What have you heard about sexually transmitted diseases?

Imagine a young man who has recently found a new lover. Three or four days after making love, he develops a burning sensation when he urinates and a bad-smelling, whitish discharge from his penis (the signs of gonorrhoea). After ten days, the symptoms are no better and he goes to the local health centre. He is examined carefully by a nurse and given an intramuscular injection (a single, 2g dose of Kanamycin). ‘This will cure your infection,’ she tells him, ‘but you must tell your girlfriend to come in for treatment as well — even if she has no obvious symptoms — otherwise she will re-infect you, and may become very ill herself and never be able to have children.’ The nurse also tells him about the serious consequences of other sexually transmitted diseases (STDs) if they are not treated early enough, and about the newest and deadliest one — HIV infection and AIDS. ‘This disease kills and there is no cure. I am going to tell you how to protect yourself and your sexual partner from AIDS.’

Some time later the young man leaves the clinic with a free packet of condoms and sets off to discuss all this with his lover. For the first time, he recognises that he may be at risk from AIDS. ‘But I needn’t be,’ he thinks, remembering all the advice about condoms, and keeping to one partner.

Now imagine the outcome of this story if there had been no free medical treatment, no kanamycin or co-trimoxazole (the other drug used to treat gonorrhoea), and no trained nurse who could explain the dangers of STDs and how to prevent them. Unfortunately, this is the situation in much of the developing world.

Preventing STDs — and AIDS

AIDS is essentially an STD, since the most common method of HIV transmission is through penetrative sex. However, AIDS is rarely considered in the context of other STDs, even though the methods for the primary prevention of AIDS are the same as those for STDs i.e. promoting safer sexual behaviour, including the use of condoms and having fewer sexual partners. Resources are often channelled into single focus AIDS initiatives without integrating these into STD prevention and control. There are a number of benefits to establishing an integrated approach (see pp.2-3):

- Treating and counselling people with STDs gives health care workers a valuable opportunity to counsel people at particularly high risk of acquiring or transmitting HIV infection.
- Clinical studies suggest some STDs may facilitate the sexual spread of HIV infection (i.e. act as risk-factors) by increasing both the infectivity of a person with HIV and/or increasing the sexual partner’s susceptibility to HIV infection. The type of STD that appears to act as a risk-factor is genital ulcer disease (GUD), including chancroid, syphilis and genital herpes. Chlamydial infection is also a potential risk-factor.

How common are STDs?

Every year, over 200 million cases of gonorrhoea are reported worldwide, and over 50 million cases of syphilis. The real figures are unknown — in large parts of the world STDs go unreported and untreated. The most common of the serious STDs [excluding HIV infection] are gonorrhoea, syphilis, chancroid (common in parts of Africa, although rare in most developed countries) chlamydial infections and herpes. In Africa, chancroid and syphilis cause around 80 per cent of genital ulceration, and herpes around

The international newsletter for information exchange on AIDS prevention and control
Continued from front page
10 per cent. Genital ulcer disease is more common in Africa than in developed countries (which tend to have a higher incidence of other STDs, such as genital warts); since GUD may facilitate the spread of HIV, this could explain the more rapid spread of heterosexually acquired HIV infection in some parts of Africa. Widespread STD control could have a significant impact on the spread of HIV in areas where GUD is prevalent.

Time to act
The exact role of STDs as risk factors in the transmission of HIV has to be further researched. The World Health Organisation (WHO) is proposing large-scale intervention studies (see WHO Report) setting up widespread STD monitoring and treatment services in a number of communities and comparing rates of HIV transmission with rates in similar communities still lacking treatment services. However, the Head of WHO’s STD programme, Dr André Meheus, warns: ‘Even if STDs were not a risk-factor, we must still control STDs to control HIV — because STDs reflect the practice of risky sexual behaviour which we have to change. Most of the things we have been saying about the prevention of STDs, we are now saying about AIDS. Now decision-makers have to act on what we’ve all been arguing for, over the past twenty years.’

The political will and economic resources behind AIDS initiatives worldwide should be used to strengthen STD health education and treatment services as an integral part of HIV control. This means ensuring that essential drugs programmes are effective; more paramedics are trained in the management of STDs, and the general population is made aware of the availability of counselling and treatment services.

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Treating HIV infection like a Sexually Transmitted Disease

How can the spread of HIV infection and AIDS be most effectively prevented at the primary health care level? Dr Pallangyo from Tanzania argues that integration of AIDS initiatives within widespread STD prevention and control activities is now vital to any national programme.

AIDS is the most recent and deadly of the sexually transmitted diseases (STDs). Not only is sexual activity common to the spread of HIV and other STDs — some STDs may also facilitate the spread of HIV infection. The social and psychological similarities in the prevention and control of HIV infection and other STDs are numerous — both require intensive health education on sexual behaviour, and provoke debates on social attitudes, civil rights and public health.

What are the main aims of STD control programmes?

Firstly, to stop or interrupt transmission. This is where key similarities with AIDS prevention and control strategies exist. Early diagnosis of disease, followed by treatment and health education on methods of prevention, are crucial to interrupting the spread of STDs. Contact tracing (i.e. contacting past and/or present sexual partners for treatment and counselling) is also essential, as is more wide-reaching public health education on prevention.

Secondly, to prevent complications and their consequences. STDs should be treated as early as possible, to prevent serious long-term physical disabilities or death. For example, gonorrhoea can cause permanent infertility in men and women if not treated early enough and a baby born to a woman with gonorrhoea may develop an eye infection which can cause blindness. Syphilis can also be passed on to the unborn child, causing still-birth or death soon after birth. Similarly, HIV infection and AIDS have implications for the unborn child. In adults, untreated syphilis progresses and can permanently damage the heart and brain, and may eventually be fatal.

Unfortunately, it has been difficult or impossible to implement recommendations for STD control in most developing countries, often due to a lack of diagnostic facilities, trained health workers — and, most important of all, a lack of political will. AIDS, however, has provoked an extraordinary degree of anxiety, interest and commitment from communities, governments and international bodies. Consequently, AIDS control programmes are being set up in many countries where STD control programmes are either poorly run, or non-existent.

Why are STD programmes important for AIDS prevention and control?

Many experts believe that to launch AIDS control initiatives without integrating them within broader STD control programmes may well be ineffective and certainly uneconomical. The reasons for this are:

- STD treatment centres have direct contact with patients at high risk of acquiring HIV infection. All patients with symptoms of a common STD have in theory been at risk of acquiring HIV infection, since their sexual behaviour has already led to them getting a sexually transmitted disease. The disease they caught could have been HIV infection/AIDS. Patients may continue to put themselves at risk, unless convinced otherwise through appropriate health education. This should be provided at all STD treatment centres as well as through public education campaigns.

In addition, studies have shown that HIV infected individuals are more
likely to have a greater number of other STDs than individuals not infected with HIV. A person with HIV infection is likely to present with at least one other STD long before symptoms of AIDS develop (HIV infection has a longer incubation period than most other STDs) therefore providing an early opportunity for health education.

O Health workers already trained in STD management and control can offer some of the best expertise needed in an AIDS control programme. STD clinics often have extensive experience in providing specialised counselling on sexual behaviour and the use of condoms, for example.

O Since some STDs could actually facilitate the spread of HIV infection (see below), developing more extensive STD control programmes within primary health care could slow the current rapid spread of HIV in many parts of the world.

O Infection with STD activates the immune system, stimulating the replication of HIV in infected cells, which could speed up the progression to full-blown AIDS. Early treatment of STDs could therefore help prolong the life of an HIV-infected patient.

O Monitoring the occurrence of STDs with short incubation periods — and those easier to diagnose than HIV — can provide useful indicators of the effectiveness, or ineffectiveness, of AIDS control programmes and/or significant changes in sexual behaviour. The incidence of STDs in a given population reflects the degree of unsafe sexual behaviour and hence the risk of HIV transmission. For example, the reduction in the incidence of syphilis and gonorrhoea amongst the male homosexual community in the USA and Europe indicates widespread change in sexual behaviour.

Do STDs facilitate transmission of HIV?

There are strong theoretical reasons, as well as clinical evidence, to suggest that certain STDs are a potential risk-factor in the transmission of HIV i.e. they might help the virus to pass from one infected person to their partner during sexual intercourse. It has been suggested that the high prevalence of some STDs reported in most urban centres in tropical Africa, could be a major factor contributing to the rapid spread of heterosexually acquired HIV in the region.

Several small-scale clinical studies have suggested that genital ulcer disease (GUD) in particular is a potential risk-factor in HIV transmission. GUD is a term which includes a number of ulcer-producing STDs, including chancroid, syphilis and herpes. At the STD clinic in Dar-es-Salaam, Tanzania, HIV seropositivity among patients presenting with GUD is currently four times that for all other patients attending STD clinics.

GUD could increase the risk of HIV transmission by increasing the infectivity of an HIV infected person (e.g. as a result of passage of HIV through the ulcer) and/or increasing the susceptibility of a person to HIV infection (e.g. by facilitating entry of the virus through genital ulcers, or through broken skin or mucous membranes).

Most STDs cause inflammation and/or genital ulceration of the skin or mucous membranes. Broken skin or mucous membranes allow easier entry or exit of HIV.

In addition, inflamed skin or mucous membranes and ulcers contain increased numbers of the cells that HIV attacks — the lymphocytes and macrophages which contain receptors for HIV on their surfaces (see AIDS Action, issue three, for an explanation of how HIV attacks the body's defence system). Thus, any STD which increases the number of these cells in the genital area could facilitate the transmission of HIV.

Does HIV infection affect the clinical symptoms of other STDs?

Since HIV infection destroys the body's ability to fight off other diseases, the clinical picture of common diseases in HIV infected individuals is often atypical and treatment may be more difficult. Many STD clinics in East and Central Africa are now having to cope with increasing numbers of HIV infected patients with GUD symptoms which persist for several weeks, sometimes months, despite the provision of normal medical treatment. Chancroid ulcers in HIV infected patients, for example, tend to be larger, more numerous, and persist for longer than usual. Response to the recommended single oral dose of Trimethoprim sulphametrole (640mg/3200mg — i.e. eight standard tablets each containing 80mg trimethoprim/400mg sulphametrole) is sometimes disappointing (note: this drug is not as widely available as co-trimoxazole — see following treatment guidelines).

Herpes simplex infections of the skin and/or mucous membranes are common in patients with AIDS and can cause severe genital, peri-anal and rectal ulcers. Extensive genital ulceration due to Herpes Simplex Virus type 2, may be the first indication of underlying immunodeficiency (damage to the immune system caused by AIDS).

In HIV infected patients, it also appears that late syphilis (see pp. 4-5) may develop within an unusually short period of time (less than five years) after initial infection with Treponema pallidum (the bacterium which causes syphilis). However, most HIV infected patients with early syphilis respond well to doses of Benzathine benzyl penicillin G (2.4 million units).

Genital viral warts, candidosis and trichomoniasis are also STDs more commonly found in HIV infected patients than in non-HIV infected individuals in Dar-es-Salaam; symptoms tend to be more serious in patients suffering from immunodeficiency.

There is certainly sufficient evidence to suggest that HIV infection may alter both the clinical presentation and the natural history of STDs, and that some STDs may facilitate the spread of HIV and affect the clinical picture of AIDS. Strengthened STD programmes are urgently needed: in Tanzania, for example, reports to the Ministry of Health between 1973 and 1978 showed gonorrhoea to be the ninth most frequent cause of hospital outpatient attendance in the country.

Since HIV infection/AIDS is predominantly an STD, it should be treated as such in integrated prevention and control strategies. Attempts to control the spread of HIV in the absence of STD prevention and control activities are less likely to succeed.

Dr K J Pallangyo, Consultant Physician and Senior Lecturer, Muhimbili Medical Centre, PO Box 65066, Dar-es-Salaam, Tanzania.
General guidelines on diagnosis, treatment and prevention of genital ulcer disease.

The following guidelines deal with the most common causes of genital ulcer disease.

The management of all sexually transmitted diseases should include counselling on safer sex, information on HIV infection and AIDS and the use of condoms for the prevention of STDs. Remember to call in sexual partners of patients for treatment and counselling, whether or not they have symptoms. Above all, try to be welcoming and emotionally supportive to patients - many of whom feel embarrassed or worried by their infection.

Chancroid

This is the leading cause of genital ulcers in many developing countries, but is less common in developed countries. Chancroid is caused by a bacterium known as Haemophilus ducreyi.

Signs and symptoms

Both males and females with chancroid develop painful, dirty-grey, genital ulcers. In males, ulcers are commonly found on the edge of the glans penis, but can appear anywhere on the external genitalia. In females, ulcers may be found anywhere on the external genitalia, including around the vulva, clitoris and anus, or inside the vagina and on the cervix. Chancroid ulcers are painful and the syphilis one is not.

Patients often develop enlarged lymph nodes in the groin, called bubos.

Treatment

Co-trimoxazole, two tablets (each tablet 80mg trimethoprim, 400mg sulphamethoxazole) orally twice a day for seven days, or Erythromycin 500mg six hourly for seven days. See also treatment protocol page five.

Note: there is considerable geographical variation in the sensitivity of H. ducreyi to antimicrobials; in some parts of the world this bacterium is resistant to sulphonamides and possibly also to trimethoprim (including co-trimoxazole), tetracycline and streptomycin. Nevertheless, co-trimoxazole is still highly effective in many areas, but not in Thailand.

An appropriate choice can be made from the above, or: 640mg Trimethoprim/3200mg sulphameterole (ie. eight tablets where each contains 80mg/400mg), orally in a single dose.

Amoxycillin 500mg with clavulanic acid 250mg orally every eight hours for three days.

Enlarged lymph nodes (bubos) should be aspirated with wide-bore needle every two days if necessary. When a bubo is ready for aspiration, the overlying skin is shiny and the area underneath is soft. Take a sterile 5ml syringe and a wide-bore needle. Clean the skin over the bubo with methylated spirit on a cotton wool swab. Pierce the shiny skin entering only 2mm and suck out as much pus as possible into the syringe.

Syphilis

This is caused by a bacterium known as Treponema pallidum. This disease can affect all organs of the body. It occurs in two forms — early (primary and secondary stages) and late syphilis. During early syphilis, the patient is infectious to his/her sexual partner. During late syphilis, the patient is not infectious to sexual partners.

Between early and late syphilis, the disease enters a latent phase which may continue for many years, when there are no symptoms or signs.

Signs and symptoms

Primary syphilis:

Three weeks after contact with an infected partner an ulcer develops at the site of infection. This ulcer is the ‘primary chancre’. It may be found anywhere on the penis in males, or in females on the external genitalia, the vaginal opening, inside the vagina or on the cervix. In both cases, it is a painless, single, firm ulcer with a ‘punched out’ (ie. raised lump) appearance. It may heal without treatment. The inguinal (pelvic) lymph nodes become enlarged and feel rubbery.

Secondary syphilis:

Between two and four months following initial infection, patients may develop secondary syphilis. The first sign is a non-itchy rash all over the body which may become papular (round, solid raised lesion of skin), pustular (infected pimples), or may develop into flat warts (condylomata lata). There may be whitish lines on the tongue and mucous membrane of the mouth called ‘snailtrack’ ulcers. There may be generalised lymph node enlargement.

Continued on page five
Treatment guidelines

Continued from page four

**Latent syphilis:**

During this stage, there are no signs or symptoms but a blood test is positive and the patient should be treated.

**Late syphilis:**

Untreated syphilis may progress. After between two and 15 years, the heart and brain may be affected. At this time the disease cannot be passed to other people.

**Laboratory diagnosis**

Many Third World countries lack the necessary equipment for laboratory diagnosis of syphilis — STD programmes should be supplied with testing equipment as a matter of urgency.

There are two types of blood tests for syphilis: non-specific and specific tests.

**Non-specific tests:** These are the VDRL and Rapid Plasma Reagin (RPR) tests. These tests are cheap and quick to perform but may give a false positive result i.e. sometimes the test is positive when the patient is not infected. Treat all patients whose blood gives a positive result. These tests will give a positive result about five weeks after initial infection, and should revert to negative within six months of successful treatment. If the result does not become negative, the patient should be re-treated.

**Specific tests:** These tests are only for syphilis but are expensive. Tests may remain positive for life despite adequate treatment. The Absorbed Fluorescent Treponemal Antibody (FTA-Abs) test is highly specific for syphilis and becomes positive three weeks after initial infection. The Treponema Pallidum Haemagglutination Assay (TPHA) is also a specific test which becomes positive five weeks after infection.

**Treatment**

Educate your patient about syphilis: this is a serious disease that causes permanent disability, and may affect the unborn child (see previous article). All sexual partners should be traced, examined and treated even if they have no symptoms or signs.

For primary and secondary syphilis, give a single dose of Benzathine penicillin by intramuscular injection of 2.4 million units (1.2m units in each buttock).

For patients without signs or symptoms, but who have had a positive blood test for syphilis, give Benzathine penicillin 2.4 m units, weekly for three weeks. For late syphilis, patients should be treated in a hospital. For patients allergic to penicillin, give tetracycline 500mg orally, every six hours for 14 days except to pregnant or breast-feeding women — in which case, treat with erythromycin instead, 500mg orally every six hours for 14 days.

Following treatment, review the patient after a month. Have the symptoms disappeared? If the sore persists, treat as chancroid. Has the partner been treated?

**Genital herpes**

This is caused by the herpes simplex virus and is the major cause of genital ulcers in the developed world. The incubation period is short.

**Signs and symptoms**

In males, the patient develops itchiness at the site of infection. This may be on the foreskin, the shaft of the penis or the glans penis. A small area of redness appears which develops into small blisters. These may break down to reveal painful, shallow ulcers. In the first attack lesions are more extensive and cause severe pain. The lesions heal after about two to three weeks. In females, the lesions are on the cervix, the labia, the vagina, or around the anus. During the first attack there may be quite extensive inflammation of the cervix, the vulva and vagina.

Recurrence of lesions occur in about 50% of patients, and lesions are usually less extensive and heal within five to seven days. Recurrences in both males and females may follow sexual contact, stress and, in females, the menstrual period.

**Treatment**

There is no effective cure. Patients should be reassured but warned that a recurrence of ulceration is a possibility and he/she should not have sexual intercourse while lesions are present, as the Herpes Simplex Virus can be passed on during this stage. Tell the patient to keep the lesions clean and dry and wash with soap and water.

**Treatment protocol for genital ulcer(s)**

Frequently, in an ulcer that looks like chancroid, the bacterium causing syphilis can also be found. It is safe to assume that all large genital ulcers could be double infections of both chancroid and syphilis. Where there are no diagnostic tests for syphilis, and the patient is not likely to be seen again, the following treatment protocol is particularly useful:

**Genital ulcer (syphilis and/or chancroid)**

<table>
<thead>
<tr>
<th>Benzathine penicillin 2.4 million units, intramuscular injection (1.2m units in each buttock)</th>
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<tr>
<td>co-trimoxazole, two tablets twice daily for seven days</td>
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<td>or</td>
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<tr>
<td>Erythromycin 500mg orally, six hourly for seven to ten days</td>
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<tr>
<td>or</td>
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<tr>
<td>640mg trimethoprim/3200mg sulphamethoxazole orally in a single dose</td>
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</tbody>
</table>

Follow up in seven days

| cure or healing |
| stable or worse |
| observe |
| refer |

In cases of possible double infection with chancroid and syphilis in areas where H. ducreyi is known to inactivate penicillin, treat and cure chancroid before treating syphilis. Otherwise, penicillin given to treat syphilis may be destroyed by H. ducreyi.

1. If patient allergic to penicillin, give tetracycline 500mg orally, six hourly for 14 days, EXCEPT where pregnant or breast-feeding, in which case give erythromycin (same dose and regimen) instead. If after one week the ulcer is not healing, REFER to nearest hospital or clinic.

2. Where each tablet contains 80mg trimethoprim/400mg sulphamethoxazole.

Adapted from Sexually Transmitted Diseases produced by the Zimbabwe Essential Drugs Action Programme, Training Unit, Ministry of Health.
In Spanish Gente Joven means ‘young people’ — and is the name given to a pioneering Mexican youth movement. Focusing on issues of sexuality, the organisation is dedicated to promoting a better understanding of the problems faced by adolescents and to finding some answers. Hilary Hughes, from AIDS Action, spent a day with Gente Joven’s community promoters in the northern city of Monterrey — a local group which has attracted nearly 26,000 members.

‘I’m going to show you our Sex Education Week’ exclaimed Itziar Rocha — the dynamic, 27-year-old director of Monterrey’s Gente Joven. It was 8.30 in the morning, and she had arrived to take me to the city’s largest state technical college for the launch of Sex Education Week. The college has around 8,000 students attending part-time courses, mainly in mechanical engineering, social work or tourism. Every month, Gente Joven (GJ) organises a week of educational activities on sexuality for a few hundred students at a time.

Sexuality in school
On arrival, we entered a hall in semi-darkness where over 200 students aged between 16 and 19 years were watching a film. It was a moving and well-acted story about a young boy and his relationship with his drug-addict brother and his father. It explored difficulties in family communication and personal identity. When the film had finished, Geraldo Hernández Sosa, a trained psychologist working as a volunteer for GJ, guided students into a discussion and invited comments from the audience. Students had the opportunity of writing down personal questions anonymously and putting them in a ‘discussion box’ which was passed around.

‘Most emotional problems faced by teenagers are rooted in difficulties in talking to parents and feeling accepted and understood — this is why family communication is covered in our activities’ Itziar, also a trained psychologist, explains. ‘Problems at home may lead to drug-taking, for example. Marijuana is cheap and popular in the shanty towns and in some areas, marijuana and cocaine are sold in schools!’

‘Another problem some youngsters face at home is incest (usually where fathers sexually abuse their daughters). This is very difficult to deal with, especially when tolerated by the mother.’ Some women think ‘Well, it’s better than him going off with another woman...’ But all the while, the poor girl has feelings she cannot deal with — she often feels “dirty” and guilty.”

Since communication is a two-way process, parents are invited to take part in a special introductory session at the start of Sex Education Week. Here, they are also told what their children will be learning.

Five themes
The Gente Joven ten-hour course is divided into five sessions, each two hours long, covering:

- family communication;
- human development — including the process of fertilisation, birth and the responsibility of parenthood;
- sexuality and youth — including the topics of masturbation, prostitution, premarital sex, marriage and chastity;
- sexually transmitted diseases — including symptoms, methods of transmission and prevention of common STDs, as well as HIV infection and AIDS;
- unwanted pregnancy and contraception — including physical and social consequences of teenage pregnancy, different contraceptive methods and the advantages and disadvantages of each.

At the end of the course, youngsters are given a multiple choice questionnaire to test their knowledge, and invited to join GJ as members. In addition to being part of an active social and educational movement, members receive free medical, family planning and counselling services.

‘Some schools have objected to Sex Education Week,’ states Itziar, ‘but most recognise the urgent need to give young people information that allows them to develop their sexuality in a healthy and responsible manner.’ In Mexico, there are about 20 million youngsters aged between 11 and 19
years; a significant proportion have their first sexual experience before the age of 16, and 70 per cent have an active sex life before the age of 19.

In its efforts to reach as wide a range of youngsters as possible, GJ does not confine its activities to schools, but organises educational and social events in the workplace and among street kids. The local Catholic church has also invited GJ to work with teenagers in the parish. "At first we thought it would be difficult talking about sex and condoms in front of a priest! But because of AIDS the priest knows everyone has a right to health education."

San Bernabe and the puppet show

By midday it was time to move on to San Bernabe—a large and very poor shanty town on the outskirts of Monterrey, where eight trained health promoters organise regular activities. Here, houses are built of corrugated metal and breeze blocks, spread over miles of dusty wasteland, where there is limited water supply and little or no electricity.

At the crossroads between two wide, dusty streets, we discovered a group of adults and children watching a puppet show. As I arrived, the glove-puppet housewife was beating her unfaithful husband. It was part of a story of community life, told with hand-made glove puppets representing a variety of characters—a single mother, a young street child, a homosexual man, a factory worker. But the story was not just for entertainment, it clearly showed the dangers of having unprotected sex with many partners.

Working in the shanty towns had not been easy. 'On one of our first visits here, the promoters stayed too late—as they prepared to leave (it was around 8.00pm) local gangs tried to break into the car and attack them,' Itziar recalls. 'There is a lot of violence, and alcoholism. Men can be abusive towards the female promoters. Every month there are 2,000 robberies and around 20 deaths due to violent crime. It's therefore very important to gain the confidence and cooperation of community leaders. Here, for example, we work with Maria Elena, the municipal president responsible for coordinating the provision of low-cost, state-owned land to homeless families. She is a powerful community activist and has recently offered us free land to set up a community clinic and advice centre.'

Meeting the promoters

Early afternoon we returned to the small Gente Joven office for a meeting with the community promoters. Many are young women or men attending social work courses, or on six-month attachments from courses at the School of Psychology and Media Communications. "All the promoters receive over 100 hours of training and are tested on their knowledge before starting voluntary work..." explains Patti, a 22-year-old promoter, who works more than ten hours a day coordinating activities in San Bernabe. The organisation has built up an impressive team of professional volunteers. Thirty-six community promoters now work in nearly as many districts, recruiting up to 4,000 new students every month. Most promoters are at least 18 years old: 'This is because we found that older promoters have more respect from the community—they should be quite smartly dressed, for the same reason.' Promoters have regular meetings to evaluate activities and keep detailed diaries of the courses they run, including the age and numbers of new students reached.

'One of our promoters, Pancho, is an ex-street leader,' Itziar remembers. 'He was part of a group of youngsters we wanted to work with—the street gangs or chicos bandas as they are known here—but he was very unfriendly towards us to start with. But then I said: "OK. So what do you want to do? What is it you want?"' He told me "I'm interested in body-building." So that's what we helped some of the chicos bandas to do—we set up body-building sessions in a gym. Once these activities are organised, it is easier to motivate youngsters to take part in other educational activities.

Street talks

By early evening we were on our way to the last visit of the day. Itziar and three promoters set off to a shanty town at the request of Maria Teresa, who coordinates local income-generating and social projects for young people. Tonight, Itziar was to recruit a new crowd of youngsters for the ten-hour sexuality course. As soon as the car entered the street, children were running round, banging in friendly excitement on the windows and doors. Within half an hour, teenagers and children alike had made seats out of old planks of wood and building bricks for an informal, open-air gathering. Some of the older teenagers stood at a distance, leaning casually against the car and neighbouring houses, as Itziar stood up and explained why she had come and what Gente Joven had to offer. 'For those of you who want to join in—we'll be meeting over in the building on the corner next Tuesday evening. All of you older ones are invited—especially those with girlfriends and boyfriends.' "I have a girlfriend!" shouted an eight-year-old. The older ones all laughed: 'You're too young.'

Gente Joven would like to hear from similar youth movements worldwide. Please write to: Itziar Rocha Guzman, Gente Joven, Rio Magallanes 225, Colonia Mitras Norte, 64320, Monterrey, Mexico D.F., Mexico.
Dear AIDS action,

We are writing in response to your very useful item on the simple blood testing equipment developed by DuPont — HIV chek. However, we wish to draw your readers’ attention to the following:

- The assay is ideally performed by trained staff in blood banks and clinical laboratories for screening of blood for transfusion purposes. Where individuals receive their results, appropriate pre- and post-test counseling must be given. The test should not be used by personnel with little or no knowledge of serological assays.

- Frozen blood samples should not be used as these may give false positive results.

- Each reagent in the assay requires a clean bulb pipette supplied in the kit. Bulb pipettes MUST NOT be re-used in a desire to economise — contamination of one reagent with another affects the result.

- As with other assays, positive results should be confirmed by repeat test, or by using another recognised testing method, except where blood is being screened for supplies, when positive batches are automatically discarded.

Mike Bailey and Kweisi Tsigaye, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine (UK).

Dear AIDS action,

In issue four of your newsletter I read an article on safer sex counselling. My worry is that I do not know how to have sexual relationships without penetration. Kindly print additional articles on safer alternatives to penetrative sex, and if possible further information on how to use the condom.

Your assistance would be highly appreciated.

G S, Zambia

Dear AIDS action,

I am pleased to write to you in appreciation of the AIDS action newsletters which have reached me. Many people appreciate your efforts to give others worldwide an idea of what AIDS is, how it can be prevented and how counselling HIV infected people can be approached. So many people want to read the newsletter, that the ten copies you sent me have disappeared without me keeping a copy for myself.

Please send me additional copies in both English and French.

N E Ndzi, Subdivisional Hospital, N.W. Province, Cameroon.

NEW RESOURCES

Colour slide sets

From Teaching Aids at Low Cost (TALC, UK):

HIV infection — virology and transmission

A set of 24 slides for eaching doctors, medical students, and health workers about HIV infection and AIDS.

Includes teaching notes and questions and answers for discussion. Could be used as a complete talk, or individual slides can be selected out to illustrate other lectures. Covers epidemiology, virology, immunology and transmission of HIV infection.

HIV infection — clinical manifestations

Second in the colour slide set series: aimed at doctors and nurses caring for people with AIDS and those who are responsible for teaching others about HIV infection/AIDS. This set is best used with students who have seen the above set on virology and transmission.

Both slide sets mentioned above are available from: Teaching Aids at Low Cost, PO Box 49, St. Albans, Herts. AL1 4AX, UK. Price: set of 24 colour slides, self-mount, with instructions, £2.75 (for developing countries) including p&p. Mounted slides £4.40. Add 60p for airmail.

Manuels

From the International Planned Parenthood Federation:

‘Talking AIDS’ — A guide for community workers

A practical handbook for all community workers and teachers involved in AIDS education. Provides basic information on AIDS/HIV infection, including transmission; prevention and care in social and economic contexts; approaches to counselling and how prejudices can hinder positive action. The book is well illustrated with cartoons and diagrams, stimulating thought on how readers should approach problems posed by HIV/AIDS in their own communities.


Preventing a crisis — AIDS and family planning work

A larger resource manual aimed at family planning associations, teachers and youth leaders. Includes ideas and approaches to training, education and service delivery. Can be used to develop training materials and guidelines for workers:

ISBN 0-86089-081-3 Price: free to IPPF network, or £6.00 (excluding p&p).

Both manuals available from: Macmillan Distribution Ltd, Houndsmill, Basingstoke, Hampshire RG21 2XS, UK

Apology

Please note: the Counselling Hints item on the use of condoms in issue five was produced by AHRTAG. It was not the responsibility in any way of Sister Maura O’Donohue who supplied the guidelines on the safe disposal of placenta in the adjacent Health Precautions feature.

We apologise for any confusion caused by the misleading page layout.

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World AIDS Day — a special embrace

It was probably the first occasion in history when the whole world united — on one particular day — around a single health issue. The day was December 1 1988, and the message was one of hope and international solidarity: organisations across the world presented imaginative new ideas to educate populations about AIDS. At the WHO coordinating centre in Geneva, health educator Richard Rector — a man with AIDS — stood up and gave fellow health educators worldwide the most important message of all: 'We must recognise that people with AIDS or HIV infection ... can offer expertise that cannot be learned in the laboratory. We must reach out to include their expertise in AIDS education and discussions on the provision of care.'

Beyond Geneva, people from every country joined in response to WHO's call to 'Tell the world what you are doing about AIDS'. The following is a selection of the more high-profile activities — hundreds of other groups not listed here were also busy with workshops, lectures, discussions and cultural events.

- **Benin**: AIDS messages in churches, temples and mosques. **Botswana**: music festival; song contests for local bands; poster competition for secondary schools; football match. **Brazil**: photographic exhibition on the theme of non-discrimination; art exhibition by artists with AIDS; and opening of a special care centre for AIDS patients. **Bulgaria**: special brochures; talks in schools and factories; TV programmes, films, round-tables; AIDS week.
- **Burkina Faso**: inauguration of a documentation centre; AIDS week; posters and banners displayed in the street; cycling race. **CAREC (Caribbean Epidemiology Centre)**: newsletter initiated. **China**: AIDS quiz; concert, special radio programmes on health and hygiene. **Democratic Yemen**: first laboratory on AIDS inaugurated. **Federal Republic of Germany**: painting of a 2,000 metre long cotton banner with expressions of hope for those with AIDS. **Guinea Bissau**: speech by President; anti-AIDS propaganda in bars and nightclubs; AIDS week; parades in the main street of the capital. **Israel**: hotline for questions at central blood bank; AIDS materials and discussions for prison warders and inmates, soldiers, schools, medical staff. **Kuwait**: all five national newspapers distributed WHO pamphlets on AIDS. **Malawi**: World AIDS Day message on postal franking machines; USAID to ship one million condoms to arrive by World AIDS Day. **Mauritius**: health newsletter on AIDS launched; 800 balloons released; T-shirt distribution to cycle rally and mountain climbing participants. **Sweden**; 'walkathon', and celebrity fundraising drive; parades, dances, drama. **Tonga**: address by the King; special religious services; seminars and workshops; song competition. **United Kingdom**: conference on 'AIDS needs for the 1990s'.

Putting the pieces together

One project in particular symbolised growing international solidarity. It is known as The Names Project and began in 1987 when a man from San Francisco died of AIDS. Friends and relatives made the first cloth panel of what was to become a giant patchwork quilt, commemorating the lives of those who have died of AIDS. The quilt — now made with over 10,000 panels — is displayed in California, commemorating men, women and children from different countries. On World AIDS Day, sections of the quilt were sent to Switzerland, Belgium, Brazil, Canada, Germany, Norway and the United Kingdom for exhibition.

The Names Project gives artistic expression to one of the major themes of World AIDS Day: the human face of AIDS. It reminds us all of the need to do our best to care for people with AIDS, to end discrimination and to find effective ways of disease prevention. World AIDS Day — and the many successful community-based AIDS projects it represents — points the way towards a more effective response to many other worldwide illnesses. When asked: 'Why so much emphasis on AIDS? Why AIDS when there are so many other diseases?' Dr Jonathan Mann, Director of the WHO Global Programme on AIDS, replied: 'Why not approach other diseases with this kind of solidarity?'

Adapted from AIDS Health Promotion Exchange
Consultation on Sexually Transmitted Diseases (STDs) as a Risk-factor for HIV Transmission

4-6 January 1989, Geneva

A Consultation on sexually transmitted diseases (STDs) as a potential risk-factor for human immunodeficiency virus (HIV) transmission was convened by the World Health Organisation's Global Programme on AIDS (GPA) and Sexually Transmitted Disease Programme (VDT) from 4-6 January 1989 in Geneva. A total of 32 participants from 21 countries attended, including experts in public health, epidemiology, biomedical and social science aspects of STDs and AIDS.

Introduction

On a worldwide basis, sexual transmission is the most important route of HIV spread and the Global AIDS Strategy and the national AIDS programmes have proposed extensive initiatives to prevent the transmission of HIV. In this context, information about biological factors which may influence the sexual transmission of HIV is potentially of great importance for the design and conduct of HIV prevention programmes. STDs are priority health problems in many areas of the world. Although national prevention and control programmes have been developed and implemented, many need strengthening.

Recent studies have suggested that STDs, particularly those which cause genital ulceration, may facilitate the transmission of the human immunodeficiency virus, Type 1 (HIV-1). Accordingly, WHO convened a consultation to develop consensus based on critical analysis of available evidence regarding the potential role and importance of STDs as a risk-factor for HIV-1 transmission.

The Consultation had the following objectives:

1. Review and assess the available data regarding STDs as a risk-factor for HIV transmission;
2. Identify future research priorities and methodologies for understanding of the biological interactions between HIV and STDs;
3. Consider strategic and programmatic implications of the results of discussions on objectives 1 and 2.

The following consensus statement was developed:

STDs as a risk-factor for HIV transmission

While HIV-1 is transmitted sexually in the absence of other STDs, the weight of the evidence for genital ulcer disease (GUD) as a risk-factor for HIV-1 transmission is sufficiently strong that GUD intervention may contribute to prevention of sexual transmission of HIV-1.

2. Several studies in developing countries have shown that GUD is associated with HIV-1 infection in heterosexuals. A few studies have shown association of antibody to herpes simplex virus type 2 (HSV-2) and to Treponema pallidum, which causes syphilis, to Treponema pallidum, which causes syphilis (the major causes of genital and anorectal ulcers in industrialised countries) with HIV-1 infection in homosexual men and in heterosexual men and women.

3. Evidence for these associations is consistent in most studies but because GUD and HIV-1 are both sexually transmitted it is necessary to examine only studies that have attempted to measure and adjust for confounding and bias, primarily involving sexual behaviour.

4. The evidence is strongest for GUD in Africa, where prospective studies have been done which have given consistent results. There is also evidence for a temporal association between GUD and HIV-1 infection which further suggests that GUD facilitates transmission of HIV-1.

5. Sero-epidemiological studies which have examined the relationship of HIV-1 with HSV-2 and Treponema pallidum have demonstrated a consistent association of the two with HIV-1 infection. Some evidence in homosexual men suggest a temporal association exists for HSV-2 and HIV-1.

6. While some studies have found an association between other STDs pathogens or STDs syndromes and HIV-1 infection, the available data are inconsistent and insufficient to assess their role as risk-factors for HIV-1 transmission.

7. It is biologically plausible for all STDs pathogens that cause genital ulcers or inflammation to be risk-factors for increased infectiousness or increased susceptibility to HIV-1 infection.

8. In general, it is not possible from available data to distinguish an effect on increased susceptibility to HIV-1 infection in an HIV-seronegative person with an STDs, from an effect on increased infectiousness of HIV-1 in and HIV-seropositive person with an STDs.

9. The importance of genital ulcers in increasing transmission at the population level (population attributable risk), as opposed to the individual level, has been calculated in only one study of prostitutes and STDs clinic patients, and cannot be generalised. Therefore, the proportion of sexually transmitted HIV-1 infections which can be attributed to GUD has not yet been defined for the general population.
10. Intervention trials have not yet been done, the results of which may further support GUD as a risk-factor in increasing HIV-1 transmission; such trials would further be helpful in assessing the effectiveness of GUD control in reducing the sexual transmission of HIV-1.

Research Priorities

The main needs for further research are:

Effectiveness of GUD control in reducing sexual transmission of HIV-1 (intervention trials).

2. The effects of STDs on HIV-1 transmission. Although a large volume of data is available in this area, few cohort studies have been performed and rigorously controlled for microbiologic aetiology of the STDs and the sexual behaviour of the participants. In addition, statistical methodology to examine the effects and interactions of two highly related events need to be refined and standardised. The two specific questions that need to be examined in female to male, male to female and male to male sexual relations are: (1) Among individuals not infected with HIV-1, do STDs increase susceptibility to HIV-1 infections? (2) Among those infected with HIV-1, do STDs increase the likelihood of HIV-1 transmission to their uninfected sexual partners? Important factors to be included in any study are controlling for sexual behaviour, attempting to quantify HIV-1 exposure risk, examining with reliable methods all potentially important STDs, with appropriate consideration being given to sample size and methods of analysis. Other factors to be considered in study design and analysis are circumcision, contraception, social class, duration of HIV-1 infection and stage of disease.

3. There is an urgent need for innovative strategies for control of GUD.

Studies of epidemiology and biology of STDs as pertains to HIV-1 transmission and the effect of HIV-1 on STDs. A better understanding of the epidemiology of some STDs, such as chancroid, is required. Better assessments of population prevalence and incidence of STDs are needed for determining population attributable risk and for monitoring changes in sexual behaviour. Appropriate diagnostic techniques for many STDs, especially GUD, need to be developed or improved, especially for field conditions. The effect of HIV-1 infection on manifestations, recurrence, diagnosis and therapy of STDs needs to be clarified. These studies need to take into account the effects of sexual orientation, gender and geographical setting on this interaction.

Basic research is needed on techniques for assessing sexual behaviour. In addition, it is important to collect systematic information on the sexual behaviours of different populations in all areas of the world.

6. The effect of STDs on natural history of HIV-1 infection in individuals.

Biology of the sexual transmission of HIV-1 and STDs. Basic science studies should include immunopathology of STDs, genital shedding of HIV-1 with and without STDs, the effects of mechanical damage to the genital epithelium and study of potential target tissues in the genital tract. Animal models may be useful to simulate sexual transmission of HIV-1.

8. Since all previous studies have evaluated the association of HIV-1 and STDs, it is also important to obtain information on the interaction of STDs and HIV-2.

9. The Consultation also identified priority areas for action:
   a. Development of study design and statistical methods best adapted to examining interactions between two highly related events, such as STDs and HIV infection;
   b. Promotion of exchange of information and discussion among investigators in this field;
   c. Development of intervention studies on control of GUD and on the effects of GUD control on HIV transmission.

Strategic and programmatic implications

The global importance of STDs, including complications and consequences particularly in women and newborns, as well as the emergence of the HIV pandemic, emphasise the need to develop and strengthen STDs control programmes, in all countries and at all levels. For example, in countries where effective STDs control does not yet exist, STDs interventions should be established and integrated into already existing primary health care infrastructures.

2. The AIDS pandemic further emphasises the urgent need for increased support for broad programmes of STDs prevention, control and research. At the national and international level, STDs and AIDS prevention and control programmes should work together to develop strategies and effective means of programme interaction and mutual support. In addition, it is essential that STDs and AIDS researchers collaborate in areas of common interest.

3. As modes of transmission are similar, primary prevention of either STDs or sexual transmission of HIV will help to reduce transmission of the other. For example, behavioural interventions including condom promotion will help reduce both STDs and sexual transmission of HIV and persons at high risk for HIV infection can be reached through STDs services for preventive intervention.

4. STDs and AIDS programmes need to take into account the emerging evidence on GUD and HIV-1, as early and adequate management of GUD may contribute to reducing HIV-1 transmission.

5. The World Health Organisation is requested to consider coordinated action to address the policy, programmatic and research issues discussed in this document.

1 HIV is used throughout this document unless the data are specific for HIV-1 or HIV-2.

2 Referred to as genital ulcer disease (GUD) although some of these ulcerations may not be clinically evident.
WHO Publications

AIDS Technical Bulletin

Published by WHO in collaboration with the Bureau of Hygiene and Tropical Diseases (UK). A monthly bulletin which provides an up-to-date synopsis of recent developments in AIDS research. For professionals working on AIDS who do not have regular access to the original literature.

Contains detailed summary of key papers with expert comments, abstracts of important articles and annotations of other relevant items. Supplemented by statistics and other information as appropriate.

Information is selected by the Bureau's scientific staff from its joint bibliographic collection of literature on all aspects of public health with the London School of Hygiene and Tropical Medicine. The national collection contains over 1200 journals from all over the world and is particularly strong on materials from or about developing countries. Besides journals, it contains books, reports, monographs and relevant 'grey' literature — i.e. irregular or limited circulation publications. The Bureau supplements this material with over 200 journals held elsewhere in London. Individual papers are chosen for abstracting on the basis of providing new information of particular relevance and importance.

For an initial period the Bureau of Hygiene and Tropical Diseases will supply photocopies of the original items referred to in WHO AIDS Technical Bulletin (with the exception of books and other whole publications) within the conventions of British copyright law.

Readers are encouraged to send copies of new publications that may not reach a wide audience. Correspondence on these matters should be sent to: Dr Hilary Richardson, Editor, WHO AIDS Technical Bulletin, Bureau of Hygiene and Tropical Diseases, Keppel Street, London WC1E 7HT, UK.

French and Spanish editions planned. Initially, the WHO AIDS Technical Bulletin will be distributed free of charge to subscribers from WHO in Geneva.


Guidelines for Nursing Management of People Infected with the Human Immunodeficiency Virus (HIV)

Published by WHO in collaboration with the International Council of Nurses.

This book presents guidelines to assist nurses who face the challenge of caring for HIV infected persons and their families. Includes clear and explicit guidelines on the precautions needed to prevent the transmission of HIV in health care settings. Focuses on the special skills needed to care for patients and help them and their families cope with the illness throughout the different phases of the disease.

The book opens with background information about the AIDS epidemic, and an outline of the different epidemiological patterns of the disease found in different geographical regions. Readers are then given a factual summary of what is known about the disease, including clinical manifestations and modes of HIV transmission.

The most extensive chapter is devoted to a step-by-step explanation of the professional nursing skills needed to provide the best possible nursing care, to prevent HIV transmission in the hospital, clinic or community setting. Specific topics include: counselling, HIV antibody screening and testing, maternal and child care, precautions in relation to blood and other body fluids, injections, laboratory specimens, hygiene, postmortem procedures, mucus membrane exposure to HIV etc.


Both the above publications are available from WHO, Distribution and Sales, 1211 Geneva 27, Switzerland.

International Conference

AIDS Health Promotion

The Second International Symposium on AIDS Information and Education will be held in Yaounde, Cameroon, from 22-26 October, 1989. The symposium is being organised by the government of Cameroon and the World Health Organisation, with the collaboration of UNESCO, UNICEF and the International Union of Health Education.

The theme of the symposium will be 'Innovations in AIDS Health Promotion' focusing on counselling and education for adolescents and reaching the 'hard to reach'. Specific topics to be addressed include the role of people with AIDS in education, how to work with the press, ways of combating discrimination and AIDS education in the workplace. The symposium will include plenary sessions and presentations selected from submitted abstracts, poster sessions and exhibits.


Any questions about the content of the WHO Report should be sent to WHO/GPA/HPR, 20 Avenue Appia, 1211 Geneva 27, Switzerland.