UWHC GME Global Health Emergency Plan

Purpose:
The purpose of the Global Health Emergency Plan is to identify the appropriate procedure in the event that an emergency occurs involving a resident participating in a UWHC GME-approved global health elective rotation.

Scope
The Global Health Emergency Plan is designed to assure appropriate, effective response to a variety of emergency situations that could affect the safety of UWHC residents during global health rotations.

Definition:
UWHC and the Graduate Medical Education office have made every reasonable effort to assure the safety of residents participating in global health electives. There are unavoidable risks in travel and study overseas that may not ordinarily be encountered otherwise. The following events are examples of situations that should activate the Global Health Emergency Plan. This is by no means an inclusive list of events that would warrant activation of the Global Health Emergency Plan.

- Injuries related to travel to/from and during an elective rotation
- Blood-borne pathogen exposure
- Any potential serious medical condition or illness
- Political unrest
- Involvement of the trainee with legal authorities
- Natural disasters
- Situations in which a resident feels their safety is or had the potential to be in jeopardy

Policy
The resident will contact the UWHC Access Center by calling 001-608-263-3260.

The UWHC Access Center will contact Carl Getto, M.D., VP Medical Affairs.

Dr. Getto will access the Global Health Portal that will provide access to the Travel Log Spreadsheet that includes information regarding individual personal emergency contact information for each resident. This document will also include their site location, site contact, UWHC faculty mentor, GME Program Director, and UWHC Residency Program.

Dr. Getto will notify the resident’s UW Global Health Faculty Mentor who will be connected with the resident by phone via the UWHC Access Center so that the Faculty Mentor is able to provide support, assistance, and guidance for the resident. If the situation warrants, the Faculty Mentor will contact the resident’s Personal Emergency Contact as well as the GME Global Health Subcommittee Chair. If the resident’s Faculty Mentor is unavailable, the Residency Program Director will be contacted in lieu of the Faculty Mentor. If neither the Faculty Mentor nor the Residency Program Director is available, a designated member of the GME Global Health Subcommittee will be contacted.

The faculty member in direct contact with the resident will complete an Incident Report that must be returned to the GME office within 24 hours of the initial phone call.
UWHC GME Global Health Emergency Card

The below card is to be completed by the resident and carried with them at all times during their global health elective rotation.

Call Instructions
Contact the UWHC Access Center at 001-608-263-3260.

The Access Center staff will initiate the Global Health Emergency Call Protocol. The first point of contact is Dr. Carl Getto who will then contact the resident’s UW Faculty Mentor or Residency Program Director for further assistance.

The Access Center fax number is 001-608-265-0759.

Name: ________________________________
Passport #: __________________________
UW Residency Program: __________________
UW Faculty Mentor: ____________________
Primary US Emergency Contact: __________
Host Site Contact: ______________________
US Embassy: __________________________
Health Self-Assessment

Resident Name: __________________

Current PCP ______________________ PCP Phone: ______________________

- This form is to be completed by the participant.
- The purpose of this form is to help the UWHC GME Office be of maximum assistance to you should the need arise during your global health elective. Even mild physical or psychological disorders can become serious under the stresses of life while working in an unfamiliar setting. It is important that the program be made aware of any medical or emotional problems, past or current, which might affect you during your trip.
- Working with your UW Global Health mentor, we will do our best to direct you to more specific sources of information about support services you can reasonably expect to find on site.
- Elective or off-site locations may not be able to accommodate all reported individual needs or circumstances.
- If you do not report a medical condition, our ability to assist you in case of an emergency may be compromised.
- The information provided will remain protected and will be shared only with UWHC GME program staff, faculty, or university officials, as deemed necessary.
- This information will not be shared with your Residency Program Director unless an emergency arises that requires the involvement of this person.
- This information will not affect whether your rotation will be approved.

Medical History

Yes ____ No____ 1. Are you generally in good physical condition? (If no, please explain)

Yes ____ No____ 2. Have you ever been treated or are currently being treated for any psychological or emotional problems including but not limited to depression and anxiety? (If yes, please explain)

Yes ____ No____ 3. Do you have any allergies? (If yes, please explain)

Yes ____ No____ 4. Are you taking any medications? (If yes, please list below)

Yes ____ No____ 5. Have you had any major injuries, diseases or ailments in the past five years? (If yes, please explain)

Yes ____ No____ 6. Are there any medical conditions or physical disabilities that would be helpful for the program to be aware of during your trip? (If yes, please explain)

Explanations pertaining to questions 1-6:

If you answered yes to any or all of No. 2 through No. 6 above, we strongly advise you to see your medical provider before your departure to discuss your plans to travel abroad.

I certify that all responses on this Medical Self-Assessment form are true and accurate, and that I will notify the UWHC GME Office of any relevant changes in my health that occur prior to the start of my trip.

Signature of Participant __________________________ Date ________________
University of Wisconsin Hospital & Clinics Graduate Medical Education
Guidelines for Blood-borne Pathogen Exposure and Post-Exposure Prophylaxis in Global Health Field Sites

Developed by Dr. Brian Jack and colleagues at Boston University
Adapted with permission by Dr. Cynthia Haq for the UW Center for Global Health and Dr. Sabrina Wagner for UW Hospital & Clinics Graduate Medical Education programs
Last Reviewed by Dr. Frank Graziano, April 2010

Purpose
The purpose of this policy is to delineate recommended actions that should be taken in case of an occupational exposure of any UWHC GME trainee.

This policy outlines the recommendations of the UW Center for Global Health (CGH) and UWHC GME programs. It does not replace individual choice. Each exposed person has the right to weigh the risks and benefits and make their own choice about when to take post-exposure prophylaxis (PEP).

Policy
All trainees participating in global health rotations will be given a copy of this policy and requested to be familiar with it ahead of time in case a potential exposure should occur. Exposure to blood-borne pathogens should be avoided as much as is reasonably possible, as outlined by Universal Precautions policies. Should a potential exposure occur, immediate action should be taken to protect the exposed person. Trainees are strongly encouraged to bring starter packs of PEP medications, along with a copy of this policy with them on their global health rotations. If a potential exposure occurs, they should seek access to counseling and a medical visit with an HIV specialist within less than 3 days and a regular follow-up schedule of visits and testing in recommended. Likewise, risk of hepatitis B infection will be prevented by vaccination but, if for whatever reason vaccination has not been done and immunity is documented, options for the reduction of transmission risk should be sought. Records will be kept of any event of potential exposure and the outcome. Program members taking PEP will be encouraged but not required to share the information about the course of their PEP and the final outcome for the record. Those who prefer not to take PEP when it is recommended by this policy will be asked to sign a statement of informed consent to decline PEP.

Reduction of Risk
All trainees participating in global health rotations are required to have a full course of vaccination against hepatitis B. If possible, antibody titers should be obtained to prove immunity. It is highly recommended that all trainees be tested for HIV on a yearly basis regardless of personal risk factors.

It is also the policy of the UWHC GME that all trainees should use Universal Precautions when potentially exposed to blood or body fluids.

PEP Background Information

Definition of Exposure
Occupational exposure is defined as any contact with an infectious body fluid as a result of an injury with a needle or any other sharp instrument, or via mucous membranes or an existing cutaneous condition (wound, eczema, scratch, etc.). Non-occupational exposures to infectious body fluid may also occur, such as in the case of unprotected intercourse or blood exposure during a motor vehicle crash. A potentially infectious body fluid that comes from a person who carries an infection is termed infectious.

- Potentially infectious body fluids include: blood, CSF, synovial fluid, pleural fluid, pericardial fluid, amniotic fluid, semen, or vaginal secretions.
- Non-infectious body fluids include feces, nasal secretions, saliva, sputum, sweat, tears, urine, and vomit, as long as these are not visibly contaminated with blood.
Risk of Infection due to Exposure
People are considered to be at risk of infection from hepatitis B, hepatitis C, and HIV as the result of an occupational or non-occupational exposure.

The average risk for HIV transmission after a single percutaneous exposure to HIV-positive blood is low (see table 1) and this risk is considerably lower than that arising from hepatitis B and C viruses (respectively 100 times and 10 times less). The risk of transmission of HIV due to intercourse is summarized in table 2.

There is also a risk, although a lower one, of transmission of any other infectious agent present in the blood (hemorrhagic fevers, trypanosomiasis, etc.).

Factors of the exposure that are associated with higher risk of HIV transmission are a percutaneous injury with a needle that has been placed in a vein or artery of the source patient, a sharp that is visibly contaminated with HIV-positive blood, or a source patient with primary HIV infection or end-stage HIV.

The HIV prevalence in some world regions is high. Estimates of prevalence in sub-Saharan African countries range from approximately 3% to 30% depending on what population is considered. The inpatient population is estimated to be roughly 50% HIV-positive. Hepatitis B and C rates are often unknown.

Definition of Post-Exposure Prophylaxis (PEP)
Post-exposure prophylaxis refers to medications given to prevent infection after exposure. The prophylactic treatment offers both benefit and risk to the exposed person (see table 3). This policy provides a recommendation about when to take PEP and describes how PEP should be administered but does not mandate that PEP be taken when recommended, or not taken when not recommended. The exposed person must be advised of the risks and benefits and make their own decision whether or not to take PEP.

Actions to Follow in Case of an Exposure:

1. **The exposed person will stop what they are doing immediately and rinse/disinfect the exposed area.** Percutaneous injuries should be allowed to bleed, and rinsed thoroughly in running water for 5 minutes. Mucous membranes including the eyes should be rinsed with saline or with water for 5 minutes.

2. **Alert on site supervisor,** as well as UW Faculty Mentor (utilize Emergency Protocol by calling the UW Hospital Access Center). Do not delay the rest of the steps while waiting for supervisor or faculty member. The faculty member will initiate the incident report.

3. **Evaluate the mode of exposure** according to table 4. For percutaneous injuries, categorize into more or less severe exposure. For mucous membranes or non-intact skin exposure, categorize into small-volume or large-volume. For exposure through unprotected sexual contact, categorize into higher and lower risk exposure.

4. **Evaluate the source patient** and categorize according to table 6. If a current HIV and Hepatitis B test for the source patient is not immediately available, have someone gain consent from the source patient and coordinate testing. The best person to coordinate this testing will vary depending on the clinical situation. The patient has the right to refuse testing. Do not delay the administration of PEP more than 2 hours post-exposure while obtaining laboratory results. Refer to table 5 for considerations regarding HIV testing and interpretation of test results. The two tests may be available are rapid HIV testing and HIV DNA PCR. The patient may also be tested for Hepatitis B SAg. All three of these tests are recommended to be sent, although only the rapid HIV BSaAg and HIV DNA PCR may help in later decision-making or may add to peace of mind. In all cases where there is an identifiable source patient, evaluate the patient clinically for signs and symptoms of HIV, or hepatitis, including signs and symptoms of primary HIV. In some cases the source patient may not be identified, for example, in the case of a needle-stick from a discarded sharp or sexual assault by a perpetrator who is not in custody.

5. **The exposed person must have the following laboratory tests** as soon as possible: HIV Rapid Test, Hepatitis B Surface Antigen, Full Blood Count, ALT, AST, and Urine HCG (for
females only). Do not delay the administration of PEP more than 2 hours post-exposure while obtaining laboratory results. If the exposed person is HIV-positive, do not initiate PEP; instead refer to HIV clinic for routine care.

6. **Use table 7 to determine whether HIV PEP is recommended and table 8 to determine the recommended prescription and initiate PEP if indicated.** When choosing PEP prescription, keep in mind that Efavirenz is contraindicated in pregnancy. If it is indicated, PEP should be initiated as soon as possible after the exposure. If more than 72 hours have passed since the exposure, PEP may not be recommended. Seek consultation with an HIV specialist in this case. PEP should be taken every 12 hours. Take the first dose as soon as possible after the exposure, then take the second dose at a time convenient for ongoing use and continue on a 12 hourly schedule. Do not allow more than 12 hours between the first and second doses.

When two-drug PEP is recommended, some exposed people find themselves desiring to use three-drug PEP rather than two-drug PEP in order to feel more protected. The exposed person should be encouraged to keep in mind that the side effects of three-drug PEP are often more severe, and so a full course of three-drug PEP is harder to complete. There is also little good evidence that three-drug PEP is superior to two-drug PEP, hence the recommendation for two-drug PEP is sound in the cases where it is recommended.

Obtaining the testing and medication: Check with on site supervisor to find nearest site where testing and medication can occur.

7. **For hepatitis B** PEP: All exposed persons should receive the hepatitis B vaccine, except for those who have received it within the last five years AND have had antibody testing to prove response with anti-HbS level >10 IU/L. If the person has ever had an antibody anti-HbS >100IU/L, there is no need for re-vaccination regardless of when the last vaccine was given. In the case that the exposed person has never been vaccinated against hepatitis B, the vaccine should be given and the option to travel and to obtain Immune Globulin treatment should be considered. If this option is chosen, the person will receive time off of work in the form of sick days. The cost of this travel and treatment will be paid for by the exposed person.

8. **The exposed person must fill out and hand in an on site incident report if this is the policy the site where the incident has taken place.** The exposed person must also alert their UW Faculty Member that the exposure has occurred; the UW Faculty Member will fill out an incident report to be kept on file in the UWHC GME office. The incident report will contain the name of the person exposed, the date, a narrative of the details of the exposure, the classification of the exposure and the source patient according to tables 4 and 6, and a record of whether the exposed person decided to take PEP. The case will be reviewed by clinical faculty in six months and the ultimate outcome will be recorded in the report, including any changes in the PEP plan, and final HIV and hepatitis B and C results. The disclosure of information about test results or the course of PEP is completely voluntary on the part of the exposed person, who may not opt to disclose. Disclosure of this information is requested in order to help the program to assess the utility and efficacy of the PEP policy.

9. If the exposed person has any medical conditions, is pregnant or breastfeeding, is currently taking medications, if the source patient is currently on antiretrovirals, or if there are any other questions, concerns, or ambiguities that come up when considering PEP, then **seek consultation with an HIV specialist as soon as possible** concerning management of these situations. Do NOT delay initiation of PEP while awaiting consultation.

10. **The exposed person should follow up with an HIV specialist visit and blood work according to the schedule in table 9 even if they have no medical conditions are having no symptoms or side effects.** The exposed person should not engage in unprotected sex or to donate blood during the first six months after exposure in order to prevent the possible spread of HIV to partner or pregnancy. They may keep in mind that seroconversion between three and six months is highly unlikely.

11. Many people taking PEP experience uncomfortable side effects and choose to discontinue before the 28 days are complete. **Discontinuation is highly discouraged** without first
consulting with an HIV specialist. Many side effects can be managed symptomatically, so a person taking PEP and experiencing side effects is encouraged to seek medical consultation in order to consider options before self-discontinuing PEP. If three-drug PEP and the side effects are intolerable even with symptomatic treatment, a step down to two-drug PEP may be considered in consultation with an HIV specialist.

12. There is no post-exposure prophylaxis for hepatitis C, and no easily available laboratory testing in many resource-limited settings. Exposed persons should seek medical attention immediately if they experience any symptoms of hepatitis. **One hepatitis C antibody test should be performed six months after exposure to rule out hepatitis C infection.** Likewise, complete hepatitis B serologies are recommended after the six-month interval to rule out hepatitis B infection and to document hepatitis B immunity.

**Tables:**

**Table 1: Risk for transmission after occupational exposure to infected blood**

<table>
<thead>
<tr>
<th>Agents</th>
<th>Exposure Mode</th>
<th>Risk of Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Percutaneous exposure</td>
<td>0.3%</td>
</tr>
<tr>
<td>HIV</td>
<td>Mucocutaneous contact*</td>
<td>0.03-0.09%</td>
</tr>
<tr>
<td>HBV</td>
<td>Percutaneous exposure</td>
<td>10-30%</td>
</tr>
<tr>
<td>HCV</td>
<td>Percutaneous exposure</td>
<td>0-10%</td>
</tr>
</tbody>
</table>

*This refers to the exposure of mucus membranes or cutaneous cuts or abrasions.

**Table 2: Risk for HIV transmission after a single event of sexual activity**

<table>
<thead>
<tr>
<th>Exposure Mode</th>
<th>Risk of Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receptive anal intercourse</td>
<td>0.5%</td>
</tr>
<tr>
<td>Receptive vaginal intercourse</td>
<td>0.1%</td>
</tr>
<tr>
<td>Insertive anal intercourse</td>
<td>0.065%</td>
</tr>
<tr>
<td>Insertive vaginal intercourse</td>
<td>0.05%</td>
</tr>
<tr>
<td>Receptive oral sex with male partner</td>
<td>0.005%</td>
</tr>
<tr>
<td>Other sexual exposure</td>
<td>0.004%</td>
</tr>
<tr>
<td>Rape</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Table 3: Description of post-exposure prophylaxis (PEP)**

<table>
<thead>
<tr>
<th>Virus</th>
<th>PEP Options</th>
<th>Benefit</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>28 days of combined antiretroviral medications</td>
<td>80% reduction of risk of infection</td>
<td>Medication side effects. These depend upon the antiretroviral agents used.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No good data as an occupational form of PEP, but when given in combination with HBIG, perinatal transmission from mother to child is prevented in 85%-95% of cases</td>
<td>Allergic reaction, pain at injection site, risk of bacterial infection.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Hepatitis B vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4: Categorization of severity of exposure

<table>
<thead>
<tr>
<th>Mode of exposure</th>
<th>Category of exposure</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous injury</td>
<td>Less severe</td>
<td>Solid needle or superficial injury</td>
</tr>
<tr>
<td></td>
<td>More severe</td>
<td>Large-bore hollow needle, deep puncture, visible blood on device, or needle used in source patient’s artery or vein</td>
</tr>
<tr>
<td>Mucus membrane</td>
<td>Small-volume</td>
<td>A few drops</td>
</tr>
<tr>
<td></td>
<td>Large-volume</td>
<td>A major splash</td>
</tr>
<tr>
<td>Sexual contact</td>
<td>Higher risk</td>
<td>Receptive intercourse of any kind or intercourse causing trauma</td>
</tr>
<tr>
<td></td>
<td>Lower risk</td>
<td>All other sexual exposure</td>
</tr>
</tbody>
</table>

Table 5: Considerations regarding HIV testing and window periods

Rapid HIV testing
The window period for the rapid HIV test is 12 weeks. This means that if the patient’s infection began within 12 weeks of the test, the test may be falsely negative. Very rarely someone will develop a true positive test during the time between 12 weeks and six months after infection.

HIV DNA PCR testing
The window period for HIV DNA PCR is six weeks. This means that if the patient’s infection began within six weeks of the test, the test may be falsely negative. Most people will have a positive HIV DNA PCR well before six weeks after time of infection, so six weeks is a conservative estimate. Given limited availability of this test in some settings, most decisions whether or not to initiate PEP must be made without the information from this testing, but in some cases a negative HIV DNA PCR test may allow discontinuation of PEP or may offer reassurance to the exposed person.

Timing of vertical transmission of infection
Remember than an infant’s infection can start antenatally, during delivery, or during breast-feeding. Even asymptomatic infants can have very high viral loads.

Maternal antibodies detected in infant with rapid HIV testing
An infant born to a mother with circulating HIV antibodies may have a positive rapid HIV test detecting mother’s antibodies that have been transferred to child transplacentally or in breast milk. This may be the case for up to 18 months of age, even if the infant is HIV-negative.

Table 6: Categorization of the source patient

<table>
<thead>
<tr>
<th>Adult case</th>
<th>Pediatric case*</th>
<th>Category of source patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic HIV infection or known viral load &lt;1500 RNA copies/mL, has never taken antiretrovirals</td>
<td>No pediatric case in this category</td>
<td>HIV-positive class 1</td>
</tr>
<tr>
<td>Symptomatic HIV infection, AIDS, acute serconversion, or known high viral load, or is taking/has taken antiretrovirals</td>
<td>Infant/child &lt;18 months: positive HIV DNA PCR test</td>
<td>HIV-positive class 2</td>
</tr>
<tr>
<td></td>
<td>Infant/child &gt;18 months: positive rapid HIV test OR positive HIV DNA PCR test</td>
<td></td>
</tr>
<tr>
<td>Cannot test for HIV but has clinical signs and symptoms consistent with HIV/AIDS, including but not limited to: oral thrush, wasting, and recurrent illnesses OR clinical signs and symptoms of primary HIV</td>
<td>Infant with positive rapid HIV test (or whose mother has a positive rapid HIV test) for whom no HIV DNA PCR test has been done OR who have a negative HIV DNA PCR test but were still exposed (in utero, during birth,</td>
<td>HIV unknown, high risk</td>
</tr>
</tbody>
</table>
infection, including: flu-like syndrome with fever, ± rash, lymphadenopathy or oral ulcers or through breastfeeding) within 6 weeks prior to that test

<table>
<thead>
<tr>
<th>Source Patient</th>
<th>Exposure</th>
<th>Percutaneous</th>
<th>Mucus membranes</th>
<th>Sexual contact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Less severe</td>
<td>More severe</td>
<td>Small-volume</td>
</tr>
<tr>
<td>HIV-positive class 1</td>
<td>2-drug PEP</td>
<td>3-drug PEP</td>
<td>Consider 2-drug PEP</td>
<td>2-drug PEP</td>
</tr>
<tr>
<td>HIV-positive class 2</td>
<td>3-drug PEP</td>
<td>3-drug PEP</td>
<td>2-drug PEP</td>
<td>3-drug PEP</td>
</tr>
<tr>
<td>HIV unknown, high risk</td>
<td>3-drug PEP</td>
<td>3-drug PEP</td>
<td>2-drug PEP</td>
<td>3-drug PEP</td>
</tr>
<tr>
<td>HIV unknown, lower risk</td>
<td>2-drug PEP</td>
<td>2-drug PEP</td>
<td>Consider 2-drug PEP</td>
<td>2-drug PEP</td>
</tr>
<tr>
<td>HIV-negative, at risk for false negative</td>
<td>No PEP</td>
<td>No PEP</td>
<td>No PEP</td>
<td>Consider 2-drug PEP</td>
</tr>
<tr>
<td>HIV-negative</td>
<td>No PEP</td>
<td>No PEP</td>
<td>No PEP</td>
<td>No PEP</td>
</tr>
<tr>
<td>Unknown source</td>
<td>2-drug PEP</td>
<td>2-drug PEP</td>
<td>Consider 2-drug PEP</td>
<td>2-drug PEP</td>
</tr>
</tbody>
</table>

*Assuming vertical transmission, i.e.: transmission in early infancy, children infected via an exposure at a later stage in development can be assessed by using the criteria in the adult column.

Table 7: PEP recommendations according to source patient and exposure categories

<table>
<thead>
<tr>
<th>PEP</th>
<th>Prescription</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-drug PEP</td>
<td>• Combivir® (zidovudine 300 mg/lamivudine 150mg) one tablet twice daily</td>
<td></td>
</tr>
</tbody>
</table>
| 3-drug PEP | • Combivir® (zidovudine 300 mg/lamivudine 150 mg) one tablet twice daily  
• Kaletra® (lopinavir 200mg/ritonavir 50 mg) two capsules twice daily with food | |
| Source patient taking Kaletra | • Combivir® (zidovudine 300 mg/lamivudine 150 mg) one tablet bid  
• Efavirenz 600 mg, qhs | Pregnancy test before using efavirenz because efavirenz contraindicated in pregnancy |
| Source patient taking ZDV (Zidovudine, AZT) | May consider substituting d4T ( stavudine) for ZDV (zidovudine, AZT):  
• D4T 30 mg, one capsule twice daily | D4t associated more commonly with severe side effects, such as lactic acidosis, peripheral neuropathy, and |
Administer d4T along with 3TC and Kaletra or with 3TC and Efavirenz:

- 3TC (lamivudine) 150 mg, one tablet twice daily
- Kaletra® (lopinavir 200 mg/ritonavir 50 mg) two capsules twice daily with food
- Efavirenz 600 mg qhs

* Please consult CDC website and an HIV specialist for most up to date country/site specific recommendations

<table>
<thead>
<tr>
<th>Time after exposure</th>
<th>Taking PEP</th>
<th>Not taking PEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial visit as soon as possible after exposure</td>
<td>Rapid HIV test, Urine HCG, ALT, AST, FBC. Consider utility of sending Hep B SAb</td>
<td>Rapid HIV test, ALT, AST, Urine HCG. Consider utility of sending Hep B SAb</td>
</tr>
<tr>
<td>2 weeks</td>
<td>Rapid HIV test, Urine HCG, ALT, AST, FBC</td>
<td></td>
</tr>
<tr>
<td>6 weeks</td>
<td>Rapid HIV test, Urine HCG, ALT, AST, FBC</td>
<td>Rapid HIV, Urine HCG if at risk for pregnancy</td>
</tr>
<tr>
<td>12 weeks</td>
<td>Rapid HIV test, Urine HCG, ALT, AST, FBC</td>
<td></td>
</tr>
<tr>
<td>6 months</td>
<td>Rapid HIV test, ALT, AST, FBC, Hep C, Hep B SAg, Hep B CAB, Hep B SAb</td>
<td>Rapid HIV, Hep C, Hep B SAg, Hep B CAB, Hep B SAb</td>
</tr>
</tbody>
</table>

Sources:
1. Centers for Disease Control and Prevention. Updated U.S. Public Health Service guidelines for the management of occupational exposures to HIV and recommendations for Post-Exposure Prophylaxis. MMWR 2005; 54 (No.RR-9)
Dear UWHC Resident,

Thank you for applying to participate in a global health elective rotation. Participating in this rotation will be one of the most interesting and challenging experiences you will have during your training and we are pleased to be able to help you have that experience.

The safety and security of UWHC residents is of paramount importance. We encourage you and your faculty mentor to monitor the information provided by the U.S. Department of State at www.travel.state.gov for warnings and alerts related to the country in which you plan to travel.

It is your responsibility to determine whether the U.S. Department of State has issued a travel warning for the country in which you wish to complete your elective. If this is the case for the country for your proposed rotation, the UWHC GME Office requires you to review and sign an additional safety waiver for your rotation, a copy of which is below. After consulting this document, reviewing the U.S. Department of State website, and discussing your plans with your faculty mentor, please return the signed safety waiver in PDF format to the UWHC GME Office via email at globalhealth@uwhealth.org.

Sincerely,

Sabrina Wagner, MD
Chair, UWHC Graduate Medical Education Global Health Subcommittee
Waiver for Countries with U.S. Department of State Travel Warning Issued

I understand and acknowledge that my participation in an elective rotation located in a country with an issued U.S. Department of State Travel Warning is voluntary. Without reservation or limitation, I assume all risks associated with my participation in said program. I understand that there are always many unpredictable and serious risks associated with travel abroad, and that such risks are common in countries for which a Travel Warning has been issued. These risks can and do have many underpinnings, including but not limited to the following: travel to and from and within a particular state, country or region; foreign political, legal, military, social and economic conditions; different standards of civil defense procedures, design, safety and maintenance of buildings, public places and modes of transportation; local medical and emergency services; local weather and environmental conditions.

Given the range of risks generally associated with travel, and the likelihood that some or all of these risks are pertinent to an academic program located in a country with a U.S. Department of State Travel Warning, I hereby acknowledge that I assume all responsibility for my personal health, safety and welfare as a consequence of my voluntary participation in an elective rotation in the country named below. I further acknowledge that no person at the University of Wisconsin or University of Wisconsin Hospital & Clinics has or can offer me any guarantees regarding my personal health, safety and welfare, and that I have not been provided with any assurances about local conditions in the country to which I will travel that I construe as such assurances.

_______________________________________    Date___________________________
Signature

____________________________________________________________________
Print name

_____________________________________________________________________________
Print name of country in which you wish to participate in an elective

Adapted with permission by:
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