and clinical case management

## Section Two : Clinical Case Management

This section of the handbook is for all the clinical staff who directly participate in patient management, including doctors, nurses, counselors and educators. The essential elements of clinical management are presented in form of a checklist and summarised procedures to serve as ready reference for clinic staff.

The important points from the Avahan project Clinic Operational Guidelines and Standards [COGS] are summarised in Sections One and Two which also draws on information presented in the FHI/ WHO training module entitled "*STI Treatment Services for Female, Male and Transgender Sex Workers.*"

The handbook is not a substitute for the COGS. It is essential for each clinic to have a copy of the COGS on hand as several sections of the handbook refer to the COGS for more detailed information on clinic management and clinical case management.

# Section One

## CLINIC MANAGEMENT

1. RANGE OF SERVICES
2. REFERRAL SYSTEMS
3. CLINIC SETUP
4. CLINIC OPERATIONS
5. DRUG AND SUPPLIES MANAGEMENT
6. INFECTION CONTROL
7. RECORDING AND REPORTING

# Chapter One: Range of Services

Clinics which are supported by Avahan state-lead partners (SLPs) provide a full range of STI services and a limited range of general health services for sex workers and their clients. These services are listed below:

- Syndromic management of STIs;
- Regular monthly health checkup of sex workers (history taking and physical examination);
- Asymptomatic STI treatment for gonorrhea and chlamydia infection at first visit and repeated if sex worker has not come for STI screening for six months;
- Free STI treatment to all sex workers;
- General health consultation;
- Rapid simple STI laboratory services and non-STI laboratory services in selected clinics with at least 1000 registered sex workers including:
  - Rapid Plasma Reagin [RPR];
  - Microscopic examination of vaginal swab specimens;
  - Hemoglobin and blood group determination;
  - Urine – routine and microscopic examination; and
  - Pregnancy test.
- Health education and counseling services;
- Condom promotion;
- Partner notification and treatment;
- Family planning services; and

- TB clinical screening and referral to DOTS center for TB confirmation and treatment.
- Additional services to be provided through referral include:
  - Serologic syphilis screening, in clinics without laboratory facilities;
  - Confirmatory tests for reactive syphilis serology;
  - Integrated counseling and testing center (ICTC) for HIV;
  - Tertiary care for complicated STIs and treatment failures;
  - HIV/AIDS care and support;
  - Special counseling services;
  - Harm reduction services for injecting drug users; and
  - Other social services, including legal services.

# Chapter Two - Referral systems

## 2.1 Formal referral systems

Referral arrangements should be operationalised for services which the clinic cannot provide but are needed by the community. These include the above listed services and/or any additional services that are not provided by the clinic. The process of operationalizing a formal referral is summarised as follows:

- Referral sites should be investigated prior to making referral arrangements, with particular attention to the cost, quality and timeliness of their services and their acceptance of the sex worker community. Similar to SLP-supported clinic services, referral services should be non-discriminatory, non-judgmental and confidential;
- A **referral agreement** should be drawn up and signed by both the referral site representative and the SLP-supported clinic manager. A sample referral agreement is provided in COGS, Annex R. The agreement should include:
  - Definition of services to be provided;
  - Statement of confidentiality;
  - How referrals will be handled (need for appointments, payment, etc.);
  - Communication mechanism (from clinic to referral site and vice versa); and
  - Quality assurance.
- Detailed and up-to-date information about each referral site should be compiled in a referral directory, including:
  - Type of service;

- Name of the referral provider or organization;
- Address;
- Phone number;
- Name of key contact persons; and
- Hours of operation.

✦ For each referral, the following steps should be taken:

- Fill out **referral form** (see Annex 1),
- Record all referrals in the referral logbook, including
  - ▲ Reason for referral; where referred, follow-up information and patient feedback.
- Accompany patient if possible, do not coerce; and
- Request patient to come back after the referral *or* request feedback from the referral service provider through an acknowledgement form (included in referral form). In either case, a written report from the referral provider should be obtained.

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

✦ A monthly report on referrals made and actions taken should be maintained.

## 2.2 Laboratory referrals

In the case of laboratory referrals for syphilis testing or other laboratory services, specimens should be collected on-site, stored and transported properly to the referral laboratory by the clinic staff. The following standards should be met by the referral laboratory:

- All diagnostic tests are performed by a qualified laboratory technician;
- Written Standard Operating Procedures [SOPs] in place for diagnostic testing and infection control;
- Recording system in place;
- Internal quality control conducted routinely;
- Participation in external quality assessment schemes or willingness to cooperate with external assessment through Avahan; and
- Results of tests made available in a timely fashion.

In the case of laboratory referrals, detailed instructions should be included in the clinic's SOPs for:

- Specimen collection;
- Storage of specimen;
- Transportation to the referral laboratory; and
- Timely collection and recording of test results.

## 2.3 ICTC referrals

For referrals to Integrated Counseling and Testing Centres (ICTC) for HIV testing, SLP-supported clinics should develop a formal referral linkage with a local ICTC center that is acceptable and accessible to the sex worker community. Explore options of linking with a government-sponsored ICTC center that follows national ICTC guidelines. SLP-supported clinics should have a trained counselor on site, who can provide both pre test and post test counseling including information that will allow the sex worker to decide voluntarily to be tested

and return to the NGO clinic to receive on-going counseling. The *Avahan STI/HIV Counseling Guidelines and Standards in the COGS* provides detailed guidelines on on-going STI/HIV counseling; and pre- and post-test counseling.

# Chapter Three: Clinic setup

## 3.1 Internal structure

The internal structure of the clinic should provide physical privacy, auditory privacy and confidentiality for patients in the following rooms and areas:

- Waiting and registration area;
- Consultation and examination room, with door;
- Laboratory area (if feasible); and
- Counseling room, with door.

All areas should have adequate lighting and ventilation.

## 3.2 Staffing

Staffing should be adequate for the following clinic functions to be carried out in an efficient and timely manner, to avoid long waiting periods for patients:

- Clinic administration, patient registration, record-keeping and reporting;
- Sexual and reproductive health history-taking, clinical examination and treatment, including counseling and education;
- Laboratory-based diagnostic testing (where applicable);
- Maintenance of clinical standards for STI management; and
- Procurement and maintenance of clinic supplies.

Detailed job descriptions for each staff position should be included in the clinic's standard operating procedures. An example of a job description can be found in Annex 2.

All clinic staff positions should be filled at all times with appropriately trained personnel. New staff should be trained in elements of Syndromic Case Management (SCM) and COGS.

### 3.3 Equipment

Equipment should be maintained in good working order by ;

- Wiping/dusting daily with clean cloth; and
- Using a protective covering.

A detailed equipment list can be found in COGS Annex C. Condoms, drugs and other supplies should always be in stock in the clinic. (See Chapter 5 )

# Chapter Four: Clinic operations

## 4.1 Operational flowchart

The operational flowchart should be kept up-to-date, clearly showing patient flow and staff responsibilities. An example of a clinic operational flowchart can be found in COGS, Annex B.

## 4.2 Coordination between clinic staff and outreach services

Close collaboration and communication between the clinic and outreach staff will help identify and address problems and issues between the clinic and community in a timely manner.

- Regular meetings should be held with clinic staff, project outreach staff and peer educators to discuss the following:
  - Clinic activities;
  - Community needs and concerns;
  - Ways of promoting the clinic;
  - Follow-up of cases in the community; and
  - The ongoing process of coordination.
- Outreach workers should be encouraged to report back to clinic staff regarding issues such as community perception of the clinic, treatment compliance and side effects of medications;
- A community monitoring system should be in place; and
- Clinic staff should participate in outreach visits on a regular basis.

## 4.3 Sex worker friendly environment

The five components of a clinic environment that are acceptable to sex workers and promote trust within the community are:

- Respectful attitude of staff;
- Convenient location and clinic hours;
- Confidentiality;
- Anonymity; and
- Right to refusal of the services.

**Confidentiality** should be ensured at all times. This must be continually reinforced amongst the staff.

- Clinics should have a confidentiality policy that is enforced and communicated to the patients and community. A sample policy can be found in COGS, Annex P.
- Patients should be informed about how their medical information is handled, and when and how such data may be used for evaluation purposes.
- All staff should receive training in the confidentiality policies of the clinic.
- All staff should sign a confidentiality agreement. A sample agreement is provided in COGS, Annex P.
- Grievance procedures should be in place for patients who feel their confidentiality has been breached. Complaints should be considered by a STI Clinic Committee comprising of members of the community and the umbrella NGO.

**Anonymity** can be preserved by allowing sex workers to provide identifying information, such as a "working name", age, date of birth, etc., instead of their official birth name. It is not necessary to ask for identification papers. A registration

number can be assigned to each sex worker as his/her identifying information. S/he should be instructed to keep this to ensure continuity of service in the clinic.

All patients have a **right to refuse services**, even when the clinic staff may think it is not in the patient's best interest. Patients should not be coerced into attending the clinic or receiving treatment. If the patient still refuses treatment after exploring and discussing the reasons for declining examination or treatment, the clinician must respect the patient's choice. It is possible that the patient will allow examination on a subsequent visit after s/he develops trust in the clinic's staff.

In some settings, a drop-in center (DIC) is attached to the STI clinic. This has proven to increase attendance and involvement of sex workers in the clinic. The DIC is a neutral area where sex workers can:

- Access information on health care and reduction of risk and vulnerability;
- Seek help and advice from outreach workers and their peers;
- Plan and conduct activities that they identify as useful for them;
- Participate in literacy and skills training sessions;
- Relax outside their work places;
- Meet, interact and socialize together; and
- Strengthen the formation and operation of small peer groups or networks.

## 4.4 Sex worker involvement in the clinics

Clinic staff, project outreach teams and peer educators should be selected from within the sex worker community whenever possible.

Sex workers should be trained to respect their peers and ensure confidentiality and privacy. They can also be:

- Trained to fill staff positions in the clinic;
- Involved in promoting the clinic and accompanying their peers to clinic visits;
- Trained to assist clinic operations in:
  - Registering sex workers;
  - Assisting the doctor in preparing the patients for physical examination;
  - Assisting the nurse in taking vital signs (BP, pulse);
  - Promoting and distributing condoms; and
  - Assisting in follow-up treatment of their peers in the community.
- Members of the STI Clinic Committee that meets every quarter to discuss the quality of STI service provision in the clinic. The committee should discuss issues regarding clinic operations, provider attitudes, services provided and feedback from the community. The STI Clinic Committee should also ensure that confidentiality and ethical standards are maintained in the clinic; and
- Managers and staff of the drop-in center, ensuring sex worker ownership of the DIC.

# Chapter Five - Drug and supplies management

## 5.1 Record-keeping and storage system

A record-keeping and storage system should be in place to ensure an adequate stock of drugs and supplies. Key elements include:

- Established drug and consumables storage area, such as a lockable cupboard with working stock kept in the treatment area; and
- A minimum of a three-month stock of all drugs and supplies to be maintained at all times.

**Stock records** for the drug storage area should be kept on **Inventory Control Cards** (see COGS, Annex H) that include information on:

- Product name/description;
- Stock on hand/beginning stock balance;
- Receipts;
- Issues;
- Losses/adjustments;
- Closing/ending balance;
- Transaction reference (e.g., issue voucher number or name of supplier or recipient);
- Special storage conditions;
- Item codes; and
- Expiry dates.

Inventory control cards should be updated daily to keep track of drug stocks, the daily consumption of medications recorded

on the inventory control card should match the total medications issued to patients receiving treatment.

- For pre-packaged treatment packs, this information is recorded on the daily patient register form (see Chapter 7).
- For all other medications, an internal stock control system must be developed within the clinic to register drugs dispensed.

In addition, a **Monthly Consumption Report** (see COGS, Annex H) for drugs and supplies should be filled and sent to the SLP along with the clinic's monthly report.

## 5.2 Ordering drugs and supplies

A **Requisition and Issue Voucher** (see COGS, Annex H) should be used to order drugs and supplies from the central store. Orders should be made early enough to ensure a minimum three-month stock of each item within the clinic at all times.

## 5.3 Receiving stock

The following procedure should be used when receiving stock:

- Count the number of units of each product received and compare with the number on the issue voucher;
- Record the date and quantity received on a stock card.
- Check for damaged or expired stock and return it to the central store;
- Ensure the expiry date is visibly marked on every package or unit;
- Check for any special conditions for storage. It is important to follow the manufacturer's recommended storage

conditions for all products. The following terms relate to temperature and storage of medical supplies:

***Keep cool*** means: Store between 8°C and 15°C; and

***Store at room temperature*** means: Store between 15°C and 25°C, max of 30°C.

> **Remember :**
>
> Adrenaline has a shortened shelf-life when stored above 25°C.

- Arrange products in the storage area so that the first to expire is the first to be dispensed (FEFO).

> **Remember :**
>
> The order in which products are received is not necessarily the order in which they will expire. It is important to check the expiry dates and make sure the dates are visible when the products are in storage. Expired drugs should be disposed of properly (see Chapter 6 for disposal procedures of pharmaceutical waste).

## 5.4 Essential drug list

Emergency drugs and supplies for the management of anaphylaxis should be kept in the injection area and checked regularly to ensure that the packages are in good condition and that the drugs have not expired. Following is the list of emergency drugs and supplies essential for management of Anaphylaxis:

- Aqueous adrenaline (epinephrine) 1:1,000 dilution, for injection;
- Antihistamines for injection and oral administration (e.g., diphenhydramine or chlorpheniramine);
- Hydrocortisone for injection;
- Ambu bag for ventilation; and
- Oropharyngeal airway.

A wall chart explaining the steps for management of anaphylaxis (see example in COGS, Annex I) should be displayed in a place where it can be easily read without leaving the injection area.

**Table A: Essential drugs for the treatment of STIs**

| Essential STI Drugs | Primary Indication | Alternative STI Drugs |
|---|---|---|
| Acyclovir 400 mg tablets | Genital herpes (HSV-2) | Acyclovir 200 mg tablets |
| Azithromycin 500 mg, or 1 gram tablets | GUD (chancroid), UD cervicitis (chlamydia) | |
| Benzathine penicillin 2.4 million IU intramuscular injection | GUD (syphilis) Reactive syphilis test | |
| Benzyl benzoate 25% lotion or Gamma benzene hexachloride 1% lotion or cream | Scabies, pubic lice | Permethrin 5% cream |
| Cefixime 400 mg tablets | UD, cervicitis (gonorrhea) | Ceftriaxone 250 mg intramuscular injection |
| Clotrimazole 500 mg vaginal pessaries or Fluconazole 150 mg tablets | Vaginal candidiasis (fluconozole is also recommended treatment for oral and esophageal candidiasis) | Clotrimazole 1% cream or Miconazole 2% creamMiconazole 100 mg vaginal pessaries Nystatin 100,000 IU vaginal supp. |
| Doxycycline 100 mg tablets | Alternative treatment for chlamydial infection or syphilis | |
| Erythromycin 250 mg or 500 mg tablets | Alternative treatment for chlamydial infection or syphilis (pregnant women) | |
| Metronidazole 400 mg tablets | Bacterial vaginosis, trichomoniasis | Tinidazole 500 mg tablets (optional) |
| Podophyllin tincture 20% | Genital warts (Condylomata acuminata) | Trichloroacetic acid 80 to 90% |

Essential drugs for Post-exposure Prophylaxis (PEP) (see section 6) should be available in the clinic at all times and checked for shelf life and expiry dates on a regular basis. These include:

- Zidovudine (AZT) 300 mg;
- Lamivudine (3TC) 150 mg;
- Indinavir 400 mg or, Efavirenz 200 mg or 600 mg or, Nelfinavir 250 mg or 625 mg; and
- Zidovudine 300 mg and Lamivudine 150 mg may also be provided as a combination tablet.

The clinic should keep enough stock on site for a 28-day treatment course for one person, at all times.

## 5.5 Other supplies and consumables

All other supplies and consumables for patient examination and treatment, cleaning, disinfecting and sterilizing should be inventoried and included in the drug and supplies management system to ensure adequate stock at all times.

# Chapter Six - Infection control

Universal precautions should be implemented at all times by all staff, regardless of the patient's level of infection or contamination. Training in universal precautions should be provided for clinical, housekeeping and any other staff who come in contact with body fluids, waste and/or spills.

## 6.1 Proper hand washing

Wash hands for 10-15 seconds with soap and running water. Air dry or dry with paper or personal towel. Hands should be washed:

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

## 6.2 Use of gloves

Gloves should be worn to prevent contact with body fluids when:

- Examining mucous membranes or non-intact skin (for example, genital examination);

- Drawing blood (phlebotomy), finger pricks/heel pricks establishing intravenous access;
- Handling soiled instruments, equipment or linen; and
- Disposing of contaminated medical waste (cotton, gauze or dressings).

> **Remember :**
>
> Clinical staff should change gloves when examining different patients and in between clinical procedures on the same patient.

- Two types of gloves should be made available:
  - Examination gloves when there is possibility of coming in contact with body fluids or mucous membranes; and
  - Heavy duty utility gloves to be used when cleaning equipment or handling hospital waste.

## 6.3 Safe handling and disposal of needles and sharps

Following are the important points to remember while handling needles and sharps:

- Use only disposable needles and syringes;
- Needles and syringes are for single use only, do not re-use;
- Do not bend, break or recap needles;
- Place needles and sharp objects in puncture-proof containers (either specially manufactured or other puncture-proof buckets or containers with lids), whether needle destroyers have been used or not.

- Place containers within easy reach in all areas where needles are used;
- Seal and remove containers when they are three-quarters full;
- Decontaminate the container with 0.5% bleach for at least 30 minutes before disposing it; and
- Containers should be disposed off by incineration.

## 6.4 Cleaning, disinfecting and sterilizing surfaces and equipment

As part of universal precautions for infection control, all instruments and equipment should be decontaminated and sterilized prior to use. It is important to :

- **SOAK** equipments in decontaminant prior to cleaning (10 minutes in 0.5% bleach);
- **WASH** equipment with soap and water prior to sterilization or disinfection;
- **STERILIZE** medical equipment and instruments (e.g. speculum, ovum forceps, kidney basins) by boiling (high level disinfection-HLD) or autoclaving;
- **DISINFECT** objects and equipment which do not need sterilization (e.g. surgical scissors, laser tips) by soaking in 0.5% bleach solution for 30 minutes and rinsing with sterile water;
- **CLEAN SURFACES** such as floors, walls, tables and counter tops with a disinfectant cleansing solution. Use heavy-duty or utility gloves when cleaning; and
- **CLEAN SPILLS** with proper disinfecting solutions. Wear heavy duty or utility gloves.

For detailed instructions on cleaning, disinfecting and sterilizing, refer to COGS, Annex K.

**Table B : Process of Sterilization**

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

## 6.5 Housekeeping

- At the start of each day:
  - Clean examination tables, trolleys, lamps and other office furniture with a damp cloth to remove dust; and
  - Use a damp mop to remove excess dust from the floors.
- In between patients:
  - Clean examination tables, counters, lamps, blood pressure cuffs and other patient care equipment and surfaces that are at a risk of contamination with a disinfectant cleaning solution; and
  - Clean floors, ceiling and/or walls with disinfectant solution if there is evidence of soiling.
- At the end of each day:
  - Use a disinfectant solution to clean all counters, tables, sinks, lights, door handles, walls, blood pressure cuffs and other patient care equipment and floors;
  - Floors should be cleaned weekly in patient care areas using a mop or other appropriate instrument dampened with a disinfectant solution; and

- For facilities with toilets/commodes, clean the seat and other areas with warm water and ph neutral detergent using cleaning cloth or sponge and then wipe them dry. Then use a disinfectant solution, such as 1-2% sodium hypochlorite and dry again.

### 6.6 Waste management

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

> **Remember :**
>
> Waste disposal does not end at the clinic door
>
> All hazardous waste should be decontaminated (soaked in bleach or autoclaved) prior to disposal.
>
> SLP-supported clinics should dispose off hazardous waste through arrangements with a recognized medical waste disposal service or a nearby hospital.

Potentially infectious or toxic waste includes:

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

Heavy duty gloves should be used by anyone transporting waste to the site of disposal.

Waste should be segregated into color-coded bags and handled as follows:

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

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

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

***Infectious waste:*** Blood and body fluids.

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

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

## 6.7 Post-exposure prophylaxis (PEP)

PEP is provided to staff members when infection control procedures fail and they are considered to be at high risk of infection with HIV. The most common infections transmitted by blood and body fluids are Hepatitis B and HIV.

**For Hepatitis B protection:** All clinic staff who come in contact with patients should receive a three-dose vaccination series for Hepatitis B at the time they start working at the clinic.

**For HIV protection**: Drugs for PEP should be kept on hand at all times as described in Chapter 5 of this handbook. In case of exposure:

- The staff member should be seen by the clinic physician as soon as possible to determine the level of risk and need for PEP;
- The physician should follow the SOP for PEP described in the Clinic Operational Guidelines and Standards (COGS), Annex M; and
- An incident report should be filled in for each case and reported to the clinic supervisor. The incident report form can be found in COGS, Annex M.

# Chapter Seven- Recording and reporting

For each form, the person(s) responsible for filling it out should be clearly designated. All records should be:

- Accurate;
- Complete;
- Promptly prepared and submitted;
- Kept confidential in a locked room; and
- Safely and systematically handled.

**Table D : Required recording forms**

| Form | Content | Frequency | Next steps |
|---|---|---|---|
| Client encounter form | Details of patient visit | Daily | Transfer key information to patient register<br>Keep in confidential file that can be easily retrieved on patient's next visit |
| Patient register | Daily summary of key patient information | Daily | Column totals tallied at end of day<br>Totals recorded for later use on monthly summary sheet<br>Send to data entry service at end of month |
| RPR report | Details of RPR testing and results | Daily | Tallied at end of month for monthly summary sheet<br>Send to data entry service at end of month |
| Monthly summary report | Summary of all clinic activities | Monthly | Filled in monthly<br>Submit to Project Coordinator |

Two types of monitoring data are available to clinic managers:

- Data compiled at the clinic level for monthly reports; and
- Reports generated by the SLP, based on patient registers.

Data analysis reports should be regularly shared with clinic staff so that:

- Reports are discussed at staff meetings and appropriate action is taken; and
- Monitoring and reporting data can help guide management decisions.

When used effectively, a monitoring and reporting system can be a valuable management tool for guiding decisions on clinic policies and procedures, identifying staff training needs and designing strategies to improve service utilization by the sex worker community.

# Section Two

## CLINICAL CASE MANAGEMENT

1. THE SEX WORKER VISIT

2. HISTORY-TAKING

3. EXAMINATION OF FEMALE SEX WORKERS

4. EXAMINATION OF MALE AND TRANSGENDER SEX WORKERS

5. DIAGNOSIS AND TREATMENT

6. PREVENTION AND MANAGEMENT OF ANAPHYLAXIS

7. EDUCATION AND COUNSELING

# 1. The Sex Worker Visit

## 1.1 Checklist for creating a sex worker-friendly environment

- ✓ Sex workers and their clients treated with respect
- ✓ Confidentiality maintained
- ✓ Visual and auditory privacy provided
- ✓ Identification details and documents not demanded
- ✓ Patients have a right to refuse services

## 1.2 Checklist for sex worker visit

- ✓ History
- ✓ Physical examination :
  - General;
  - External genital;
  - Speculum;
  - Bimanual; and
  - Rectal/proctoscopic/anoscopic, if indicated.
- ✓ Laboratory investigations
  - RPR every 6 months
- ✓ Drug treatment for:
  - STI syndromes; and
  - Asymptomatic coverage at first visit or $\geq$ 6 months since last STI screening
- ✓ Partner treatment
- ✓ Education and counseling
- ✓ Condom provision
- ✓ Referral if needed
- ✓ Schedule follow-up visit

# 2. History-taking

## 2.1 Checklist for History-taking

- ✓ Help the patient feel at ease
- ✓ Be tactful, tolerant and non-judgmental
- ✓ Provide auditory and visual privacy
- ✓ Assure absolute confidentiality
- ✓ Use simple terms that the patient understands
- ✓ Ask the least sensitive questions first
- ✓ The information you need to collect includes:
  - General details;
  - Present illness;
  - Medical history; and
  - Sexual history.

✓ When taking a sexual history, reassure the patient that the information:

- Is being obtained only to help in treating him or her;
- Will be kept absolutely confidential; and
- Is routinely asked of all patients.

> **Remember :**
>
> A good way to start off the questions regarding sexual behavior is by saying:
>
> "I would now like to ask you some very personal questions. Please try to answer the questions as best you can. The answers to the questions will help me plan your treatment."

✓ Perform sputum exam or refer to sub-district TB center if the patient has:

- A cough of >1 week and history of pulmonary TB; <u>or</u>
- A cough of > 3 weeks with or without history of pulmonary TB.

| Table E. Guide on history taking of female sex workers | |
|---|---|
| **General details** | Age :<br>Number of Children : |
| **Present illness** | Presenting complaints and duration |
| If a vaginal discharge | Itching?<br>Odor?<br>Color and consistency of discharge? |
| If lower abdominal pain | Vaginal bleeding or discharge?<br>Painful or difficult pregnancy of childbirth?<br>Painful or difficult or irregular menstruation?<br>Missed or overdue period?<br>History of recent delivery or abortion?<br>Painful vaginal intercourse?<br>Fever? |
| If a genital or peri-anal ulcer | Site?<br>Is it painful?<br>Recurrent?<br>Appearance?<br>Spontaneous onset?<br>Pain and Swelling in the inguinal region? |
| If urinary symptoms | Pain while passing urine?<br>Frequency? |
| Any other symptoms | Warts?<br>Lumps or swelling?<br>Skin rashes? |
| **Medical History** | |
| Regular STI check-ups | Date of last STI check-up?<br>Any medications provided? |
| Any past STI? | Type?<br>Dates?<br>Any treatment (medications) and response?<br>Result of any prior tests? |
| Obstetric History? | Pregnancies and outcomes?<br>Date of last menstrual period?<br>Contraceptive use? |
| Other Illness? | Type?<br>Dates?<br>Any treatment and response?<br>Result of tests? |
| Medication?<br>Drug allergies?<br><br>Drug and alcohol use? | Current medications?<br>Name of drugs?<br>Type of reaction?<br>Patterns and frequency of use?<br>Injection drug use?<br>Harm minimization strategies? |
| **Sexual history** | Duration of sex work?<br>Number of partners in last working day?<br>Number of partners in past one week?<br>Sites of sexual exposure (Vaginal, oral, anal)?<br>Regular partner?<br>Symptomatic partner?<br>Condom use with paying clients?<br>Condom use with regular partners?<br>Partner violence? |

| Table F. History taking of male and transgender sex workers | |
|---|---|
| **General details** | Age :<br>Others as needed : |
| **Present illness** | Presenting complaints and duration |
| If a urethral discharge | Color and consistency of discharge?<br>Difficulty or pain with urination?<br>Frequency of urinations? |
| If rectal pain or discomfort? | Rectal bleeding or discharge?<br>Diarrhea?<br>Abdominal pain or cramping?<br>Fever?<br>Difficulty or pain with defecation? |
| If a genital or peri-anal ulcer | Site?<br>Is it painful?<br>Recurrent?<br>Appearance?<br>Spontaneous onset?<br>Pain and Swelling in the inguinal region? |
| If oral or pharyngeal symptoms | Sore throat or oral ulcers? |
| **Medical History** | |
| Regular STI check-ups | Date of last STI check-up?<br>Any medications provided? |
| Any past STI? | Type?<br>Dates? |
| | Any treatment and response?<br>Result of any prior tests? |
| Other Illness? | Type?<br>Dates?<br>Any treatment and response?<br>Result of tests? |
| Medication?<br><br>Drug allergies?<br><br>Drug and alcohol use? | Current medications?<br>Feminization practices (where relevant)?<br>Name of drugs?<br>Type of reaction?<br>Patterns and frequency of use?<br>Injection drug use?<br>Harm minimization strategies? |
| Sexual history | Duration of sex work?<br>Number of partners in last working day?<br>Number of partners in past one week?<br>Type of sexual behavior practiced (oral, anal, receptive or penetrative role)?<br>Gender of sexual partner?<br>Contraceptive use by female partners?<br>Regular partner?<br>Symptomatic partner?<br>Condom use with paying clients?<br>Condom use with regular partners?<br>Partner violence? |

# 3. Examination of female sex workers

## 3.1 Procedure for examination of female sex workers

- Put the patient at ease by talking about informal topics
- Explain the procedures that will be done and why
- Perform the examination gently and carefully
- Maintain a confident and professional demeanor
- Cover parts of the body not being examined
- If the clinician is male, ensure that a female health care worker is also in the room
- Ask patient to pass urine if she hasn't done so within the past one hour
- Wash hands before conducting the examination

## 3.2 Procedure for general examination

- Examine the mouth with the aid of a tongue depressor and examination light for sores, pharyngeal inflammation and candidiasis
- Palpate the neck, the axillae, supraclavicular, submandibular and epitrochlear areas for enlarged lymph nodes
- If the patient is unwell, take pulse and blood pressure, and auscultate lungs
- Look for rashes, swellings and sores on the chest, back and abdomen
- Inspect the patient's hands, forearms and inside the elbow Note any rashes, nail changes or "needle track" marks

- Palpate the abdomen, feeling for areas of tenderness and for swellings. Check particularly for tenderness deep in the pelvis.

## 3.3 Procedure for external ano-genital examination

- Wear gloves for the examination.
- Ask the patient to lie on her back and bend the knees and separate the legs.
- Inspect pubic hair for signs of ectoparasite infestations.
- Palpate for any inguinal lymph nodes or rashes.
- Inspect the labia and then retract them to inspect the urethral meatus, clitoris, introitus, perineum and perianal areas. Note any discharge, ulcers, warts or growths

## 3.4 Procedure for speculum examination

- Wear gloves to carry out a speculum and bimanual examination
- The patient should lie with her legs bent at the knees and her feet and knees separated
- Remember to explain each step of the procedure as you carry it out

**Remember:**

A correctly performed speculum examination is not painful. Do not hurt the patient.

(If a patient has extensive genital ulcerations, it may not be possible to carry out a speculum examination until after treatment.)

- Use a Cusco bivalve speculum of appropriate size. Be sure it has been properly sterilized before using it
- Wet the speculum with clean warm water. A light coating of water-based (K-Y) lubricant can be used

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

## 3.5 Procudure for bimanual examination

- The examiner should stand to perform the bimanual examination. Remember to explain to the patient each step of the procedure as you carry it out. This helps to put the

patient at ease and gain confidence.

- Lubricate the gloved index and middle fingers of your examining hand. Insert them into the vaginal opening.
- Locate the cervix and gently move it side to side while watching the expression on the woman's face. Pain on cervical motion suggests infection.
- Place your other hand on the lower abdomen while your fingers are still in the vagina. Check the size of the uterus while palpating it between your hands. A soft, large uterus may indicate pregnancy. A hard or lumpy uterus may be due to fibroids or other growths. A painful uterus may indicate infection.
- Move your upper hand to the right lower quadrant of the abdomen and your intravaginal hand to the right fornix. Palpate the ovaries between your hands. Repeat on the left side. Ovaries are often slightly tender on palpation. Any severely painful area or lump larger than an almond may indicate infection or other emergency. If there is a painful lump and the woman's period is late, it could indicate an ectopic pregnancy.

**Remember :**

Any patient with history or physical findings of lower abdominal pain or tenderness should undergo bimanual examination to check for the presence of cervical motion tenderness.

### 3.6 Checklist for Proctoscopic/anoscopic examination

Proctoscopic/anoscopic examination is recommended:

- ✓ If there are anorectal signs or symptoms; and
- ✓ As a routine examination for patients who engage in receptive anal sexual activity and non-penile penetration with fingers and sex toys.

Instructions are given in the next section on examination of male and transgender sex workers.

## 3.7 Procedure for specimen collection

If it is necessary to take specimens, follow the laboratory protocol that has been developed for the clinic. Specimens should be collected while the speculum is inside the vagina. The procedure is as follows:

- Take one swab from the vaginal secretions or discharge. Make a smear of this on two microscope slides; one for KOH prep and the other for saline prep;
- Wipe the cervix with a cotton wool swab and discard the swab;
- Insert a clean swab into the cervix, roll it around inside the cervix for 30 seconds and then remove it and make a smear on a glass slide for Gram stain; and
- After the examination is over, take 5 ml of venous blood from the arm and place it in a blood tube. Send it to the laboratory for syphilis tests.

# 4. Examination of male and transgender sex workers

## 4.1 Procedure for examination of male and transgender sex workers

- Put the patient at ease by talking about informal topics
- Explain which procedures will be done and why
- Perform the examination gently and carefully
- Maintain a confident and professional demeanor
- Cover parts of the body not being examined
- The patient should NOT pass urine prior to examination.

## 4.2 Procedure for general examination

- Look in the mouth with the aid of a wooden tongue depressor and examination light. Inspect for sores, pharyngeal inflammation and candidiasis
- Palpate the neck, the axillae, supraclavicular, submandibular and epitrochlear areas for enlarged lymph nodes
- Look for rashes, swellings and sores on the chest, back and abdomen
- Inspect the patient's hands, forearms and inside the elbow. Note any rashes, nail changes or "needle track" marks
- Palpate the abdomen, feeling for areas of tenderness and for swellings. Check particularly for tenderness deep in the pelvis

## 4.3 Procedure for external ano-genital examination

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

## 4.4 Checklist for proctoscopic/anoscopic examination

Proctoscopic/anoscopic examination is recommended:

- ✓ If there are anorectal signs or symptoms; and

- ✓ As a routine examination for patients who engage in receptive anal sexual activity.

## 4.5 Procedure for Proctoscopic/anoscopic examination

- ✦ Wear gloves to carry out a proctoscopic/anoscopic examination. The patient should lie in a left lateral position (described in the previous section).
- ✦ A bright light source is necessary to inspect the rectal walls.
- ✦ Remember to explain to the patient each step of the procedure as you carry it out.

> **Remember :**
>
> A correctly performed proctoscope/anoscope examination is not painful. Do not hurt the patient.If a patient has extensive anal ulcerations, it may not be possible to carry out a **proctoscope/anoscope** examination until after treatment.

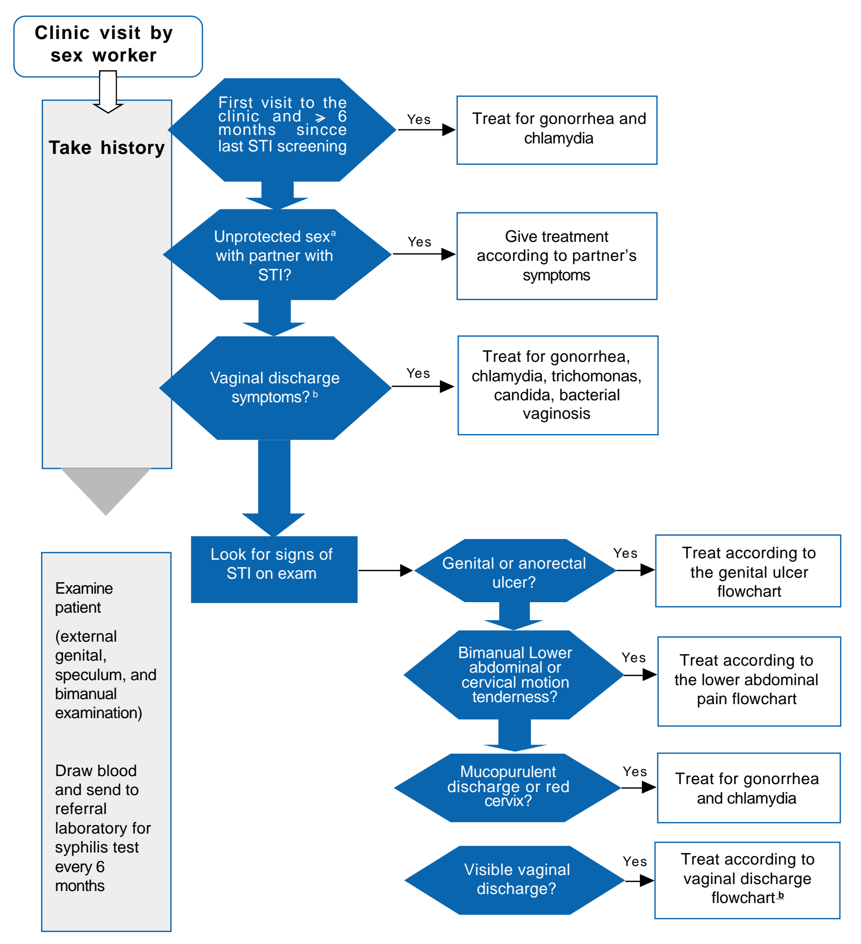
- ✦ Start with a digital examination using a lubricated and gloved right index finger. Place the pad of your finger over the anus and ask the patient to bear down. As the sphincter relaxes, insert your finger into the anal canal, in the direction of the umbilicus. Ask the patient to relax. Palpate the prostate and lower rectum. Feel for the presence of masses or lumps beneath the rectal mucosa, location of painful areas and size and contour of the prostate gland. You will need to rotate your hand to palpate all walls of the rectum. Return your hand to neutral position and withdraw your finger slowly
- ✦ The examiner should change gloves between the digital rectal examination and proctoscopy. Some clinicians double-glove the right hand and discard the outer glove

after the digital exam and before proctoscopy

- Be sure that the proctoscope/anoscope has been properly sterilized before using it
- Warm the proctoscope/anoscope with water and apply lubricating jelly to both the perianal area and the length of the proctoscope/anoscope
- Rest the proctoscope/anoscope at the anal verge until the sphincter relaxes, then insert it slowly applying gentle constant pressure. Allow the proctoscope/anoscope to follow the line of least resistance rather than pushing it. Generally aim towards the navel. Elevation and relaxation of the buttocks aids insertion, as does asking the patient to “bear down” as if opening the bowels
- Remove the introducer once the proctoscope/anoscope has reached its limit. With the aid of the patient examination light, observe the colour and texture of the rectal mucosa and the presence and characteristics of discharge, ulceration, bleeding, or lesions
- If laboratory facilities are available, take specimens while the proctoscope/anoscope is inside the rectum. Take a swab of the rectal mucosa and make a smear on a glass slide for Gram stain
- Slowly remove the proctoscope/anoscope, checking for hemorrhoids and/or other lesions on withdrawal.

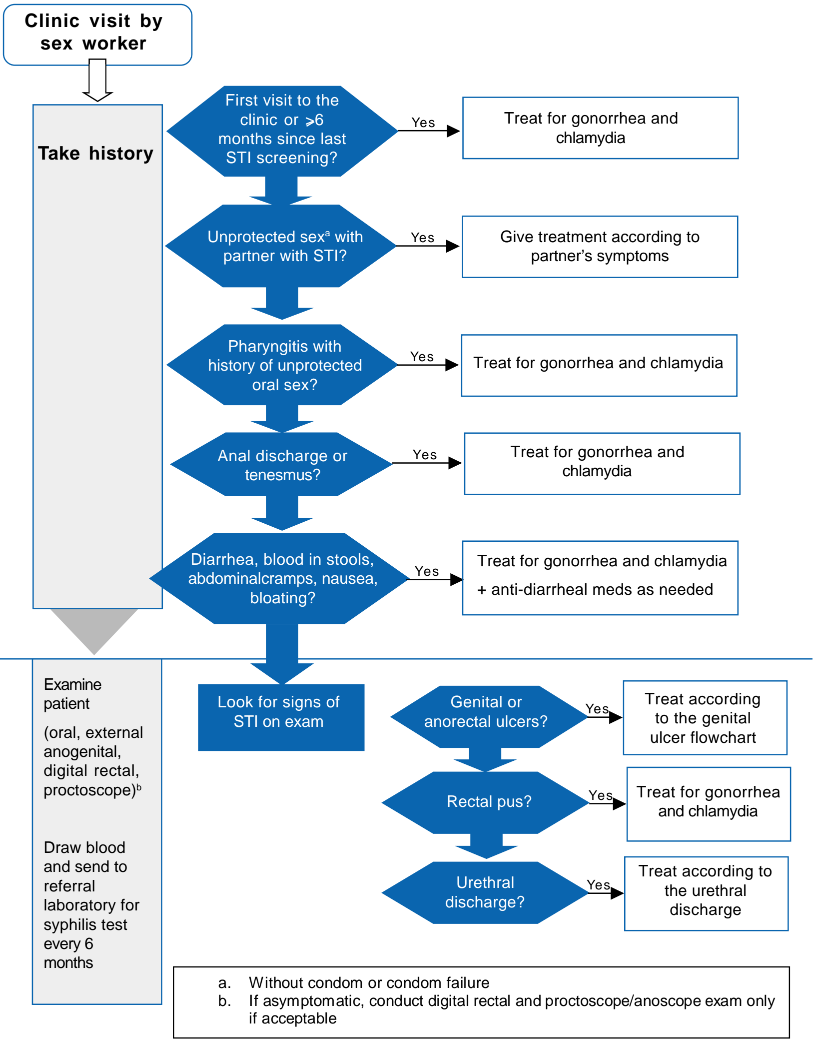
# 5. Diagnosis and treatment

## 5.1 Flowchart for routine visits for female sex workers in clinics without on-site laboratory services




(*The flowchart for sites with on-site laboratory services is found in Annex 3.)

## 5.2 Flowchart for routine visits for male and transgender sex workers in clinics without on-site laboratory services.




(* The flowchart for sites with on-site laboratory services is found in Annex 4.)

## Table G : Summary of antibiotic treatments (based on NACO syndromic management flowcharts)

| Kit | Signs and symptoms | Syndrome | Medicines to be given No. |
|---|---|---|---|
| 1. | ● Urethral discharge<br>● Burning on urination | Urethral Discharge(UD) | Cefixime 400 mg orally single dose ***AND***<br>Azithromycin 1 gram orally single dose |
| | ● Rectal discharge OR bleeding<br>● Tenesmus | Ano-rectal discharge (ARD) | |
| | ● Vaginal discharge<br>● Presence of red cervix or mucopus in the cervix | Vaginal Discharge (Cervicitis)* | |
| | ● Scrotal Swelling or tenderness<br>● No history of trauma<br>● Testis not rotated or elevated | Scrotal Swelling Syndrome | |
| | ● Sex worker's first visit or ⩾6 months since last STI screening | Asymptomatic treatment | |
| | ● No symptoms and signs of cervical and vaginal infection | | |
| 2 | ● Vaginal discharge<br>(All women complaining with vaginal discharge are provided with vaginitis treatment) | Vaginal Discharge (Vaginitis) * | Metronidazole 2gm single dose ***OR***<br>Metronidazole 400 mg or 500mg orally BD for 7 days<br>***AND***<br>Fluconazole 150 mg ***OR***<br>Clotrimazole pessary 500mg intravaginally single dose |
| 3 | ● Sore or ulcer<br>(anogenital area) | Genital Ulcer Syndrome<br>(Non Herpetic) | Inj. Benzathine penicillin 2.4 million units IM<br>***AND***<br>Azithromycin 1 gram orally single dose |
| 4 | ● Vesicle present | Genital Ulcer Syndrome<br>(Herpes) | Acyclovir 400 mg orally TDS for 7 days |
| 5 | ● Lower abdominal tenderness<br>● Cervical motion tenderness<br>● Refer if the following are present<br>▴ Rebound tenderness or guarding<br>▴ Presence of mass<br>▴ No bowel sounds<br>▴ Pulse > 110<br>▴ Missed period or abortion<br>▴ Abnormal vaginal bleeding | Lower Abdominal Pain (PID) | Cefixime 400 mg orally single dose<br>***AND***<br>Doxycycline 100 mg BD orally for 14 days<br>***AND***<br>Metronidazole 400 mg BD orally for 14 days |
| 6 | ● Urethral discharge - persistent | Urethral discharge | Metronidazole 2 grams single dose |
| Nil | ● Enlarged and painful inguinal node *without ulcers* | Inguinal Swelling Syndrome | Doxycycline 100 mg BD orally for 21 days |
| Nil | ● Warts | Genital Warts | Apply podophyllin 20% in the area, wash after 1-4 hrs., repeat |

* Sex workers complaining of vaginal discharge should be treated for both cervicitis and vaginitis

## 5.3 Syphilis screening

- All sex workers should be encouraged to undergo syphilis screening at least every 6 months.
- For all SW who are willing to undergo syphilis screening:
  - Collect 5 ml. of blood; and
  - Ask patient to come back after one week for the result.

> **Remember :**
>
> Record syphilis testing in laboratory register. If laboratory facilities are not available on-site, record in referral register.

## 5.4 Procedure for Specimen processing and transport

- Let blood stand for one hour
- Separate blood from serum by centrifuging
- Store serum in refrigerator. Maintain temperature from 2°C to 8°C
- Perform RPR test in clinic laboratory OR transport serum within 7 days (in cold box at 2 to 8°C) for RPR testing at the referral laboratory. A detailed syphilis testing procedure can be found in Annex 5
- Carry out TPHA confirmatory testing for all reactive RPR results at referral laboratory when feasible

### Interpretation of results

- Quantitative titer results should be provided for all serum with confirmed reactive RPR tests
- For all sex workers with reactive RPR:
  - Administer Benzathine PCN 2.4. M units weekly for three weeks; or
  - Doxycycline 100 mg. 2 x a day for 30 days plus Azithromycin 1 gram single dose. (N.B. Ensure

compliance with doxycycline regimen through peer educator/outreach worker compliance monitoring)

- Repeat RPR titers at 3 months, 6 months and 12 months after treatment.
- If titer decreases two-fold or remains low after 3 months, advise repeat testing after 6 months.
- If titer remains high, consider possibility of re-infection or neurosyphilis and treat accordingly.

**Table H : Summary of partner treatment**

| Kit No. | Primary Infection of STI Patient | Partner Treatment | Medicines to be given |
|---|---|---|---|
| 1 | Urethral Discharge(UD) | Treat partner for gonorrhea and chlamydia | Cefixime 400 mg orally single dose ***AND*** Azithromycin 1 gram orally gonorrhea and chlamydia single dose |
| | Ano-rectal discharge (ARD), | Treat partner for | |
| | Vaginal Discharge (Cervicitis)* | Treat partner for gonorrhea and chlamydia | |
| | Scrotal Swelling Syndrome | Treat partner for gonorrhea and chlamydia | |
| | Asymptomatic treatment | No treatment for partner | |
| 2 | Vaginal Discharge (Vaginitis) * | Physician to make clinical judgment If trichomonas, treat partner with Metronidazole | Metronidazole 2gm single dose ***OR*** Metronidazole 400 mg or 500 mg orally BD for 7 days |
| 3 | Genital Ulcer Syndrome (Non Herpetic) | Treat partner for syphilis and chancroid | Inj. Benzathine penicillin 2.4 million units IM ***AND*** Azithromycin 1 gram orally single dose |
| 4 | Genital Ulcer Syndrome (Herpes) | Partner requires full sexual health history and examination If herpes lesion present, then treat for herpes | Acyclovir 400 mg orally TDS for 7 days |
| 5 | Lower Abdominal Pain (PID) | Treat partner for gonorrhea and chlamydia | Cefixime 400 mg orally single dose ***AND*** Azithromycin 1 gram orally single dose |
| Nil | Inguinal Swelling Syndrome | Treat for LGV | Doxycycline 100 mg BD orally for 21 days. |
| Nil | Genital Warts | Partner requires full sexual health history and examination If genital warts present, then treat for genital warts | Apply podophyllin 20% in the area, wash after 1-4 hrs, repeat after 1 week as necessary |

# 6. Prevention and management of anaphylaxis

## 6.1 Checklist for History taking

Before administering penicillin, ask the patient about any past history of allergic reaction to penicillin. If yes, ask the following questions:

- ✓ What was the patient's age at the time of the reaction?
- ✓ What were the characteristics of the reaction?
- ✓ How long after beginning penicillin therapy did the reaction begin?
- ✓ How was penicillin administered?
- ✓ What other medications was the patient taking at the time?
- ✓ What happened when the penicillin was discontinued?
- ✓ Has the patient taken any antibiotics related to penicillin (i.e. amoxicillin, ampicillin, or cephalosporins) and if so, what were the reactions?

**A strong history of penicillin allergy includes:**

- Anaphylaxis;
- Angiodema/urticaria;
- Pruritic rash; and
- Bronchospasm.

Symptoms such as maculopapular rash, gastrointestinal upset, or other unknown reactions are less predictive of allergy.

## 6.2. Procedure of skin testing for penicillin.

Intradermal Sensitivity Testing For Penicillin

- May result in anaphylactic reactions in allergic persons and staff must be prepared for emergency treatment.
- Must not interfere with penicillin treatment of syphilis.

> **Remember :**
>
> Prior to skin testing and IM injections, the emergency Anaphylaxis Kit should be available near the injection and skin testing area.

DO NOT administer penicillin in the presence of the following conditions:

- Acute illness (flu-like symptoms, running nose, bad cold);
- Itchy skin rashes; and
- Wheezing

When administering the injection:

- Indicate in the client record that history of allergies has been noted and skin test performed;
- For skin testing: record the type of medication tested, time of testing and results of the skin test;
- Ask the physician who reads the skin test report to sign in the patient record;
- Ask the patient to wait at least 30 minutes after any injection before leaving the health facility; and
- In case of anaphylaxis, record all the management procedures followed with the patient, including the type and time of drugs administered.

## 6.3 Management of Anaphylaxis[1]

Before administrating drugs or injections, ask the patient about previous allergies to drugs.

---

[1] Protocols for the management of a person with a Sexually Transmitted Disease. Department of Health, South Africa, Pretoria, 1998 (adapted).

## Signs of possible ANAPHYLAXIS:

- Shock
- Difficulty breathing
- Itchy rash or hives

| Table I. Steps in Anaphylaxis management | |
|---|---|
| 1. | Call for help – preferably a doctor |
| 2. | CHECK<br>**A**irway<br>**B**reathing – Give mouth-to-mouth respiration<br>**C**irculation – Perform CPR if necessary |
| 3. | If Anaphylaxis, give Adrenaline intramuscularly<br>● Dosage: Adult 0.5 ml (if elderly 0.3 ml), repeat every 5-10 minutes until adequate response<br>● Check blood pressure and pulse at 5- to 10-minute intervals |
| 4. | Give Hydrocortisone IM – Dosage: Adult 250 mg |
| 5. | Give chlorpheniramine 10-20 mg<br>***OR***<br>diphenhydramine 50-100 mg IM |
| 6. | TRANSFER PATIENT TO HOSPITAL<br>● Repeat Adrenaline if necessary. Take extra doses with you.<br>● Record all details of treatment. Give copy to hospital.<br>● Stay with the patient until another doctor takes over the care in person. |

# 7. Education and Counseling

Education sessions may take place in clinic during routine checkups or symptomatic visits but may also be carried out or continued by outreach workers and peer educators in the community. Trained community members may be the most effective educators since they understand the social context of the sex workers.

During counseling sessions, be sure to provide:

- ✦ Auditory and visual privacy; and
- ✦ Confidentiality.

## 7.1 Checklist for education and counseling

In every counseling session, be sure to cover the following topics:

- ✓ The diagnosed STI, its implications and treatment and the importance of complying with the treatment.
- ✓ The patient's risk level.
- ✓ The need to change sexual behaviour.
- ✓ Barriers the patient may have to changing behaviour;

Some common barriers are:

- ✦ Lack of knowledge regarding the prevention of STIs and HIV infection;
- ✦ Inability to obtain condoms;
- ✦ Inability to negotiate condom use; and
- ✦ Use of drugs and alcohol.

- ✓ Changes the patient can and will make in his/her sexual behaviour. An individual sex worker's risk for STIs and HIV depends on his/her frequency of exposure to unprotected sexual acts. To reduce risk, the sex worker can:

- Use male or female condoms with every sex act, including with regular clients and boyfriends; and
- Use safer sex practices such as hand sex, oral sex, thigh sex, or fantasy sex stories when clients refuse to use condoms.

✓ The need to treat sexual partners;

✓ The importance of monthly routine checkups, even when asymptomatic:

- Explain the high risk of exposure to STIs for sex workers and that many STIs are asymptomatic but can cause severe complications if left untreated.

✓ Referral for voluntary counseling and testing for HIV

- Recommended at 6 or 12-month intervals only if ongoing care and support services are available in case of a positive result;
- Leave the decisions to the patients after explaining advantages and disadvantages of testing; and
- All HIV testing should be accompanied by pre and post-test counseling.

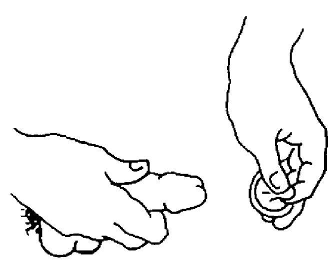
✓ Lubricant and condom distribution and information

- Demonstrate the procedure with a model;
- Provide lubricants (water-based only); and
- Provide condoms.

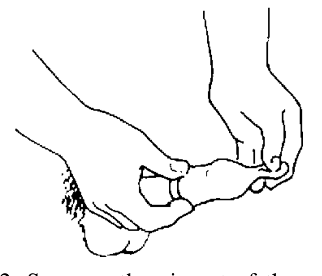
**Remember :**

Many sex workers don't use condoms with their regular clients or boyfriends. Encourage condom use with **every sexual act**

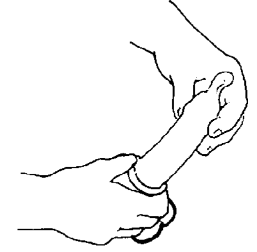
## 7.2 Instructions for Use of Male Condom [2]



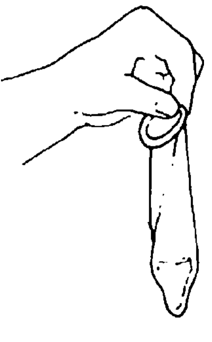
1. Remove the condom from the package carefully, to avoid tearing.



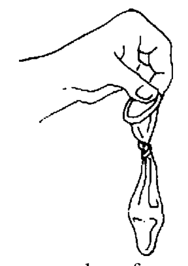
2. Squeeze the air out of the tip of the condom.



3. Unroll the condom onto the erect penis.



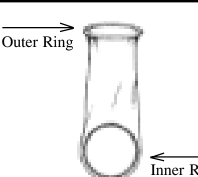
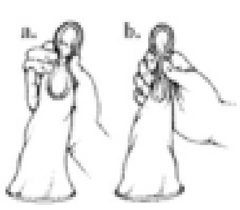
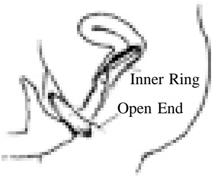
4. After ejaculation, withdraw the penis from the vagina while the penis is still erect. Hold on to the rim of the condom while withdrawing to prevent it from slipping off and the semen spilling into the vagina.



5. Remove condom from penis and tie a knot to prevent spills or leaks. Dispose of condom safely (where it cannot cause any hazard)

[2] World Health Organization. 2005. *Sexually Transmitted and Other Reproductive Tract Infections. A Guide to Essential Practice.*

## 7.3 Instructions for Use of Female Condom[3]

| The female condom is a soft, loose-fitting sheath with a flexible polyurethane ring at each end.<br>The inner ring at the closed end is inserted into the vagina.<br>The outer ring at the open end remains outside the vagina during intercourse and covers outer genitalia. | <br>1. Remove the female condom from the package and rub it between two fingers to be sure the lubricant is evenly spread inside the sheath. If more lubrication is required, squeeze two drops of the extra lubricant included in the package into the condom sheath. | <br>2. The closed end of the female condom will go inside the vagina. Squeeze the inner ring (closed end) between your thumb and middle finger. Insert the ring into the vagina. |
|---|---|---|
| <br>3. Using the index finger, push the sheath all the way into the vagina as far as it will go. It is in the right place when it cannot be felt. | <br>4. The ring at the open end of the female condom should stay outside the your vagina and rest against the labia (the outer lip of the vagina). Be sure the condom is not twisted. Once you begin to engage in intercourse, you may have to guide the penis into the female condom. If you do not, be aware that the penis could enter the vagina outside of the condom's sheath. If this happens, you will not be protected. | <br>5. After intercourse you can safely remove the female condom at any time. If you are lying down, remove the condom before you stand to avoid spillage.<br>Dispose of the female condom safely (where it cannot cause any hazard). Do not reuse it. |

[3] World Health Organization. 2005. *Sexually Transmitted and Other Reproductive Tract Infections. A Guide to Essential Practice*.

# Annexes

1. REFERRAL FORM
2. JOB DESCRIPTIONS
3. FLOWCHART FOR ROUTINE VISIT OF FEMALE SEX WORKER IN CLINICS WITH ON-SITE LABORATORY SERVICES
4. FLOWCHART FO R ROUTINE VISIT OF MALE AND TRANSGENDER SEX WORKERS IN CLINICS WITH ON-SITE LABORATORY SERVICES
5. SYPHILIS TESTING PROCEDURE

# ANNEX 1: Referral Form

Referral Form

Date: _______________ Patient ID # : _________________________

To: _____________ Address: ___________________ Time: __________

This is to refer the bearer of this letter for further management:

____________________________________________________________

Findings:

____________________________________________________________

Impression / Diagnosis: ________________________________________

Referred by: ________________________________

Name and Signature

________________________________

Organization and Contact Details

____________________________________________________________

Referring Person's Copy : To be returned to STI Clinic

Date: ____________________________

Participant ID#: ___________________

Findings: ________________________________________________

Impression / Diagnosis: __________________________________________

Action Taken:

____________________________________________________________

____________________________________________________________

Name and Signature of Physician

# ANNEX 2: Job Descriptions

## ✦ Clinic Physician

- Conduct history taking and examination, make a diagnosis and prescribe treatment
- Provide health education for treatment compliance, condom use, partner management, follow-ups and suggest HIV testing where appropriate
- Fill up patient records completely and accurately
- Refer patients for syphilis screening, ICTC, higher levels of STI care or for other relevant services
- Ensure infection prevention and monthly reports submission
- Train and supervise ANM for community awareness and screening of cases
- Supervise of STI clinic staff
- Request *laboratory tests where available.*

## ✦ Auxillary Nurse/ Midwife

- Ensure cleanliness of the clinic, proper infection control procedures including sterilization of reusable instruments, disposal of needles, gloves and other biohazard waste
- Patient registration and supervise flow of patients to MO/LT
- Assist physician during examination
- Dispense drugs and condoms
- Provide directly observed therapy for STI single dose regimes

- Provide health education, condom promotion and counseling
- Maintain clinic records
- Prepare monthly reports
- Ensure availability of STI drugs, medical and other supplies – timely request and maintain inventory of supplies
- Conduct individual tracking of SWs for:
  - asymptomatic treatment every six month
  - syphilis screening every six month
  - for quarterly check-ups
  - for follow-ups
- Counseling *on periodic check-ups, screening and treatments.*

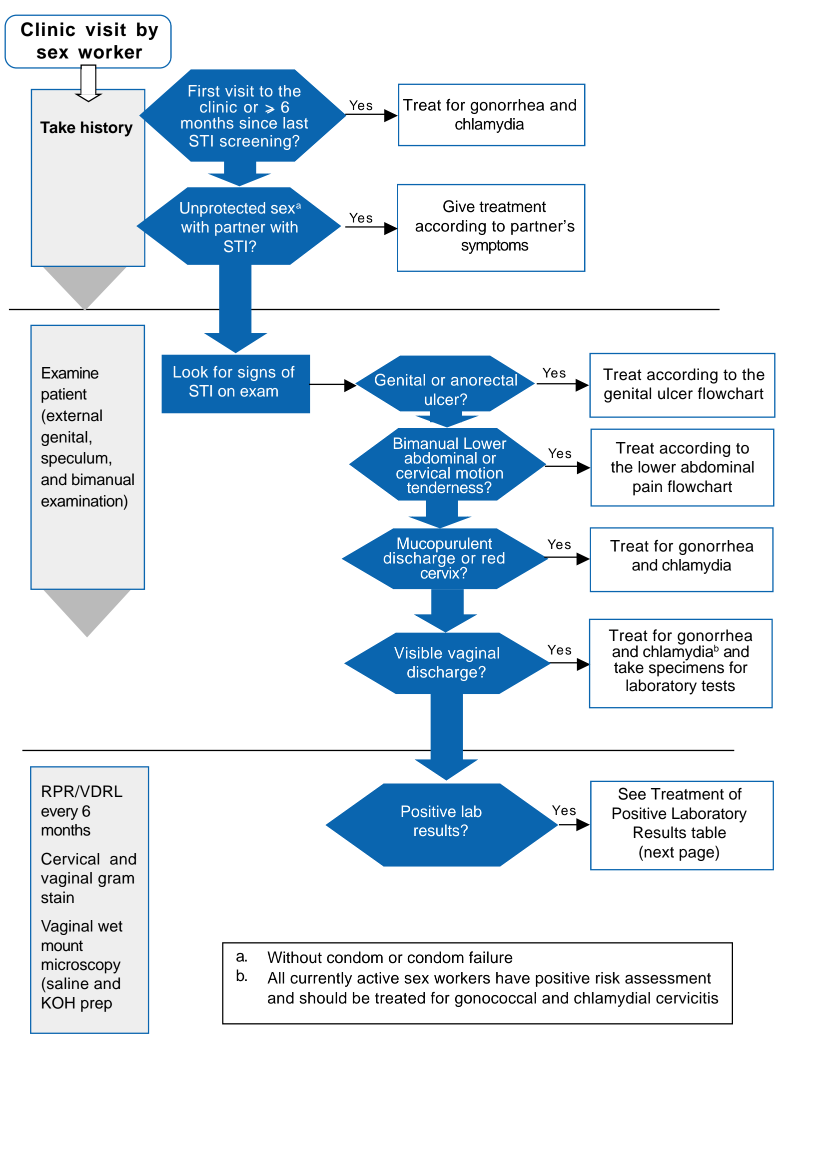
## ✦ Counselor

- Health education and counseling on treatment compliance, correct and consistent condom use, partner management, follow ups and need for ICTC.
- Counseling on risk reduction and psycho-social support
- Facilitate systematic referral systems and follow- ups
- Maintain counseling records

## ✦ Laboratory technician

- Assist doctor in collection of vaginal/cervical/urethral/ rectal samples
- Draw blood for syphilis testing
- Perform tests for STIs
- Maintain patient reports and laboratory registers
- Procure and maintain laboratory supplies
- Implement *infection control procedures*

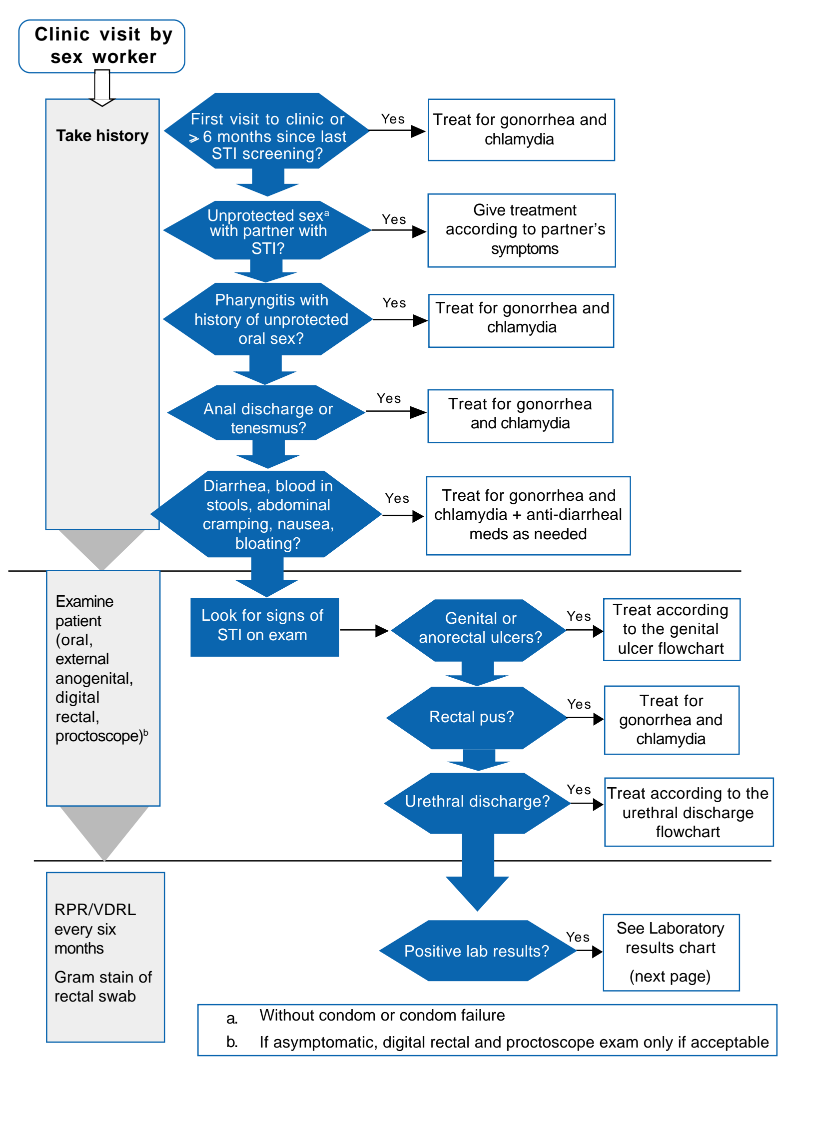
# Annex 3. Flowchart for routine visit of female sex worker in clinics with on-site laboratory services.




a. Without condom or condom failure
b. All currently active sex workers have positive risk assessment and should be treated for gonococcal and chlamydial cervicitis

| Treatment of Positive Laboratory Results | |
|---|---|
| | |
| Gram-negative diplococci or >20 WBC/hpf on cervical Gram stain* | Treat for gonorrhea and chlamydia |
| Motile trichomonads on vaginal wet mount | Treat for *Trichomonas vaginalis* |
| Budding yeast/hyphae on vaginal KOH prep | Treat for *Candida albicans* |
| Nugent score >6 on vaginal Gram stain or positive Amsel test* | Treat for bacterial vaginosis |
| Positive RPR/VDRL | If reactive, quantify RPR titer and confirm with TPHA test if available.<br>Treat for syphilis according to stage (even if TPHA confirmation is not available)<br>Repeat RPR test at 3, 6, 9 and 12 months after initial test to watch for decreasing titers |

# Annex 4. Flowchart for routine visit of male and transgender sex workers in clinics with on-site laboratory services.



| Treatment of Positive Laboratory Results | |
|---|---|
| Gram-negative diplococci or ≥1 WBC/hpf on rectal Gram stain | Treat for gonorrhea and chlamydia |
| Positive RPR/VDRL | If reactive, quantify RPR titre and confirm with TPHA test if available.<br>Treat for syphilis according to stage (even if TPHA confirmation is not available)<br>Repeat RPR test at 3, 6, 9 and 12 months after initial test to watch for decreasing titres |

# ANNEX 5: Syphilis Testing Procedure

Rapid Plasma Reagin (RPR Card test)

## ✦ Principle:

Antibody like substance is present in syphilitic persons and occasionally in serum of persons with an acute or chronic infection. The reagin binds itself to the test antigen, which consists of cardiolipin-lecithin cholesterol coated charcoal particles, causing macroscopic flocculation.

### Reagents, Materials and Equipment:

### RPR Card Test Kit:

- RPR card antigen suspension;
- Dispenstirs and capillaries;
- Needle and antigen dispensing bottles;
- RPR test cards (18 mm); and
- RPR control cards.

### Rotators (100 rotations/min)

- 0.9% NSS
- Adjustable pipettor (20 ul and 200ul) (for quantitative testing)
- Non-reactive serum (used for quantitative dilution)
- Known positive and negative sera for controls (optional)
- Plasma or serum (0.5-1.0ml)

**Sample collection/preparation:**

- Collect the venous blood sample (3-5ml);
- Label tube with patient's ID and write down the patient's information in the laboratory logbook;

- Spin the blood tubes in the centrifuge (minimum 1,500 rpm for 5 minutes);
- Separate serum from red cell within 6 hours after collection; and
- Run test immediately, if not possible, store serum at 4°C for 7 days or freezer (-20 °C or lower) if test cannot be done within 7 days.

## Procedure of Test for Qualitative Reaction

- Fill up sample worksheet;
- Using a dispenstir or pipettor, place 50 ul of serum on one 18 mm circle of the test card. Spread the specimen to the entire circle with the reserve end of the dispenstir. Repeat procedure for number of specimens to be tested;
- Gently re-suspend antigen suspension. Holding dispensing bottle in a vertical position, add exactly one free falling drop (1/ 60ml) of suspension to each area containing serum. Do not stir.
- Rotate for 8 minutes (± 30 sec.) under humidifying chamber on mechanical rotator at 100 ± 2 rpm;
- Read the reactions immediately in the "wet" state under a high intensity light source immediately after removing the card from the rotator;
- To help differentiate non-reactive from reactive minimal to moderate results, a brief rotating and tilting of the card by hand (3 or 4 to-and-fro motions) should be made;
- Report result as follows:
    - Reactive – showing characteristic clumping/ flocculation ranging from slight but definite

(minimum-to-moderate) to marked and intense; and

- Non- reactive – no clumping or flocculation.

**Remember :**

ALL REACTIVE samples should be confirmed using Treponemal test to rule out any biological false positives.

Perform the quantitative test: If the test is reactive (scheduled time or batch testing)

## Procedure for Quantitative Test

It is a test used to monitor treatment status wherein a decrease in titer about four-fold means that the patient has responded to drug.

- For each specimen to be tested, place 50ul of 0.9% normal saline onto circles numbered 2-5. Do not spread saline.
- Using a pipetting device, place 50 ul of serum onto circles numbered 1 and 2.
- Mix saline and sample in circle #2 (1:2), transfer 50 ul to # 3 (1:4), mix, transfer 50 ul to #4 (1:8), mix, transfer 50 ul to #5 (1:16), mix, and discard 50 ul.
- Using a new dispenstir or spreading device start at highest dilution (circle #5), spread sample, filing the entire surface of the circle. Proceed to circles 4, 3, 2, 1 and do similar spreading.
- Gently re-suspend antigen suspension. Holding dispensing bottle in a vertical position, add exactly one free falling drop (1/ 60ml) of suspension to each area containing

serum. Do not stir.

- Rotate for 8 minutes (± 30 sec.) under humidifying chamber on mechanical rotator at 100 ± 2 rpm.
- Read the reactions immediately in the "wet" state under a high intensity light source immediately after removing the card from the rotator.
- To help differentiate non-reactive from reactive minimal to moderate results, a brief rotating and tilting of the card by hand (3 or 4 to-and-fro motions) should be made.
- Report results as follows: Highest dilution giving a reactive including minimal-to moderate reactions.

| (undiluted) 1:1 | 1:2 | 1:4 | 1:8 | 1:16 | Report |
|---|---|---|---|---|---|
| Minimal Reactive | N | N | N | N | Reactive, 1:1 dilution |
| Reactive | R | R | N | N | Reactive, 1:4 dilution |
| Reactive | R | R | R | N | Reactive, 1:8 |

- If the titer is 1:16 proceed as follows:
    - Prepare a 1:50 dilution (1 part non-reactive serum +49 parts 0.9% saline to be used as diluent and in making 1:32 and higher dilutions of specimens to be quantitated).
- Prepare sample, 1:16 dilution (1 part reactive sample + 15 parts 0.9% saline).
- Place 50ul of 1:50 NR dilution in circle # 2-5.
- Place 50ul of 1:16 dilution of test sample in circle # 1 and 2.
- Mix samples in circle # 2 (1:32), transfer 50 ul in circle #3 (1:64), report procedure in circles #4 (1:128), #5

(1:256). Discard 50 ul from circle #5.

- Using a new dispenstir or spreading device start at highest dilution (circle #5), spread sample, filling the entire surface of the circle. Proceed to circle 4, 3, 2, and 1 and do similar spreading.
- Gently re-suspend antigen suspension. Holding dispensing bottle in a vertical position, add exactly one free falling drop (1/ 60 ml) of suspension to each area containing serum. Do not stir.
- Rotate for 8 minutes (± 30 sec.) under humidifying chamber on mechanical rotator at 100 ± 2 rpm.
- Read the reactions immediately in the "wet" state under a high intensity light source immediately after removing the card from the rotator.
- To help differentiate non-reactive from reactive minimal to moderate results, a brief rotating and tilting of the card by hand (3 or 4 to-and –fro motions) should be made.
- Report results as follows: Highest dilution giving a Reactive including minimal-to moderate reaction.

**Procedure of Reporting/Interpretation:** Report in terms of the highest dilution giving *reactive* result including minimal to moderate reaction (e.g. reactive 1:32 dilution)

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