Recommendations for Reproductive and Sexual Health Care of Trafficked Women in Ukraine:

Focus on STI/RTI Care

European Union

International Organization for Migration

London School of Hygiene & Tropical Medicine

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The authors do not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use. The recommendations are based on the most recent knowledge, internationally accepted best practices, and Ukrainian health policy available in early 2005. It is strongly advised that the recommendations be periodically updated to ensure they conform to national and international protocols and locally available treatment in Ukraine. The guidance and views expressed do not necessarily reflect any official policy of LSHTM.

These *Recommendations* were written for use in Ukraine. If these recommendations are used in other country settings, appropriate revisions to fit the standards, resources, and practices in the new setting should be made prior to implementation.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
bDNA	Branched Deoxyribonucleic Acid
BV	Bacterial vaginosis
CDC	U.S. Centers for Disease Control and Prevention
DFA	Direct Immunofluorescence Assay
DNA	Deoxyribonucleic Acid
EIA	Enzyme Immunoassay
ELISA	Enzyme-linked immunosorbent assay
FTA-ABS	Fluorescent Treponemal Antibody Absorption Test
GC	*Neisseria gonorrhoeae*
HBIG	Hepatitis B immune globulin
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HSV	Herpes Simplex Virus
IOM	International Organization for Migration
LCR	Ligase Chain Reaction
MHA-TP	Microhemagglutination Assay
NASBA	Nucleic Acid Sequence-Based Amplification
NGO	Non-Governmental Organization
PCR	Polymerase Chain Reaction
PID	Pelvic Inflammatory Disease
RNA	Ribonucleic Acid
RPR	Rapid Plasma Reagin
RTI	Reproductive Tract Infection
RT-PCR	Reverse Transcriptase - Polymerase Chain Reaction
RSH	Reproductive and Sexual Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SoT	Survivor(s) of Trafficking
UTI	Urinary Tract Infection
VDRL	Venereal Disease Research Laboratory
VoT	Victim of Trafficking
WHO	World Health Organization

1. Introduction

As the International Organization for Migration (IOM) continues to expand its medical rehabilitation services for survivors of trafficking in Kyiv and through partnerships with local-level NGOs, it sought to develop standardised guidelines on the provision of reproductive and sexual health (RSH) care. Towards this end, it commissioned staff from the London School of Hygiene & Tropical Medicine to review current practice and international guidelines, and to use this to develop *Recommendations for Reproductive and Sexual Health Care of Trafficked Women in Ukraine*. The Recommendations have been developed based on internationally accepted protocols issued by the World Health Organization (WHO Geneva and the European Office), the Ukrainian Ministry of Health Sexually Transmitted Infections guidelines, and the U.S. Centers for Disease Control and Prevention (CDC). They were developed following consultation with IOM Rehabilitation Center staff, experts in trafficking, gender-based violence, STI control, management and diagnostics, and using data from a limited health facility survey conducted by IOM among its partner agencies and Ukrainian physicians.

These recommendations are intended for use by IOM medical Rehabilitation Center staff, NGOs, partner agencies providing medical assistance, and local referral medical providers involved in reproductive and sexual health care. The purpose of these recommendations is to provide a set of RSH standards that correspond to nationally and internationally accepted quality standards to which IOM and its NGO partner agencies may refer when caring for women who have been trafficked.

The recommendations are divided into eleven sections: (1) introduction; (2) overview of the health consequences and rights of trafficked women; (3) recommendations to guide NGO partner agencies in identifying and working with a local RSH care provider; (4) background on STIs/RTIs including information on classifying, diagnosing and screening; (5 and 6) a medical practitioner's step-by-step guide for providing medical care to survivors of trafficking; (7) partner management guidelines; (8) laboratory aetiological diagnosis; (9) management of specific STIs/RTIs; (10) management of symptomatic STIs/RTIs; (11) communication and rights; (12) medical records; and (13) reporting and monitoring. The *Recommendations* present priorities of STI/RTI management and care for women who have been trafficked. Key aspects of the management of HIV/AIDS are discussed throughout the document; however, detailed management protocols are beyond the scope of this document. The recommendations recognize that the capacity of health services will vary by locality and thus, where possible, several options are presented from which clinicians may choose when diagnosing and treating survivors of trafficking.

These recommendations use commonly accepted terms in RSH care provision. A list of abbreviations is provided on page 7.

The term woman/women is used throughout the document to refer to survivors of trafficking (SoT).

The recommendations are based on the most recent knowledge, internationally accepted best practices, and Ukrainian health policy available in early 2005. It is strongly advised that the recommendations be periodically updated to ensure they conform to national and international protocols and locally available treatment. These *Recommendations* were written for use in Ukraine. If they are used in other country settings, revisions must be made to fit the standards, resources, and practices in the new setting prior to implementation.

2. Trafficking and Health Overview

2.1. Health Consequences of Trafficking

Trafficked women face numerous and often overlapping health risks and abuses. Women are physically beaten to force them to have sex, raped as a psychological tactic to intimidate them into future submission, isolated to disable them psychologically, and economically deprived to create a reliance on traffickers. The effects of trafficking generally differ from other single traumatic events (i.e. rape, disaster), as trafficking most often involves prolonged and repeated traumatic events.

While these *Recommendations* focus exclusively on the management of sexually transmitted infections (STI) and reproductive tract infections (RTI), it is important to recognise that women's sexual and reproductive health is one among many health problems women face as a result of having been trafficked. By being aware of the range of physical, mental and social complications women may be experiencing, providers will be able to offer more effective STI/RTI diagnoses and care.[2] Table 1 presents some of the health risks, abuse and potential reproductive and sexual health consequences of sexual violence.

Table 1. Health Risk, Abuse and Consequences of Trafficking[1]

Risks and Abuse from Sexual Violence	Reproductive & Sexual Health Consequences
• Forced vaginal, oral or anal sex; gang rape; degraing sexual acts • Forced prostitution, inability to control number or acceptance of clients • Forced unprotected sex and sex without lubricants • Unwanted pregnancy, forced abortion, unsafe abotion • Sexual humiliation, forced nakedness • Coerced misuse of oral contraceptives or other cotraceptive methods • Inability to negotiate sexual encounters	• Sexually transmitted infections (STIs), reproductive tract infections (RTIs) and related complications, including pelvic inflammatory disease (PID), urinary tract infections (UTI), cystitis, cervical cancer, and infertility • HIV/AIDS • Amenorrhea and dysmenorrhoea • Acute or chronic pain during sex; tearing and other damage to vaginal tract • Negative outcomes of unsafe abortion, including cervix incontinence, septic shock, unwanted birth • Difficulties forming intimate relationships

2.2. Health Rights of Trafficked Women

The health rights of trafficked women have been prioritized by the Ukraine Cabinet of Ministers. The *Model Regulation of Rehabilitation Centers for Victims of Trafficking in Persons (Decree No. 987)* and the national *Comprehensive Programme to Counteract Trafficking in Human Beings 2002-2005* address the need for the general provision of health care services and hiring of psychologists and public health professionals. Appendix 1 presents principles for promoting the health rights of trafficked women.

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[1]The conceptual framework developed by Zimmerman *et al* (2003) includes eight additional forms of risk and abuse and corresponding health consequences associated with trafficking: physical abuse → physical health; psychological abuse → mental health; forced, coerced use of drugs and alcohol → substance abuse and misuse; social restrictions and manipulation → social well-being; economic exploitation and debt bondage → economic-related well-being; legal insecurity → legal security; abusive working and living conditions → occupational and environmental well-being; and risks associated with marginalization→ health service uptake and delivery.

3. NGO Partner Agencies – Selecting and Working with Medical Service Providers

3.1. NGO Partner Agencies Role in Case Management and Referral

NGO partner agencies play an essential role in providing medical rehabilitation services to women throughout the Ukraine. Many women will access services directly through IOM, but as outreach and national coordination efforts continue to grow, women will seek services through NGO partner agencies. NGO Partner agencies are encouraged to counsel women to access the comprehensive services available at the Kyiv Rehabilitation Center, but in cases where this is not possible, NGOs should identify and establish relationships with appropriate local health care providers and facilities that are willing to address the care needs of trafficked women.

Suggested guidelines for NGO partner agencies' role in the RSH case management and referral process are described in the following sections. NGOs are encouraged to appoint an NGO-level case manager to oversee each woman's case. The NGO should then identify and establish a relationship with trusted local medical providers who meet the recommended minimum standards of care (see Section 3.2). If no medically qualified staff is available at the NGO, a local general practitioner (*therapist*) should be identified. The general practitioner should function as a Medical Case Manager, overseeing the woman's medical treatment. In this role, she or he will ensure that the woman is receiving appropriate care and treatment, especially in cases where the woman may require multiple referrals. An obstetrician/gynaecologist and dermo-venerologist should also be identified. All medical providers should be sensitive to and aware of the issues of working with survivors of trafficking. The suggested NGO case management process presented in Figure 1 is based on the current practices of the Kyiv Rehabilitation Center and various NGO partner agencies.

3.2. Recommended Minimum Standards of Care

IOM and its NGO partner agencies play an important role in addressing women's medical needs. Medical rehabilitation services offered to trafficked women are most successful when they address some of the common difficulties faced by women seeking RSH care, including issues around accessibility, acceptability, cost, confidentiality, adequately-equipped facilities and effective treatment.[3]

Women who are unable to, or do not wish to access the comprehensive services offered at the Kyiv IOM Rehabilitation Center will be obliged to seek care from other qualified medical personnel. Based on a review of international practices, the following describes criteria that should be considered basic and necessary to the provision of RSH care for women who have been trafficked. IOM and NGO partner agencies are encouraged to establish relationships with local health care facilities that meet or exceed these recommended minimum standards of care. A *Recommended Minimum Standards of Care Checklist* is provided in Appendix 2.

Accessibility

✓ **Location**
RSH services should be easily accessible.

✓ **Service Hours**
RSH services should be open regular hours, with the necessary services available during a reasonable number of hours and days per week to enable women with different living and work situations to

easily access the services they need.[4] For example, women who require services while living at a shelter may have more time-flexibility than women who must travel long distances or take time away from their current jobs or families.

✓ **Service Costs**
RSH services should be able to provide comprehensive and affordable RSH testing and treatment.

✓ **Accessible Medical Files and Documentation**
Women have a right to their medical files and should be given the option of how and when they receive copies of medical documentation, including their medical history, lab test results, diagnoses, and prescribed treatments. Medical records should be made available to women in a timely, confidential and convenient manner, and cost-free or at minimal expense.

Acceptability

✓ **Respectful and Sensitive Care**
Women deserve to be treated with respect and understanding. Women respond best to information that is presented in a way that makes them feel accepted and respected as intelligent human beings. It is useful for providers to make critical self-assessments that detect and remedy any stereotypes, prejudices, or misconceptions regarding issues related to trafficking.[5] Women diagnosed with STIs should be treated as all other patients, and not judged or blamed.

✓ **Privacy, Confidentiality and Anonymity**
Information contained in medical records, conversations between the health care provider(s), NGO partner agency officials, IOM and the woman should not be disseminated or disclosed to other persons without the woman's explicit consent. Women's privacy and confidentiality are best protected when RSH services use ID numbers or suggest women use pseudonyms on all of their records. RSH service facilities should be set up so that medical history taking and the clinical examination take place in a private space where the woman can be assured that her identity and conversations are protected.

✓ **Pregnancy**
Women's choices regarding their pregnancy should be respected and they should be offered a full range of medical support, including antenatal, obstetric, and post-natal care. In cases in which women request the termination of a pregnancy, appropriate facilities should be identified and referral information should be clearly communicated in order to prevent potential complications arising from women resorting to unsafe abortions.

Quality

✓ **Health Care Providers Qualifications and Quality**
At a minimum, all medical personnel should have the appropriate certification and credentials required by the national government. The quality and success of RSH care depends to a great extent on the information provided by the patient, which in turn depends on gaining a woman's trust.[5] Earning a women's trust is directly related to the RSH provider's ability to approach women with sympathy, kindness and professionalism. Providers should be selected based on their professionalism, technical competence and ability to interact with and respect the specific needs of trafficked women. Providers who understand other potential health complications (psychological trauma, rape, STIs, HIV, abortion, etc.) experienced by survivors of trafficking are likely to provide the most effective care.

✓ **Health Facility Management**
The RSH service facility should be well managed and maintained. Medical services should be delivered in a reasonable amount of time. Clinicians should be aware that survivors of trafficking may require more time than other patients, and schedule appointments accordingly. The RSH facilities should be clean, hygienic and have the necessary equipment for clinical examinations and testing.

✓ **Effective Therapy Provision**

All medications prescribed should provide effective therapy with minimum side effects. When possible, one-dose treatments are recommended to ensure treatment compliance.[4] Standardized STI/RTI recommendations should be based on internationally accepted standards for diagnosis and treatment.

✓ **Universal Precautions**

Universal precautions should be observed by all health facility personnel. Clinicians, laboratory technicians, phlebotomists, and other health care providers who are routinely exposed to blood and other body fluids should use appropriate protective barriers including latex and vinyl examination gloves, gowns, masks and protective eye wear. Needles and syringes should not be recapped and disposable syringes and other sharp items should be placed in a puncture proof sealed container located near where the procedure takes place. Gloves should be changed between patients and not worn outside of the examination or laboratory room.[6]

Supplies and Infrastructure

✓ **Drug Supply**

Drugs should be readily accessible following diagnosis, ideally at the health facility. If patients are provided with a prescription to take to an outside pharmacy, it is important to periodically check that pharmacies stock the drug and dosage prescribed.[4]

✓ **Condom Supply**

Condoms should be offered to all women and their use should be strongly encouraged to protect against pregnancy and the transmission of sexually transmitted infections.

✓ **Contraception**

The most effective RSH services provide a range of contraceptive choices for women. These are best accompanied by educational material explaining contraceptive choices, methods and techniques.[5]

✓ **Health Facility Infrastructure**

RSH services should, at a minimum, have the following: registration and waiting area, secure medical record storage location, and private room for history taking and clinical examination.[4] Ideally, the health facility will also have an on-site laboratory facility with qualified and nationally certified staff. The diagnostic processing facility (on-site or off-site) should meet all national certification criteria.

✓ **Examination Room Equipment**

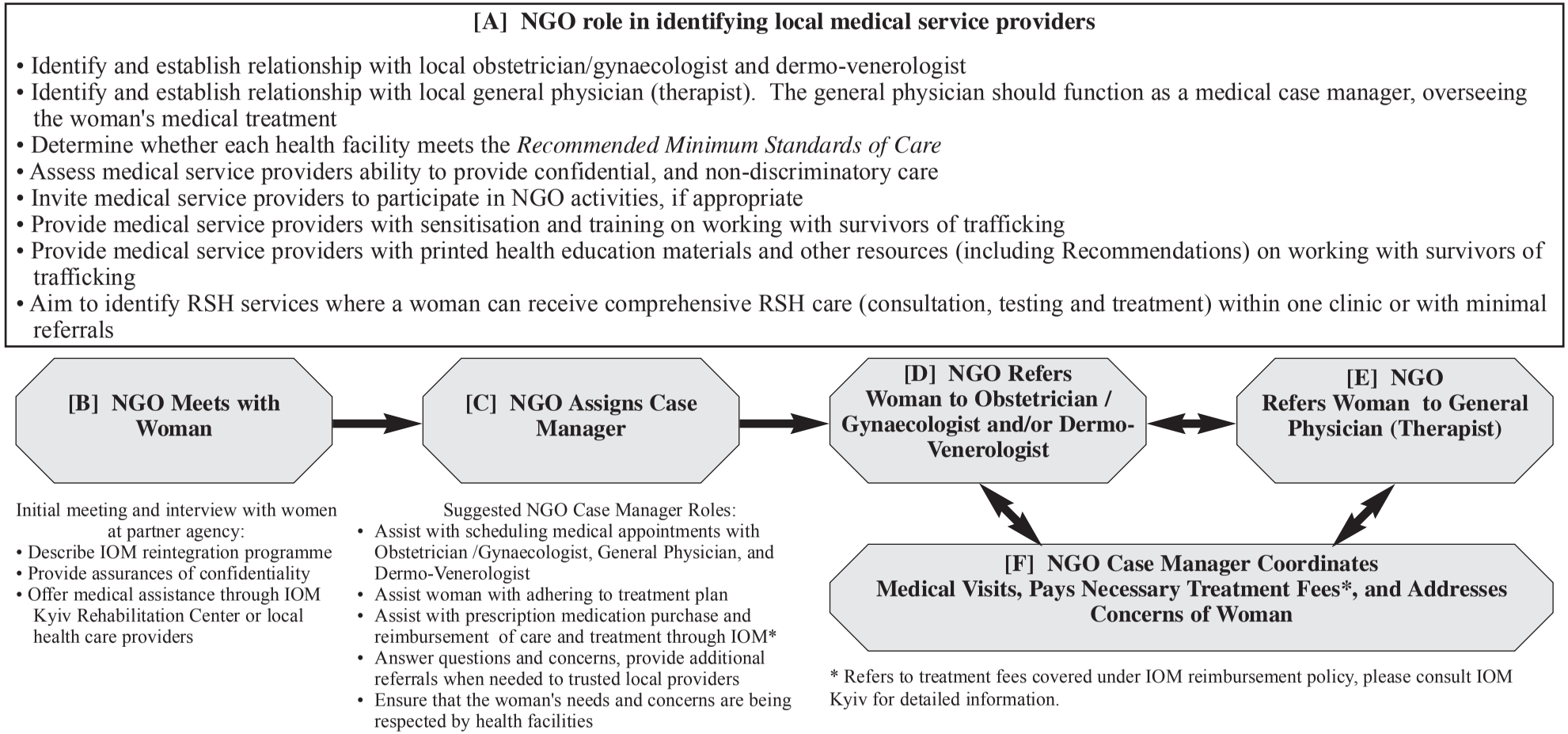
The examination room(s) should have the following available (or easily accessible): gynaecological examination bed/table, blood pressure apparatus, speculums, overhead lights, angle-pose lamp, gloves, sterilizing equipment, bowls for disinfection, soap and towels. The facility should also have available all materials needed for laboratory testing including microscope slides, cover slips, blood tubes, blood collecting instruments and specimen transport media (if appropriate).[4]

✓ **Health Education Material**

Health education material on reproductive and sexual health issues are essential to enable women to make informed choices and are most useful when offered in both Ukrainian and Russian languages. Materials are best supported by health care providers who are trained in health promotion.

Figure 1. NGO Partner Agency Referral and Case Management Process

The following is a suggested general scheme for the case management of women who require RSH care. [A] First, the NGO partner agency must identify one or several qualified medical care providers. [B] Second, the NGO will explain and offer the IOM reintegration programme to the woman. [C] Next, the NGO assigns a NGO Case Manager to each woman, who will assist her with scheduling, administrative and logistical tasks, and provide emotional support, as needed. [D] The woman's first medical visit will be to the ob/gyn and/or dermo-venerologist identified by the NGO. [E] In many cases, the woman will require referrals to several different specialists and follow-up visits. In these cases, a general physician may be necessary. Upon receiving her test results and prescriptions from her RSH care visits, the woman should then visit the General Physician (GP) identified by the NGO who can review her test results, prescriptions, and help answer questions she may not have been able to discuss with other medical providers. The GP has an important function in ensuring that the woman has not been prescribed contraindicated or unnecessary drugs, and can determine if the woman requires additional tests or treatments outside of RSH care. [F] The NGO case manager continues to help coordinate and pay for all RSH-related consultations and treatment.*



4. STI/RTI Background

4.1. Classifying RTIs and STIs

Effective control and treatment of STIs/RTIs and their resulting complications depend on having a clear understanding of sexual and reproductive health. The term 'sexually transmitted infection' (STI), widely used today, is recommended by WHO as a replacement for the term 'sexually transmitted disease' (STD). STI is used to encompass both symptomatic and asymptomatic infections and foster a public health approach to management.[7]

Reproductive tract infections (RTIs) affect the genital tract of both women and men. They are attributable to an overgrowth of organisms already existing in the reproductive tract or those introduced via sexual contact or medical procedure. Table 2 presents the three categories of RTIs - endogenous, iatrogenic and sexually transmitted - that reflect their transmission mechanisms and resulting sequelae. The effective treatment of STIs limits future transmission and the use of safe and appropriate clinical procedures decreases iatrogenic infections.

Table 2. Types of STI/RTI. Description of the three categories of reproductive tract infections including their origin, transmission route(s) and common examples.[*7,8]

Infection Type	Infection Origin	Transmission Route	Common Examples
Endogenous Infection	Organisms normally found in the vagina	Overgrowth of organisms normally present, usually not spread from person to person; influenced by environmental, hygiene, hormonal and other factors including antibiotic use, vaginal douching, certain types of contraceptive use and pregnancy	Bacterial vaginosis, Candidiasis
Sexually Transmitted Infection	STI infected individual	Sexual contact	Gonorrhoea, chlamydia, syphilis, chancroid, trichomoniasis, genital herpes, genital warts, HIV
Iatrogenic Infection	Organisms found inside or outside the body including: (1) endogenous [vagina]; (2) STI [cervix, vagina]; (3) non-sterile / contamination from outside body	Non-sterile transcervical procedures including IUD insertion and abortion; puerperal infection during delivery. Infection may be pushed through the cervix into upper genital tract leading to infections of the uterus, fallopian tubes and other pelvic organs. Contaminated needles or instruments may also transmit infection.	Pelvic inflammatory disease (PID) following abortion or other transcervical procedure; complications following childbirth and postpartum period

* Table adapted from WHO 2005 and Germain *et al* 1992.

Untreated STIs/RTIs can lead to a multitude of serious complications, particularly for women. Among women, the clinical appearance of STIs and RTIs are often similar, making it difficult to clinically differentiate between the two. Different infectious agents may be responsible for similar symptoms. These symptoms (combined with clinical signs in most cases) have been classified into well-defined STI syndromes. Each syndrome is recognised as having more than one (usually two or possibly three) common aetiological cause, and management of the symptomatic patient includes giving treatment for these [multiple] pathogens. Syndromic management (which is widely promoted by WHO and others) involves recognising a group of self-reported symptoms (combined with clinical signs in most cases) which together constitute a syndrome. Simple algorithms (flowcharts) outline how to diagnose and treat clients, promote counselling, partner management and other components of effective STI management. Syndromic management algorithms aim to standardise diagnosis and treatment for people complaining of a number of well-recognised syndromes.[9] Table 3 presents common STI/RTI syndromes affecting the reproductive tract of women.[7, 10]

Table 3. Classification of Common STI/RTI Syndromes. Description of common STIs/RTIs by syndrome and their associated causative agent.[* 7,10]

Syndrome	STI/RTI	Causative Agent	Agent Type	Sexually Transmitted*	Curable
Genital ulcer	Syphilis	*Treponema pallidum*	Bacterial	Yes	Yes
	Chancroid	*Haemophilus ducreyi*	Bacterial	Yes	Yes
	Herpes	Herpes simplex virus (HSV-2)	Viral	Yes	No
	Lymphogranuloma venereum	*Chlamydia trachomatis*	Bacterial	Yes	Yes
Discharge+	Bacterial Vaginosis	Multiple	Bacterial	No	Yes
	Yeast Infection	*Candida albicans*	Fungal	No	Yes
	Gonorrhoea	*Neisseria gonorrhoea*	Bacterial	Yes	Yes
	Chlamydia	*Chlamydia trachomatis*	Bacterial	Yes	Yes
	Trichomoniasis	*Trichomonas vaginalis*	Protozoal	Yes	Yes
Lower Abdominal Pain		*Neisseria gonorrhoea, Chlamydia trachomatis*, vaginal anaerobic bacteria	Bacterial	Both	Yes

*Table adapted from WHO 2005 and Engender Health 2005.
+This symptom is often due to factors other than STIs.
NB: Women may also present with genital itching as their primary complaint.

4.2. Diagnosing STIs/RTIs

STIs/RTIs may be diagnosed through three different and complementary approaches: clinical aetiological, laboratory aetiological and syndromic management. Any single one used in isolation is likely to miss infected women particularly in cases where the patient is asymptomatic or presents with only mild symptoms. A description of the three approaches with their corresponding advantages and disadvantages is presented in Table 4. Further details on aetiological diagnostics may be found in Section 9 and Appendix 6.

Table 4. Approaches to STI/RTI diagnosis. Description of the three common approaches to diagnosing STIs/RTIs with their corresponding advantages and disadvantages.* [10,11]

Diagnostic Approach	Operational Definition	Advantages	Disadvantages
Clinical Aetiological	Provider relies on symptoms reported by the client and clinical signs observed during physical examination to arrive at a specific diagnosis	Problem oriented; improves clinical diagnosis; treatment given in one visit; treatment standardisation; training tool for primary care providers; evaluation of training; surveillance	Low sensitivity; low specificity; requires referral level; setting-specific; requires regular updates; mixed infections cannot be detected; previous self-treatment or treatment by another provider (including traditional medication) may alter symptoms at time woman is examined; least reliable of the three approaches
Laboratory Aetiological+	Laboratory test(s) identify the specific infectious agent; often requires second visit to collect results and begin treatment	Most reliable and accurate of the three approaches if equipment, materials and well-trained staff are available; effectiveness increased when used in conjunction with syndromic management	High resource requirements; results not immediately available; tests may vary in sensitivity and specificity
Syndromic Management	Provider uses patient reported symptoms and clinical signs observed during physical examination, and then refers to a series of flowcharts (algorithms) that guide the provider through the identification and treatment of STI-associated syndromes	Treatment is effective for *all* possible infections; low-cost; one-dose immediate treatments increase effectiveness	Over-treatment costs; consequences of over-treatment; not useful for asymptomatic infections; limited effectiveness for vaginal discharge algorithm

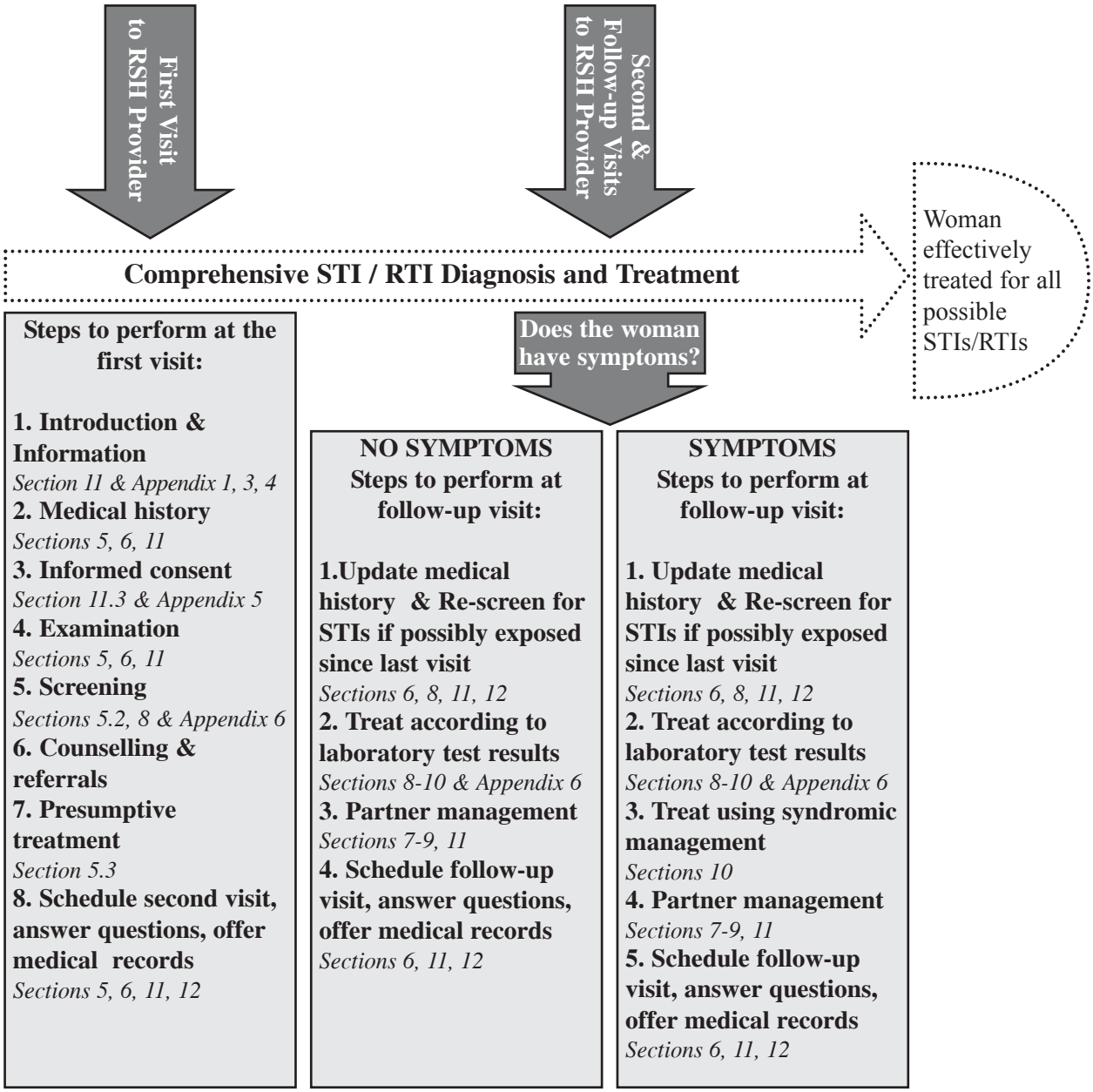
* Table adapted from Engender Health 2005 and Dalabetta *et al* 1998.
+Detailed information on recommended laboratory diagnostics is provided in Section 9 and Appendix 6.

5. Protocol for Comprehensive STI/RTI Diagnosis & Treatment: First Visit

In order to make the woman feel at ease and provide comprehensive care, several steps are recommended for the RSH service provider. Figure 2 provides an overview of the steps that should be taken by all service providers. Sections 5 and 6 provide further details for the protocol and recommended step-by-step guides to the first and follow-up RSH visits.

Figure 2. Protocol for Comprehensive STI/RTI Diagnosis and Treatment for RSH Providers Treating Survivors of Trafficking

Summary of recommended steps all RSH providers should take to ensure comprehensive STI/RTI care for women. Details of each step are provided in the indicated sections. Sections 5 and 6 provide further details on the recommended step-by-step protocol to diagnosis and treatment at the first and follow-up visits.



5.1. Step-by-step: Protocol for the first visit

The first visit should include the following:

✓ **Step 1 Introduction & Information**
Introduce self and explain slowly and clearly what will happen during this visit, the purpose for questions, exams and/or procedures, and the measures taken to ensure her privacy and confidentiality. (*Section 11 & Appendix 1, 3 ,4*)

✓ **Step 2 Medical History**
Take the woman's personal medical history including: date of her last period; type of contraception used; previous medical, surgical and gynaecological history; vaccination status; allergies; and any medication she is currently taking. (*Section 5, 6, 11*)

✓ **Step 3 Informed Consent**
Obtain informed consent for all tests and procedure to be performed.
(*Section 11.3 and Appendix 5*)

✓ **Step 4 Examination**
Perform a physical examination
- Speculum and bimanual examination to look for signs of STI/RTI not noticed by the woman. (*Section 11*)

✓ **Step 5 Screening**
Screen woman for syphilis, Hepatitis B, cervical infection, cervical dysplasia, and HIV (*Sections 5.2, 8 & Appendix 6*)
- Cultures for *N. gonorrhoea* and *C. trachomatis*
- Wet mount and culture of a vaginal swab specimen for *T. vaginalis*, BV and candidiasis
- Pap smear for cervical dysplasia evaluation
- Collection of serum samples for evaluation of syphilis, hepatitis B and HIV

✓ **Step 6 Counselling & Referrals**
Provide counselling and appropriate referrals (including for hepatitis B vaccination, if indicated)

✓ **Step 7 Presumptive Treatment**
Provide presumptive treatment for both symptomatic and asymptomatic women. (*Section 5.3*)

✓ **Step 8 Schedule Second Visit, Answer Questions, Offer Medical Records**
Schedule follow-up visit(s) to collect test results, answer questions or concerns, and offer to provide the woman with a copy of her medical records. (*Sections 11, 12*)

5.2. Screening for RTIs/STIs and HIV

Many women will only seek treatment when they are symptomatic. The use of screening strategies is an essential method for detecting and treating infections among asymptomatic women. Syphilis, gonorrhoea, HPV, Hepatitis B, and chlamydia are examples of often mild or asymptomatic infections with serious consequences that may not be recognized by the patient and can be missed by the provider.[7] WHO estimates that 60-70% of women with gonococcal and chlamydial infection go undetected when using algorithms based on symptoms, since many women will have an asymptomatic infection.[12]

Among high-risk populations such as trafficked women, routine screening for common RTIs/STIs should be implemented in all RSH service settings using a *no-missed opportunities* approach, which includes using history taking, clinical screening, and laboratory screening. Following this approach, the provider will make use of available opportunities and strategies to effectively diagnose and treat women. Table 5 provides information on the screening methods that should be employed at the first visit in order to identify a woman with asymptomatic infections. (See Sections 5.1 and 6.1 for step-by-step protocol on conducting a RSH consultation). Screening tests for syphilis, gonorrhoea cultures and cervical smears are all capable of detecting more than 80% of asymptomatic infections.

HIV testing is encouraged for all women but should not be mandatory. Active management of HIV/AIDS is recommended. That is, a woman should be aware of all the tests and treatment options available to her. Women should be counselled on the benefits of testing and assured of confidentiality. HIV/AIDS education should be provided by trained staff at either the NGO partner agency or health care provider level. If the available staff are not trained in pre- and post-test counselling, the woman should be referred to a local HIV organisation or facility. The NGO partner agency should cooperate with the regional HIV/AIDS centre to ensure that women receive confidential testing and care. The process by which a woman gives her informed consent may vary from setting to setting, but in general testing is acceptable if the woman is provided with sufficient information, treated with compassion, and understands her options.[13, 14] (See Appendix 5 and 10 for an example of a testing consent form and additional useful resources).

Table 5. STI/RTI Screening Options for Women. Description of screening tests and methods that should be performed at the first visit.[7,15]

Infection or Condition	Screening Method +	In 100 cases, number that will be detected ^	Comment
Syphilis	Non-treponemal specific serological screening tests *	80-86 [primary] 100 [secondary] 80 [latent] 71-73 [late stage]	All seropositive women should receive treatment and confirmatory tests with a treponemal specific test when available
Hepatitis B	History taking (no previous vaccination); HBsAg test	Varies	Rapid tests available; All women with no history of previous vaccinations should be referred for vaccination
Cervical Infection (Gonorrhoea and/or Chlamydia)	Culture for gonorrhoea	95	Accurate; requires laboratory with CO_2 jars, incubator and culture media
	Chlamydia test §	60-70	Expensive; misses many cases (false negatives)
	Chlamydia PCR	95	Expensive; Requires advanced equipment and training
	Clinical examination	30-40	Inexpensive; misses many cases (false negatives)
Cervical Dysplasia	Pap smear	80	Effective for early detection and prevention of cervical cancer
HIV	Various tests available through regional HIV centres	No data	Available tests in Ukraine include: Vironostika HIV Uni-Form Ag/Ab; Genscreen Plus HIV Ag-Ab; confirmatory testing and counselling recommended

+ See Laboratory Diagnostic Section 8 and Appendix 6 for details on specific diagnostic methods.
* RPR (Rapid Plasma Reagin), VDRL (Venereal Disease Research Laboratory) tests.
§ For example, ELISA (enzyme-linked immunosorbent assay) or direct Immunofluorescence test.
^ Under ideal conditions and depending on stage of disease. Field performance may be lower.

5.3. Presumptive Treatment

Presumptive treatment is recommended at the first visit. (See Section 5.1, Step 7) Presumptive treatment provides a full curative dose of drugs based on the assumption that a person is infected[7] and is recommended when the STI/RTI prevalence is high among a population and the patient is considered unlikely to return for follow-up treatment. It is strongly recommended that all trafficked women who are victims of sexual violence be given presumptive treatment.[1]

U.S. CDC guidelines recommend the following presumptive treatment regimen be given at the initial examination to victims of sexual assault:

Presumptive Treatment at Initial Examination
Recommended Regimen:

Ceftriaxone 125 mg IM, single dose
PLUS
Metronidazole 2 g orally, single dose
PLUS
Azithromycin 1 g orally, single dose
OR
Doxycycline 100 mg orally, twice daily for 7 days[1]

- Empiric antimicrobial regimen for chlamydia, gonorrhoea, trichomonas, and BV.[1] Treatment for syphilis may also be added.
- If no history of previous vaccination, post-exposure hepatitis B vaccination (without HBIG) to protect against HBV. Follow-up doses should be administered at 1-2 and 4-6 months after the first dose.

The step-by-step protocol for the first RSH visit described in Section 5.1. employs laboratory aetiological screening followed by presumptive treatment for common infections. The importance of this strategy cannot be overemphasised as several serious complications may arise among women with untreated infections including pelvic inflammatory disease (PID), infertility and congenital infections.

6. Protocol for Comprehensive STI/RTI Diagnosis & Treatment: Follow-up Visits

6.1. Step-by-step: Protocol for the second and follow-up visits

The necessity of follow-up visits should be emphasized to all women. The follow-up visits provide the clinician and woman with (a) the opportunity to discuss test results and appropriate treatment options; (b) detect any new infections or symptoms; and (c) complete counselling and treatment for other STIs/RTIs. Women should also be counselled on the signs and symptoms of other STIs/RTIs and told to return if any occur.

The second visit and subsequent follow-up visits should include the following:

✓ **Step 1 Update Medical History & Re-Screen for STIs if Possibly Exposed Since Last Visit**
Update the woman's personal medical history including: assessing completion of drug regimen prescribed at first visit; new symptoms or problems; new sexual partners; new medications; and any sexual health issues or concerns. (*Sections 8, 11, 12*)

✓ **Step 2 Treat According to Laboratory Test Results & Treat Using Syndromic Management**
If the woman returns with symptoms:

- Check results of laboratory tests and determine if appropriate treatment was prescribed during the first visit. (*Sections 8-10 & Appendix 6*)
- Assess if the symptom(s) are new or a continuation of the symptoms seen during the first visit
- Re-test for RTIs/STIs. If laboratory results indicate an RTI/STI, ensure that tests include antibiotic susceptibility patterns. (*Section 8 & Appendix 6*)
- Treat syndromically using second line drugs. (*Section 10*)

If the woman returns with no symptoms:

- Check results of laboratory tests and ensure that she has received appropriate treatment according to results of the first visit.

✓ **Step 3 Partner Management**
Counsel and offer partner treatment according to laboratory results. (*Section 7-9 & 11*)

✓ **Step 4 Schedule Follow-up Visit, Answer Questions, Offer Medical Records**
Schedule follow-up visit(s) if appropriate, answer questions or concerns, and offer to provide the woman with a copy of her medical records. (*Sections 11, 12*)

7. Partner Management

Survivors of trafficking may have current sexual partners who have a STI. The effective treatment of STIs requires the prompt treatment of infected sexual partners in order to prevent re-infection and further transmission. Partner treatment options should be discussed with women from the very first visit.

It is strongly advised that medical providers not only treat the woman, but also explain the importance of treating all accessible sexual partners within a prescribed period (3-12 months following the first visit).

However, in advising women to approach sexual partners to suggest testing and treatment, it is critical that providers learn whether this will pose any risk to the woman. A woman's current partner, family and community may not be aware of her past experience. Revealing this sensitive information to her partner may expose her to gossip, stigmatisation, community outcast, loss of future relationship or marriage possibilities, or partner violence. Yet, providing the woman with counselling and explaining the benefits of treating all partners is a necessary aspect of partner management.

The various options for partner notification and treatment should be discussed with the women. Depending on the resources of the provider and the individual situation of the woman, options may include: (1) the woman herself informing and accompanying her partner for treatment; (2) provider assisted notification and treatment; or alternatively (3) expedited partner therapy where the woman delivers the medication to her partner without a clinical examination. [2] [16, 17, 18]

In all cases, the woman's consent must be obtained and issues of confidentiality addressed.

[2]A 2005 study found that expedited partner therapy reduced the rates of persistent or recurrent gonorrhea or chlamydial infection. (Golden *et al* 2005)

Section 8.

8. Laboratory Aetiological Diagnosis

Laboratory tests are necessary to make an aetiological diagnosis of an STI/RTI; to confirm a suspected STI; to detect infections in asymptomatic women; and to monitor the pattern of antimicrobial resistance of STI pathogens and treatment efficacy.[4] Samples should be collected at the first patient consultation under sterile condition and tests results returned as quickly as possible. The laboratory staff should be well trained in standard procedures and reliable equipment should be available.

As the capacity of laboratories to carry out certain tests will vary and few laboratories are capable of performing all of the assays described, three capacity levels were developed to reflect these differences. Table 6 outlines the minimum technical and equipment requirements necessary at each laboratory capacity level. The most effective diagnostic method for each laboratory capacity level is presented in Appendix 6 by specific infection with information on their sensitivity, specificity, advantages, disadvantages, training and equipment required. Providers should choose the optimal diagnostic method based on the capacity level of their local laboratory facilities.

Table 6. Minimum Requirements for Aetiological Diagnosis by Laboratory Capacity Level. Three laboratory capacity levels are outlined with the minimum technical and equipment requirements necessary to perform the recommended diagnostic tests. The recommended diagnostic methods are detailed in Appendix 6. *

Laboratory capacity level 1
Minimum aetiological diagnosis requires a clinical exam, trained laboratory staff, rapid tests, and basic serology (RPR, TPHA) or other microbiological techniques (Gram-stain, GC smear microscopy).[19] Basic equipment includes light microscope, microscope slides, Gram-stain reagents, normal saline and microscope cover slips, blood tubes, pipettes for serological tests, centrifuge and rotator.
Laboratory capacity level 2
Aetiological diagnosis requires a clinical exam and trained laboratory staff. Necessary equipment includes the basic equipment plus a fluorescent microscope or light microscope with dark field condenser, centrifuge, incubator, rotator, and candle jar.
Laboratory capacity level 3
Aetiological diagnosis requires a clinical exam and trained laboratory staff. Necessary equipment includes basic equipment plus a spectrophotometer, microfuge, thermal cycler, incubator, heat block, luminometer, and microwell plate reader.[20]

* Table adapted from WHO. STI/HIV *Laboratory Tests for the Detection of Reproductive Tract Infections*. 1999 and U.S. CDC. *Laboratory Support*. 2005.

9. Management of Specific STIs/RTIs

9.1. Clinical Management

Reducing the burden of STIs/RTIs requires not only accurate diagnosis and treatment but also effective clinical management. Health providers working with women seeking treatment for sexual and reproductive health concerns must address several important management issues including treatment compliance and re-infection issues.

9.1.1. Treatment Compliance

Single-dose drug treatments are advised for effective treatment. Should single-dose treatments not be available or appropriate, health care providers should advise women on the necessity of completing the full therapy course. Women should understand the need to continue their treatment even if they begin to feel better, and not to share their medication with others.

To increase treatment compliance, medication should be easily available directly through the provider or an on-site pharmacy. Pharmacists should always sell the patient a full course dose.[7]

For women accessing care through IOM partner agencies, issues of treatment compliance and follow-up may be addressed through referrals to health care facilities where treatment is easily accessed and administered. A case manager should be aware of the woman's treatment plan and periodically confirm that the woman was able to obtain her medication and has completed the full regimen.

9.1.2. Current Partner Treatment and Re-Infection

Many women will have re-established family lives or relationships upon their return to Ukraine. After a discussion of the risk each woman might face if others discovered her history, the treatment of current sexual partners should be recommended to any woman diagnosed with an STI in a way that ensures her well-being. The long-term reproductive health impacts can be impressed upon the woman, as re-infection will likely occur upon return to any untreated infected partner. Her partner may or may not be symptomatic, but should be treated for the same STI.

Women should also be counselled to avoid sexual intercourse until they have completed their treatment. Women with ulcers should wait until ulcers have re-epithelialized and those with PID should avoid intercourse or use a condom. There are no special considerations for women treated for bacterial vaginosis or candidiasis.[7]

9.2. Management Guidelines for Specific Infections

Table 7 summarizes the recommended drug regimens, considerations and complications during pregnancy, and includes additional information for follow-up and partner treatment. The recommended drug regime is listed first, followed by alternative treatments. Additional considerations and possible complications are noted for pregnant women. Appendix 9 provides additional information on the use of certain medications during pregnancy. Infections where partner treatment is recommended and additional recommendations are also noted in Table 7.

Table 7. Management Guidelines for Specific Infections [7, 21]

STI/RTI (aetiological agent)	Recommended Treatment	Pregnancy/Newborn Considerations & Complications	Partner Treatment, Additional Considerations & Follow-up
Bacterial Vaginosis *(anaerobic bacteria, Gardnerella vaginalis, Mycolplasma hominis)*	• Metronidazole: 2 g orally, single dose OR 400-500 mg orally, twice daily for 7 days **Alternative treatment:** • Metronidazole: 2 g orally, single dose OR 0.75% gel OR 5 g intravaginally, twice daily for 5 days • Clindamycin: 2% vaginal cream, 5 g intravaginally at bedtime for 7 days OR 300 mg orally, twice daily for 7 days	Metronidazole is not recommended during the 1st trimester but may be given at lower dosages during 2nd and 3rd trimesters. Treat symptomatic women; re-treat women with symptom recurrence; screen women with history of pre-term delivery to detect asymptomatic infections. Risks of untreated infection during pregnancy include pre-term delivery, pre-labour rupture of membranes, chorioamnionitis, post-partum endometritis, and low-birth weight.	Partner treatment not recommended. Predisposing factors should be eliminated (i.e. antiseptic/antibiotic vaginal preparations, vaginal douching). Follow-up visits advised if symptoms continue.
Chancroid *(Haemophilus ducreyi)*	• Ciprofloxacin: 500 mg orally, twice daily for 3 days • Erythromycin base: 500 mg orally, 4 times daily for 7 days • Azithromycin: 1 g orally, single dose **Alternative treatment:** • Ceftriaxone: 250 mg by intramuscular injection, single dose	Use erythromycin, azithromycin or ceftriaxone therapies if woman is pregnant or breastfeeding.	No special treatment recommended for lesions. Ulcerative lesions should be kept clean; fluctuant lymph nodes should be aspirated as required through the surrounding healthy skin. Incision or excision may delay healing. Weekly follow-up recommended until improvement is evident.
Chlamydia *(Chlamydia trachomatis)*	• Doxycycline: 100 mg orally, twice daily for 7 days • Azithromycin: 1 g orally, single dose **Alternative treatment:** • Amoxicillin: 500 mg orally, 3 times daily for 7 days • Ofloxacin [3]: 300 mg orally, twice daily for 7 days [1] • Tetracycline: 500 mg orally, 4 times daily for 7 days • Erythromycin (if tetracycline is contraindicated): 500 mg orally, 4 times daily for 7 days	Erythromycin estolate is contraindicated during pregnancy, only erythromycin base or ethylsuccinate should be used. Erythromycin, azithromycin, or amoxicillin recommended for pregnant or lactating women. Adverse outcomes of untreated infection during pregnancy include preterm delivery, low birth weight, conjunctivitis, pneumonia, and otitis.	Evidence suggests that extending treatment beyond days does not improve the cure rate in uncomplicated infections.

[3] Ofloxacin, when used for Chlamydia infection, also treats gonorrhoea.

STI/RTI (aetiological agent)	Recommended Treatment	Pregnancy/Newborn Considerations & Complications	Partner Treatment, Additional Considerations & Follow-up
Genital Herpes *(Herpes Simplex Virus)*	***First clinical episode:*** • Acyclovir: 200 mg orally, 5 times daily for 7 days OR 400 mg orally, 3 times daily for 7 days • Valacyclovir: 1 g orally, twice daily for 7 days • Famciclovir: 250 mg orally, 3 times daily for 7 days ***Recurrent infection:*** • Acyclovir: 200 mg orally, 5 times daily for 5 days OR 400 mg orally, 3 times daily for 5 days OR 800 mg orally, twice daily for 5 days • Valacyclovir: 500 mg orally, twice daily for 5 days OR 1000 mg orally, once daily for 5 days • Famciclovir: 125 mg orally, twice daily for 5 days ***Suppressive therapy:*** • Acyclovir: 400 mg orally, twice daily, continuously • Valacyclovir: 500 mg orally, once daily OR 1000 mg orally, once daily • Famciclovir: 250 mg orally, twice daily ***Severe disease:*** • Acyclovir: 5-10 mg/kg IV, every 8 hours for 5-7 days or until clinical resolution is obtained.	Treat with oral acyclovir if first clinical episode of genital herpes otherwise use only when potential benefit outweigh risk. Topical preparations have limited absorption. Genital cultures late in pregnancy are poor predictors of shedding during delivery. Assess need for caesarean section in women with lesions by history taking and examination. Adverse outcomes of untreated infection during pregnancy include dissemination of infection (especially if acquired in the third trimester), spontaneous abortion, pre-term delivery. Complications to the newborn include neonatal herpes, encephalitis, disseminated infection, skin/eye/mouth infection.	No known cure though early detection and systemic treatment with acyclovir (or its analogues) may alter the course of symptoms. The lowest continuous suppressive dosage can only be determined empirically. Some experts recommend discontinuing acyclovir after 1 year of continuous use to reassess recurrence rate, may be safely used up to 6 years. Valacyclovir and Famciclovir may be safely used for 1 year.
Genital Warts/Cervical Lesions *(Human Papilloma Virus)*	***Vulval Warts:*** **A.1. Chemical - Patient administered**[4] • Podophyllotoxin: 0.5% solution or gel, by cotton-tipped swab twice daily for 3 days followed by 4 days of no treatment, the cycle can repeated up to 4 times (total volume should not exceed 0.5 ml per day) • Imiquimod: 5% cream at bedtime 3 times a week for up to 16 weeks. Treatment area should be washed with soap and water 6-10 hours after application, hands thoroughly washed after application.	Podophyllotoxin and Imiquimod are contraindicated during pregnancy and lactation. Adverse outcomes of untreated warts during vaginal delivery on newborns include laryngeal papilomatosis.	Partners should be examined, condom use recommended, and patients with anogenital warts should be aware they are contagious to their partners. No treatment is completely satisfactory. Specific HPV types may lead to invasive cervical carcinoma.

[4] "Patient administered" refers to self-treatment of external anogenital warts that can be identified and reached by the patient. First treatment must be applied by the provider.

STI/RTI (aetiological agent)	Recommended Treatment	Pregnancy/Newborn Considerations & Complications	Partner Treatment, Additional Considerations & Follow-up
Genital Warts/Cervical Lesions *(Human Papilloma Virus)*	**A.2. Chemical - Provider administered** • Podophyllin: 10-25% in compound tincture of benzoin, applied directly to warts avoiding normal tissue. External genital and perianal warts should be thoroughly washed 1-4 hours after application. If applied on vaginal or anal epithelial surfaces allow speculum or anoscope to dry. Repeat treatment weekly. • Podophyllotoxin: 0.5% is equal in efficacy to podophyllin but less toxic and causes less erosion. • Trichloroacetic acid (TCA): 80-90% applied directly to warts, avoiding normal tissue followed by powdering with talc or sodium bicarbonate to remove untreated acid. Repeat application weekly. **B. Physical - Provider administered** • Cryotheraphy with liquid nitrogen, solid CO_2, or a cyroprobe. Repeat application every 1-2 weeks • Electrosurgery • Surgical removal ***Vaginal Warts:*** • Cryotheraphy with liquid nitrogen • Podophyllin: 10-25%. Allow to dry before removing speculum • TCA: 80-90% ***Cervical Warts:*** • Management includes consultation with a specialist to evaluate for cervical dysplasia. Use of podophyllin or TCA is not recommended. Treatment includes cryotherapy or surgical removal and regular pap smears		
Gonorrhoea *(Neisseria gonorrhoea)*	***Urogenital and rectal gonorrhoea:*** • Cefixime: 400 mg orally, single dose • Ceftriaxone: 125 mg intramuscular injection, singe dose • Ciprofloxacin: 500 mg orally, single dose • Spectinomycin: 2 g intramuscular injection, single dose		

STI/RTI (aetiological agent)	Recommended Treatment	Pregnancy/Newborn Considerations & Complications	Partner Treatment, Additional Considerations & Follow-up
Gonorrhoea *(Neisseria gonorrhoea)*	**Alternative treatments:** • Cefotaxime: 1 g intramuscular injection • Ceftizoxime:1 g intramuscular injection • Cefuroxime: 1.5 g intramuscular injection • Levofloxacin: 250 mg orally, single dose • Norfloxacin: 400 mg orally, single dose • Ofloxacin: 400 mg orally, single dose • Trimethoprim/Sulfamethoxazole: 80/400 mg orally, 10 tablets as a single dose, daily for 3 days ***Uncomplicated gonococcal infection:*** • Cefixime: 400 mg orally, single dose • Ceftriaxone: 125 mg intramuscular injection, singe dose • Ciprofloxacin: 500 mg orally, single dose • Ofloxacin: 400 mg orally, single dose • Spectinomycin: 2 g intramuscular injection, single dose ***Disseminated gonococcal infection:*** • Ceftriaxone: 1 g intramuscular or IV injection, one time for 7 days. (3rd generation cephalosporins may be used, but more frequent administrations may be required.) • Spectinomycin: 2 g intramuscular injection, two times daily for 7 days. (Some data suggests 3 days may be adequate.) The same dosages apply for gonococcal meningitis and endocarditis but for endocarditis, the therapy duration must be increased to 4 weeks. ***Adult gonococcal conjunctivitis:*** • Ceftriaxone: 125 mg intramuscular injection, singe dose • Spectinomycin: 2 g intramuscular injection, single dose • Ciprofloxacin : 125 mg intramuscular injection, singe dose • Kanamycin (alternative regimen): 2 g intramuscular injection, single dose	Ciprofloxacin, levofloxacin, norfloxacin, ofloxacin, and trimethoprim / sulfamethoxazole are contraindicated during pregnancy. Adverse outcomes of untreated infection during pregnancy include spontaneous abortion, postpartum endometritis, prelabour rupture of membranes, preterm delivery and newborn ophthalmia neonatorum.	Resistant strains have been documented to penicillin, tetracyclines, and other older antimicrobial agents. Important to monitor *in vitro* susceptibility as well as clinical efficacy. Follow-up of clinical progress for conjunctivitis is important.

STI/RTI (aetiological agent)	Recommended Treatment	Pregnancy/Newborn Considerations & Complications	Partner Treatment, Additional Considerations & Follow-up
Hepatitis A[22]	**Treatment**: • Exposure >2 weeks: Supportive care only, no restrictions in diet or activity • Exposure <2 weeks & unvaccinated: IG, single IM dose Prevention with Hep A vaccine: First dose administered at initial visit, second dose 6-12 months after first dose		
Hepatitis B[23]	**Treatment**: Hepatitis B immune globulin (HBIG): Chronic hepatitis B in some patients is treated with interferon or lamivudine, which can help some patients.[24] Prevention based on patient immunization status - ***Never vaccinated for Hep B:*** First dose administered at initial visit, second dose 1-2 months later, third dose 4-6 months after first dose ***Not completed Hep B vaccination series:*** Complete series as scheduled ***Completed Hep B vaccination series:*** No need to re-vaccinate	HBIG and Hep B vaccines are not contraindicated during pregnancy. Pregnant women should receive vaccine. All pregnant women should be tested for HBsAg.[22] Adverse outcomes of untreated infection during pregnancy include perinatal Hep B.	
Hepatitis C[22, 25]	• Antiviral drugs such as alpha interferon taken alone or in combination with ribavirin for 6-12 months • No vaccine currently available		Treatment with interferon alone is effective in about 10% to 20% of patients. Interferon combined with ribavirin is effective in about 30% to 50% of patients. Ribavirin does not appear to be effective when used alone. Patients who test positive should be advised to avoid alcohol and taking new medications unless it is physician approved.
Lymphogranuloma Venereum	• Doxycycline: 100 mg orally, twice daily for 14 days • Erythromycin: 500 mg orally, 4 times daily for 14 days **Alternative treatment:** • Tetracycline: 500 mg orally, 4 times daily for 14 days	Tetracyclines are contraindicated in pregnancy.	Fluctuant lymph nodes should be aspirated through healthy skin. Incision and drainage or excision of nodes may delay healing. Some patients with advanced disease may require treatment longer than 14 days, and sequelae such as strictures and/or fistulae may require surgery.

STI/RTI (aetiological agent)	Recommended Treatment	Pregnancy/Newborn Considerations & Complications	Partner Treatment, Additional Considerations & Follow-up
Syphilis *(T pallidum)*	***Early Syphilis*** • Benzathine penicillin: 2.4 million IU, intramuscular injection, single dose **Alternative treatment:** • Procaine benzylpenicillin: 1,2 million IU, intramuscular injection, daily for 10 days • Doxycycline: 100 mg orally, twice daily for 14 days • Tetracycline: 500 mg orally, 4 times daily for 14 days ***During pregnancy & lactation:*** • Benzathine penicillin: 2.4 million units by single intramuscular injection • Erythromycin base or ethylsuccinate: (1) early syphilis - 500 mg orally, 4 times daily for 15 days ***Late Latent Syphilis*** • Benzathine penicillin: 2.4 million IU, intramuscular injection, once weekly for 3 consecutive weeks **Alternative treatment:** • Procaine benzylpenicillin: 1,2 million IU, intramuscular injection, daily for 20 days • Doxycycline: 100 mg orally, twice daily for 14 days • Tetracycline: 500 mg orally, 4 times daily for 14 days ***During pregnancy & lactation:*** • Erythromycin base or ethylsuccinate: 500 mg orally four times daily for 30 days. ***Neurosyphilis*** • Aqueous Benzylpenicillin: 12-24 million IU, intravenous injection, daily doses of 2-4 million IU, every 4 hours for 14 days **Alternative treatment:** • Procaine benzylpenicillin: 1,2 million IU, intramuscular injection, once daily and probenecid, 500 mg orally, 4 times daily, both for 10-14 days • Doxycycline: 200 mg orally, twice daily for 30 days • Tetracycline: 500 mg orally, 4 times daily for 30 days	Doxycycline, tetracycline and erythromycin estolate are contraindicated during pregnancy. Pregnant women should be monitored to detect possible re-infection after treatment has been administered. Patients should always be given penicillin if not allergic according to the stage of disease. Penicillin desensitisation may be performed. Possible complications during pregnancy if untreated include spontaneous abortion, postpartum endometritis, pre-labour rupture of membranes, preterm delivery, and congenital infection abnormalities. Follow-up after treatment should include quantitative non-treponemal serological tests at monthly intervals until delivery, and re-treatment if serological evidence of re-infection or relapse.	Follow-up should include an assessment of reinfection after the first year of therapy. Patients with early syphilis appropriately treated with penicillin should be clinically and serologically evaluated. Evaluations should also take place after 6 months, and at 12 months to detect possible re-infection.

STI/RTI (aetiological agent)	Recommended Treatment	Pregnancy/Newborn Considerations & Complications	Partner Treatment, Additional Considerations & Follow-up
Trichomoniasis *(Trichomonas vaginalis)*	• Metronidazole: 2 g orally, single dose OR 400-500 mg orally, twice daily for 7 days **Alternative treatment:** • Tinidazole: 2 g orally, single dose OR 500 mg orally, twice daily for 5 days ***During pregnancy & lactation:*** • Metronidazole: 200-250 mg orally, 3 times daily for 7 days OR 0.75% gel, 5 g intravaginally, twice daily for 5 days • Clindamycin: 300 mg orally twice a day for 7 days	Possible complications if untreated include pre-labour rupture of membranes, preterm delivery, post-caesarean endometritis, and newborn vaginal infection.	
Vulvovaginal Candidiasis *(Candida spp.)*	• Miconazole: 200 mg vaginal suppository, daily for 3 days • Clotrimazole: 100 mg vaginal tablet, 2 tables daily for 3 days • Fluconazole: 150 mg orally, single dose **Alternative treatment:** • Nystatin: 100 000 unit vaginal tablet, daily for 14 days	Increased susceptibility to Candida during pregnancy. Recommended therapies during pregnancy and lactation include miconazole, clotrimazole and nystatin.	

10. Management of Symptomatic STIs/RTIs

10.1. Syndromic Management

As detailed in Section 5.2., presumptive treatment should be offered on the first visit to all women who have experienced sexual violence, based on the assumption of infection and the probability that they will not return for future visits. Syndromic management can also provide an effective approach to treating common STI/RTI syndromes - symptoms and signs based on the organism most commonly responsible for each syndrome - quickly and effectively. Combining presumptive treatment (first RSH visit) and syndromic management (follow-up RSH visits) have been shown to increase the sensitivity of detecting cervical infection to nearly 100%.[26] Some common syndrome examples include vaginal discharge, lower abdominal pain and genital ulcers. (See Section 4, Table 3 for an overview of common STI/RTI syndromes.) Determining the exact cause of each syndrome may be difficult, therefore treatment should be effective for several possible infections.[7]

Syndromic management has been found useful among high-risk populations in a variety of settings. In the case of trafficking and sexual exploitation, many women will have been exposed to multiple STIs and may have never accessed RSH care. Aetiological diagnoses may not always be ideal as laboratory tests can vary widely in sensitivity and specificity and require that the woman make extra visits to the health facility for test results, inevitably resulting in treatment delays.[7] In the case of genital ulcers, at least 25% of patients will have no laboratory confirmed diagnosis even after a complete diagnostic evaluation. Immediate treatment substantially reduces the possibility of on-going STI transmission.[22]

Since their introduction in 1991 by WHO, syndromic management guidelines have become commonplace in a variety of settings, even in countries with advanced laboratory facilities.[27] However, the syndromic approach should not be relied upon as the sole means of STI/RTI management in women as several limitations have been noted. The syndromic management of vaginal discharge is not an efficient method for identifying women with cervical infections.[28] In addition, studies have shown it to have a poor sensitivity (30-80%) and specificity (40-80%) for the diagnosis of *Neisseria gonorrhoea* and *Chlamydia trachomatis*.[29]

Despite these limitations, syndromic management can be a valuable tool in helping ensure that women are effectively treated, particularly in cases where treatment follow-up may be difficult.

10.2. Management of Common STI-Associated Syndromes

WHO has developed simple algorithms (flowcharts) to aid providers in using the syndromic approach for various syndromes. Flowcharts for vaginal discharge, lower abdominal pain, and genital ulcers are described in the following sections. Please refer to Section 9 for specific management therapies. Additional useful resources on using syndromic management are presented in Appendix 10.

10.2.1. Vaginal Discharge

A vaginal infection or vaginitis is often indicated by the spontaneous complaint of an abnormal vaginal discharge (abnormal in terms of quantity, colour or odour) and is attributed to bacterial vaginosis (multiple organisms), yeast infection (*Candida albicans*), or trichomoniasis (*Trichomonas vaginalis*). Less often, vaginal discharge may be the result of mucopurulent cervicitis due to gonorrhoea (*Neisseria gonorrhoea*) or Chlamydia (*Chlamydia trachomatis*).

Treatment for bacterial vaginosis and trichomoniasis should be given to all women with abnormal discharge. Treatment for yeast infection is indicated when clinically apparent (white, curd-like discharge, redness of the vulva and vagina, and itching).

Two flowcharts are presented for treatment of vaginal discharge, for pregnant and non-pregnant women (Figures 3 and 4).[7]

Figure 3. Vaginal Discharge Flowchart (non-pregnant women) [7]

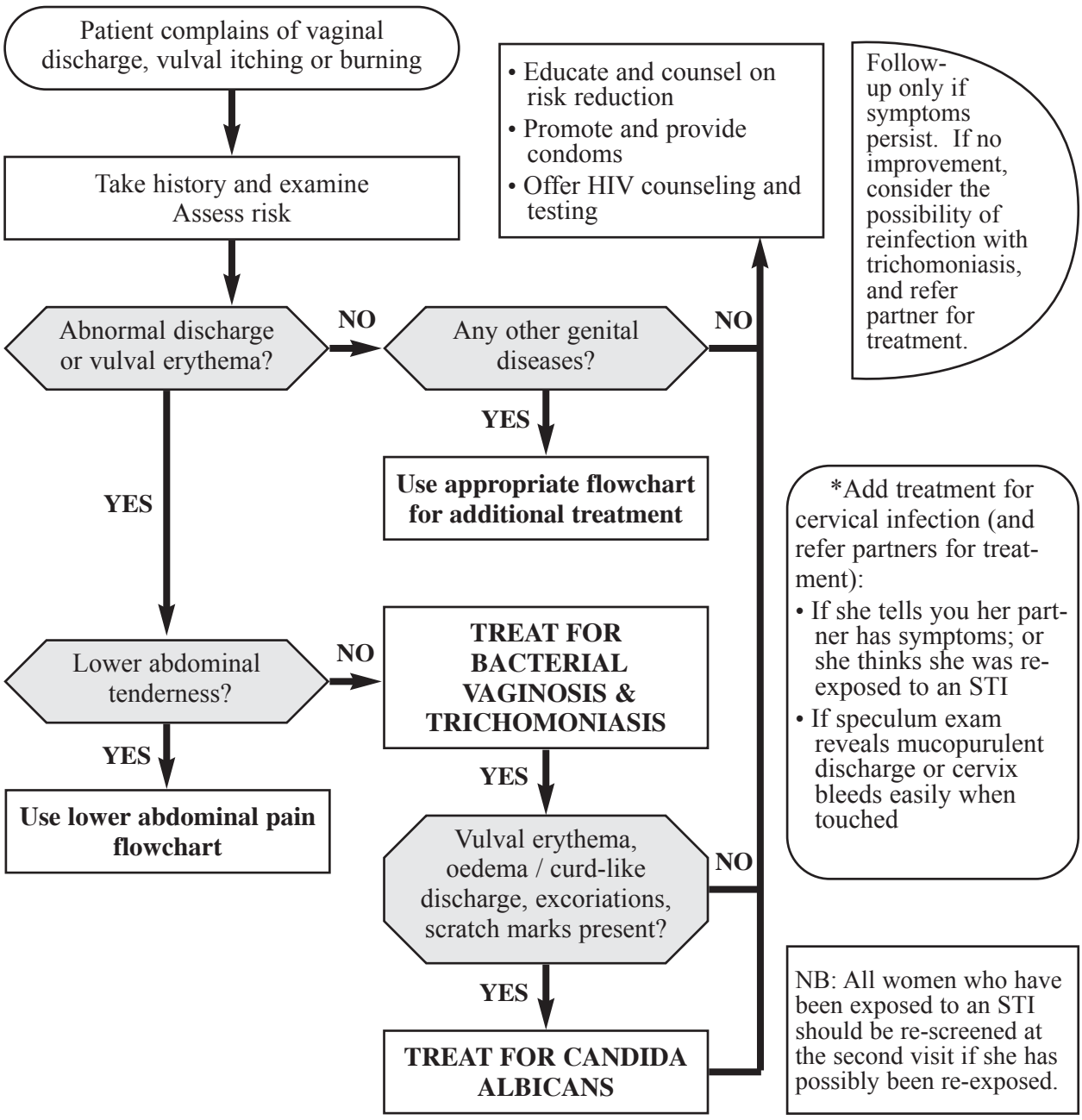
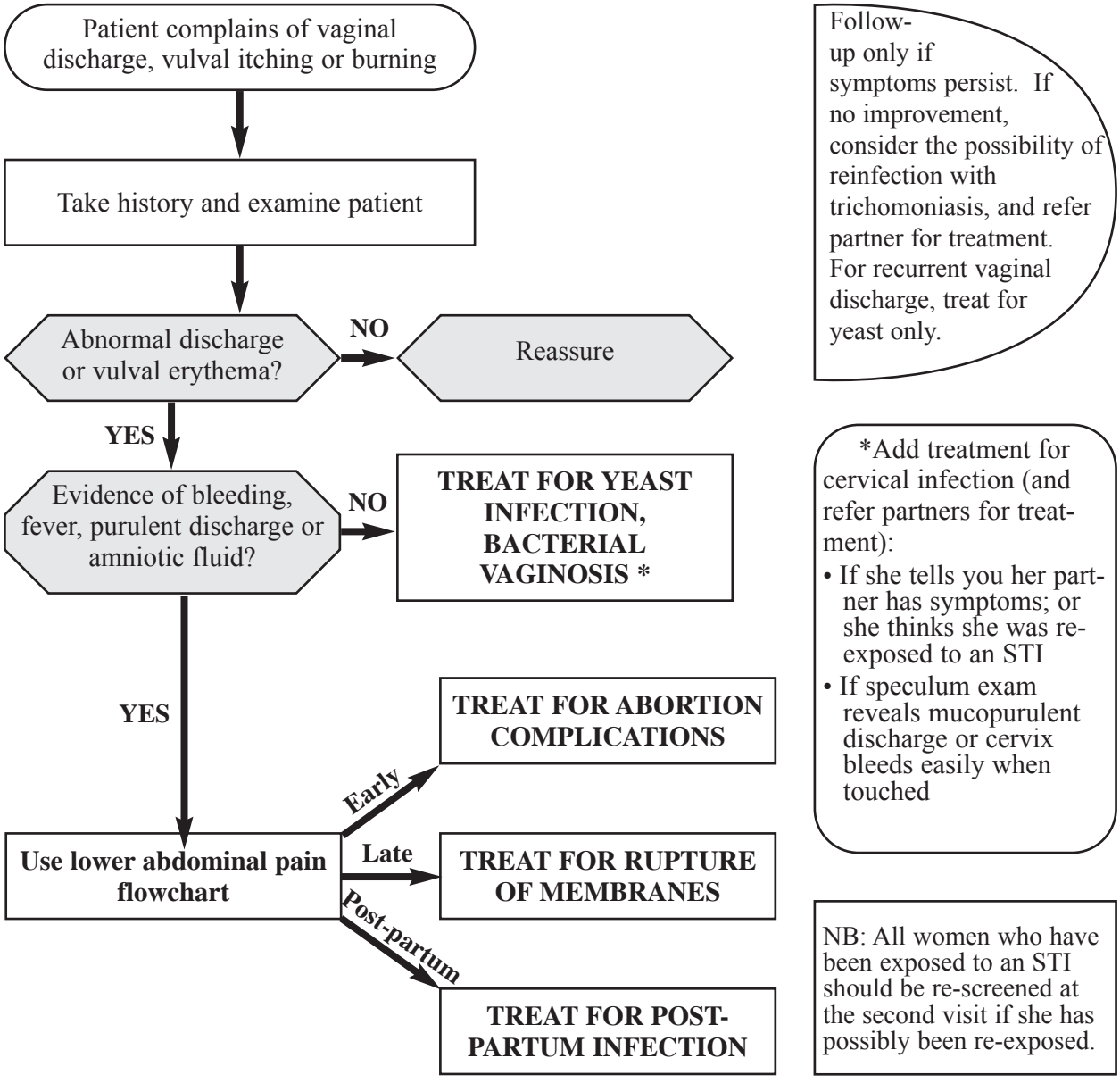


Figure 4. Vaginal Discharge Flowchart (pregnant women) [7]



10.2.2. Cervical Infection

Treatment for cervical infection should be added to the treatment for vaginitis, or if signs of cervical infection (mucopurulent cervical discharge or easy bleeding) are seen on speculum examination. The recommended treatment for cervical infection includes therapy for uncomplicated gonorrhoea plus chlamydia.[7]

10.2.3. Lower Abdominal Pain - Pelvic Inflammatory Disease (PID)

All women presenting with lower abdominal pain should be carefully evaluated for signs of pelvic inflammatory disease (PID). Clinical signs of PID are varied and may be minimal. Symptoms suggestive of PID include lower abdominal pain, pain on intercourse (dyspareunia), bleeding after sex or between periods, and pain associated with periods (if this is a new symptom). Vaginal discharge, pain on urination (dysuria), fever, nausea and vomiting may also be present. PID is highly probable when a woman has lower abdominal, uterine or adnexal tenderness, evidence of lower genital tract infection, and cervical motion tenderness. Enlargement or induration of one or both fallopian tubes, a tender pelvic mass, and direct or rebound abdominal tenderness may also be present. The patient's temperature may be elevated but is often normal.

Many cases of PID will be undiagnosed as the patient or provider will not recognize the implications of mild or non-specific symptoms (i.e. abnormal bleeding, dyspareunia, vaginal discharge). Due to the serious consequences of PID on the reproductive system and diagnostic difficulties, health care providers should treat all suspected cases. Treatment should be started as soon as the presumptive diagnosis has been made. Administering appropriate antibiotics immediately decreases the likelihood of long-term complications.[7, 22]

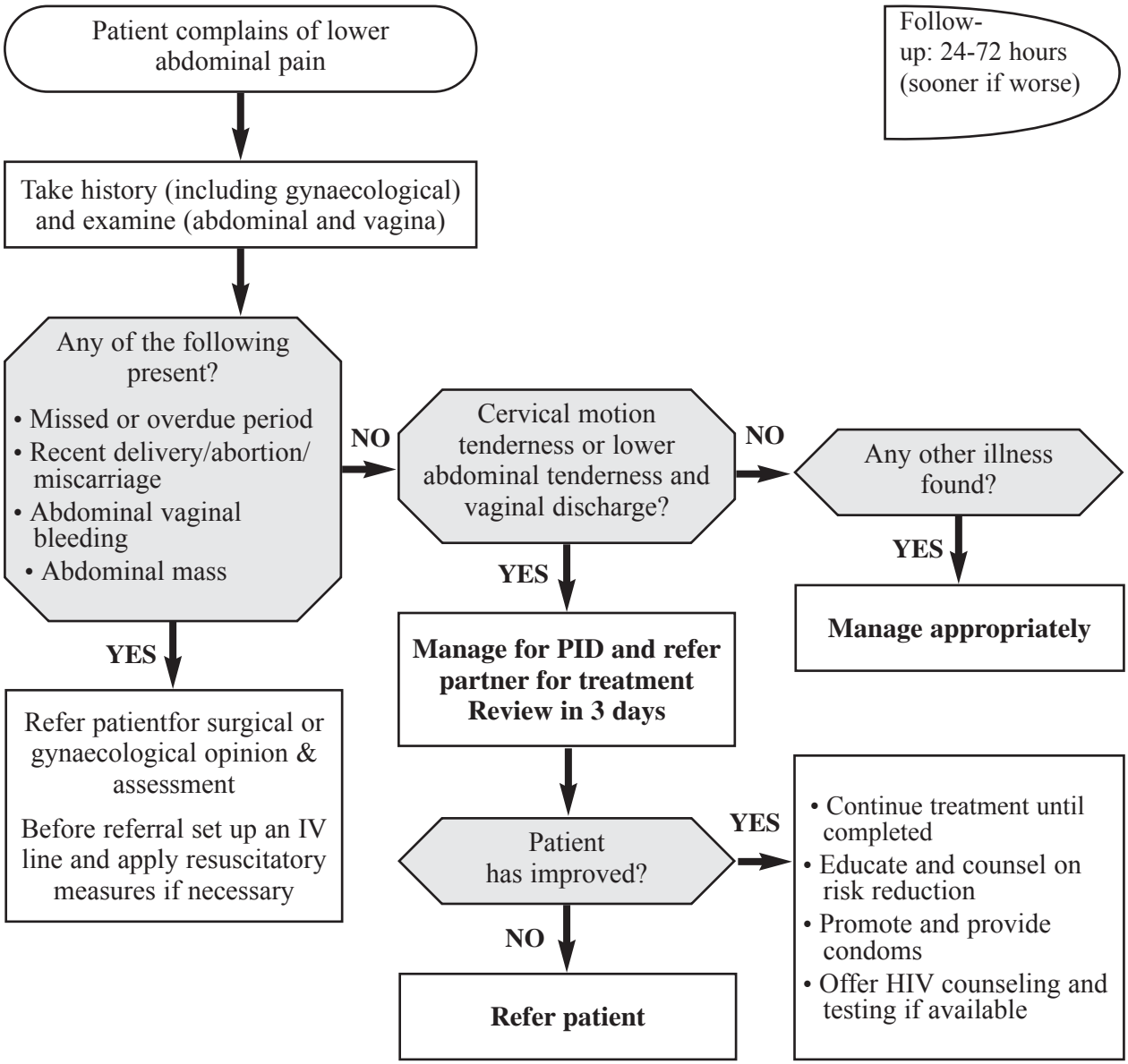
Aetiological agents found in PID include *N. gonorrhoea*, *C. trachomatis*, anaerobic bacteria, Gram-negative facultative bacteria, and streptococci. As it is impossible to differentiate between these clinically and a precise microbiological diagnosis is needed, the treatment regimens must be effective against this broad range of pathogens.[7]

Following a safety assessment to consider the implications of notifying her sexual partner, current partners should be evaluated and treated due to the risk of re-infection if there has been sexual contact in the past 60 days. Male partners of women diagnosed with *C. trachomatis* and/or *N. gonorrhoea* will often be asymptomatic and should be treated empirically.[22]

Recommended outpatient treatments for PID include single dose therapy for uncomplicated gonorrhoea, plus single (or multi) dose therapy for chlamydia, plus therapy for anaerobic infections (metronidazole 400-500mg orally, twice a day for 14 days[5]). Follow-up should take place 72 hours after treatment starts. If there is no apparent improvement, the woman should be referred to a specialist for a surgical and gynaecological assessment[7, 30] (Figure 5).

[5] Metronidazole is contraindicated during pregnancy and lactation. PID is uncommon in pregnancy. Patients taking metronidazole should avoid alcohol consumption.

Figure 5. Lower Abdominal Pain Flowchart (for women) [7]



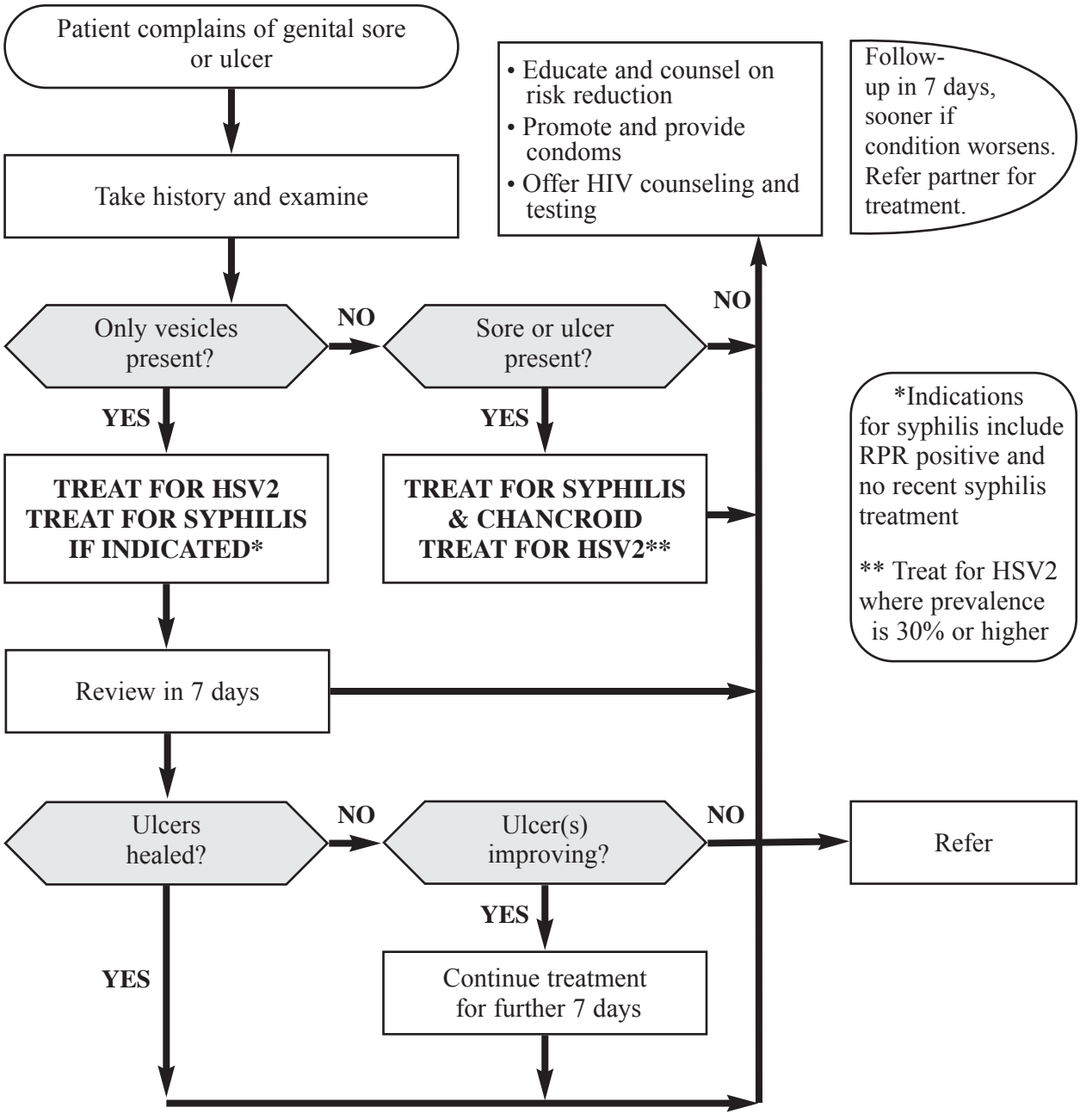
10.2.4. Genital Ulcers

Genital ulcer disease (GUD) is commonly caused by genital herpes, chancroid, and syphilis. If the clinical examination confirms the presence of a genital ulcer, treat for all possible conditions in case she does not return for follow-up visits. Laboratory-assisted differential diagnosis of GUD may not be helpful at the initial visit and at times may even be misleading due to low sensitivity and specificity in laboratory testing. Women at high risk of syphilis may have a reactive serological test from a previous infection, even when chancroid or herpes is the causative agent.[22]

Asymptomatic patients should be questioned on previous history of lesions, educated to recognize symptoms of herpes, and told to return if lesions appear.

Treatment for genital ulcers includes single dose therapy for syphilis, plus single or multi-dose therapy for chancroid, plus treatment for HSV-2 as necessary.[7] See flow chart for genital ulcers (Figure 6).

Figure 6. Genital Ulcer Flowchart [7]



11. Communication and Rights

11.1. Understanding women who have been trafficked

Women who have been trafficked and victims of sexual violence frequently sense that they have lost control in their lives, and are confronted with a hostile world. Exploitation, dependency, isolation, insecurity and instability are just some of the features of trafficking that can result in a distrust of persons in a position of authority, even of a service provider.[31] Providers should try to understand that when a woman seems uncooperative, ungrateful, or difficult, this behaviour is likely to be unintended. These are probably enduring defensive reactions women adopted to survive their former hostile environment, rather than a personal response against the service provider.

Meetings with service providers can cause a woman to feel that she has, once again, given over control of her body and personal information to someone else, making her feel helpless and ashamed. These destructive emotions can be avoided if health care providers deliver their service in a non-judgemental, respectful and gentle manner that aims to keep women informed, allowing them to make decisions over their body and health. The most successful providers allow a woman to discuss her past in her own manner and avoid asking questions that might insinuate blame (e.g., "why did you agree to do that?"). In addition, women appreciate not being asked questions that they have already answered, and those that are asked simply out of curiosity (i.e. for no clear medical purpose). Once the woman senses that her rights and wishes are respected, and that the information and specimens gathered during the consultation and examination are being collected for a good reason, she is more likely to disclose private details that are essential to correct diagnoses, treatment and to her eventual recovery.[5]

It is important to recognise that for a woman who has been trafficked every meeting with a service provider becomes part of the recovery process, because each positive interpersonal encounter helps build a woman's faith in others, increases her self-confidence, and fosters hopes she has for the future. Providers should be prepared to react to a woman's questions and possible distress with clear and patient responses.[5, 32]

Some common reactions to trafficking in a service setting and possible supportive responses are presented in Appendix 3. Appendix 4 summarizes ethical and safety provisions that should be observed during a clinical examination.

11.2. Informing and empowering women during the clinical examination

As stated above, accepting medical assistance, especially a clinical examination, may resurrect emotions of loss of control over one's body and what happens to it.[5] Informing a woman about what will happen during the medical exam, giving her the opportunity to ask questions, and make decisions can help mitigate these responses and improve the quality of the examination. Depending on the individual case, the presence of a female support person known to the woman can also reduce her anxiety during an examination.

Recommended provider discussion topics BEFORE the physical examination:

1. Reason for the examination
2. Treatment reassurance
3. Procedure explanation
4. Confidentiality assurance
5. Request to begin

At the initial consultation, it is recommended that the service provider explain clearly and slowly the purpose and content of the examination. The steps provided are not intended to be comprehensive or complete. Separate training for health professionals focusing on the development of communication skills and appropriate dialogue can be beneficial. The recommended areas that should be reviewed with the woman before the clinical examination include (1) clear and simple explanation of the reason for the examination; (2) reassurance and explanation on presumptive treatment measures; (3) step-by-step explanation of the procedures and tests to be performed; (4) assurance of confidentiality; and finally (5) a request to begin the examination.

The clinical examination should occur in a private setting and only in the presence of individuals who the woman has accepted to be in the room and who will respect and maintain her privacy.

Recommended provider discussion topics AFTER the physical examination:

1. Re-explanation of procedures and tests performed
2. Any further questions or concerns
3. Woman's right to a copy of medical records
4. How to obtain test results and query whether this form of communication is acceptable
5. Date of follow-up visit

Although the procedures have been outlined before the examination takes place, it should not be assumed that the woman has understood exactly what will take place during each step or how it will feel. Therefore, each step of the examination should be stated clearly and in a reassuring tone as it is taking place, and the provider should try to point out how it might feel (e.g., "as the speculum goes in it may feel a little cold" or "as I take this sample, you may feel a pinch or slight discomfort").

Following the examination, the clinician should conclude the visit by: (1) re-explaining the procedures and tests s/he performed; (2) asking whether the woman has any further questions or concerns; (3) informing the woman that she has the right to a copy of her medical records; (4) explaining how she can obtain her test results and inquiring if this form of communication is acceptable to the woman; and (5) setting a date and time for a follow-up visit, if necessary.

To obtain informed consent

1. Adopt a neutral, professional, yet sympathetic tone and attitude
2. Explain slowly and clearly the procedures that are being offered.
3. Explain the benefits of tests and procedures
4. Ask the woman if she has understood every thing that has been said
5. Ask if she has any questions or concerns
6. Respond to questions with patience
7. Assure the woman that there will be no negative consequences if she refuses any or all of the services and that if she consents, she may change her mind at any time during the examination
8. Use consent forms (if appropriate)
9. Confirm and record consent

11.3. Informed consent and confidentiality

Informed consent is the process of explaining to a woman what will take place, telling her about the possible benefits and risks, assuring her that she has the opportunity to decline or to accept some or all of the procedures that are offered, and then asking whether or not she would like some or all of the examination to take place. It can be coordinated with the information-giving process (above), but the request for her consent is a separate procedure. Women may be hesitant to consent to medical procedures because their experience has made them suspicious of outsiders. On the other hand, women may too readily agree to procedures that they do not truly want for fear that if they seem uncooperative this will negatively affect other services they do want. It is important that information be provided clearly and in a neutral way so that the woman does not feel pressured, but understands

the benefits of all procedures and treatments, and possible consequences if certain health conditions are left untreated. It is important to emphasize that she may decline any testing or procedure and can ask questions at anytime.

If signing her name on a consent form or other documents makes a woman ill at ease, it is not essential for her to sign a consent form. She can authorize the procedures verbally and the provider may note her verbal consent on the consent form using an identification number or pseudonym that corresponds to her medical records. Appendix 5 presents an example of a consent form that health facilities may adapt for their use.

11.4. Forensic examination and report

All women must be informed of their right to a forensic medical examination for the explicit purpose of making a criminal or civil legal claim against traffickers, or other individuals who abuse or exploited them. Reports from forensic medical examinations can be essential pieces of evidence in legal proceedings, particularly those related to sexual assault. The term "forensic medical exam" means an examination provided to a victim of a crime carried out by medical personnel trained to gather evidence in a manner suitable for use in a court of law. In the case of forensic medical examinations of sexual assault, the examination should include, at a minimum:

- Examination of physical trauma
- Determination of penetration or force
- Patient interview
- Collection and evaluation of evidence

The inclusion of additional procedures (e.g., testing for STIs) to obtain evidence or provide treatment may be determined in accordance with current laws, policies, and practices. If fees are associated with this exam, women must be informed in advance of any procedure. Timing is nearly always of the essence in the case of gathering medical evidence. It is of the utmost importance that support staff of the NGO partner organization immediately (i.e. upon first contact) inform individuals of their right to a forensic medical exam, and once a woman has requested an exam, the staff should arrange for a professional forensic medical examination. It is the responsibility of the medical facility conducting the forensic exam to ensure that women receive copies of any resulting reports promptly.[5]

12. Medical Records

Careful and thorough documentation of a woman's medical conditions and treatment regimen ensures that the woman and the other agencies providing medical care have access to accurate information on diagnoses, medication, follow-up treatment and referrals. Without these records, errors in ongoing and future medical care may occur.

Every woman must be informed of her right to obtain copies of medical and other health-related records, including diagnostic test results, x-rays, and treatment follow-up notes. Access to medical records is a basic entitlement that must be encouraged at all times, but particularly when there is (a) referral to other health workers, health institutions or coordinating service partners; (b) at the end of certain treatment milestones as part of assuring the woman she has been cured; and (c) upon demand from the woman.[5] Women should be encouraged to maintain their records in a safe place and/or bring copies to a designated case manager or support person at the NGO partner agency that is or will be providing primary assistance.

If however, the woman's safety or well-being may be put in jeopardy should other persons (e.g., spouses, family members, friends) see her medical records, she should be informed that she can obtain a copy at any time from the health facility.

Documentation should NEVER be mailed or delivered to an address, such as woman's home or other location, without the woman's explicit agreement. She should be asked when and how she would like to receive medical information. Records should be provided at no cost, or minimal expense, and the woman should be informed of any expenses in advance.

Great care should be taken to keep medical records confidential. Confidentiality measures ensure that unauthorized persons do not learn of personal information shared in confidence. The U.S. CDC defines confidential information as "any material, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a person and is directly related to their health care."[33] Women who have been trafficked are sometimes uneasy about having their names and personal details documented. Each woman should be offered the option of not using her name on her medical files, and instead being given an identification number, or selecting a pseudonym if she is uncomfortable giving her real name. Service providers should try to be as flexible as possible, understanding that some standard care procedures may need to be altered to meet the needs of this special patient group.

Documentation of medical conditions should be conducted by a health care provider who is authorized to record in the women's medical record.

During a history-taking, providers should record the patient's statements and avoid judgemental language (e.g., write in record: "patient states" instead of "patient alleges").[34] Terms that may reveal information that women wish to be kept secret, and stigmatising terms (e.g., trafficking, prostitution) should not be used. Although it is important to know about a woman's abusive past in order to offer the necessary care and patience, it is not necessary for clinical diagnoses or treatment. Neither the medical records nor the bills should identify the woman as a survivor of trafficking. If it is necessary to communicate this information to another care provider, it is essential to first obtain the woman's permission, after which this information should be shared in a private conversation-reminding the other medical professional of his or her obligations of confidentiality.

13. Reporting & Monitoring System

STI/RTI reporting is one useful method of estimating the extent of medical care needs. It is important that the record forms be completed as accurately and regularly as possible. The data gathered from the reporting system will be useful in further understanding the problems faced by trafficked women and demonstrate the effect of multi-sectoral partnerships. The collected data will allow IOM to estimate the extent of RSH care needs faced by women not accessing the Kyiv rehabilitation centre; guide IOM and NGO partner agencies in providing adequate material, training and financial resources; and monitor STI/RTI trends among returned trafficked women.[4] In addition, reliable statistics will allow for clearer advocacy work around counter-trafficking.[35]

A simple, anonymous STI/RTI reporting form is presented in Appendix 7 to record STI/RTI episodes, the number of new patients seen by the referral centre, and the number who return for follow-up examinations after treatment. The reporting form is a simple tally sheet where the monthly totals are recorded to monitor the pattern of attendance and STIs/RTIs diagnosed. Next to each diagnosis, age groups are listed in columns with circles. Each time a women is seen by the health care provider a line should be placed through one of the circles in the appropriate column against the appropriate diagnosis.[4] The form should be completed on a routine basis by all referral health facilities providing RSH care and then returned to the partner agency. It is recommended the forms be returned to IOM at regular three-month intervals.

The NGO partner agency should decide if reporting STI/RTI figures to IOM is appropriate and feasible within their local context.

APPENDICES

Appendix 1. Principles for Promoting the Health Rights of Trafficked Women[2]

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1. The right to health of trafficked women, including the right to necessary care and treatment, is a fundamental human right.

2. Trafficked women have the right to be asked specific questions to determine whether they require medical assistance (physical or psychological). State authorities must fully inform women of their rights to health care, and the health service options available to them. Medical assistance must be provided to trafficked women who request it or require it, before any other action may be taken.

3. No legal proceedings, or other actions that are likely to negatively impact the physical security, or physical or psychological health of trafficked women should be taken by State authorities unless women's health and wellbeing can be assured.

4. Trafficked women, given the level of harm and mistreatment they have experienced, should be offered access to quality health care on the same basis as citizens of the country where they are located.

5. Trafficked women have the right to non-discriminatory, gender-appropriate health care.

6. In all health interventions for trafficked women, the best interests of the woman must be the primary consideration. Governments, medical professionals, public health workers, and NGOs should collaborate to ensure that necessary and appropriate medical resources, including physical health care and psychological support, are made available. Care should be provided in women's own language, whenever possible.

7. Trafficked women should not be subjected to mandatory medical investigation, procedures or clinical testing, including for HIV/AIDS.

8. Trafficked women's right to privacy and confidentiality must be respected. This includes the right to a private setting for interviews, confidential testing, treatment, and medical files, and non-disclosure of personal information.

9. Trafficked women have the right to their medical and health records. In cases of deportation, removal or voluntary return, these records must be made available to women prior to their departure.

10. Trafficked women have the right to timely forensic examinations and medical reports to pursue cases of sexual or other violence against traffickers.

Appendix 2. Recommended Minimum Standards of Care Checklist

Protocols	**Available**
Written medical protocol for working with survivors of trafficking	
Personnel	**Available**
Trained health care professional committed to working with survivors of trafficking	
Female health worker or companion in room during examination (if appropriate)	
Privacy and Confidentiality	**Available**
Consent Forms	
Women may use pseudonyms or ID numbers for any aspect of diagnosis or treatment	
Setting	**Available**
Examination room (private, quiet, accessible, access to toilet)	
Health facility easily accessed (via public transportation or within walking distance)	
Service hours, waiting times, and consultation times are reasonable and appropriate	
Well maintained and managed (clean, hygienic)	
Furniture	**Available**
Examination Table	
Light (fixed and/or hand light)	
Gynaecologic examination table/bed	
Supplies	**Available**
Speculum	
Blood pressure apparatus	
Disposable latex gloves	
Needles and syringes	
Condoms	
Choice of contraceptive methods	
Access to autoclave for sterilization purposes	
Bowls for disinfection, towels and soap in examination room	
Supplies for universal precautions	
Drugs	**Available**
Accessible drugs for treatment of STIs/RTIs	
Emergency contraception	
Drugs for pain relief	
Antibiotics	
Administrative Supplies	**Available**
Medical chart / records	
Secure filing area for records	
Written heath education information on sexual and reproductive health care	

* Note: Please refer to Section 3 for a detailed description of the recommended minimum standards of care

Appendix 3. Supportive Responses in a Service Setting

Table 8. Supportive Responses to Common Psychological Reactions to Trafficking

Common reactions to trafficking	How reactions may manifest in a service setting	Supportive responses to negative reactions
Fear, insecurity, anxiety	Reluctance to meet people, to go outside, or to be alone; trembling, shaking or heart racing; difficulty sleeping and nightmares; difficulty sitting still, or concentrating	Implementation of security measures; description, and reassurance of security measures; confidentiality, and security of physical venue; accompaniment to outside appointments
Mistrust of others	Wariness of service provider and of offers of assistance; reluctance to disclose information; provision of false information; difficulties in relationships with support persons, co-residents, others in programme, family, etc.	Patience and persistence in developing relationships; unconditional provision of practical assistance and moral support; regular inquiries into needs and well-being
Mistrust of self, low self-esteem	Passivity, difficulty making decisions or trusting one's decisions; difficulty planning for the future; hyper-sensitivity or hyper-responsiveness to others and outside influences	Creating small tasks, setting short-term goals, fostering short-term accomplishments, validating achievements
Self-blame, guilt, shame	Difficulty making eye contact, difficulty expressing oneself; difficulty disclosing details of events and feelings; reluctance to undergo physical examinations, participate in group or other forms of therapy	Reassurance that what happened was not her fault, reminder that trafficking is a crime that victimizes many people and they are not alone; reminder of her courage and resourcefulness under extreme circumstances
Anger or aggression towards self or others	Hostility or violence towards support persons or others (e.g., co-residents, family); physical self-harm; sabotaging her own recovery progress; over-reactions; unwillingness to participate blaming or accusatory towards others; uncooperative or ungrateful responses	Patience; remaining calm in the face of hostility; not reacting with anger, hostility, or showing frustration; implementation of reasonable and proportionate measures to ensure person's safety; implementation of reasonable and proportionate measures to ensure safety of others
Memory lapses, dissociation	Inability to recall details or entire passages of past; altering accounts of past events; seeming unwillingness to respond or answer questions	Not judging or condemning the person; not pressuring or harassing the person; understanding the importance of forgetting for some people
Isolation, loneliness	Sadness, depression, disengagement from others and activities, lethargy; seeming self-absorbed or self-centred; believing no one can understand	Offering phone contact (or other contact) with family, friends, etc.; opportunities to participate in one-on-one or group activities; planned tasks or events
Dependence, subservience or defensiveness	Inability or reluctance to make decisions; desire to please; easily influenced; inability to assert self or preferences; regular complaining; (refusal or reluctance to accept assistance, advice)	Assigning small tasks; setting limited goals; reassuring the person of their abilities and capacity, not fostering dependence by undertaking all responsibility for person's welfare (allowing the person to choose when, how or if they wish to be assisted)

Appendix 4. Ethical and Safety Provisions for a Health Care Setting[2]

Principles, responsibilities and skills which health practitioners need to develop/acquire when working with trafficked persons:

- Do no harm
- Ensure safety, security and comfort
- Ensure privacy
- Ensure confidentiality
- Provide information
- Request informed consent
- Ask questions in a sensitive and sensible manner by paying attention to the purpose, sequence and tone of the question
- Listen actively and responsively by not talking, asking questions and providing clarification, giving the person time to answer, being perceptive and acknowledging what the person says
- Observe signs indicating the woman needs a break during the procedure
- Consider any preconception and prejudices you may hold
- Believe, do not judge[36]
- Maintain professionalism while treating persons with respect and compassion
- Ensure trafficked persons feel in control of their body and communications
- Reassure trafficked persons they are not to blame
- Inform trafficked persons of their right to a forensic medical exam and report
- Inform the individual of their rights to copies of all health & medical records
- Remind the trafficked person of their strengths

Appendix 5. Informed Consent Form

Informed Consent Information

Please take a few minutes before the examination to read this information sheet to each patient.

The *International Organisation for Migration* (IOM) will be glad to assist you in your medical examination and treatment.

The examination is intended to identify your state of health so that we may provide you with necessary health care assistance if you have any health problems.

We guarantee that all personal medical information will be treated as strictly confidential. It is important for you to understand that in some cases this confidential information may be disclosed to persons involved in your care; however, no information will be released without your prior approval.

If you have any questions regarding the results of your examination or methods of treatment, the medical staff will provide you with necessary explanations.

If you decide to decline any aspect of the examination, the medical staff will respect your decision.

In the course of the medical examination, you will be asked to answer some questions about your health. It is very important that you respond truthfully to the questions so that the diagnoses and treatment will be correct.

Please be aware of the following:

- You may undergo a chest X-ray (except pregnant women) and an ultrasonic examination.
- You may be examined by a physician, including a primary examination.
- You have the option to undergo tests for HIV, syphilis, chlamydia and other STI tests that may be offered. If you have any questions, you can ask any medical personnel for an explanation.
- You will be provided detailed information on the HIV test along with pre and post-test counselling.
- You may need additional tests and consultations from other specialists. A doctor will explain to you the nature of any illnesses and the need for the above tests.

If you would like, you may ask a rehabilitation/NGO staff member to be present during the course of your medical examination.

Please remember that if you have any questions, reservations or anxieties about your medical examination, I or other medical personnel, will gladly provide you with any necessary explanations.

Consent Form for
Medical Interview, Examination, Procedures and Tests

I, _____, hereby voluntarily request and agree to have the physician whose name appears below perform the following medical interview(s), examination(s), test(s) and/or procedure(s).

		(Circle)
General medical history	**YES**	**NO**
General physical examination	**YES**	**NO**
Routine gynaecological examination	**YES**	**NO**
The following laboratory tests:		
Routine blood and urine tests	**YES**	**NO**
X-ray or ultrasound	**YES**	**NO**
Blood tests for sexually transmitted infections (STIs)	**YES**	**NO**
Blood test for HIV	**YES**	**NO**
Other examinations/procedures (specify):		
	YES	**NO**
	YES	**NO**
	YES	**NO**

The physician whose signature appears next to mine has explained to me the benefits, risks and reasons for each procedure, examination, and/or test, including pre and post test counselling. The physician has given me a reasonable opportunity to ask any questions regarding each procedure, examination and/or test. The physician has promised to maintain, to best of her/his ability, the confidentiality of the interview, results of each procedure, examination, and/or test. However, I understand the confidentiality cannot be guaranteed. I also understand that I have the right to a second medical opinion about any aspect of the abovementioned procedure(s), examination(s), and/or test(s).

Patient Name/Signature - Date

x_____

Physician Name/Signature - Date

x_____

Translator Name/Signature - Date (if applicable)

x_____

Appendix 6. Laboratory Aetiological Diagnostics

Table 9. Laboratory Aetiological Diagnostic Methods

Using the criteria described in Section 9, laboratory diagnostic methods are presented with details on their sensitivity, specificity, advantages, disadvantages and the equipment required to carry out the test.

Infection	Diagnostic Method[6]	Sensitivity	Specificity	Advantages	Disadvantages	Equipment Required
Bacterial Vaginosis *(anaerobic bacteria, Gardnerella vaginalis, Mycoplasma hominis)*	**Level 1** Gram Stain using Nugent's Criteria[7]	97%	98%[37]	Gold standard, can be done at Level 1 lab facilities	Subjective, requires expert personnel[38]	Microscope
	Level 2 Proline aminopeptidase	93%	93%	Objective	Takes longer than stain	Centrifuge, incubator
	Level 3 Hybridization Assay	94%	81%	Objective, can also detect *Candida* and *Trichomonas*	Expensive, requires special equipment, test read immediately after completion	Heat block, special processor
Chancroid *(Haemophilus ducreyi)*	**Level 1** Diagnosis from clinical signs and ruling out of other causes of genital ulcers					
	Level 2 Culture[39]	35-75%	94-100%	Provides isolate for later antimicrobial sensitivity testing	Fastidious organism, requires high level of training	Incubator
	Level 3 DNA Detection - PCR	77-98%	98-100%	Very sensitive	Inhibitors of PCR cause false negatives, complex, expensive	Microfuge, thermal cycler, microwell plate reader, OR gel detection system
Chlamydia *(Chlamydia trachomatis)*	**Level 1** Microscopy - DFA	74-90%	98-99%	Rapid, easy	Labour intensive, subjective	Fluorescent Microscope
	Antigen detection - Rapid	52-85%	>95%	Rapid, easy	Insensitive, requires confirmation	None
	Level 2 Antigen detection - EIA	71-97%	97-99%	Batch samples	Requires confirmation	Microwell plate reader

[6] Unless otherwise noted, all diagnostic methods presented are based on STI/HIV Laboratory Tests for the Detection of Reproductive Tract Infections. World Health Organization. 1999.

[7] See Appendix 5 for additional detail on using Nugent's Criteria.

Infection	Diagnostic Method [1]	Sensitivity	Specificity	Advantages	Disadvantages	Equipment Required
Chlamydia *(Chlamydia trachomatis)*	**Level 3** RNA detection - Chemiluminescent DNA probe	75-85%	98-99%	Can also detect *N. gonorrhoea*, automated	Less sensitive than PCR, requires confirmation	Heat block, luminometer
	Multiplex PCR	90%	99-100%	Can also detect *N. gonorrhoea*, non-invasive sampling	False negatives	Thermal cycler, microwell plate reader
	LCR	90-97%	99-100%	Less affected by inhibitors, non-invasive sampling	No test for sample inhibitors	Thermal cycler, LCx processor
Genital Herpes *(Herpes Simplex Virus)*	**Level 1** n/a					
	Level 2 Viral Culture	20-90% (depending on stage of lesion)	100%	Viral typing possible with monoclonal antibodies	Yield depends on stage of lesion and proper collection method, expensive, time consuming	Availability of tissue culture, Incubator, microscope, centrifuge
	Level 3 Antigen detection	70-95%	90-100%	Rapid, inexpensive, more sensitive than culture for detection in late-stage lesions	Less sensitive	Fluorescent or light microscope, microwell plate reader
	DNA Detection - multiplex PCR	More sensitive than culture	98-100%	High sensitivity, specificity, allows for self-collected sample	Inhibitors of PCR cause false-negatives, complex, expensive	Microfuge, thermal cycler, incubator, microwell plate reader
Genital Warts *(Human Papilloma Virus)*	**Levels 1 & 2** Diagnosis on basis of visual appearance of lesions and ruling out other causes, including syphilis or cancerous conditions					
	Level 3 PCR	80-90%	100%	Gold standard detection; ability to type strains	Expensive; requires high level of expertise	DNA extraction kits, thermocycler, microwell plate reader

Infection	Diagnostic Method [1]	Sensitivity	Specificity	Advantages	Disadvantages	Equipment Required
Gonorrhoea *(Neisseria gonorrhoea)*	**Level 1** Microscopy - Gram Stain	~50% (cervix sample)	>98% (cervix sample)	Rapid, inexpensive	Insensitive	Light microscope
	Level 2 Culture	80-90% (cervix sample)	100%	Gold standard, isolates available for antimicrobial sensitivity testing	Labour intensive, requires up to 3 days	Autoclave and facilities for media preparation, Incubator, light microscope, candle jar
	Level 3 DNA detection - Hybridization assay	80-90% (cervix sample)	99%	Rapid, viable organism not required	Expensive	Water bath, luminometer
	PCR	89-90%	94-100%	Viable organism not required, sensitive, non-invasive sampling, can also detect *C. trachomatis*	Expensive, expertise required, no test for sample inhibitors	Microfuge, thermal cycler, incubator, microwell plate reader
	LCR	95-100%	98-100%	Viable organism not required, sensitive, non-invasive sampling, can also detect *C. trachomatis*	Expensive, expertise required, no test for sample inhibitors	Heat block, thermal cycler, microfuge, lmx processor
HIV[20, 40]	**Level 1** Antibody detection - DOT	100%	99-100%	Sensitive, specific, differentiates between HIV-1 and 2	Expensive	None
	Level 2 Antibody detection - EIA	100%	95.8-100%	Inexpensive, sensitive, automated	Requires confirmation using viral antigen test, false-positives, no serotyping	Centrifuge, microwell plate reader
	Antigen Detection		100%	Detects earlier than antibody tests	Insensitive	Centrifuge, microwell plate reader
	Level 3 DNA detection - PCR	As sensitive as culture	100%	High sensitivity, perinatal diagnosis	Expensive, time consuming	Microfuge, thermal cycler, incubator, microwell plate reader
	RNA detection - Quantitative (RT-PCR, bDNA or NASBA)	Earliest detection	100%	HIV titres possible	Expensive, time consuming	RT-PCR: microfuge. Thermal cycler, incubator, microwell plate reader bDNA: ultracentrifuge, luminometer NASBA: microfuge, luminometer

Infection	Diagnostic Method [1]	Sensitivity	Specificity	Advantages	Disadvantages	Equipment Required
Syphilis *(T pallidum)*	**Level 1** Non-treponemal - RPR	72-100%	93-98%	Inexpensive, rapid, quantitative	False positives, less sensitive to early syphilis; requires confirmation with treponemal specific test	Centrifuge, rotator
	VDRL	69-90%	98-100%	Inexpensive, rapid, quantitative	Mediocre specificity; difficult to interpret	Centrifuge, rotator, microscope
	Level 2 Antibody detection - MHA-TP	69-90%	98-100%	Specific, confirms non-treponemal test	More difficult, expensive	Centrifuge, rotator
	FTA-ABS			High sensitivity, specificity	Expensive, time consuming, requires expertise, not for screening confirmation	Fluorescent microscope
	Level 3 Antigen detection - PCR	81%	89%	Detects *T pallidum* before antibodies are positive	Expensive, time consuming	Spectrophotometer, microfuge, thermal cycler, incubator, microwell plate reader
	DNA Detection - multiplex PCR	91%	99%	Sensitive, specific, allows self-collected sample	Inhibitors of PCR reaction cause false-negatives, complex, expensive	Microfuge, thermal cycler, incubator, microwell plate reader
Trichomoniasis *(Trichomonas vaginalis)*	**Level 1** Microscopy - Wet Mount	38-82%	100%	Rapid, inexpensive	Low sensitivity, must be performed immediately, subjective	Light microscope
	Antigen Detection	86%	99%	Rapid	Expensive	Light or Fluorescent Microscope
	Level 2 Culture	98%	100%	Sensitive	Takes 1-4 days	Incubator, light microscope
	Level 3 Hybridization Assay	88-91%	100%	Rapid, objective, can also detects *Gardnerella* and *Candida*	Expensive, special equipment, test must be read immediately after completion	Heat block, special processor
	PCR	93%	96%	Very sensitive, allows patient self-sampling	Expensive, trained technician	Thermal cycler, microwell plate reader
Vaginal Yeast Infection *(Candida spp.)*	**Level 1** Microscopy - Wet Mount	35-45%	99%	Rapid, inexpensive	Subjective	Light microscope
	Level 2 Antigen Detection	61-81%	97%	Rapid, can also detect *Trichomonas*	Expensive	Exam room, on-site lab
	Level 3 DNA Detection	80%	98%	Rapid, objective, can also detect *Trichomonas* and *Gardnerella*	Expensive, special equipment, test must be read immediately after completion	Heat block, special processor

Appendix 7. Nugent's Scoring Criteria for Bacterial Vaginosis Diagnosis

Table 10. The Nugent Scoring Criteria (0-10)

Score	*Lactobacillus* morphotype per field	*Gardnerella* and *Bacteroides spp.* morphotype per field	Curved bacteria (*Mobiluncus)* per field
0	>30	0	0
1	5-30	<1	1-5
2	1-4	1-4	>5
3	<1	5-30	
4	0	>30	

How to Use Nugent's Gram Stain 0-10 Scoring Criteria to Diagnose Bacterial Vaginosis.

Assign a score of 0-4 for each morphotype based on the average number seen per oil immersion field. Total score = *lactobacilli* + *G. vaginalis* and *Bacteroides spp*. + curved rods. A total score of 7 or higher indicates Bacterial Vaginosis; a score of 4-6 is considered intermediate, and 0-3 is considered normal.[41, 42]

Appendix 8. NGO Partner Agency STI/RTI Reporting Form

Reporting of STI/RTI Episodes in Survivors of Trafficking

Name of health centre:	Region:
Period covered (from):	(to):
Form completed by:	
Date sheet completed:	

Diagnosis	Age Group (years)						
	<15	15-19	20-29	30-39	40-49	>49	Total
Vaginal discharge	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Lower abdominal pain / PID	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Genital ulcers	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
No STIs/RTIs found	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
New patients attending for registration and initial consultation	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Clients attending for follow-up after treatment	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Total							

CLINICIAN INSTRUCTIONS:

Each time you see a survivor of trafficking attending for a routine visit, please put a line through one of the zeros (0) in the appropriate row and column. In addition, indicate in the appropriate row and column those clients who are new or are attending for follow-up after having received treatment for an infection previously found. Please return sheet to your local partner agency at the end of the month.

Reporting of STI/RTI Episodes Aetiological Diagnosis in Survivors of Trafficking Attending Health Facilities

Name of Health Facility:: Region:

Diagnosis	Age Group (years)						
	<15	15-19	20-29	30-39	40-49	>49	Total
Bacterial Vaginosis *(anaerobic bacteria, Gardnerella vaginalis, Mycoplasma hominis)*	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Chancroid *(Haemophilus ducreyi)*	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Chlamydia *(Chlamydia trachomatis)*	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Genital Herpes *(Herpes Simplex Virus)*	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Genital Warts *(Human Papilloma Virus)*	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Gonorrhoea *(Neisseria gonorrhoea)*	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
HIV	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Lymphogranuloma Venereum	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Pelvic Inflammatory Disease	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Syphilis *(T pallidum)*	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Trichomoniasis *(Trichomonas vaginalis)*	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Vaginal Yeast Infection *(Candida spp.)*	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	00000 00000	
Total							

CLINICIAN INSTRUCTIONS:

Each time you see a client with a laboratory confirmed STI/RTI put a line through one of the zeros in the appropriate row and column. Return sheet to your local partner agency at the end of the month.

Appendix 9. Medications in Pregnancy

Drugs should be prescribed during pregnancy only when the expected benefits outweigh the risk to the foetus. All drugs should be avoided if possible during the first trimester. The table adapted from the World Health Organization (WHO) presents some common drugs and information on their use during pregnancy. This list is not intended to be comprehensive and the exclusion of any drug does not imply that it is safe.[7]

Drug Name	Notes
Acyclovir	Experience limited - use only when potential benefits outweigh risk; limited absorption from topical preparation
Amoxicillin	No evidence of teratogenicity
Amoxicillin + Clavulanic Acid	No evidence of teratogenicity
Ampicillin	Not known to be harmful
Benzathine benzylpenicillin	Not known to be harmful
Benzylpenicillin	Not known to be harmful
Ceftazidime	Not known to be harmful
Ceftriaxone	Not known to be harmful
Chloramphenicol	Third trimester; neonatal "grey baby" syndrome
Ciprofloxacin	Avoid - arthropathy in animal studies; safer alternatives available
Clindamycin	Not known to be harmful
Cloxacillin	Not known to be harmful
Doxycycline	First trimester: effects on skeletal development in animal studies Second & third trimesters: dental discoloration in children; maternal hepatoxicity with large parenteral doses
Erythromycin	Not known to be harmful
Fluconazole	Avoid in first trimester - multiple congenital abnormalities reported with long-term high doses
Gentamicin	Second & third trimester; auditory or vestibular nerve damage; risk probably very small, but use only if potential benefit outweighs risk (if given, monitoring of serum gentamicin concentration essential)
Metronidazole	Avoid high-dose regimens (>1g)
Minocycline	First trimester; effects on skeletal development in animal studies Second & third trimesters: dental discoloration in children; maternal hepatoxicity with large parenteral doses
Nalidixic Acid	Avoid - arthropathy in animal studies; safer alternatives available
Nystatin	No information available, but absorption from gastrointestinal tract negligible
Ofloxacin	Avoid - arthropathy in animal studies; safer alternatives available
Podophyllum resin	Avoid -neonatal death and teratogenesis
Streptomycin	Second & third trimesters: auditory or vestibular nerve damage; avoid unless absolutely essential (if given, monitoring of serum streptomycin concentration essential)
Sulfadiazine	Third trimester; neonatal haemolysis and methaemoglobinaemia; suggestion of increased risk of kernicterus in neonates appears to be unfounded
Sulfamethoxazole + Trimethoprim	First trimester: theoretical teratogenic risk (trimethoprim is a folate antagonist) Third trimester: neonatal haemolysis and methaemoglobinaemia; suggestion of increased risk of kernicterus in neonates appears to be unfounded
Sulfasalazine	Third trimester: theoretical risk of neonatal haemolysis; adequate folate supplements should be given to mother
Tetracycline	First trimester: effects on skeletal development in animal studies Second & third trimesters: dental discoloration; maternal hepatoxicity with large parenteral doses
Trimethoprim	First trimester: theoretical teratogenic risk (folate antagonist)
Vancomycin	Use only if potential benefit outweighs risk - monitoring of plasma vancomycin concentration essential to reduce risk of foetal toxicity
Zidovudine & other antiretroviral	Avoid if possible in first trimester; benefit of treatment considered to outweigh risk in second & third trimesters

Appendix 10. Useful Resources

STI/RTI Management Guidelines	
Title:	*Guidelines for the Management of Sexually Transmitted Infections*
Source:	World Health Organization
Year:	2003 (revised version)
Summary:	Treatment recommendations for comprehensive management of patients with sexually transmitted infections in the broader context of control, prevention and care programmes for STIs and HIV. The document addresses both the syndromic approach to the management of patients with STI symptoms, and the treatment of specific STIs. Also included is information on the notification and management of sexual partners and on STIs in children.
Available at:	http://www.who.int/reproductive-health/publications/rhr_01_10
Title:	*Sexually Transmitted Diseases Treatment Guidelines 2002*
Source:	Centers for Disease Control and Prevention
Year:	2002 (updated)
Summary:	Treatment recommendations developed by the U.S. CDC. Updated version includes information on alternative regimens for bacterial vaginosis and early syphilis, an expanded section on the diagnosis of genital herpes; new recommendations for the treatment of genital herpes among persons infections with HIV; a revised approach to the management of victims of sexual assault; and the inclusion of hepatitis C as a sexually transmitted infection; and recommendations for vaccine-preventable STDs, including hepatitis A and hepatitis B. In addition, the guidelines emphasize education and counselling for persons infected with human papillomavirus; clarifies the diagnostic evaluation of congenital syphilis, and presents information on the emergence of quinolone-resistant Neisseria gonorrhoea and implications for treatment.
Available at:	http://www.cdc.gov/std/treatment/default.htm
Title:	*Sexually transmitted and other reproductive tract infections: A guide to essential practice*
Source:	World Health Organization
Year:	2005
Summary:	This publication is intended to assist health care managers and practitioners in resource-limited reproductive health care settings around the world to meet the needs of individuals who may be at risk of reproductive tract infections (RTIs). It is assumed that readers are familiar with certain clinical knowledge, such as drugs and their dosages, although they may not have experience with management of sexually transmitted infections (STIs) and RTIs.
Available at:	http://www.who.int/reproductive-health/publications/rtis_gep/index.htm
Laboratory Diagnostic Guidelines	
Title:	*STI/HIV: Laboratory tests for the detection of reproductive tract infections*
Source:	World Health Organization
Year:	1999
Summary:	This publication describes methods for detecting eleven reproductive tract infections (RTI). The types of assay presented fall into several categories and include detection of the organism by direct microscopy, detection of metabolic products, culture, and the detection of specific antibodies, antigens, DNA or RNA. It summarizes only the methods that are most useful in detecting each organism. Sampling procedures, sensitivity and specificity, the advantages and disadvantages of laboratory testing, as well as the appropriate level of use, training and equipment required and ease of performance are also discussed.
Available at:	http://www.wpro.who.int/publications/pub_9290611480.htm

Syndromic Approach	
Title:	*(1) Training Manual on STD Case Management / The Syndromic Approach for Primary Health Care Settings - Facilitator's Version* *(2) Training Manual on STD Case Management / The Syndromic Approach for Primary Health Care Settings - Participant's Version*
Source:	World Health Organization
Summary:	Training material package designed to aid primary health care works improve their management of STD cases. The syndromic approach to STD case management allows health workers to diagnose STDs and treat patients without a lengthy waiting period, and includes measures to educate patients about their infection(s), and how STDs are transmitted and cured.
Available at:	(1) http://www.wpro.who.int/NR/rdonlyres/2E4A6567-7F1F-484F-8C5D-A1DE3AF4C050/0/FacilitatorsVersion.pdf (2) http://www.wpro.who.int/NR/rdonlyres/73F8E5F9-BFEA-4895-AAF8-3079AD4F104F/0/ParticipantsVersion.pdf

Trafficking, Migrants and Health	
Title:	*WHO Ethical and Safety Recommendations for Interviewing Trafficked Women*
Source:	World Health Organization
Year:	2003
Summary:	Recommendations on the basic standards for interviewing women who are in or have left a trafficking situation. The significance of each issue is explained and examples offered on how each one may be addressed. The recommendations present information on the risks, ethical considerations, and the practical realities related to trafficking in order to minimize the dangers and increase the likelihood that a woman will disclose relevant and accurate information. The recommendations are intended for service providers unfamiliar with the situation of trafficked women, researchers and members of the media.
Available at:	http://www.lshtm.ac.uk/hpu/docs/WHO.pdf
Title:	*The Health Risks and Consequences of Trafficking in Women and Adolescents: Findings from a European Study*
Source:	European Commission's Daphne Programme
Year:	2003
Summary:	Report presenting the findings of a two-year multi-country study on women's health and trafficking to the European Union. It is an initial inquiry into an area with little previous research. Interviews were conducted by researchers inAlbania, Italy, the Netherlands, Thailand, and the United Kingdom with women who had been trafficked, health care and other service providers, NGOs working against trafficking, law enforcement officials, and policymakers.
Available at:	http://www.lshtm.ac.uk/hpu/docs/traffickingfinal.pdf
Title:	*The Mental Health Aspects of Trafficking in Human Beings: A Set of Minimum Standards*
Source:	International Organization for Migration: Budapest, Hungary
Year:	2004
Title:	*The Mental Health Aspects of Trafficking in Human Beings. Training Manual*
Source:	International Organization for Migration: Budapest, Hungary
Year:	2004
Title:	*Psychosocial Support to Groups of Victims of Human Trafficking in Transit Situations*
Author:	International Organization for Migration: Geneva, Switzerland
Source:	Psychosocial Notebook, Vol. 4
Year:	2004
Title:	*Health issues associated with the smuggling and trafficking of migrants*
Author:	Gushulak B., MacPherson DW.
Source:	Journal of Immigrant Health 2(2): 68-78
Year:	2000

Trafficking, Migrants and Health	
Title:	*The challenges in extending assistance, health care access and advocacy for trafficked woman and children*
Author:	Motus N.
Source:	Health Series: Trafficking in Women and Children: Public Health Risks, Strategies and Challenges. London, United Kingdom
Year:	22 October 2003
Title:	*The reproductive health of the unaccompanied minors, travel & epidemics*
Author:	Grondin D., Onyebuchi C.
Source:	IIIrd European Conference on Travel Medicine, Abstracts; Abstract 12 of presentation, 25
Year:	2002
Title:	*Sexual health of mobile and migrant populations*
Author:	Haour-Knipe M., Grondin D.
Source:	Sexual Health Exchange, 2, pgs. 1-3
Year:	2003
Title:	*Trafficking in Human Beings in the Modern World.*
Author:	Szilard I,Weekers J, Jakab G, Grondin D.
Source:	Agricultural Medicine and Rural Health, 23(1):30-36
Year:	2004
HIV / AIDS	
Title:	*AIDS Alliance Ukraine*
Source:	International HIV/AIDS Alliance
Year:	2005
Summary:	The Alliance has several publications available on its website including: HIV/AIDS and Mass Media; HIV/AIDS News: Policy and Advocacy; Substitution Therapy: Analytical Review; booklets for people living with HIV/AIDS who are recently diagnosed, and on adherence to anti-retroviral therapy; and dozens of additional themed publications published by grantees.
Available at:	http://www.aidsalliance.kiev.ua/ http://www.aidsalliance.org/sw7229.asp
Title:	*National Program to ensure HIV prevention, care and treatment of HIV-infected and AIDS patients for 2004-2008*
Source:	Cabinet of Ministers of Ukraine and UNAIDS
Year:	2004
Summary:	Report issued by the Cabinet of Ministers of Ukraine outlining Ukraine's priorities for HIV/AIDS prevention and care.
Available at:	http://www.unaids.org/html/pub/topics/nsp-library/nsp-europe/nsp_ukraine_2004-2008_en_pdf.pdf
Title:	*Population, Mobility and HIV/AIDS*
Source:	International Organization of Migration: Geneva, Switzerland
Year:	July 2004
Available at:	www.iom.int/documents/publication/en/iom_hiv_brochure_july_2004.pdf
Title:	*Salud sexual y reproductiva, enfermedades de transmission sexual y VIH/SIDA en jovenes de 10 a 24 anos de una ciudad receptora de poblacion desplazad*
Authors:	Eriksson L, Guarnizo C, Mejia A & Prieto F.
Source:	International Organization for Migration: Monteria, Colombia
Year::	2004
Title:	*HIV-infected migrants in Europe: missing out on the benefits of early care*
Author:	Haour-Knipe M.
Source:	AIDS and Mobility News. 3-4
Year:	2002

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