

# 9

CHAPTER NINE

## Sexually Transmitted Infections

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### 1 Introduction

#### Box 33: Terminology: STI versus RTI

Not all sexually transmitted infections (STIs) are reproductive tract infections (RTIs); and not all reproductive tract infections are sexually transmitted:

- **STI refers to the way of transmission**

whereas

- **RTI refers to the site where the infections develop**

Reproductive tract infection is a broad term that includes sexually transmitted infections as well as other infections of the reproductive tract that are not transmitted through sexual intercourse. Because STIs in most cases have much more severe health consequences than other RTIs, the term STI/RTI is used in this manual to highlight the importance of STIs within RTIs. When information provided in the document is relevant to sexually transmitted infections only, the term STI is used alone.

# Sexually Transmitted Infections

Sexually transmitted infections (STIs) cause a large proportion of the global burden of ill-health. WHO estimates that more than 340 million new cases of four curable STIs (gonorrhoea, chlamydia, syphilis and trichomoniasis) occurred in 1999. If viral (noncurable) STIs, such as human papillomavirus (HPV), herpes simplex virus (HSV), hepatitis B and HIV infections are included, the number of new cases may be three times higher. Among women, non-sexually transmitted reproductive tract infections (RTIs), such as yeast infection or bacterial vaginosis, are even more common.

STIs/RTIs are found worldwide, but transmission and prevalence (how common they are) are influenced by social and economic factors as well as by biology and behaviour. Therefore, the burden of STIs/RTIs varies greatly from region to region and from community to community. For example:

- STIs such as syphilis, gonorrhoea and chancroid may spread more rapidly in places where communities are disrupted, migrant labour is common and commercial sex networks are active.
- Iatrogenic infections (caused by medical procedures or examination) are more common where there are many STIs and where service providers do not have the training or supplies to perform procedures safely. Postpartum and postabortion infections are more common where safe services and follow-up care are not available.
- Endogenous infections, such as yeast infection and bacterial vaginosis, are

common worldwide and are influenced by environmental, hygienic, hormonal and other factors.

The emergence of HIV has focused greater attention on the control of STIs. There is a strong correlation between STIs and HIV transmission. The presence of other STIs has been found to increase the risk of sexual transmission of HIV.

In humanitarian settings, the risk of STI (including HIV) transmission may be high due to increased sexual violence, the presence of workers in high mobility jobs (truck drivers, peace keepers), transactional sex, alcohol and drug use, lack of information and access to condoms and high population density in camps.

## 2 Objective

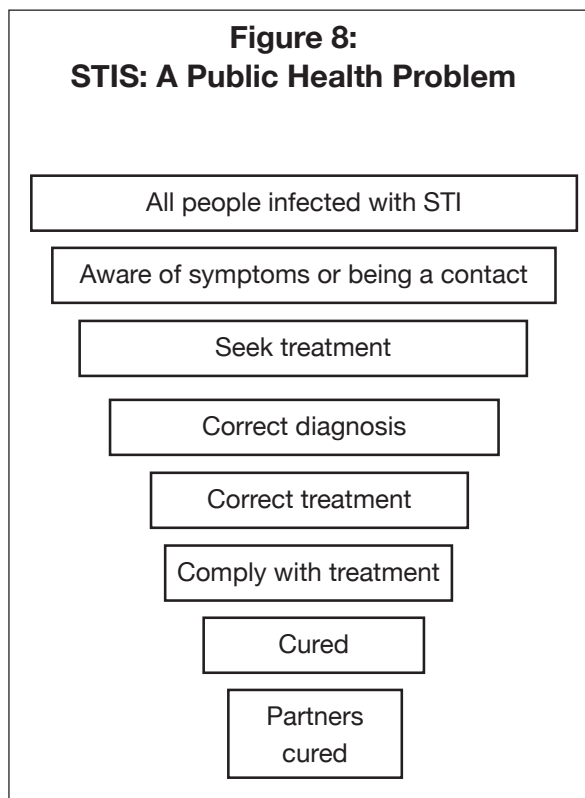
The objective of this chapter is to assist reproductive health (RH) officers, programme staff and service providers in humanitarian settings to:

- meet the needs of individuals infected by RTIs/STIs or who may be at risk of RTIs/STIs;
- support the implementation of effective public health approaches to reduce the transmission of STIs.

### 3 Programming

#### 3.1 STI public health package

Sexually transmitted infections are a public health problem of major significance in most parts of the world. Failure to diagnose and treat STIs at an early stage may result in severe and life-threatening consequences, including infertility, miscarriage, preterm delivery, stillbirth, ectopic pregnancy, ano-genital cancer and premature death, as well as neonatal and infant infections. There are a number of challenges to providing effective STI/RTI services to the people who need them. Figure 8 shows these challenges: many people are asymptomatic or not aware that they have an STI (e.g. STIs are more often asymptomatic in women) and therefore do not seek care. Others who have symptoms choose to treat themselves or seek treatment at pharmacies or from traditional healers. Those who come to the clinic may not get the appropriate diagnosis and treatment. In the end, only a small proportion of people with an STI are cured and avoid reinfection.



The objective of STI programming is to reduce the prevalence of STIs by interrupting their transmission, reducing the duration of infection and preventing the development of complications in those infected.

Controlling the spread of STIs is challenging. Public health programmes must not only ensure accessible, good-quality health services that provide comprehensive STI case management, but also address biological, behavioural and social factors that influence the spread of STIs.

The complete public health package includes:

##### At community level

- Safer-sex promotion campaigns (see 3.3.1)
- Condom programming (see 3.3.2)
- Public awareness of STIs and promotion of early use of clinic services (see 3.3.3)

##### At health service level

- Comprehensive STI case management at first contact (see 3.4)
- Specific services for populations at risk, including sex workers, adolescents, military and prisoners (see 3.4.6)

##### Integration of STI management

- Integrate STI prevention, screening and care into other services (see 3.5)

#### 3.2 Needs assessment

Although STI programming is not part of the Minimum Initial Service Package (MISP), it is important to make treatment available for patients presenting with STI/RTI symptoms as part of routine clinical services at the onset of the humanitarian response.

After the MISP is in place, integrate STI considerations into needs assessments for comprehensive RH service planning in order to design appropriate and comprehensive STI prevention, treatment and control programmes. RH officers

need to collect the following information, in coordination with other health sector/cluster actors:

- Prevalence and types of STIs in the host and home country, region or area. This information may be available from the national STI programmes and WHO.
- The presence of at-risk groups and the location within the affected community where interventions should be targeted as a priority (e.g. where sex work take place, bars). This information can be obtained through interviews with key informants from the community.
- Cultural and religious beliefs, attitudes and practices concerning sexuality, reproductive health and RTIs/STIs. This information can be obtained through qualitative research using focus groups, interviews and, if possible, KAP surveys (knowledge, attitudes and practices).
- Existence of a reliable and sustainable medical commodity supply chain that can support the implementation of STI/RTI services.

RH officers must be familiar with national legislation and policies related to STIs:

- Are there national guidelines or protocols on the management of STIs? If yes, are there discrepancies between national policies and WHO guidelines?
- Are all appropriate STI treatment drugs included in national drug treatment guidelines? Do national guidelines include drugs that are no longer effective against certain infections?
- Are there any restrictive policies limiting STI service provision?
- Are there laws or national policies regarding partner notification?
- Are there national policies relating to STI control programmes?

It is also necessary to:

- liaise with national health authorities to

identify or develop a syndromic management protocol for STIs;

- identify a reliable medical commodity supply chain to ensure sustainable supply of effective STI drugs;
- identify people in the affected community who have been trained in STI prevention and control and staff training needs;
- identify appropriate sites to set up STI management services as well as other RH services that should integrate it.

### 3.3 Community interventions

The community-level approach to prevention and control of STI/RTI includes:

- safer sex promotion campaigns — including consistent condom use, fewer partners and delaying onset of sexual activity;
- condom programming;
- public awareness of STIs and promotion of early use of clinic services.

#### 3.3.1 Safer sex promotion

The best approach to prevent STIs is to avoid exposure which can be achieved by:

- using condoms correctly and consistently;
- decreasing the number of sex partners;
- giving support to young people for decisions to delay sexual activity.

**Condoms** are the most reliable method available for people to protect themselves or their partner from any risk of STI. When used correctly and consistently during every act of intercourse, condoms can greatly reduce the risks of pregnancy and STIs (including HIV infection). STIs can still occur despite condom use. Genital ulcers or warts can be transmitted through contact with parts of the body not covered by the condom. People commonly get an STI because they misuse condoms or use them inconsistently. When handled or stored incorrectly, for example in wallets or in a hot place, or if used with oil-based lubricants, male condoms may fail. Condom

breakage is usually due to incorrect use, not to defects in the device.

**Male condoms** are mostly made of latex and are widely available, inexpensive and highly effective. Because they are easy to carry, protection can be available at any time.

**Female condoms** are made of polyurethane or nitrile plastic which is sturdier than latex, and are becoming more widely available at lower cost than when first introduced. They have the advantage of giving the woman control over their use.

**Limiting the number of sex partners** can help reduce exposure to STI. People in mutually monogamous relationships (where both partners have no other sex partners) have no risk of STIs if both are free of infection. Sexual abstinence is another way to avoid risk of STIs (although other RTIs are still possible).

Many people need prevention strategies other than monogamy or abstinence. Monogamous relationships do not provide protection from STIs when they follow one another in rapid succession (serial monogamy). Couples who are separated from each other for periods of time may also require other strategies. Men and women whose jobs involve travel (e.g. migrant workers, vendors, truck drivers, soldiers) are more likely to have multiple partners and to return home with an STI. Whatever the circumstances, both women and men with multiple partners (or whose partners have multiple partners) need reliable protection from STI.

**Delaying sexual activity.** Young people, in particular adolescents, can avoid STIs and pregnancy at a time when they are particularly vulnerable by delaying sexual activity until they are older. Young people should know that they can get support and confidential information on methods, including condom use, for preventing pregnancy and STIs when they decide to become sexually active.

Support for delaying sex is most important for

young girls as they may face severe social and health consequences if they become pregnant or develop an STI. Adolescent girls are particularly vulnerable to cervical infections that can lead to pelvic inflammatory disease (PID), infertility, ectopic pregnancy and, in the long term, cervical cancer.

### 3.3.2 Condom programming

Good-quality condoms are essential for the protection of the consumer and the credibility of the RH programme. There are many brands of condom on the market. Several agencies can facilitate the purchase of bulk quantities of good-quality condoms at low cost.

To ensure access to condoms, a system of procurement and distribution must be in place. Condoms and instructions for their use must be available on request in health facilities, distribution centres (such as food and non-food item distribution areas), community centres, shops, bars, youth and women's groups, etc. Discuss with authorities and partners whether or not to continue making condoms available free of charge after the initial humanitarian response (see Chapter 2: MISP). The introduction of some form of partial cost-recovery (social marketing) may be considered in situations where this is feasible and appropriate. Social marketing strategies may be explored with appropriate partners (such as Population Services International - PSI).

Community health workers and peer educators need to be trained in the promotion, distribution and use of condoms. Promotional campaigns can be launched at public events such as football matches, mass rallies, dance parties, theatres and group discussions. Liaise with groups involved in HIV prevention and family-planning activities in the area.

### 3.3.3 Public awareness of STIs

Community education and outreach are needed to promote early use of health-care services to cure STIs/RTIs and prevent complications.

Develop messages to teach people how to recognize symptoms and when and where to seek care. Disseminate the messages through public advertisements, radio, papers, teaching sessions at clinics, etc.

### 3.4 STI/RTI case management

Effective and prompt management of STIs is one of the cornerstones of STI control, as it prevents the development of complications for the individual, decreases the spread of STIs in the community and offers a unique opportunity for targeted education about STI prevention. The sooner an STI is cured, the less chance it will be transmitted to other people. Appropriate treatment of STIs at the first contact between patients and health-care providers is therefore an important public health measure. In the case of young people (see Chapter 4: Adolescent Reproductive Health), there is a potential to influence future sexual behaviour and treatment-seeking practices.

STI management involves more than diagnosis and treatment. Even when STIs are correctly treated, treatment failure or reinfection may occur. Some patients stop taking their medicines as soon as they start to feel better or they fail to arrange for their sex partners to be treated or they do not use condoms or abstain from sex during treatment. Drug resistance may also be a reason for treatment failure. Therefore comprehensive case management must take place at first contact and include:

- diagnosis
- prompt and effective treatment according to protocols
- education and counselling of the patient, including condom provision
- partner notification and treatment
- follow-up as appropriate
- quality of care.

#### 3.4.1 Diagnosis

Diagnosing STIs is challenging, as there is no

simple tool that provides the correct diagnosis within a short time and without using expensive laboratory tests. Diagnosing STIs can be done in three ways:

#### Clinical diagnosis

The service provider determines the underlying cause of the infection based on clinical examination and personal experience. This approach is not reliable, as even the most experienced providers cannot make specific diagnosis based on clinical assessment alone. Furthermore, mixed infections cannot be detected.

#### Laboratory diagnosis

This approach uses laboratory tests to determine the cause of the STI/RTI. However, this approach is problematic in many settings, because inexpensive, simple, reliable tests do not exist. Most available tests do not give immediate results, which will lead to delays in treatment or in no treatment if patients do not return for care. In addition, the sensitivity and specificity of commercially available tests vary and false negatives are common. Where laboratory facilities are available, they must be staffed by suitably qualified personnel. This puts a constraint on the time and resources of the health services, increases costs and reduces access to treatment.

Exceptions to this are laboratory tests for HIV (see Chapter 10: HIV) and syphilis (Rapid Plasma Reagin (RPR) test or the Rapid Diagnostic Test (RDT)). These tests can be conducted by health-care staff with minimal training and give results in a short time. They can be used for screening (see 3.5, integration of services).

#### Syndromic approach

Many STIs/RTIs can be identified and treated on the basis of characteristic signs and symptoms that can be grouped together into syndromes (see Table 22: STI Syndromes).

It is often difficult to know exactly what organism is causing the syndrome and treatment

**Table 22: STI Syndromes**

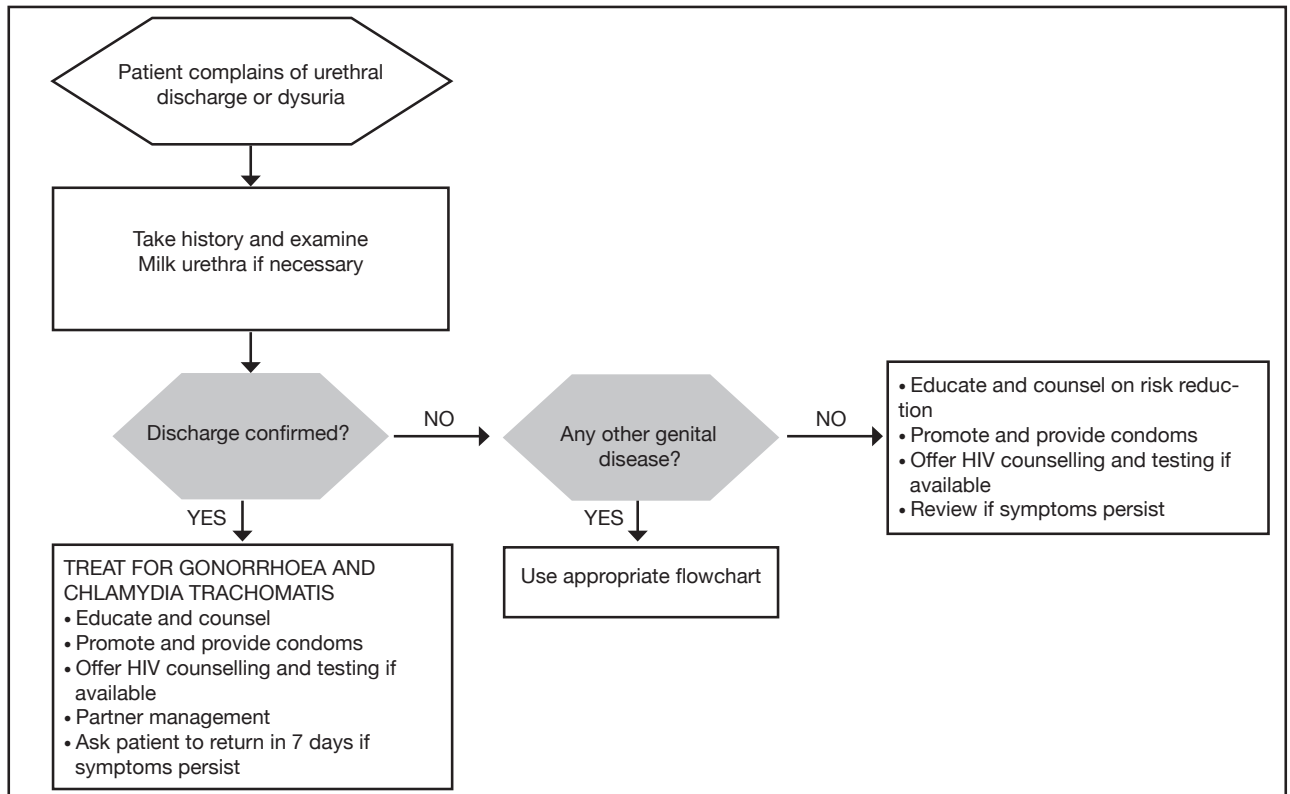
Syndrome	STI/RTI
Genital ulcer (for both men and women)	<ul style="list-style-type: none"> <li>• Syphilis</li> <li>• Herpes</li> <li>• Chancroid</li> <li>• Granuloma inguinale</li> <li>• Lymphogranuloma venereum</li> </ul>
Urethral discharge (in men)	<ul style="list-style-type: none"> <li>• Gonorrhoea</li> <li>• Chlamydia</li> </ul>
Vaginal discharge	<ul style="list-style-type: none"> <li>• Bacterial vaginosis</li> <li>• Yeast infection</li> <li>• Trichomoniasis</li> <li>• Gonorrhoea</li> <li>• Chlamydia</li> </ul>
Lower abdominal pain (in women)	<ul style="list-style-type: none"> <li>• Gonorrhoea</li> <li>• Chlamydia</li> <li>• Anaerobic infections</li> </ul>
Inguinal bubo (in men and women)	<ul style="list-style-type: none"> <li>• Chancroid</li> <li>• Lymphogranuloma venereum</li> <li>• (Granuloma inguinale or Donovanosis where prevalent)</li> </ul>
<p>Other common STIs/RTIs include <b>ano-genital warts</b> and <b>infestations</b>, such as pubic lice and scabies. <b>Scrotal swelling</b> in men under 35 is commonly a complication of STIs and can be treated in the same way as urethral discharge. However, scrotal swelling can be due to other causes and can be an emergency. If the patient reports a recent history of trauma, if the testicle appears elevated or rotated, or whenever you are suspicious of testicular torsion, refer immediately for surgical evaluation.</p>	

needs to cover several possible causative infectious agents. Therefore, the syndromic approach is based on:

- the identification of consistent groups of symptoms and easily recognized signs;
- the provision of treatment that will deal with the majority of or the most serious organisms responsible for producing a particular syndrome.

ers in the implementation of syndromic management of STIs (see Figure 9 for an example).

A simplified tool (flow chart) guides health work-

**Figure 9: Flowchart for Urethral Discharge in Men**

The advantages of the syndromic approach:

- Patients are treated at the first contact with the health-care system, which leads to a decrease in complications for the individual and eventually a reduction in transmission of STIs in the population.
- The approach is cost saving (no expensive lab tests).
- Prompt treatment improves client satisfaction.
- It is easier to monitor a service that uses the syndromic approach, because of the standardization of staff training, diagnosis, treatment and supplies management.

The disadvantages of the syndromic approach:

- Over-diagnosis and over-treatment increase treatment cost (but this is outweighed by the overall cost-effectiveness of the syndromic approach).
- Giving multiple antimicrobials possibly

increases the risk of side-effects.

- The syndromic approach cannot be used for screening because asymptomatic infections cannot be detected.
- If the patient is not counselled properly, there may be an increased risk of domestic violence (see Box 35: RTIs/STIs and Stigma).



### Box 34: The Case of Vaginal Discharge

Syndromic approach works well for urethral discharge and ulcerative STIs, but is not as effective for vaginal discharge. Most vaginal discharge is the result of an RTI, such as yeast infection and bacterial vaginosis. These organisms cause vaginal infections and are not sexually transmitted. Much less often, vaginal discharge may be the result of an inflammation of the cervix (cervicitis) caused by gonorrhoea or chlamydia. These organisms are sexually transmitted. Vaginal discharge algorithms are not designed to detect the more serious and often asymptomatic cervical infections. At present, accurate detection of gonococcal and chlamydial cervicitis requires expensive laboratory tests (polymerase chain reaction – PCR), which are not available in most settings. Other screening tools include speculum examination (which may detect many, but not all, cervical infections) and culture for gonorrhoea (which is accurate and not expensive or technically difficult, but needs to be set up in established laboratories).

In humanitarian settings, service providers must take a no-missed-opportunities approach. This means that they look for risk factors in a patient's history (e.g. Does the partner have symptoms? Is the client a sex worker?) and for signs on examination (Is there mucopurulent discharge? Does the cervix bleed easily when touched?). Screening may be done during pregnancy or any time a speculum examination is performed for other reasons. Service providers must offer regular screening to people with frequent exposure to STIs, such as sex workers (see Table 23).

**Table 23: Some Examples of STI/RTI Detection and Treatment Strategies**

Method	Example – no missed opportunities
History-taking	Ask about STI/RTI symptoms or concerns at each RH visit
Clinical screening	Speculum and bimanual examination to look for signs of STI/RTI not noticed by the patient
Laboratory screening	Serological screening for syphilis Pap smear for early detection of cervical cancer Voluntary counselling and testing for HIV
Presumptive treatment on basis of risk criteria	Treatment of partners of STI patients, sex workers who have had unprotected exposure, etc. Survivors of sexual violence Treatment of women having a transcervical procedure
Combination strategies	Presumptive treatment of sex workers at first visit followed by regular visits for speculum/bimanual examination and Gram stain of cervical smear

### 3.4.2 Treatment

STI/RTI symptoms and signs are treated based on the organisms most commonly responsible for each syndrome. Antibiotic resistance to several sexually transmitted pathogens is increasing, which may render some widely available and low-cost antibiotic regimens ineffective. Therefore treatment algorithms need to be adapted based on:

- local epidemiology (the prevalence of STIs/RTIs and the pathogen underlying the syndromes in the population);
- antimicrobial sensitivity patterns (e.g. which antibiotics are effective against *Neisseria gonorrhoeae* and *Haemophilus ducreyi*);
- cultural and behavioural practices.

In the early days of the humanitarian response, it may be necessary to use the WHO standard treatment guidelines with antimicrobials that are known to be effective globally (see 6: Further Reading). Some recommended antimicrobials from these guidelines are included in the Inter-agency RH Kit 5 (see Chapter 2: MISP). In many countries the Ministry of Health (MoH) has developed standard national STI protocols. It is important to encourage the use of the appropriate protocol in the setting you work in as soon as possible. Such standardized treatment guidelines will facilitate staff training and procurement of supplies for STI programmes and this will help ensure that all patients receive adequate treatment.

Therefore, RH officers must implement national STI protocols where these exist. Where they do not exist, encourage discussions between the MoH and WHO to develop an adapted national or regional protocol.

### 3.4.3 Patient education and counselling

Patient education and compassionate and confidential counselling are essential components of

STI/RTI management and include:

- explaining of the nature of the infection, possible complications (such as infertility), the medication to be taken and the importance of compliance with the treatment;
- promoting safer sexual behaviour. People may adopt safer sexual behaviours following treatment of an STI. Therefore, each clinic visit is an opportunity to promote future prevention;
- promoting, demonstrating and providing condoms, as well as negotiating condom use with partners;
- discussing the risk of HIV infection and offering voluntary HIV testing;
- informing and communicating with sexual partner(s), options for partner tracing and the risk of violence or stigma (see Box 35).

#### Box 35: STI/RTI and Stigma

Note that not all RTIs are sexually transmitted. Therefore, service providers must be careful not to mislabel or stigmatize someone as having an STI when the diagnosis is an RTI or is not clear. For instance, vaginal discharge is usually associated with an endogenous vaginal infection and not with an STI. Attempting to notify and treat sexual partners in this situation would be unnecessary as partners do not need treatment, and notifying them may be damaging to their relationship. Violence, distrust and divorce are possible consequences of partner notification if not managed correctly.

### 3.4.4 Partner management

#### Principles

When managing sexual partners, service providers must be sensitive and respectful, ensure confidentiality and offer a voluntary and non-coercive approach. A patient who is successfully

treated for an STI will experience relief of symptoms, but may return later with a reinfection if sexual partners are not also treated. The sexual partner may or may not have symptoms and, if left untreated, could spread infection to others in the community as well. It is essential for STI control to help patients notify their sexual partners and arrange for treatment. Note that partners include not only current partner(s) but all partners within the last two to three months. Partner management includes notification, referral and treatment.

### Figure 10: Example of Partner Referral Slip

Kindly present yourself to:  
Townville Clinic, New Town

Tel: 456 834

Opening hours

Monday 9:00 am – 3:00 pm

Tuesday 9:00 am – 3:00 pm

Wednesday 9:00 am – 3:00 pm

Friday 9:00 am – 1:30 pm

Date: dd/mm/yyyy

Code: ABCD

#### Notification and referral

Many sexual partners are reluctant to wait or pay for services, particularly when they are asymptomatic and feel healthy. Organize services so that sexual partners have easy access to treatment (avoid long waiting times, waive normal clinic fees, etc.).

Partner notification can be offered in several ways:

**1) Patient referral:** Patients are encouraged to contact their sexual partners themselves. They can be given referral slips for their partners. These referral slips explain how to arrange a clinic visit and must include a code to indicate the syndrome that was diagnosed in the index patient (the original patient who had symptoms). If confidentiality can be guaranteed, it is useful to include the record number of the index patient on the referral slip to help monitor partner referral rates (see Figure 10).

**2) Provider referral.** Service providers with training in contact-tracing techniques notify partners and arrange for necessary treatment.

**3) A combination of 1) and 2)** can be used where patients are first asked to contact partners

themselves (patient referral). If unsuccessful after one to two weeks, trained service providers attempt to trace the contact for treatment (provider referral).

Because of the expense of provider referral and the perceived threat to patient confidentiality, the more practical and workable option is patient referral (Option 1).

#### Treatment of sexual partners

The primary objective is for the partners to be seen by a service provider for screening, treatment and education. However, this may not be possible in humanitarian settings, and three possible strategies to ensure the treatment of partners can be applied:

1. Immediate treatment when partner presents to the service provider (based on the diagnosis in the index patient, whether or not partners have symptoms or signs of infection)
2. Immediate treatment and taking specimens for laboratory testing

WHO recommends immediate treatment with the same antibiotic regimen as for the index patient.

### 3.4.5 Treatment follow-up

In humanitarian settings, routine follow-up visits can be inconvenient for patients and burdensome for clinic staff. Syndromic management usually provides effective treatment for the most common STIs/RTIs and most patients will get better quickly. It is good practice to advise patients to come back if symptoms get worse or no improvement is seen after a week of treatment (two to three days for pelvic inflammatory disease). Patients with genital ulcers have to return after seven days if not getting better. Treatment should be prolonged beyond seven days if a new layer of skin has not formed over the ulcer.

When patients do not get better, the following questions will help service providers determine whether this is due to treatment failure or reinfection:

**Treatment failure:** Did the patient take all the medicines as directed? Did the patient stop taking medicines after feeling some improvements? Was the treatment based on national treatment guidelines? (Consider the possibility of drug resistance if this was not the case.)

**Reinfection:** Did the partner(s) receive treatment? Did the patient use condoms or abstain from sex after starting treatment?

**Recurrence** is also common with endogenous vaginal infections, especially when underlying reasons are not addressed in patient education (e.g. vaginal douching or drying agents). Refer patients to a higher level when the complexity of their case exceeds the capacity of your health centre.

### 3.4.6 Quality of care

In order to ensure the quality of STI programmes, services must be available, accessible, affordable and appropriate. RH officers and programme managers can achieve this by reducing barriers to services (e.g. appropriate opening times; private, confidential, respectful and

technically good-quality care, etc.) and reaching out to people who may not typically use STI services: sex workers and their clients, military, prisoners and adolescents who are at higher risk of STIs. Encourage men to participate in STI/RTI prevention.

Quality of services and staff technical skills and motivation will improve if RH officers and programme managers:

- post standard national STI management protocols in examination rooms;
- put in place a confidential and voluntary partner tracing system;
- arrange for training of service providers to become proficient in both technical and counselling skills;
- collaborate with health coordinators to integrate a sustainable supply of effective STI drugs into the medical commodity supply line
- conduct regular supervisory visits and in-service training.

### 3.5 Integration of services

RH officers need to aim for the integration of STI/RTI services into primary health care and other RH programmes, including:

- STI assessment in family planning services, by ensuring that service providers:
  - ▶ discuss STI/RTI with all clients at each visit (including inquiring about symptoms in partners);
  - ▶ screen for STIs if necessary;
  - ▶ encourage dual protection (against pregnancy and STIs).
- STI presumptive treatment/treatment in post-rape care services (see Chapter 2: MISPP)
- STI/RTI programming in adolescent health-care services
- STI/RTI assessment and management in the antenatal, delivery and postpartum period (see Chapter 6: Maternal and Newborn

Health). For example:

- ▶ STI/RTI risk assessment for all clients in antenatal care, including syphilis screening and HIV voluntary counselling and testing (see Box 36: Rapid Diagnostic Tests for Syphilis Screening).
- ▶ Vesicles or ulcers suggestive of genital herpes and occurring near delivery may be an indication for referral for caesarean section, since vaginal delivery carries a risk of disseminated herpes in the newborn and a high risk of newborn death;
- ▶ Prophylaxis for ophthalmia neonatorum is given routinely to all newborns.
- prevention of cervical cancer activities in comprehensive RH services (see Box 37).

### **Box 36: Rapid Diagnostic Tests for Syphilis Screening**

In most countries, the rapid plasma reagin (RPR) test is used to screen for syphilis. RPR is a non-treponemal antibody test, which means that a positive result is suggestive of active infection. The test will become negative when the disease has been treated early and is cured. RPR is difficult to use in many humanitarian settings because it requires refrigeration and skilled laboratory staff.

Many rapid diagnostic tests (RDT) for syphilis have become commercially available in the last few years. RDTs provide accurate, qualitative detection of antibodies to *Treponema pallidum* and an infection can readily be detected very soon after exposure, as well as in its later stages.

The advantages of RDTs are that they do not require refrigeration and have long shelf lives, making them a good option for humanitarian settings. It takes 10 to 30 minutes for the result and there is no need for a laboratory or other instrumentation. Service providers can easily interpret the results visually. The small blood volume needed allows for a finger-stick sample in place of a venous blood draw.

In view of the importance of early treatment in the prevention of neonatal syphilis, RDTs present an excellent opportunity for the implementation of routine screening for syphilis in antenatal care services in humanitarian settings, where the RPR test is not available or cannot be done. The disadvantage of RDTs is that, because they are treponemal antibody tests, they cannot distinguish between active and cured disease. However, in antenatal care, all patients who have a positive RDT, even if they had a positive test in a previous pregnancy, should be treated (again). Even if they were treated in a previous pregnancy, there is the possibility of reinfection with severe consequences for mother and baby if left untreated. The benefits of such presumptive treatment outweigh the risks associated with not getting treated (see Chapter 6: Maternal and Newborn Health).

RDTs are not recommended for screening of blood for transfusion, as they would lead to too many false positives. Rapid non-treponemal antibody (RPR-like) tests for syphilis will become available in the near future. Please look for updates on [www.iawg.net](http://www.iawg.net).

### Box 37: HPV and Cervical Cancer

Human papillomavirus (HPV) is a very common infection and more than three-quarters of sexually active women are estimated to be infected at least once in their lifetimes. The risk of acquiring HPV infection is highest soon after sexual activity begins. Most of these infections are self-limiting and harmless, but persistent infection can cause cervical cancer in women. HPV also causes other ano-genital cancers (e.g. of the vagina, vulva and penis), head and neck cancers and genital warts in both men and women.

#### Cervical cancer screening

Screening and treatment of early stages of cervical cancer (cervical dysplasia or precancer) is effective in reducing morbidity and mortality from cervical cancer. Indications for screening depend on local resources. Where cytology is available and well established, all women over 35 years old should be screened every five to ten years. Where cytology services are limited, such as in humanitarian settings, service providers must ensure that all women are screened once around the age of 40. Cytology by Papanicolaou (Pap) smear is currently recommended. However, it is resource intensive, as it requires staff who can perform a speculum examination and who are trained in smear collection techniques, as well as the availability of cytology services for reading smears. Newer techniques such as Visual Inspection using Acetic Acid (vinegar) (VIA) or Visual Inspection using Lugol's Iodine (VILI) have recently proven to be cost effective in resource-constrained settings. When followed by cryotherapy for treatment of dysplasia, either through referral or immediate treatment ("single visit approach"), visual inspection is shown to be safe, acceptable, feasible and effective in reducing cervical cancer incidence and mortality.

#### HPV vaccination

The greatest impact of current HPV vaccines will be on girls who are immunized before they are exposed to HPV, that is, before they are sexually active. The full vaccination consists of three doses and produces a very high immune response that lasts for at least five years. The overall impact of the HPV vaccines will depend upon their delivery to those populations most in need of them. It is in resource-limited countries, where cervical cancer screening programmes are poor or absent and cervical cancer incidence and mortality highest, that women are in greatest need of primary prevention through HPV vaccines. Yet the high cost of HPV vaccines is an important barrier to widespread access and the expected costs and benefits need to be considered in the overall health budget.

## 4 Human rights and legal issues

The right to safe, confidential and appropriate prevention, care and treatment of STIs is protected as a human right under "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." This *right* includes the *right to prevention, treatment and control of diseases*.

Respect for human rights must inform all as-

pects of planning for STI programming during a humanitarian response, where sexual violence, disruption in sexual norms and practices and access to treatment and medication exacerbate existing barriers.

The right to STI-related services is inherent to many human rights:

- Access to STI diagnosis, treatment and care is a component of respecting a person's

*right to health and right to life.*

- ▶ The right to health includes the prevention, treatment and control of epidemic, endemic, occupational and other diseases and “requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases”.
- ▶ STI management in antenatal care is essential in protecting both the rights of the mother and the rights of the child.
- These rights equally apply to children and adolescents. Service providers who deny access to STI services based on age, marital status or parental or guardian consent without considering the developmental stage of the child may not be respecting that child’s human rights.
- The right to privacy requires that health workers act in such a way to make patients feel safe and protected when receiving diagnosis, treatment or counselling for STIs.
- Providing access to STI services for the entire population, including adolescents, sex workers and men who have sex with men, regardless of the legal status of prostitution and homosexuality in a country, protects the *right to equality and nondiscrimination*.
- Everyone has a *right to impart and receive information* on STIs. This right also pertains to the inclusion of adolescents in all STI education, awareness-building and outreach activities.
- The *right to enjoy the benefits of scientific progress and its applications* can be limited when clients are denied access to new STI prevention and treatment technologies (such as VIA, cryotherapy and HPV vaccine).

#### 4.1 Challenges and opportunities

At times, providing appropriate access to care and treatment for STIs can place a service provider in an uncomfortable situation. Stigma, restrictive national policies and social and cultural norms may interfere with service delivery and

patients’ right to access care. For example,

- Health centres that do not offer services to sex workers in countries with laws against prostitution or discriminatory practices against people engaged in sex work.
- Service providers not willing to assess adolescent clients due to beliefs that unmarried individuals should not engage in sex.
- Clients reluctant to seek services due to policies on mandatory reporting of certain STIs and nonconfidential partner tracing.

It is important to remember that many barriers to STI care and treatment access are against internationally accepted human rights principles. Be aware of your agency’s position on these issues and include it as part of your analysis of the situation and possible next steps.

Reproductive health programme managers or service providers facing a similar dilemma must give priority to their client’s safety and health, and their own and colleagues’ safety. Then, they may:

- talk to their supervisor;
- discuss options with the client;
- discuss programming options and strategies within their organization or clinic structure:
  - ▶ For example, if clients become nervous and uncomfortable when approached about STIs or refuse to talk about the issue, evaluate the amount of privacy available in your clinic and suggest physical changes that would make patients feel protected and encourage discussion.
- explore linkages with and referrals to local organizations that might be able to help the client;
- find out whether their agency is engaged in advocacy on the issue and how to contribute;
- while respecting the confidentiality of the client, identify with colleagues how to avoid or handle situations them in the future;
- raise these concerns in health coordination meetings.

## 5 Monitoring

Indicators to monitor STI programmes include

- The proportion of service providers who received training in ST/RTI case management according to current protocol.
- The proportion of STI/RTI clients who were assessed, treated and counseled according to protocol (disaggregated by age and sex).

For more information on monitoring and evaluation see Chapter 3.



## 6 Further reading

### Essential reading

*Integrating STI/RTI Care for Reproductive Health. Sexually Transmitted and Other Reproductive Tract Infections, a guide to essential practice.* World Health Organization (WHO), 2005. [whqlibdoc.who.int/publications/2005/9241592656.pdf](http://whqlibdoc.who.int/publications/2005/9241592656.pdf)

*Guidelines for the management of sexually transmitted infections.* WHO, 2003. [http://www.who.int/reproductive-health/publications/mngt\\_stis/index.html](http://www.who.int/reproductive-health/publications/mngt_stis/index.html)

*Training modules for the syndromic management of sexually transmitted infections (2nd edition).* WHO, 2007. <http://www.who.int/reproductive-health/publications/rtis/9789241593407/en/index.html>

### Additional reading

*Comprehensive cervical cancer control, A guide to essential practice.* WHO, 2006 [http://www.who.int/reproductive-health/publications/cervical\\_cancer\\_gcp/index.htm](http://www.who.int/reproductive-health/publications/cervical_cancer_gcp/index.htm)

For more information on prevention of congenital syphilis: [www.who.int/reproductivehealth/topics/rtis/syphilis/en/](http://www.who.int/reproductivehealth/topics/rtis/syphilis/en/)