SHORT-TERM STAY SHELTER PROTOCOL

PRESUMPTIVE TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS AND SYNDROMIC MANAGEMENT OF GENITOURINARY INFECTIONS IN TRAFFICKED WOMEN AND GIRLS

Kathleen Morrow, CNM, MA
Doctors of the World-USA
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PRESUMPTIVE TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS AND SYNDROMIC MANAGEMENT OF GENITOURINARY INFECTIONS IN WOMEN AND GIRLS

I. PURPOSE STATEMENT

This protocol is intended for the treatment of trafficked women and girls on arrival to the Center to Protect Victims and Prevent Trafficking of Human Beings shelter in Kosovo. The short-term stay protocol is for treatment of those who will stay in the shelter for two to seven days. Presumptive treatment for chlamydia, gonorrhea, incubating or early syphilis, and trichomoniasis should be offered to trafficked women and girls who report possible exposure resulting from sexual exploitation and rape. In addition, syndromic treatment may be provided for head lice, scabies, phthirus (pediculosis pubis), bacterial vaginosis (BV), candidiasis, and urinary tract infection (UTI). Due to low resources and inadequate laboratory facilities for microbiological testing in Kosovo, the following guidelines are provided for presumptive and syndromic treatment. For the purposes of these guidelines, a minor is an adolescent girl between the age of 12 to 18 years and an adult woman is 19 years and older.

Every individual should be offered presumptive treatment only after she has been informed of the risk of exposure to, and the dangers of, untreated sexually transmitted infections (STIs). In addition, the benefits of treatment and possible side effects of the medications should be explained and informed consent obtained.

The treatment protocols are based on the World Health Organization's *Guidelines for the Management of Sexually Transmitted Infections*, 2003 and the Centers for Disease Control and Prevention's (CDC) *Sexually Transmitted Diseases Treatment Guidelines,* 2002.

II. INFORMED CONSENT

Obtaining informed consent from adults is a recommended step when providing all medical care and services. However, obtaining informed consent from trafficked adolescent girls is problematic. According to the First Annual Report on Victims of Trafficking in South Eastern Europe[1]:

> *There are no specialized procedures and services for internally or foreign trafficked minors in Kosovo… In theory, the Centers for Social Work (CSW) should grant formal permission for each stage of the assistance process for minors, but this does not happen at present. Service providers and Kosovo's CSW must create practical protocols and service agreements regarding assistance for foreign minors [and internal minors], including appropriate allocation of responsibility and availability of respective organizations… These guidelines must address the division of responsibility and practical allocation of service provision for minors, in addition to protocols for appointment of a guardian and mechanism for obtaining consent in cases of medical emergencies.*

Currently, there are no legal procedures for minors to provide informed consent for medical treatment. However, the risk and impact of untreated STIs cannot be overlooked, and should be weighed against the potential benefit of presumptive treatment.

When providing education on STIs and medical treatment for minors, care must be taken to use language and terms they can understand. Once the physician feels that the minor understands the risks and benefits of treatment, the medications may be provided. Therefore, the process of obtaining informed consent from a minor follows the same recommendations as for an adult.

In this setting, informed consent is the process of providing essential information and education in order for the individual to understand the need for presumptive STI treatment. Provide the following information, ideally in the primary spoken language:

- Benefits: description and medical rationale for the presumptive STI treatment and possible complications or consequences of not receiving treatment.
- Risks: the possible side effects of medications.
- Education: providing information on STIs and the impact on reproductive health.
- Documentation: written consent is recommended for treatment and then recorded in the medical chart, including type of treatment to be received, or if treatment is declined and the reason.
- Feedback: giving enough time to answer questions and clarify issues of concern.

III. GENERAL GUIDELINES AND ASSESSMENT

The individual needs to be interviewed and examined in a private room, and should be reassured that all information will be considered confidential. A medical chart will contain the following information:

- Symptoms reported.
- A complete medical history, as well as documentation of known drug allergies.
- A brief psycho-social assessment for emotional status and stability, including:
    - Level of orientation and awareness of person, place, and time
    - General mood and affect
    - Past history of mental illness
    - Recent alcohol/drug use or abuse
    - Any evidence of emotional or psychological trauma
    - Immediate risk of harm to self or others
- The date of the last menstrual period (LMP). A pregnancy test is done if individual is unsure of LMP or late by two weeks or more for her menses.
- A complete physical examination is done for general assessment, including:
    - Confirmation of reported symptoms, such as abdominal tenderness, vaginal discharge, pelvic pain, and pyrexia.
    - Identification of any physical injuries or any other conditions such as: pelvic inflammatory disease (PID), pyelonephritis, appendicits, ectopic pregnancy, or acute abdominal pain.
    - Rule out head lice, scabies and phthirus pubis (pediculosis pubis/crab louse).
- An examination of the external genitalia is carried out to evaluate the vulva for lesions, erythema, swelling, or vaginal discharge (if present, the amount, color, consistency, and/or odor should be noted). Any evidence of genital and perianal trauma or injuries are carefully inspected and documented.
- A general pelvic exam is offered. If the individual accepts, a pelvic examination is carried out to evaluate for possible internal injuries. If laboratory testing is available, obtain specimens for chlamydia, gonorrhea and vaginal discharge.
- If any injuries or acute medical conditions are identified, the individual is referred for immediate medical attention or surgery.
- Individuals with a history or evaluation suggesting emotional or psychological trauma are referred to the shelter psychologist for evaluation and treatment.
- A TB skin test is carried out using 0.3 ml of Tuberculin PPD solution of (2 T.U./0.3ml) intradermally on the left forearm and the results are measured after 48 hours. Record results in the chart. A Chest X-Ray must be obtained if TB test is Positive.

IV. RATIONALE FOR PRESUMPTIVE TREATMENT[2]

Sexually transmitted infections remain a public health problem of major significance in most parts of the world. The incidence of acute STIs is believed to be high in many countries. Failure to diagnose and treat STIs at an early stage may result in serious complications and sequelae, including infertility, pregnancy loss, ectopic pregnancy, anogenital cancer, premature death, as well as neonatal and infant infections.

Effective management of STIs is integral to STI control, as it prevents the development of complications and sequelae, decreases the spread of those infections in the community, and offers a unique opportunity for targeted education about HIV prevention.

Appropriate treatment of STIs at the first contact between patient and health care provider is therefore an important public health measure. Adolescent patients are at a critical stage of development, and there is the potential to influence future sexual behavior and treatment-seeking practices.

Lack of patient compliance with multi-dose antibiotic regimens is a problem that seriously limits their effectiveness. Single-dose or very short course regimens should therefore be given preference. Appropriate counseling and health education have been shown to increase compliance and should be a part of clinical management.

Presumptive treatment or prophylaxis may be provided in low-resource settings where laboratory testing and diagnosis are not feasible prior to treatment. These guidelines are to be used if the individual has no fever or other symptoms of severe infection, such as pyelonephritis or PID, and accepts presumptive treatment.

Many low-resource settings lack the equipment and trained personnel required for etiologic diagnosis of STIs. To overcome this problem, WHO has developed a syndrome-based approach for the management and treatment of STIs. The syndromic approach is based on identification of consistent groups of symptoms and easily recognized signs (syndromes), and the provision of treatment that will deal with the majority of, or the most serious, organisms responsible for producing the syndrome.

This protocol combines presumptive treatment and syndromic management. Presumptive treatment guidelines are based on the potential exposure of women and adolescent girls who have reported sexual exploitation and rape that included unprotected vaginal, anal, or oral penetration. Therefore, presumptive treatment is for chlamydia, gonorrhea, incubating or early syphilis, and trichomoniasis. Syndromic management offers treatment for symptoms of bacterial vaginosis, candidiasis, and uncomplicated urinary tract infection.

The following documents highlight the need for medical treatment for adolescent girls in the shelter:

- According to the Budapest Declaration and Conference in March 2003[7,8]:
  - Trafficked children and adolescents are an especially vulnerable group with special health needs.
  - Minors should be granted special protection and assistance, including the State's responsibility to assume guardianship until the parents can resume their role and an expedited process to guarantee the minor's protection.

- According to WHO's Clinical Management of Survivors of Rape[9]:
  - Adolescent minors may be able to give consent themselves.
  - Find out about specific laws in your setting that determine who can give consent for minors.

- According to the CDC[10]:
  - Chlamydia is concentrated among female adolescents, who are physiologically more susceptible to chlamydial infection than older women.
  - If not diagnosed and treated effectively, chlamydial infections can have serious consequences.
  - Chlamydial infection is a key risk factor in pelvic inflammatory disease (PID).

V. STI TREATMENT GUIDELINES FOR WOMEN 19 YEARS AND OLDER[3,4]

This section covers the management of women 19 years and older. Other severe medical conditions and infections should first be ruled out as outlined in Sections III and IV. A spontaneous complaint of vaginal discharge is most commonly a result of a vaginal infection with *Trichomonas vaginalis,* bacterial vaginosis or *Candida albicans.* Sometimes a vaginal discharge may be the presenting symptom of gonorrhea and chlamydia, or these may be present as co-infections. Without access to laboratory testing, identification of the causative organism is not possible, hence the need to treat presumptively. This is particularly important when the population is at high risk of having an STI.

The presumptive treatment plan is for chlamydia, gonorrhea, incubating or early syphilis, and trichomoniasis. The recommended regimens are for single-dose treatments. Alternative dose regimens for pregnant women and individuals with drug allergies are provided, along with special notations. Treatment for chlamydia and gonorrhea may be given on the same day, one hour before meals or two hours after meals. The following day, give treatment for incubating or early syphilis and trichomoniasis. In the unusual event of an individual staying 48 hours or less, all single-dose treatments may be given within 24 hours.

As with all antibiotics, observe for allergic reactions, such as rash, hives, respiratory difficulty, and anaphylactic shock. Often mild drug intolerances can occur, such as diarrhea, nausea or vomiting, headache or body aches. If vomiting occurs shortly after an oral dose, wait one day and repeat treatment with small amount of food. Antibiotics used for treatment may worsen or trigger symptoms of candidiasis, though this is uncommon with single-dose therapies.

<u>Chlamydia Treatment Non-Pregnant</u>:

Recommended Regimen:

- Azithromycin 1 g orally: in a single dose.

Alternative Regimen:

- Doxycycline 100 mg orally: 2 times a day for 7 days.

OR

- Erythromycin 500 mg orally: 4 times a day for 7 days.

Special Notations:

- ✓ Azithromycin is safe for pregnant women, but caution should be exercised during lactation.

- ✓ Doxycycline and other tetracyclines are contraindicated in pregnancy and lactation.
- ✓ Erythromycin estolate is contraindicated in pregnancy because of drug related hepato-toxicity. Hence, only erythromycin ethylsuccinate should be used.
- ✓ Erythromycin should not be taken on an empty stomach.

Chlamydia Treatment During Pregnancy:

Recommended Regimen:

- Erythromycin 500 mg orally: 4 times daily for 7 days.

OR

- Amoxycillin 500 mg orally: 3 times daily for 7 days.

Special Notations:

- ✓ Amoxycillin is contraindicated in individuals with known drug allergy to penicillin.
- ✓ Treatment for chlamydia is very important in pregnancy. If not treated the infection may cause complications such as: pre-term labor, pre-mature rupture of the membranes, low birth weight, and neonatal infections.
- ✓ Erythromycin estolate is contraindicated in pregnancy because of drug related hepato-toxicity. Hence, only erythromycin ethylsuccinate should be used.
- ✓ Doxycycline and other tetracyclines are contraindicated in pregnancy and lactation.
- ✓ Azithromycin is safe for pregnant women, but caution should be exercised during lactation.
- ✓ Erythromycin should not be taken on an empty stomach.

Gonorrhea Treatment Non-Pregnant:

Recommended Regimen:

- Ciprofloxacin 500 mg orally: in a single dose.

Alternative Regimen:

- Cefixime 400 mg orally: in a single dose.

OR

- Ceftriaxone 125 mg intramuscularly (IM): in a single dose.

Special Notations:

- ✓ Ciprofloxacin is contraindicated in pregnancy and lactation.

- ✓ A large proportion of gonococcal isolates worldwide are now resistant to penicillins, tetracyclines and other antimicrobial agents. It is important to assess periodically all treatment regimens for gonococcal infections.

Gonorrhea Treatment During Pregnancy:

Recommended Regimen:

- Cefixime 400 mg orally: in a single dose.

Alternative Regimen:

- Ceftriaxone 125 mg intramuscularly (IM): in a single dose.

Special Notations:

- ✓ Treatment for gonorrhea is very important in pregnancy. If not treated, the infection may cause complications such as: pre-term labor, pre-mature rupture of the membranes, low birth weight, and neonatal infections.
- ✓ Ciprofloxacin is contraindicated in pregnancy and lactation.
- ✓ A large proportion of gonococcal isolates worldwide are now resistant to penicillins, tetracyclines and other older antimicrobial agents. It is important to assess periodically all treatment regimens for gonococcal infections.

Early Syphilis

Early syphilis is defined as primary, secondary, and early latent syphilis of not more that two years duration. Primary syphilis is characterized by an ulcer or chancre at the site of infection or inoculation. Clinical manifestations of secondary syphilis include a skin rash, condylomata lata, mucocutaneous lesions, and generalized lymphadenopathy. Latent syphilis has no clinical manifestations. An infection of more than two years and without clinical evidence of treponemal infection is referred to as late latent syphilis. Late syphilis refers to late latent syphilis, gummatous, neurological and cardiovascular syphilis. The following treatment regimens are not adequate for the treatment of late latent syphilis, gummatous, neurological, or cardiovascular syphilis but only for early stages of infection. Refer to other guidelines for further details.

Early Syphilis Treatment Non-Pregnant:

Recommended Regimen:

- Benzathine Penicillin G 2.4 million units intramuscularly (IM), at a single session. Because of volume involved, divide single dose in half and give as two separate injections at separate sites.

Alternative Regimen:

- Doxycycline 100 mg orally: 2 times daily for 14 days.

OR

- Tetracycline 500 mg orally: 4 times daily for 14 days.

OR

- Erythromycin 500 mg orally: 4 times daily for 14 days.

Special Notations:

- ✓ Penicillin is contraindicated in individuals with known drug allergy to penicillin.
- ✓ The alternative regimens are less effective than the recommended regimen and should be utilized only when the individual is allergic to penicillin or penicillin is unavailable.
- ✓ Doxycycline and other tetracyclines are contraindicated in pregnancy and lactation.
- ✓ Erythromycin should not be taken on an empty stomach.
- ✓ If either doxycycline or erythromycin is used, no additional treatment for chlamydia is required.

Early Syphilis Treatment During Pregnancy:

Recommended Regimen:

- Benzathine Penicillin G 2.4 million units intramuscularly (IM), at a single session. Because of volume involved, divide single dose in half and give as two separate injections at separate sites.

Alternative Regimen:

- Erythromycin 500 mg orally: 1 tablet 4 times daily for 14 days.

Special Notations:

- ✓ Congenital syphilis may occur if the expectant mother has syphilis, but the risk is minimal if she has been given penicillin early in pregnancy.

- ✓ Erythromycin estolate is contraindicated in pregnancy because of drug related hepato-toxicity. Hence, only erythromycin ethylsuccinate should be used.
- ✓ Doxycycline and other tetracyclines are contraindicated in pregnancy and lactation.
- ✓ Erythromycin should not be taken on an empty stomach.
- ✓ If either doxycycline or erythromycin is used, no additional treatment for chlamydia is required.

Trichomoniasis Treatment Non-Pregnant:

Recommended Regimen:

- Metronidazole 2 g orally: in a single dose.

Alternative Regimen:

- Metronidazole 400 mg or 500 mg orally: twice daily for 7 days.

Special Notations:

- ✓ Use only after 12 weeks of pregnancy.
- ✓ Metronidazole should be taken with food to prevent nausea and vomiting.
- ✓ No alcohol for 24 hours before, during treatment, or for 24 hours after the last dosage.

Trichomoniasis Treatment During Pregnancy:

Recommended Regimen:

- Metronidazole 2 g orally: in a single dose (avoid during first 12 weeks of pregnancy).

Alternative Regimen:

- Metronidazole 200 mg or 250 mg orally: three times daily for 7 days.

Special Notations:

- ✓ Use only after 12 weeks of pregnancy.
- ✓ Treatment for trichomoniasis is very important in pregnancy. If not treated the infection may cause complications such as: pre-term labor, pre-mature rupture of the membranes, low birth weight, and neonatal infections.

- ✓ Although metronidazole is not recommended for use in the first trimester of pregnancy, treatment may be given where early treatment has the best chance of preventing adverse pregnancy outcomes. In this instance a lower dose should be used (2 g single oral dose rather than a long course).
- ✓ Metronidazole should be taken with food to prevent nausea and vomiting.
- ✓ No alcohol for 24 hours before, during treatment, or for 24 hours after the last dosage.

VI. STI TREATMENT GUIDELINES FOR ADOLESCENT GIRLS AGE 12 to 18 YEARS[5,6]

This section covers the management of adolescent girls 12 to 18 years of age. In the unusual case of a girl being less than 12 years of age, consult with a pediatrician before treatment. Other severe medical conditions and infections should first be ruled out as outlined in Sections II, III, and IV. A spontaneous complaint of vaginal discharge is most commonly a result of a vaginal infection with *Trichomonas vaginalis,* bacterial vaginosis, or *Candida albicans.* Sometimes a vaginal discharge may be the presenting symptom of gonorrhea and chlamydia, or these may be present as co-infections. Without access to laboratory testing, identification of the causative organism is not possible, hence the need to treat presumptively. This is particularly important when the population is at high risk of having an STI.

The presumptive treatment plan is for chlamydia, gonorrhea, incubating or early syphilis, and trichomoniasis. The recommended regimens are for single-dose treatments. Alternative dose regimens for pregnant adolescent girls and individuals with drug allergies are provided, along with special notations. Treatment for chlamydia and gonorrhea may be given on the same day, one hour before meals or two hours after meals. The following day, give treatment for early syphilis and trichomoniasis. In the unusual event of an individual staying for less than 48 hours, administer all single-dose treatments within a 24-hour period of time.

As with all antibiotics, observe for allergic reactions, such as rash, hives, respiratory difficulty, and anaphylactic shock. Often mild drug intolerances can occur, such as diarrhea, nausea or vomiting, headache, or body aches. If vomiting occurs shortly after an oral dose, wait one day and repeat treatment after a small amount of food. Antibiotics used for treatment may worsen or trigger symptoms of candidiasis, though this is uncommon with single-dose therapies.

<u>Chlamydia Treatment Non-Pregnant</u>:

Recommended Regimen:

- Azithromycin 1 g orally: in a single dose.

Alternative Regimen:

- Doxycycline 100 mg orally: 2 times a day for 7 days.

OR

- Erythromycin 500 mg orally: 4 times daily for 7 days.

Special Notations:

- ✓ Azithromycin is safe for pregnant women, but caution should be exercised during lactation.
- ✓ Doxycycline and other tetracyclines are contraindicated in pregnancy and lactation.
- ✓ Erythromycin estolate is contraindicated in pregnancy because of drug related hepato-toxicity. Hence, only erythromycin ethylsuccinate should be used.
- ✓ Dosage for azithromycin, doxycycline, and erythromycin is the same for adolescent girls as for adults.
- ✓ Erythromycin should not be taken on an empty stomach.

Chlamydia Treatment During Pregnancy:

Recommended Regimens:

- Erythromycin 500 mg orally: 4 times daily for 7 days.

OR

- Amoxycillin 500 mg orally: 3 times daily for 7 days.

Special Notations:

- ✓ Amoxycillin is contraindicated in individuals with known drug allergy to penicillin.
- ✓ Treatment for chlamydia is very important in pregnancy. Untreated infection may cause complications such as: pre-term labor, pre-mature rupture of the membranes, low birth weight, and neonatal infections.
- ✓ Erythromycin estolate is contraindicated in pregnancy because of drug related hepato-toxicity. Hence, only erythromycin ethylsuccinate should be used.
- ✓ Doxycycline and other tetracyclines are contraindicated in pregnancy and lactation.
- ✓ Azithromycin is safe for pregnant women, but caution should be exercised during lactation.
- ✓ Dosage for erythromycin is the same for adolescent girls as for adults.
- ✓ Erythromycin should not be taken on an empty stomach.

Gonorrhea Treatment Non-Pregnant:

Recommended Regimen:

- Cefixime 8 mg/kg of body weight up to 400 mg maximum orally: in a single dose.

Alternative Regimen:

- Ceftriaxone 125 mg intramuscularly (IM): in a single dose.

Special Notations:

- ✓ Dosage for ceftriaxone is the same in adolescent girls as for adults.
- ✓ A large proportion of gonococcal isolates worldwide are now resistant to penicillins, tetracyclines and other older antimicrobial agents. It is important to assess periodically all treatment regimens for gonococcal infections.

Gonorrhea Treatment During Pregnancy:

Recommended Regimen:

- Cefixime 8 mg/kg of body weight up to 400 mg maximum orally: in a single dose.

Alternative Regimen:

- Ceftriaxone 125 mg intramuscularly (IM): in a single dose.

Special Notations:

- ✓ Treatment for gonorrhea is very important in pregnancy. Untreated infection may cause complications such as: pre-term labor, pre-mature rupture of the membranes, low birth weight, and neonatal infections.
- ✓ Ciprofloxacin is generally not recommended in adolescents below the age of 16 years and in pregnancy.
- ✓ Dosage for ceftriaxone is the same in adolescent girls as for adults.
- ✓ A large proportion of gonococcal isolates worldwide are now resistant to penicillins, tetracyclines and other older anti-microbial agents. It is important to assess periodically all treatment regimens for gonococcal infections.

Early Syphilis

Early syphilis is defined as primary, secondary, and early latent syphilis of not more that two years duration. Primary syphilis is characterized by an ulcer or chancre at the site of infection or inoculation. Clinical manifestations of secondary syphilis include a skin rash, condylomata lata, mucocutaneous lesions, and generalized lymphadenopathy. Latent syphilis has no clinical manifestations. An infection of more than two years duration and without clinical evidence of treponemal infection is referred to as late latent syphilis. Late syphilis refers to late latent syphilis, gummatous, neurological and cardiovascular syphilis. The following treatment regimens are not adequate for the treatment of late latent syphilis, gummatous, neurological, or cardiovascular syphilis, but only for early stages of infection. Refer to other guidelines for further details.

Early Syphilis Treatment Non-Pregnant:

Recommended Regimen:

- Benzathine Penicillin G: 50,000 IU/kg (up to a maximum 2.4 million units), intramuscularly (IM): at a single session. Because of volume involved, divide single dose in half and give as two separate injections at separate sites.

Alternative Regimen:

- Doxycycline 100 mg orally: 2 times daily for 14 days.

OR

- Tetracycline 500 mg orally: 4 times daily for 14 days.

OR

- Erythromycin 500 mg orally: 4 times daily for 14 days.

Special Notations:

- ✓ Penicillin is contraindicated in individuals with known drug allergy to penicillin.
- ✓ The alternative regimens are less effective than the recommended regimen and should be utilized only when the individual is allergic to penicillin or penicillin is unavailable.
- ✓ Doxycycline and other tetracyclines are contraindicated in pregnancy and lactation.
- ✓ Erythromycin estolate is contraindicated in pregnancy because of drug related hepato-toxicity. Hence, only erythromycin ethylsuccinate should be used.
- ✓ Dosage for erythromycin and doxycycline is the same for adolescent girls as for adults.
- ✓ Erythromycin should not be taken on an empty stomach.
- ✓ If either doxycycline or erythromycin is used, no additional treatment for chlamydia is required.

Early Syphilis Treatment During Pregnancy:

Recommended Regimen:

- Benzathine Penicillin G: 50,000 IU/kg (up to a maximum 2.4 million units), intramuscularly (IM): at a single session. Because of volume involved, divide single does in half and give as two separate injections at separate sites.

Alternative Regimen:

- Erythromycin 500 mg orally: 4 times daily for 14 days.

Special Notations:

- ✓ Penicillin is contraindicated in individuals with known drug allergy to penicillin.
- ✓ Congenital syphilis may occur if the expectant mother has syphilis, but the risk is minimal if she has been given penicillin during early pregnancy.
- ✓ The alternative regimens are less effective than the recommended regimen and should be utilized only when the individual is allergic to penicillin or penicillin is unavailable.
- ✓ Erythromycin estolate is contraindicated in pregnancy because of drug related hepato-toxicity. Hence, only erythromycin ethylsuccinate should be used.
- ✓ Doxycycline and other tetracyclines are contraindicated in pregnancy and lactation.
- ✓ Dosage for erythromycin and doxycycline is the same for adolescent girls as for adults.
- ✓ Erythromycin should not be taken on an empty stomach.
- ✓ If either doxycycline or erythromycin is used, no additional treatment for chlamydia is required.

Trichomoniasis Treatment Non-Pregnant:

Recommended Regimen:

- Metronidazole 2 g orally: in a single dose.

Alternative Regimen:

- Metronidazole 400 mg or 500 mg orally: twice daily for 7 days.

Special Notations:

- ✓ Dosage for metronidazole is the same for adolescent girls as for adults.
- ✓ Metronidazole should be taken with food to prevent nausea and vomiting.
- ✓ No alcohol for 24 hours before, during treatment, or for 24 hours after the last dosage.

Trichomoniasis Treatment During Pregnancy:

Recommended Regimen:

- Metronidazole 2 g orally: in a single dose (avoid during first 12 weeks of pregnancy).

Alternative Regimen:

- Metronidazole 200 mg or 250 mg orally: three times daily for 7 days.

Special Notations:

- ✓ Use only after 12 weeks of pregnancy.
- ✓ Treatment for trichomoniasis is very important in pregnancy. If not treated the infection may cause complications such as: pre-term labor, pre-mature rupture of the membranes, low birth weight, and neonatal infections.
- ✓ Although metronidazole is not recommended for use in the first trimester of pregnancy, treatment may be given where early treatment has the best chance of preventing adverse pregnancy outcomes. In this instance a lower dose should be used (2 g single oral dose rather than a long course).
- ✓ Dosage for metronidazole is the same for adolescent girls as for adults.
- ✓ Metronidazole should be taken with food to prevent nausea and vomiting.
- ✓ No alcohol for 24 hours before, during treatment, or for 24 hours after the last dosage.

VII. BACTERIAL VAGINOSIS[11]

<u>Bacterial Vaginosis</u> (BV):

An individual with symptoms such as: vaginal discharge with prominent "fishy" odor, and/or vulvar irritation, but usually without redness or swelling, may be treated with:

Recommended Regimen:

- Metronidazole 400 mg or 500 mg orally: 2 times daily for 7 days.

Alternative Regimen:

- Metronidazole 200 mg or 250 mg orally: 3 times daily for 7 days.

OR

- Metronidazole 2 g orally: in a single dose.

OR

- Clindamycin 2% vaginal cream, 5 g intravaginally: at bedtime for 5 nights.

Special Notations:

- ✓ Clindamycin vaginal cream is contraindicated in pregnancy and for adolescent minors 12 to 16 years old.
- ✓ Clindamycin vaginal cream is used only if unable to tolerate metronidazole, as it is the treatment of choice.
- ✓ Metronidazole 400 mg or 500 mg is contraindicated in pregnancy.
- ✓ Metronidazole 200 mg or 250 mg is used in pregnancy after 12 weeks gestational age.
- ✓ Metronidazole 2 g is used in pregnancy less than 12 weeks gestational age and treatment is imperative.
- ✓ BV should be treated with metronidazole if reproductive tract surgery or therapeutic abortion is required.
- ✓ Untreated BV may lead to adverse pregnancy outcomes such as: pre-term rupture of membranes, pre-term delivery, and low birth weight.
- ✓ Dosage for metronidazole is the same for adolescent girls as for adults.
- ✓ Metronidazole should be taken with food to prevent nausea and vomiting.
- ✓ No alcohol for 24 hours before, during treatment, or for 24 hours after the last dosage.

VIII. CANDIDIASIS

Candidiasis:

An individual with symptoms of vulvar itching and a curd-like vaginal discharge or noted signs of genital redness, excoriation, and/or swelling, may be presumptively treated as follows. All of these regimens may be used in pregnancy and for adolescent girls.

Recommended Regimen:

- Miconazole 200 mg vaginal cream, 1 applicator intravaginally: at bedtime for 7 nights. Cream may also be applied to vulva 2 times a day for 7 days.

OR

- Clotrimazole 200 mg or 500 mg vaginal cream, 1 applicator intravaginally: at bedtime for 7 nights. Cream may also be applied to vulva 2 times a day for 7 days.

Alternative Regimen:

- Nystatin 10,000 IU vaginal tablets/suppositories, 1 tablet/suppository intravaginally: at bedtime for 14 nights. This can be used, but is a less effective treatment.

IX. URINARY TRACT INFECTION

Urinary Tract Infection (UTI):

Acute cystitis is the most common clinical manifestation of uncomplicated urinary tract infection, especially in young women. Signs of an acute infection of the lower urinary tract include dysuria, urgency, frequency, and hematuria. Dysuria may be easily confused with secondary symptoms due to superficial vulvar burning on urination that could be caused by herpes simplex ulcers, trauma of the vulva, or vaginal infections. An examination of the external genitalia will assist in developing a differential diagnosis. The dysuria resulting from chlamydia or gonorrhea may be indistinguishable from the symptoms of cystitis. Therefore, consideration should be given to presumptively treating an individual presenting with dysuria for STIs as well. Individuals with dysuria, frequency and hesitation, with or without hematuria, may be presumptively treated as follows.

Recommended Regimen:

- Trimethoprim 80 mg/Sulfamethoxazole 400 mg orally: 12 hours apart for a single-day dose. If symptoms persist, continue dosage for 3 to 7 days.

Alternate Regimen:

- Amoxycillin 500 mg orally: 3 times a day for a single day dose. If symptoms persist, continue dosage for 7 days.

OR

- Nitrofurantoin 100 mg orally: 2 times a day for 7 days.

Special Notations:

- ✓ Trimethoprim/Sulfamethoxazole is contraindicated in pregnancy.
- ✓ Adult dosage is used for trimethoprim/sulfamethoxazole in adolescent girls over 40 kg based on the following dosage: 8 mg/kg trimethoprim/40 mg/kg sulfamethoxazole (maximum adult dosage of 320 mg trimethoprim/1600 mg sulfamethoxazole in 24 hours).
- ✓ Amoxycillin is contraindicated in individuals with known drug allergy to penicillin.
- ✓ Amoxycillin may be used in pregnancy to full term and may be used for adolescent girls.
- ✓ Dosage for amoxycillin is the same for adolescent minors as for adults.
- ✓ Nitrofurantoin is contraindicated in pregnancy after 35 weeks gestational age.
- ✓ Nitrofurantoin is contraindicated in adolescent.
- ✓ Untreated UTIs increase risk of pyelonephritis and pre-term labor in pregnancy. If pregnant, try to obtain a urinalysis with culture and

sensitivity before treatment. If unable to confirm infection by laboratory results, then treat as per alternative regimen above.

- ✓ Provide referral for individuals with temperature 38° C or greater, abdominal pain, or flank pain for evaluation of pyelonephritis, kidney stones or injury from trauma.
- ✓ Increase oral fluids to at least two liters a day.

X. TREATMENT FOR HEAD LICE, SCABIES AND PHTHIRUS (PEDICULOSIS PUBIS)[12,13]

Careful inspection of the scalp, skin, pubic region and adjacent hairy areas is necessary for identification and diagnosis of ectoparasitic infestations. Treat according to the following guidelines.

Head Lice:

Recommended Regimen:

- Permethrin 1% lotion is applied to the wet hair and left on for 10 minutes. The hair is then rinsed, dried, and nits (eggs) are combed from the hair shafts. Treatment may be repeated after one week if necessary.

OR

- Lindane 1% shampoo is worked into the hair and left on for 4 minutes. The hair is then rinsed, dried, and nits (eggs) are combed from the hair shafts. Re-treatment is rarely needed.

Special Notations:

- ✓ Lindane 1% lotion/cream is contraindicated in pregnancy.
- ✓ Permethrin 1% lotion may be used in pregnancy.
- ✓ Lindane will occasionally cause eczematous skin rashes and has the potential for central nervous system toxicity, but occurrence of convulsions is rare.
- ✓ All clothing, towels and bed linen should be washed in hot water to prevent re-infection.

Scabies:

Recommended Regimen:

- Benzyl benzoate 25% lotion/cream applied to the entire body from the neck down to and including feet, nightly for 2 nights; patients may bathe before reapplying the drug, and then should not bathe until 24 hours after the second application.

OR

- Crotamiton 10% lotion applied to the to all areas of the body from the neck down to and including the feet, nightly for 2 nights and washed off thoroughly 24 hours after the second application. Crotamiton has the advantage of an antipruritic action.

OR

- Lindane 1% lotion/cream applied sparingly to all areas of the body from the neck down to and including feet, and washed off thoroughly after 8 hours. Usually only one application is needed.

Special Notations:

- ✓ Lindane 1% lotion/cream is contraindicated in pregnancy.
- ✓ Benzyl benzoate 25% lotion/cream may be used in pregnancy.
- ✓ Crotamiton 10% lotion may be used in pregnancy.
- ✓ Benzyl benzoate may cause irritant dermatitis.
- ✓ Lindane will occasionally cause eczematous skin rashes and has the potential for central nervous system toxicity, but occurrence of convulsions is rare.
- ✓ Itching may persist for several weeks following successful treatment of scabies and does not suggest the need for repeat treatment unless re-infection is suspected.
- ✓ If skin is wet at time of application of Lindane 1% lotion/cream, toxicity may occur from increased absorption.
- ✓ If crusted lesions are present, provide a warm bath and allow skin to dry thoroughly by waiting 1 hour before applying the lotion/cream.
- ✓ Special attention for applying lotion/cream under the finger nails. If self-applied, do not wash hands after application.
- ✓ If lotion/cream applied by an assistant, protective gloves must be worn.
- ✓ All clothing, towels and bed linens should be washed in hot water to prevent re-infection.

Phthirus (Pediculosis Pubis/Crab Louse):

Recommended Regimen:

- Permethrin 1% lotion is applied to the infested area and adjacent hairy areas and washed off after 10 minutes; re-treatment is indicated after 7 days if lice are found or eggs are observed at the hair-skin junction.

OR

- Crotamiton 10% lotion is rubbed gently but thoroughly into the infested area and adjacent hairy areas and washed off after 8 hours.

OR

- Lindane 1% lotion/cream is rubbed gently but thoroughly into the infested area and adjacent hairy areas and washed off after 8 hours; as an alternative Lindane 1% shampoo, applied and thoroughly washed off after 4 minutes.

Special Notations:

- ✓ Lindane 1% lotion/cream is contraindicated in pregnancy.
- ✓ Permethrin 1% lotion may be used in pregnancy.
- ✓ Crotamiton 10% lotion may be used in pregnancy.
- ✓ If skin is wet at time of application of Lindane 1% lotion/cream, toxicity may occur from increased absorption.

- ✓ Lindane will occasionally cause eczematous skin rashes and has the potential for central nervous system toxicity, but occurrence of convulsions is rare.
- ✓ All clothing, towels and bed linens should be washed in hot water to prevent re-infection.

XI. ADDITIONAL HEALTH CONSIDERATIONS

- Individuals are to be informed and advised to undergo screening for the following sexually transmitted infections and health screening after returning to their home country:
  - HIV
  - Hepatitis B and C
  - Evaluation and treatment for genital warts
  - Syphilis serologic testing
  - Pap smear
- Individuals may also be referred for the following services as appropriate:
  - Counseling for family planning needs
  - Follow-up of gynecological problems that could not be treated in the shelter
  - Follow-up of any primary health care problems and dental problems
  - Follow-up of any emotional and/or psychological problems warranting continuing counseling and treatment

XII. ENDNOTES

[1] *First Annual Report on Victims of Trafficking in South Eastern Europe,* pgs. 135, 151 and 154. Counter-Trafficking Regional Clearing Point: ICMC, Stability Pact and IOM. www.icmc.net/files/rcp100301.en.pdf.

[2] *Guidelines for the Management of Sexually Transmitted Infections,* pgs. 1-3, 65 and 83. WHO 2003.

[7] *Budapest Declaration On Public Health & Trafficking In Human Beings*, pg. 2. March 2003.

[8] *Summary & Report of the Regional Conference On Public Health &Trafficking in Human Beings in Central, Eastern & Southeast Europe*, pg. 7. Budapest, Hungary, March 19-21, 2003.

[9] *Clinical Management of Survivors of Rape,* pg. 25. WHO/RHR/02.08.

[10] Fact Sheet, *New CDC Treatment Guidelines Critical to Preventing Health Consequences of Sexually Transmitted Diseases*: "Re-screening for Chlamydia Helps Protect Young Women from Infertility." www.cdc.gov/od/oc/media/pressrel/fs020509.htm.

[3] *Guidelines for the Management of Sexually Transmitted Infections,* pgs. 21-55. WHO 2003.

[4] *Clinical Management of Survivors of Rape*, pg. 39. WHO/RHR/02.08.

[5] *Clinical Management of Survivors of Rape*, pgs. 17, 20, 27 and 40. WHO/RHR/02.08.

[6] *Guidelines for the Management of Sexually Transmitted Infections,* pgs. 21-55. WHO 2003.

[11] *Guidelines for the Management of Sexually Transmitted Infections,* pgs. 56-58. WHO 2003.

[12] *European STI Guidelines*, International Journal of STI & AIDS, Vol. 12, Supplement 3, pgs. 58-62. WHO, October, 2001.

[13] *Guidelines for the Management of Sexually Transmitted Infections,* pgs. 60-62. WHO 2003.