

# **FIRST LINE COMPREHENSIVE MANAGEMENT AND CONTROL OF SEXUALLY TRANSMITTED INFECTIONS (STIs)**

*Protocol for the management of a person with a  
Sexually Transmitted Infection*

*According to the Essential Drug List  
“Edited” MARCH 2008*



**health**

Department:  
Health  
REPUBLIC OF SOUTH AFRICA

***Choose a healthy lifestyle***



## IMPROVE THE QUALITY OF STI SERVICES

### Make services accessible and user friendly

- All PHC facilities should offer STI services during normal working times of the facility.
- Address the problem of long waiting times.
- Utilize waiting time for creative health promotion techniques.
- Consider extended hour if needed for your community so that patients can come after work or weekends
- Promote integrated and comprehensive “one stop” services.
- Avoid stigmatizing patients with STIs: Avoid having services in a particular room or only on specific days or certain times.
- Ensure confidentiality at the point of registration. There is no need for disclosure at registration.
- Ensure positive and friendly attitude of all staff towards all patients/clients coming to your facility.
- Aim for adolescent friendly services where adolescents also receive education and counseling on life skills.
- Address barriers to attending your facility related to sex, race or age group.
- Public services at PHC level are free of charge.

### Ensure regular supply of drugs and consumables, availability of equipment and improved infrastructure

- Avoid stock outs of essential drugs at any time: Cefixime, Ciprofloxacin, Doxycycline, Metronidazole, Benzathine-penicillin, erythromycin, Ceftriaxone, Clotrimazole, and Amoxicillin.
- Avoid stock out of condoms at any time.
- Avoid stock out of partner notification slips (English and Local language) at any time.
- Ensure availability couch and couch covers (paper roll), examination light, examination torch, clinical thermometer, wash basing with running water and soap, specula sizes “small”, “medium”, “large”, gloves, condom box with condom, dildo (if female condom site: condom demonstrator and pamphlets, EDL PHC book, National Guidelines for First Line Comprehensive Management and Control of STIs, client education material (English and local language) and STI wall charts with treatment flow charts in each consultation room.
- Ensure privacy, consultation room to have doors and sufficient ventilation.
- Have access to equipment to sterilize speculae.

### Ensure access to and availability of laboratory services and access control

- Avoid stocks out of on site or rapid test kit in use at your facility: for example HIV test, RPR test, new Treponema palladium specific rapid test (if approved).
- Have standard operation manual available to all staff for each test kit available at your facility.
- Keep a record in a laboratory book of each test conducted at including result, unique laboratory number, date and name of person who has conducted the test.
- Agree and implement with the NHLS a regular scheme for external quality control of laboratory tests conducted at your facility.
- Routinely document and archive results of each round of external quality control, implement and document measures of improvement if recommended.
- Ensure regular transport to external laboratories and prompt communication to receive results
- Develop and make accessible to all staff standard operation manual for procedures to take specimen, to store them (if necessary), to send them out to external laboratories, to receive results, to follow up patients and to document.
- Document routinely turn-around time of laboratory results, agree with NHLS and local laboratories on turn-around targets for each test conducted externally and monitor the implementation of the targets.

## **Ensure well-functioning patient referral systems**

- Strengthen your contact with the consulting doctor at you facility or at the next referral facility
- Establish and strengthen teamwork with the referral to (from) lay counselors, community health worker and other external service provider from the public and private sector
- Make referral criteria and procedure available to staff and ensure implementation
- Strengthen the routine of “in house” documentation of referrals and professional referral letters.
- Have national guidelines in place and develop “in-house” procedures for the management and referral of sexual violence, rape and child abuse
- Insist on report-back from all referral sites, follow u if necessary.
- Conduct team meetings with consulting doctors and all referral sites at regular intervals and ensure implementation of recommendation for improvement.
- care and advocate for your patient and insist on good quality from all referral sites.

## **Develop communication skills and gain the trust of your patient**

- Realise that the patient has come up with a problem which is of a very sensitive nature
- Welcome your patient, greet and offer him/her a seat
- Ensure privacy: make sure that the door is closed and that nobody enters during consultation. Sit at an appropriate distance to enable comfortable and private communication.
- Assure the patient that all information will be kept confidential
- Make eye contact, listen to and look at your patient as he/she speaks
- Manage patient in a caring, non-judgmental way
- Ask questions to understand the specific problems of the individual patient
- Be patient and remember that patients with an STI are often anxious and afraid due to the way in which STIs are acquired, because of the problems it might raise within his/her relationship and because of the risk of HIV infection
- Realise that for most patients it was not an easy decision to come by to you for help. Your attitude will determine to a great extent whether his/her visit was helpful

## **Monitor and evaluate your work**

- Ensure proper record keeping (patient records, daily and month health statistics, store and drug management).
- Ensure timely submission (latest 7th day of following month) of monthly PHC form for the District Health Information System (DHIS).
- Display graphs of key performance indicators (incidence of STI treated new episode partner notification rate, STI partner tracing rate, condom distribution rate) at your facility.
- Discuss and agree on target for these indicators with all staff at your facility and withy your district/sub-dsitric coordinators. Monitor those targets on your graph with a target line
- Conduct quality assessment at your facility at regular intervals using the DISCA+ tool.
- Ensure that you receive performance summaries from all other facilities of your sub-district at regular intervals and discuss them amongst your staff.
- Listen to and address comments of patients and community members on their perception of the of your services.
- Conduct patient satisfaction surveys using standardized questionnaires at regular intervals and discuss results with community members and clinical staff
- Develop and agree with all staff an action plan based on you statistics and assessment in order to improve performance on a continuous basis and to achieve target

## IDENTIFICATION & COMPREHENSIVE MANAGEMENT OF A PATIENT WITH A SYMPTOMATIC STI

### Identification of a patient with an STI

- Patients with an STI are not always aware of their infection even when there are symptoms and/or signs
- Others might be aware, but are not concerned and would not visit a health facility specifically for this reason.

Given the high prevalence of STIs in the community and even more amongst the clients attending your facility, it is important for the control and appropriate management of STIs that symptoms and signs are actively identified amongst all clients in the sexually active age groups attending your facility.

History taking and examination of all clients in the sexually active age group attending your facility should therefore include checking symptoms and signs of STI, irrespective of whether they come for antenatal care, family planning, VCT or other services!

### Steps involved in the comprehensive management of a patient with an STI

Comprehensive Management of a patient with a symptomatic STI (overview)

- History taking
- Physical examination
- Screening of cervical cancer according to protocol
- Correct diagnosis
- Treatment using the syndromic approach or referral if indicated
- Health education
- Counseling
- VCT
- Partner notification and treatment
- Condom promotion, demonstration and provision
- Referral to other services as indicated (family planning, antenatal care, PMTCT, TB, HIV treatment and care etc.)
- Documentation (patient record, daily statistics)

### Take a good history from your patient

- Good history is your guide for health education and counseling
- Add your communications skills
- Good history taking lest the patient talk, but without losing focus
- Your structured approach and guiding questions will help you to achieve success with the 3 goals of history taking
  - \* To gain the patient's trust
  - \* To develop an initial understanding about the person and his or her problems
  - \* To gain specific information relevant for the diagnosis, therapy, assessment of potential complications and assessment of risk factors including risk behaviour.

Remember that the patient coming to your clinic may not spontaneously report STI symptoms. Also remember that a patient can have more than one STI at the same time.

- Include an assessment of the risk of exposure to an STI. There may be some other cause of the symptoms and signs
- It is important to find about:
  - \* The presenting complaint
  - \* Past STIs and if there has been any treatment recently
  - \* Other illness and drug allergies
  - \* Contraception, menstruation and symptoms of pregnancy
  - \* Risk factors

## **Physical examination: gently and with respect**

### **Always examine your patient**

- Conduct a bimanual examination in women to exclude cervical motion tenderness. Whenever possible do a speculum examination. Feel and view the cervix. If an abnormality is suspected, refer
- Identify one or more of the syndromes based on symptoms and signs and treat patients according to the appropriate protocol(s)
- Encourage the patient to return if the STI does not get better. If the full course has not been completed or if the re-infection is possible, treat once again before referring the patients
- Use this opportunity for the further prevention and control of the STIs

### **Laboratory examinations**

All pregnant women are screened for syphilis during their first antenatal visit. The test most widely used in the RPR test. HIV testing should be promoted among all patients at your facility. Patients with a symptomatic STI who have a negative HIV result should have the test repeated after 3 months.

For all laboratory tests performed at your facility, a quality assurance schemes should be in place in collaboration with the NHLS. For CD4 count testing, consult the national VCT And HIV treatment guidelines  
In case of symptoms and/or signs of any disease other than STI's consult the appropriate guidelines.

Since the treatment of STIs is based on the syndromic approach, there is no need for any further routine laboratory tests for STIs as part of the first line management.

### **Diagnosis – The time for your decision**

Good history taking is one half and good physical examination the other half of deciding the right diagnosis, it is now time for your decision. In the vast majority of clinical situation this decision will be straight forward.

### **Syndromic management of symptomatic STIs**

The following (see next pages) national flow charts for the syndromic management of symptomatic STIs are based on the clinical, microbiological and epidemiological evidence from data available in South Africa, from international studies and recommendations of the WHO.

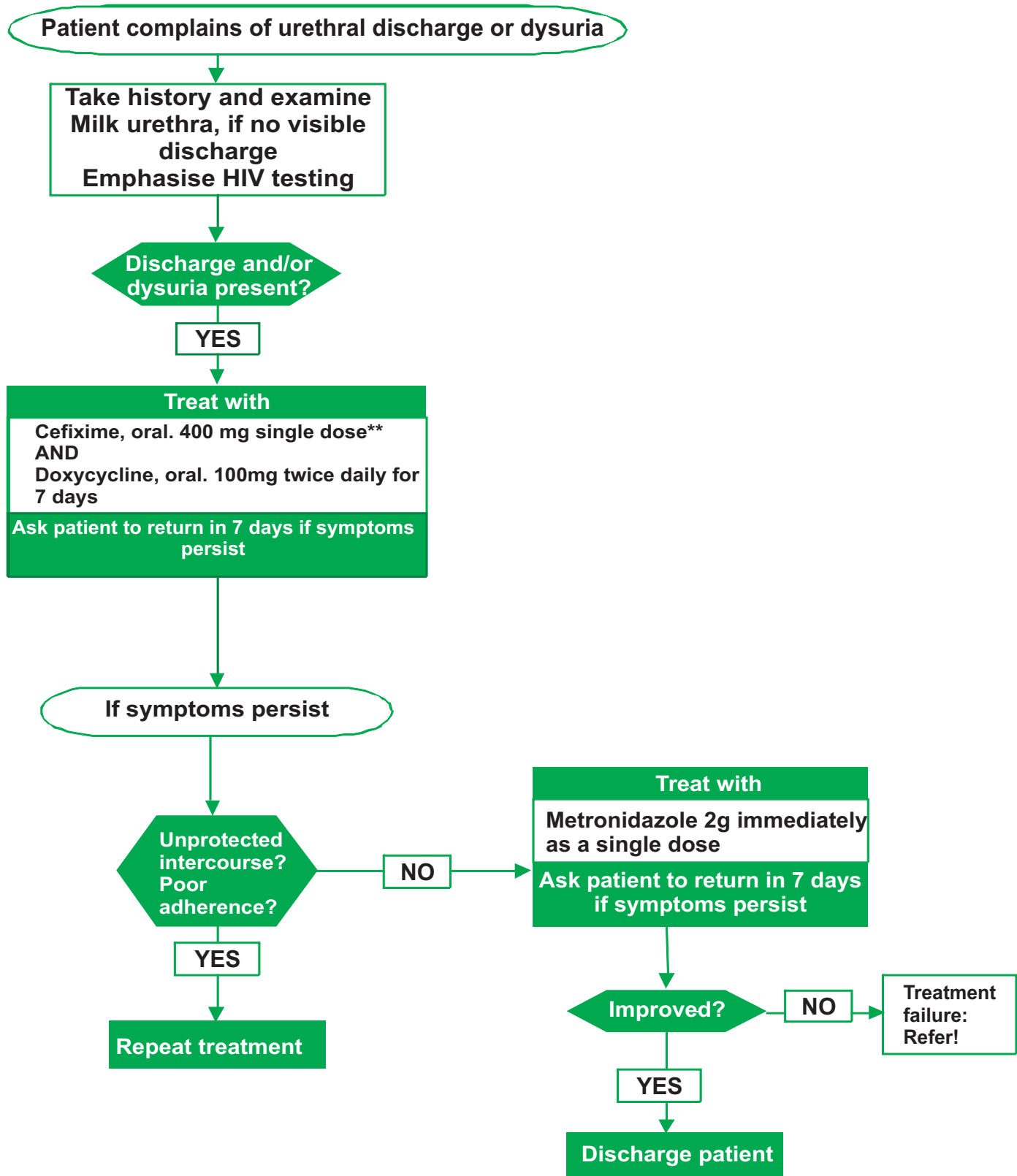
The goal of the recommended first line treatment is to achieve a cure rate of 90%. Ongoing studies, clinical and microbiological surveillance as well as monitoring of drug resistance pattern will provide the basis for any future review as necessary.

All first line health service providers in public and private sector should adhere to these guidelines.

- It is the most feasible and cost effective first line management of STIs.

It is therefore important that all first line health service providers are familiar with the following flow chart. They provide an easy to use guide and should be available in each consultation room. They also provide clear indications when to refer to a doctor for second line STI treatment or other reasons.

# MALE URETHRITIS SYNDROME (MUS)



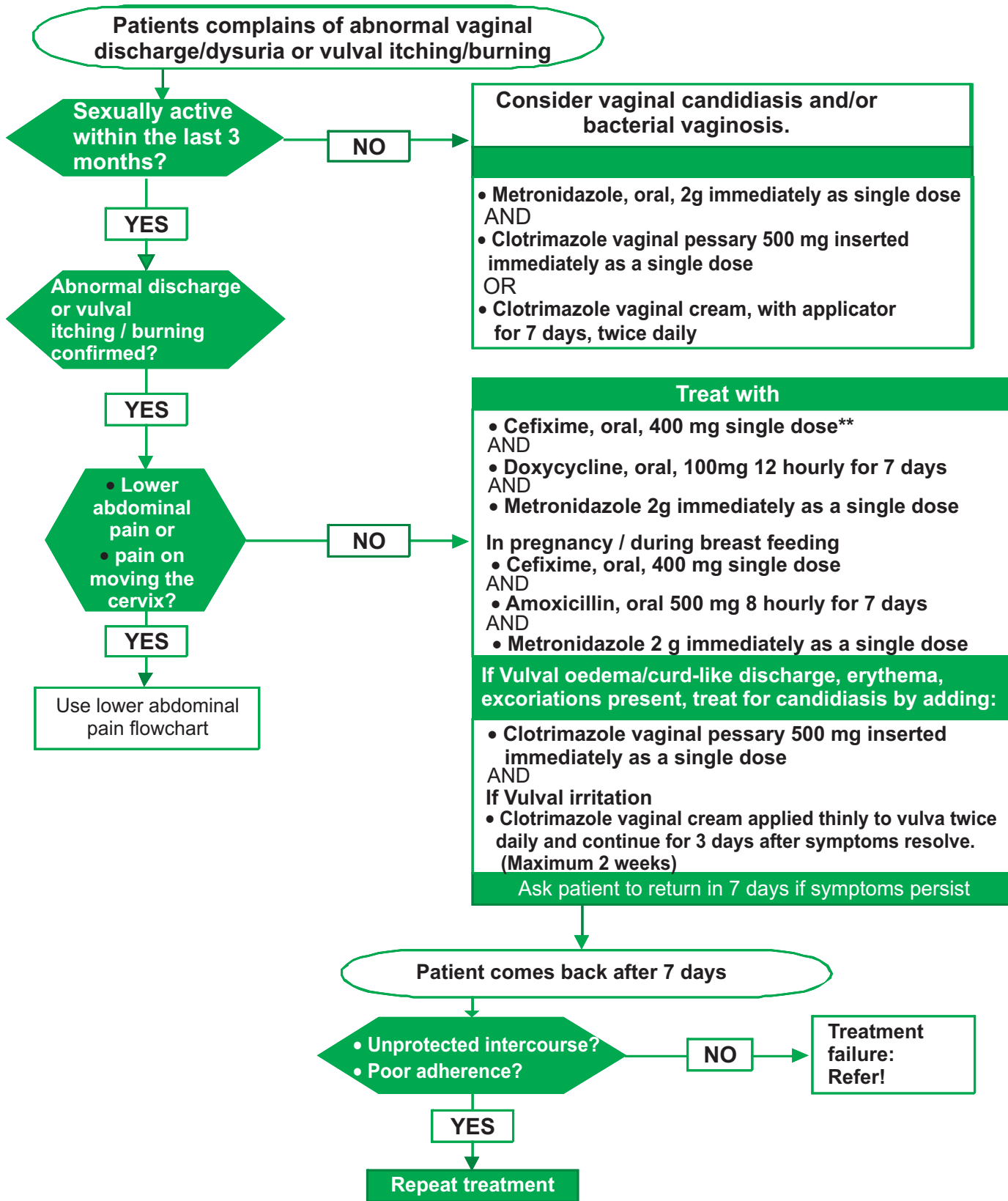
People who are penicillin allergic may also react to cephalosporins.

\*\*If severe penicillin allergic, i.e. angioedema, anaphylactic shock or bronchospasm

**Ciprofloxacin**, oral, 500 mg single dose

If no response after 48 hours - refer

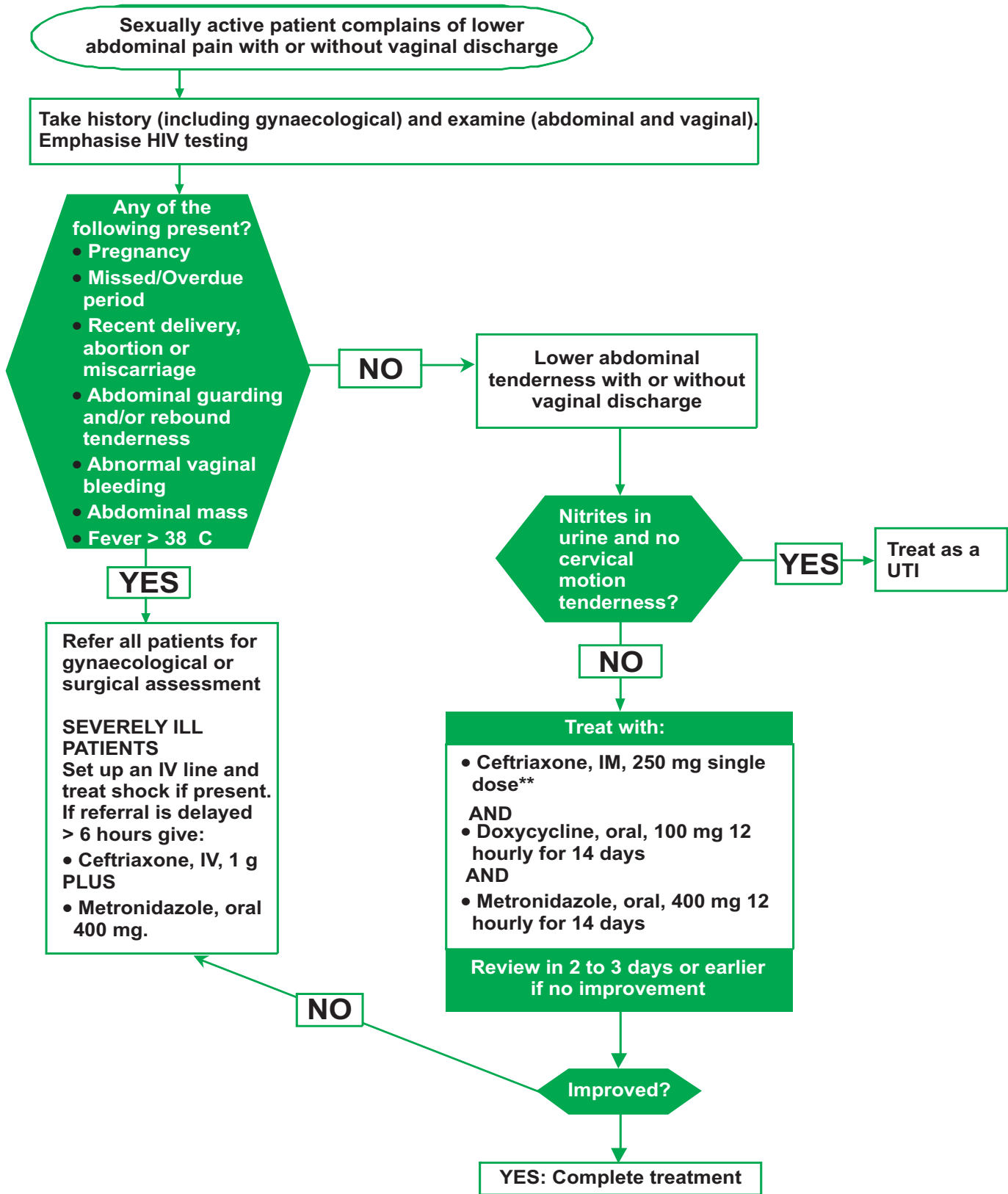
# VAGINAL DISCHARGE SYNDROME (VDS)



People who are penicillin allergic may also react to cephalosporins.  
 \*\*If severe penicillin allergic, i.e. angioedema, anaphylactic shock or bronchospasm  
**Ciprofloxacin**, oral, 500 mg single dose  
 If no response after 48 hours - refer  
 Pregnant and penicillin allergic: Replace Amoxicillin, oral with Erythromycin, oral, 500mg qid x 7 days.

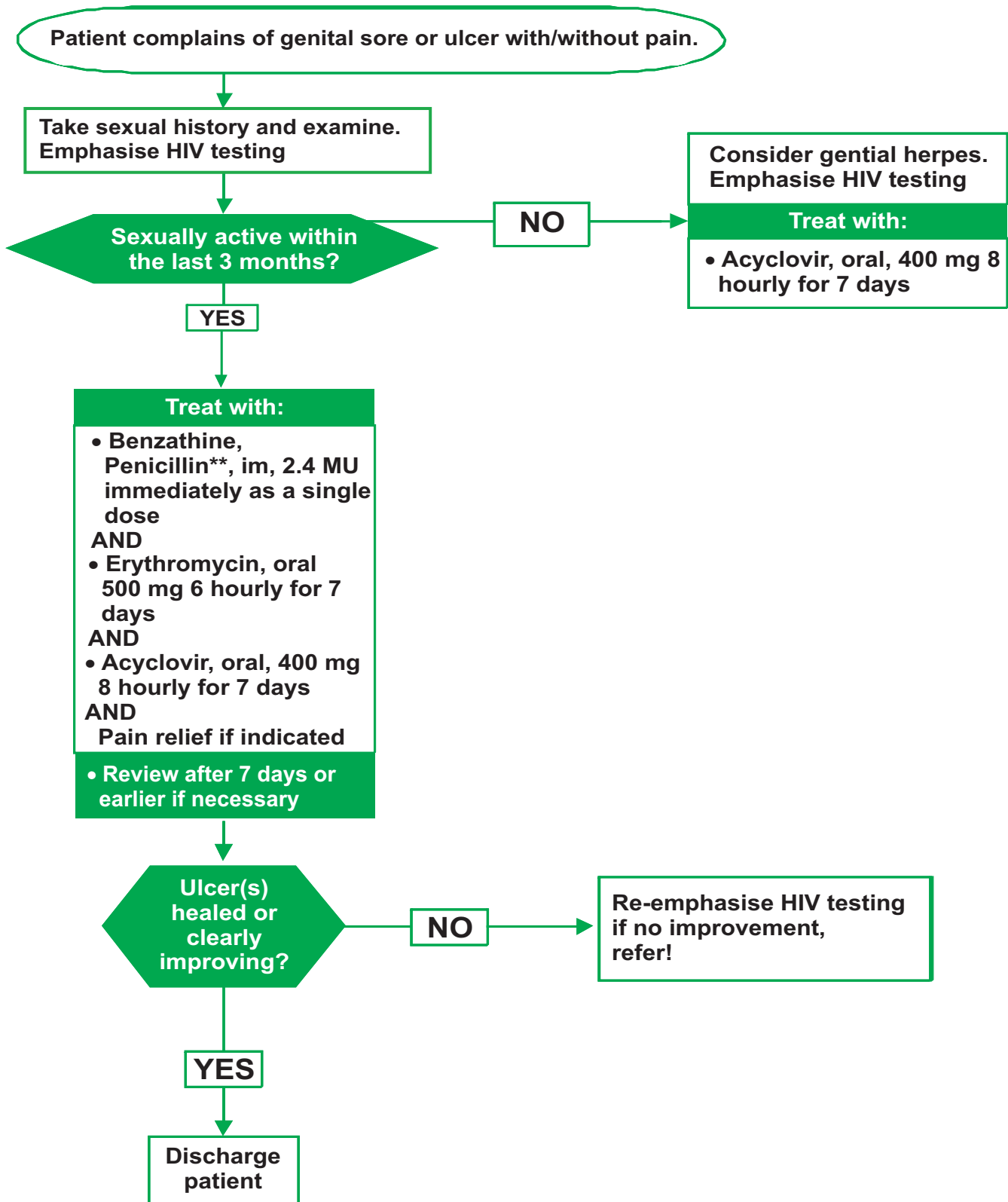


# LOWER ABDOMINAL PAIN (LAP)



People who are penicillin allergic may also react to cephalosporins.  
 \*\*If severe penicillin allergic, i.e. angioedema, anaphylactic shock or bronchospasm  
**Ciprofloxacin**, oral, 500 mg 12 hourly for 3 days.  
 Advise patient to return if no improvement within 2 to 3 days referral  
 Pregnant / Breastfeeding, refer.

# GENITAL ULCER SYNDROME (GUS)



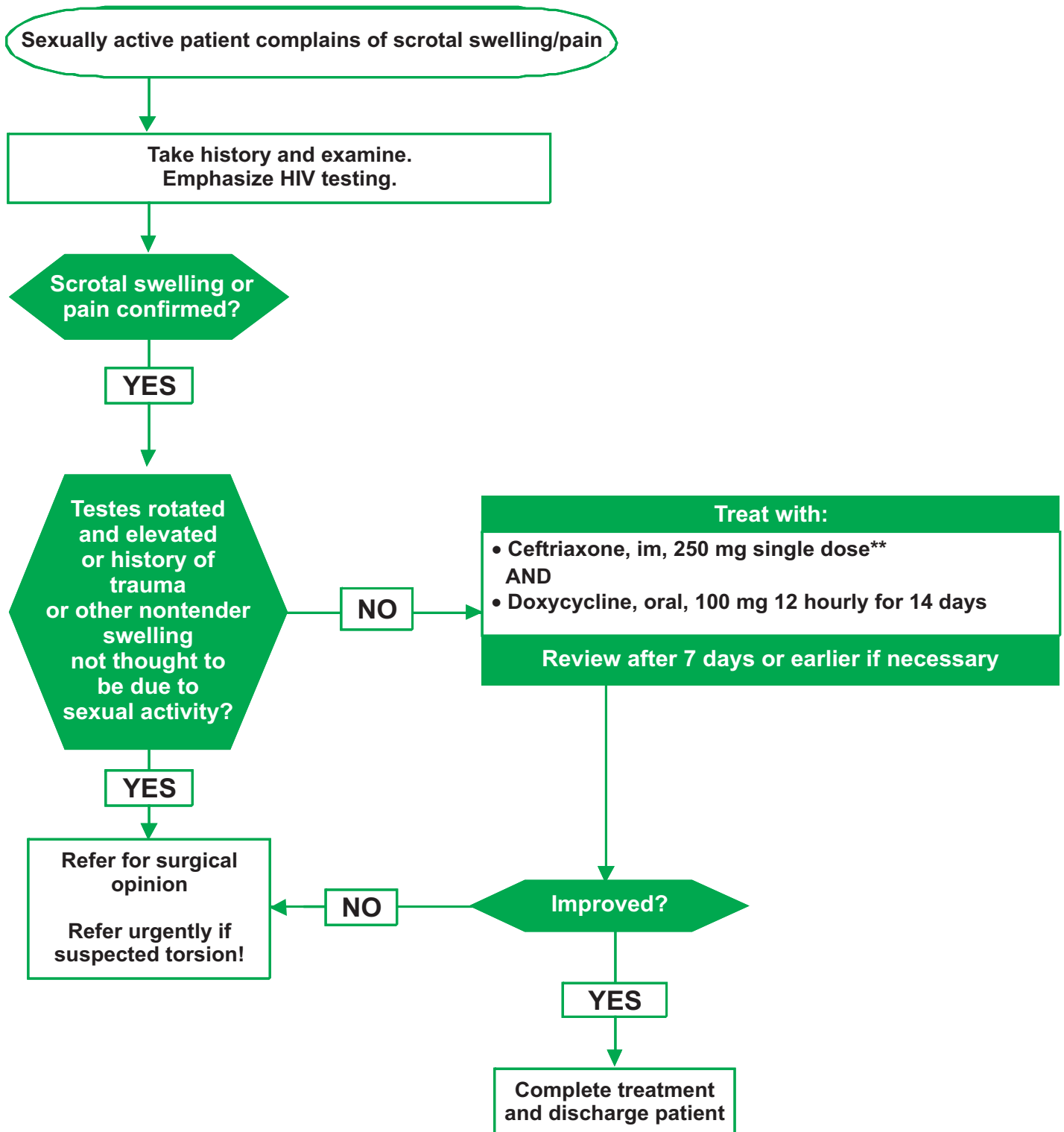
People who are penicillin allergic.

\*\*If severe penicillin allergic, i.e. angioedema, anaphylactic shock or bronchospasm.

Non Pregnant females and males: Replace Benzathine Penicillin with doxycycline 100mg b.d x 14 days

Pregnant women: Increase to Erythromycin 500mg qid x 14 days

# SCROTAL SWELLING (SSW)



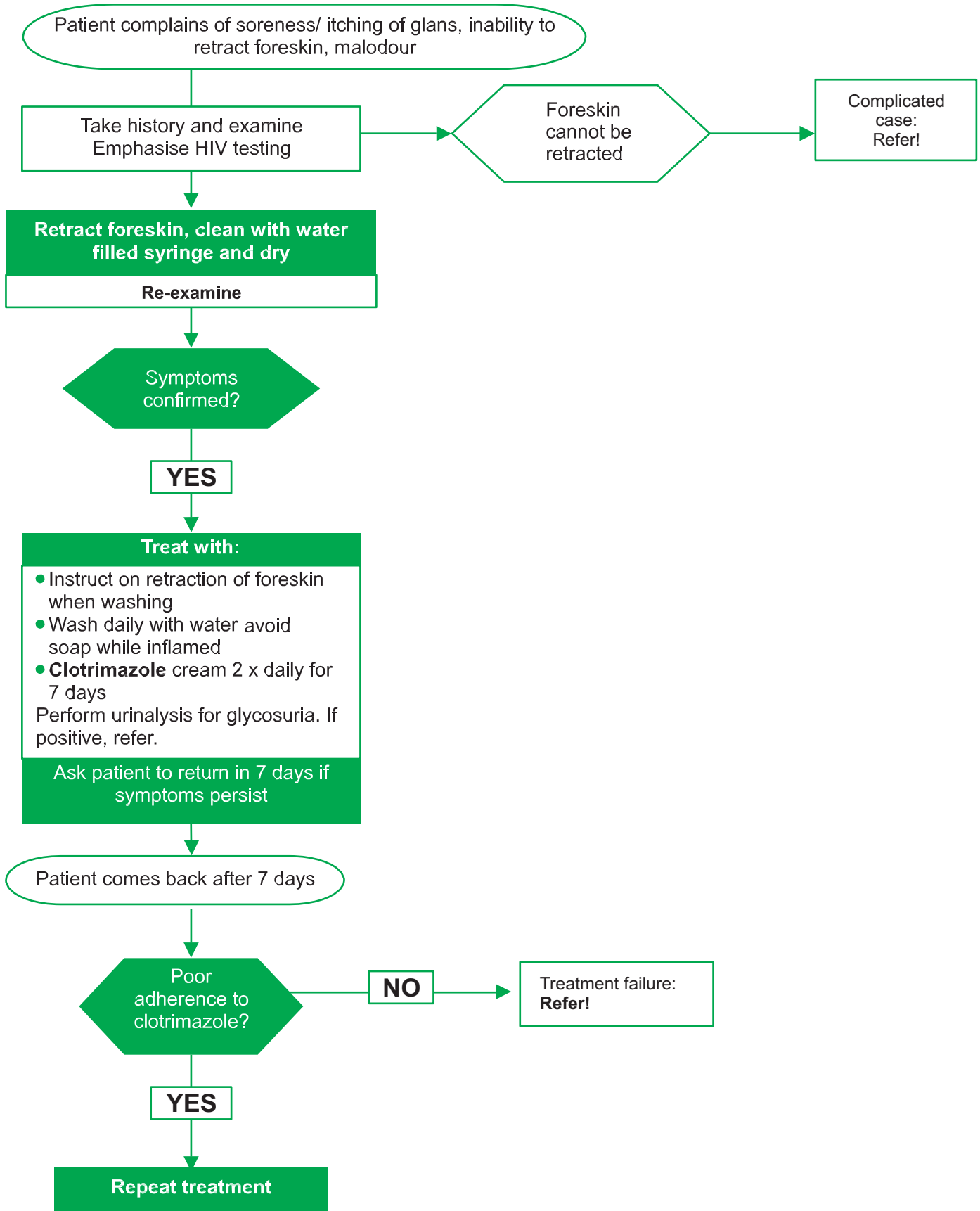
People who are penicillin allergic may also react to cephalosporins.

\*\*If severe penicillin allergic, i.e. angioedema, anaphylactic shock or bronchospasm

**Ciprofloxacin**, oral, 500 mg 12 hourly for 3 days

If no response after 48 hours - refer

# BALANITIS / BALANOPOSTHITIS (BAL)



# BUBO

Patient complains of hot tender inguinal swelling with surrounding erythema and/or oedema

Take history and examine.  
Encourage HIV testing.  
Exclude hernia or femoral aneurysm.

**Bubo confirmed?**

YES

## Treat with

- **Doxycycline**, oral, 100 mg 12 hourly for 14 days
  - AND
  - **Ciprofloxacin**, oral, 500 mg 12 hourly for 3 days
- IN PREGNANCY/DURING BREAST FEEDING, replace the above with:**
- **Erythromycin**, oral, 500 mg 6 hourly for 14 days

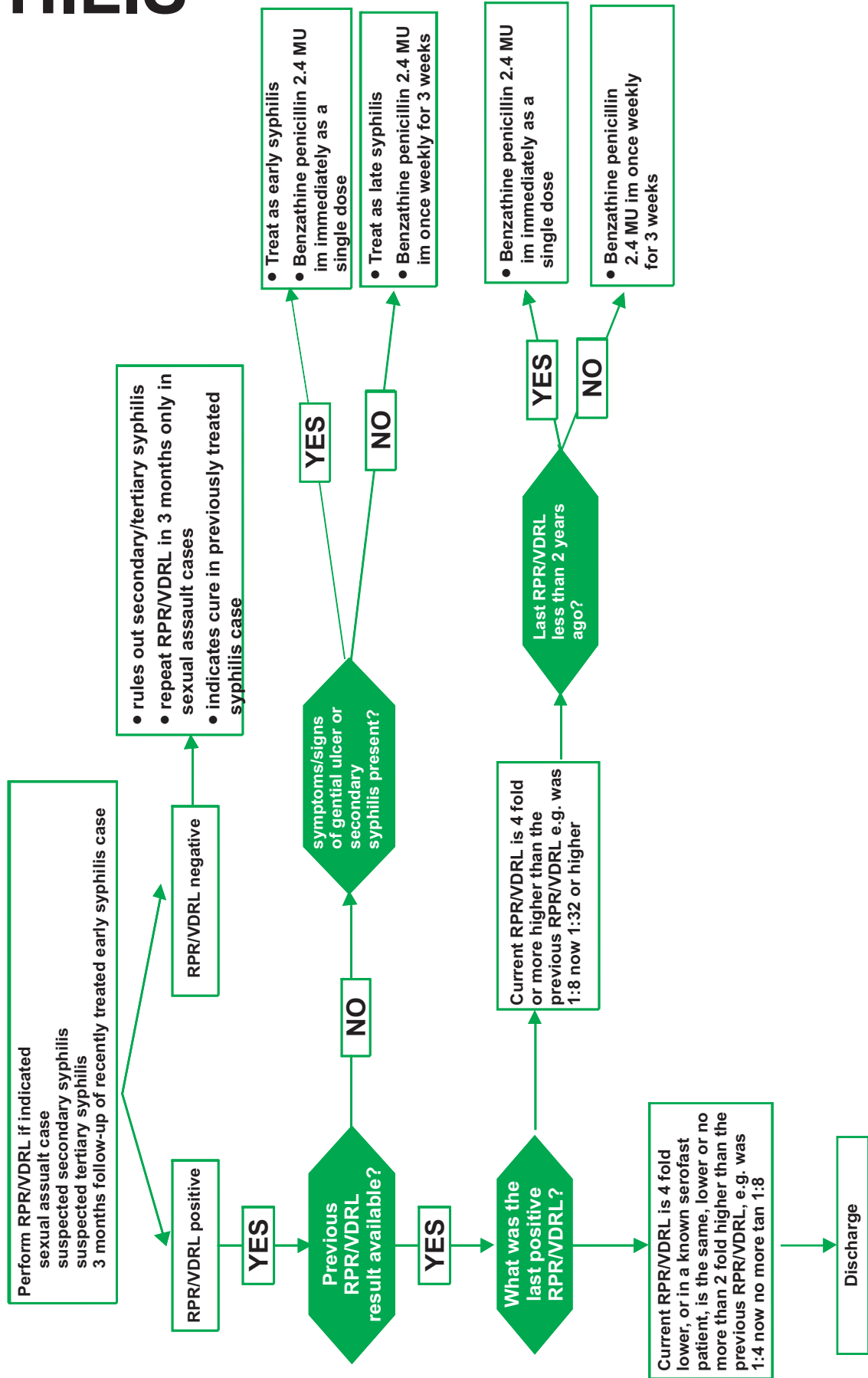
## If bubo is fluctuant:

Aspirate pus in a sterile manner. (Check policy)  
Repeat every 72 hours as necessary

## If ulcer also present:

Add **Acyclovir**, Oral, 400mg 8 hourly for 7days

# SYPHILIS



## Drug Treatment of more than one STI syndrome

STI Syndromes	Drug Treatment
<b>MUS + SSW</b>	Treat according to SSW flow chart
<b>MUS + BAL</b>	Treat according to MUS flow chart Plus Clotrimazole cream 2 x daily for 7 days
<b>MUS + GUS</b>	<ul style="list-style-type: none"> <li>● Cefixime 400mg p.o. stat plus</li> <li>● Benzathine penicillin* 2.4 mu im stat plus</li> <li>● Erythromycin, oral, 500mg 6 hourly for 7 days plus</li> <li>● Acyclovir, oral, 400mg 8 hourly for 7 days</li> </ul>
<b>VDS + LAP</b>	Treat according to LAP flow chart plus Treat for candidiasis, if required
<b>VDS + GUS (non-pregnant)</b>	<ul style="list-style-type: none"> <li>● Cefixime 400mg p.o. stat plus</li> <li>● Metronidazole 2g p.o. stat plus</li> <li>● Benzathine penicillin* 2.4 MU imi stat plus</li> <li>● Erythromycin, oral, 500mg 6 hourly for 7 days plus</li> <li>● Acyclovir, oral, 400mg 8 hourly for 7 days plus</li> <li>● treat for candidiasis, if required</li> </ul>
<b>VDS + GUS (pregnant, breastfeeding)</b>	<ul style="list-style-type: none"> <li>● Cefixime 400mg p.o. stat plus</li> <li>● Metronidazole 2g stat plus</li> <li>● Benzathine penicillin* 2.4 MU imi stat plus</li> <li>● Erythromycin, oral, 500mg 6 hourly for 7 days plus</li> <li>● Acyclovir, oral, 400mg 8 hourly for 7 days plus</li> <li>● treat for candidiasis, if required</li> </ul>
<b>SSW / LAP + GUS</b>	<ul style="list-style-type: none"> <li>● Ceftriaxone 250mg imi stat plus</li> <li>● Metronidazole 400mg 2 daily x for 14 days plus</li> <li>● Erythromycin, oral, 500mg 6 hourly for 14 days plus</li> <li>● Acyclovir, oral, 400mg 8 hourly for 7 days</li> </ul>
<p><b>Penicillin allergic men and non pregnant women, replace benzathine penicillin with:</b></p> <ul style="list-style-type: none"> <li>● Doxycycline, oral, 100mg 12 hourly for 14 days</li> </ul> <p><b>Penicillin allergic pregnant or breast feeding women, replace benzathine penicillin and amoxicillin with:</b></p> <ul style="list-style-type: none"> <li>● Erythromycin, oral 500mg 6 hourly for 14 days</li> </ul> <p>NB: Erythromycin covers Chanchroid / LGV, Chlamydial Urethritis and Cervicitis</p>	

### **Genital Warts (code GW): Condylomata Accuminata**

#### **Description**

The clinical signs are:

- Warts on the ano-genital areas, vagina, cervix, meatus or urethra
- They can be soft or hard

#### **Non-drug treatment**

RPR to exclude secondary syphilis which may present with similar lesions

Encourage HIV testing

#### **Treatment**

Soft warts (<10mm)

- Tincture of podophyllin solution 20%, applied at weekly intervals to the lesions at the clinic by a health care professional until lesions disappear.
- Apply petroleum jelly to the surrounding skin for protection.
- Wash the solution off after 4 hours.
- If lesions do not improve after 5 treatments, refer.
- Podophyllin is cytotoxic agent. Avoid systematic absorption.
- Contraindicated in pregnancy. Exclude pregnancy before using podophyllin.

#### **Referral**

All patients with:

- Hyper-keratinised wart warts
- Warts larger than 10mm
- Inaccessible warts, e.g. intra vaginal or cervical warts
- Pregnant women
- Non-responding soft warts

### **Pubic Lice (code PL)**

#### **Description**

Infestation of lice mostly confined to pubic and peri-anal areas, and occasionally involves eyelashes. The bites cause intense itching which often result in scratching with bacterial super infection

#### **Non-drug Treatment:**

Clothing and bed linen that may have been contaminated by the patient in the 2 days prior to start of treatment should be thoroughly washed in hot water and then ironed.

#### **Drug treatment**

- Benzyl benzoate 25%, applied to affected area
  - Leave this on for 24 hours, then wash thoroughly
- Repeat in days

#### **Pediculosis of the eyelashes or eyebrows**

- Petroleum jelly applied to the eyelid margins daily for 10 days to smother lice and nits
- Do not apply to eyes

#### **Referral**

- All children with lice on eyelashes to exclude sexual abuse

### **Genital MOLLUSCUM CONTAGIOSUM (code MC)**

#### **Description**

This viral infection can be transmitted sexually and non-sexually.

It is usually self limiting but can be progressive in an advanced stage of immunodeficiency.

Clinical signs are papules at the genitals or other parts of the body

Usually, the papules have a central dent (umbilicated papules)

#### **Drug treatment**

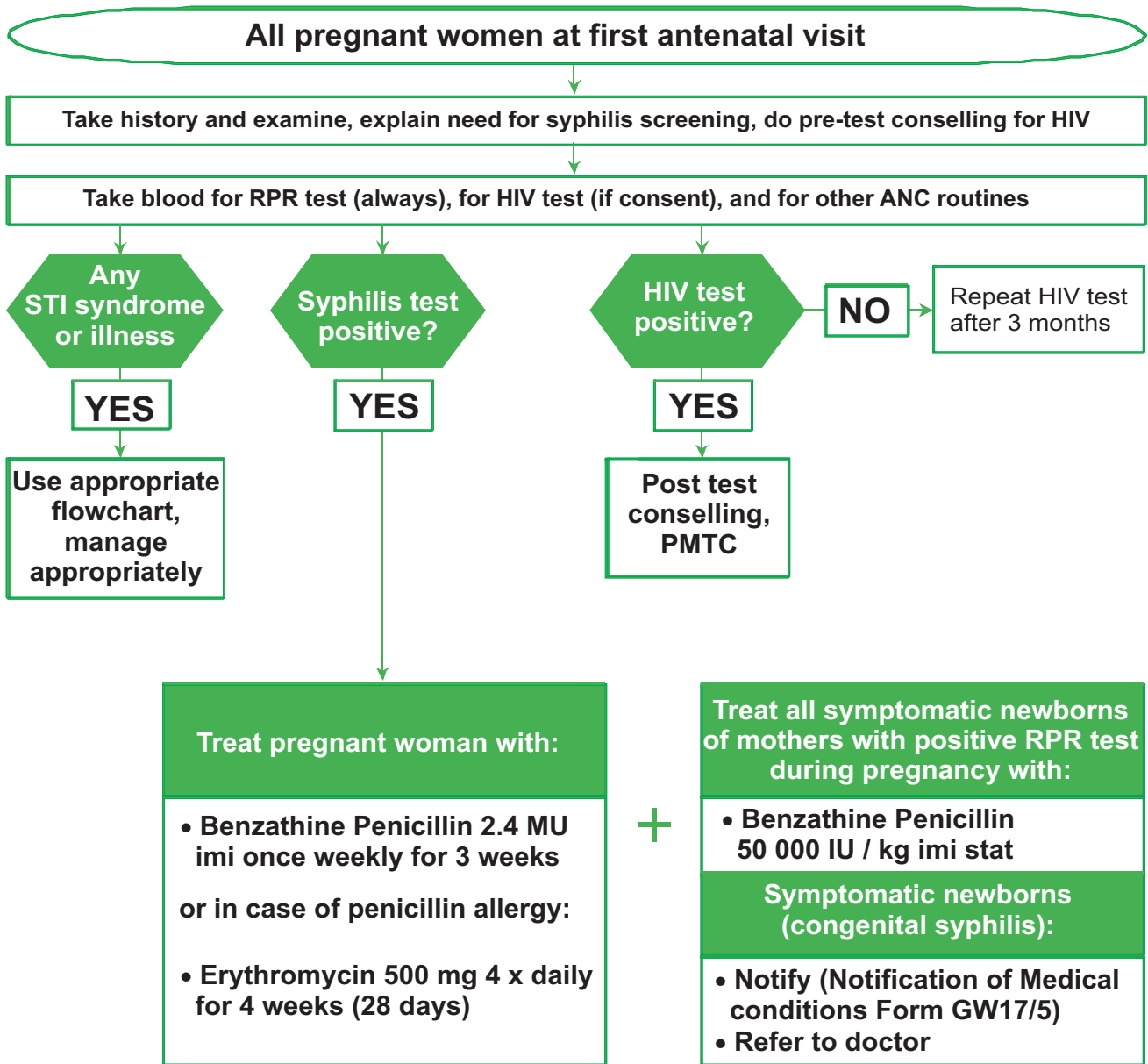
Tincture of iodine, apply with an applicator to the core of lesions



## TREATMENT OF ASYMPTOMATIC PARTNERS

Female Patient	Male Partner	Male Patient	Female Partner
<b>VDS</b>	<b>MUS plus</b> metronidazole 2 g stat	<b>MUS</b>	VDS
<b>LAP</b>	<b>MUS plus</b> metronidazole 2 g stat	<b>SSW</b>	VDS
<b>GUS</b>	GUS	<b>BAL</b>	Cotrimazole vaginal pessary 500mgs inserted stat 2
<b>GW</b>	GW if signs	<b>GUS</b>	GUS
<b>PL</b>	PL	<b>GW</b>	GW if signs
<b>MC</b>	MC if signs	<b>PL</b>	PL
<b>RPR+</b>	Benzathine Penicillin 2.4mu im stat in addition RPR test	<b>MC</b>	MC if signs
	<i>In addition: treat any symptomatic STI</i>		<i>In addition: treat any symptomatic STI</i>
		<b>RPR+</b>	Benzathine Penicillin 2.4mu im stat in addition to RPR test

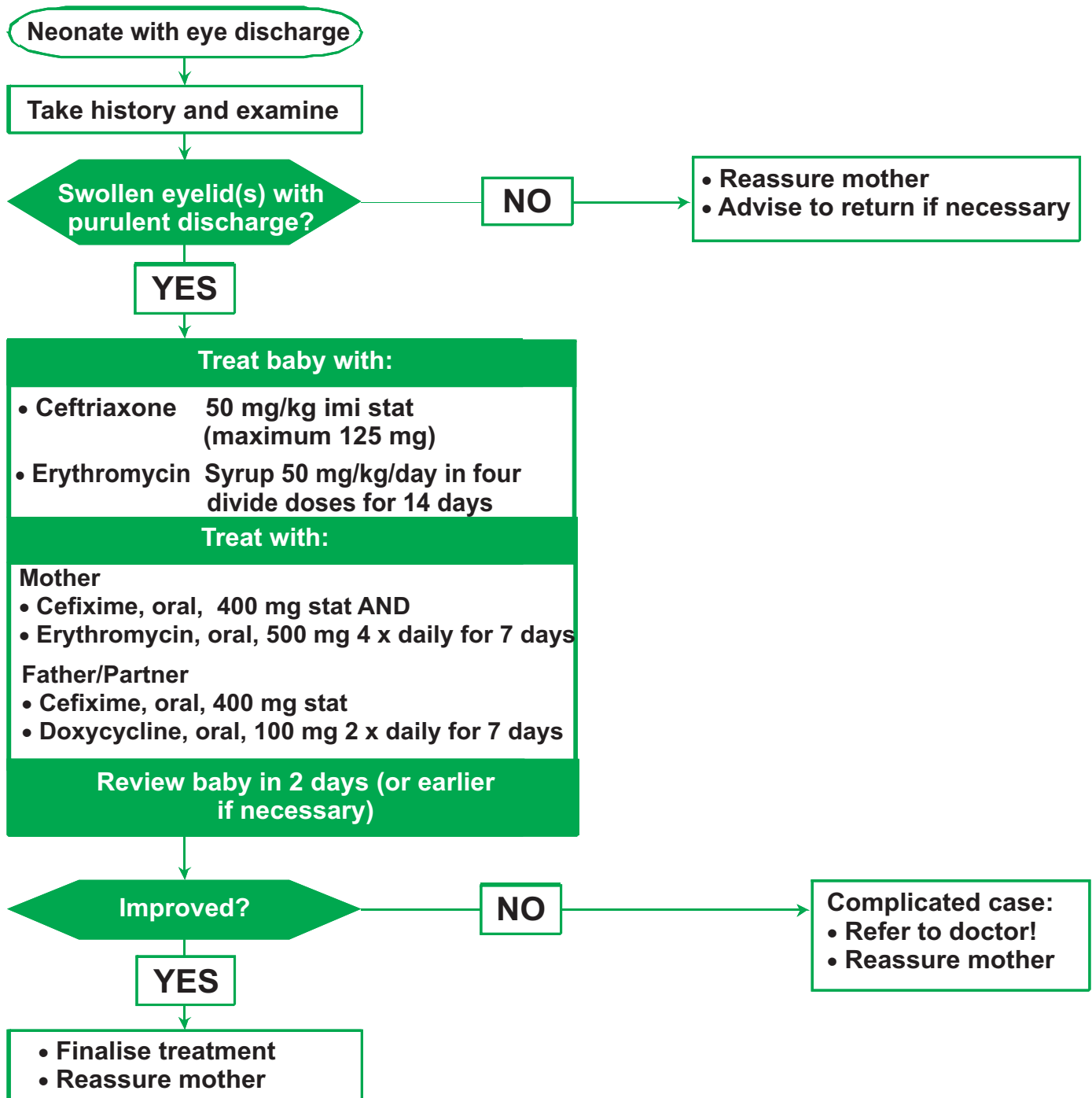
# SYPHILIS SCREENING OF PREGNANT WOMEN



## ALL PREGNANT WOMEN:

- Educate, ensure compliance and counsel; promote couple-counselling if applicable
- Explain the risk of vertical transmission
- Promote consistent condom use particularly during pregnancy, demonstrate condom use, provide condoms
- Stress the importance of partner treatment, issue one notification slip for each sexual partner
- Promote HIV counselling and testing of partner

# NEONATAL CONJUNCTIVITIS



## PARENTS OF BABY WITH CONFIRMED NEONATAL CONJUNCTIVITIS

- Educate, ensure compliance and counsel; promote couple-counselling if applicable
- Promote abstinence from penetrative sex during the course of treatment
- Promote and demonstrate condom use, provide condoms
- Stress the importance of partner treatment, issue one notification slip for each sexual partner follow up partner treatment during review visit!
- Promote HIV counselling and testing, for negative results repeat test after 3 months

## ANAPHYLAXIS PROTOCOL

Before administering drugs or injections, ask your patients about previous allergies to drugs. A rash after previous treatment may be a warning sign.

Signs of possible anaphylaxis:

- Shock
- Difficulty in breathing
- Rash (may be present)

If signs of anaphylaxis confirmed, do the following:

### 1. Call for help – preferably a doctor

### 2. Check ABC

- **A**irway
- **B**reathing: give mouth to mouth respiration
- **C**irculation: do CPR if necessary

### 3. If anaphylaxis give adrenaline subcutaneously

- Site
- Dosage:
 

Adult	0.5 ml
Children over 3 years	0.2 – 0.3 ml
Children under 3 year	0.1 ml
Elderly	0.3 ml

### 4. Put up an intravenous infusion as soon as possible

- Normal saline run in according to blood pressure response
- Give Adrenaline diluted in 10 ml sterile water slowly
- Dosage:
 

Adult	5 ml
Children over 3 years	2 – 3 ml
Children under 3 years	1 ml
Elderly	3 ml

Heart rate not to exceed 160 beats per minute



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