The impact of AIDS is highlighting the need to prevent and treat other infections that, like HIV, are passed on during unprotected sexual intercourse. Having an STD (sexually transmitted disease) increases the risk of being infected with HIV, or of passing on the HIV virus, by as much as nine times during sex (where one partner has HIV). STDs are also much more difficult to treat effectively for people with HIV infection.

The World Health Organization estimates that, annually, at least one in ten sexually active people is infected with an STD. STDs have a major impact on people's health, especially for women and new-born babies (see box on page 2). In many developing countries, STDs are among the five most common health problems for which people seek treatment. The situation is most serious in urban areas, where up to a third of people aged between 13 and 35 may have an STD at any one time. Services are often not available, inaccessible or of poor standard.

Women are often affected at a younger age than men. They are frequently blamed and stigmatised for having an STD, or they may not have any symptoms. Untreated infections can result in conditions that are very painful and distressing, and sometimes life-threatening.

As highlighted in AIDS Action 6, many countries are setting up combined HIV and STD control programmes. This makes sense because transmission of both HIV and other STDs is affected by similar social and economic factors. HIV and other STDs require the same kinds of education and prevention efforts. During the last two years several countries such as Costa Rica, Thailand and Zimbabwe have reported a reduction in curable STDs, achieved by providing the following:

- community-based and mass media education about STDs (including HIV) to reduce stigma, and encourage people to prevent transmission, to change their behaviour, and to seek medical care if they suspect they have an infection
- effective and early treatment at affordable prices, together with education about preventing re-infection, advice about partner notification and condoms
- training for primary level health workers to use locally adapted management guidelines, and develop a non-judgemental and sympathetic approach
- reliable drug supplies, surveillance systems and referral centres with diagnostic facilities.

Continued on next page.
What are STDs?

The term 'sexually transmitted disease' or STD is used for all infections that are transmitted mainly through sexual contact, during unprotected vaginal or anal intercourse. Some are also transmitted from mother to child before or during birth, and through unsafe blood donations.

Most STDs affect the male and female reproductive tracts, and therefore are also known as ‘reproductive tract infections’. Female reproductive tract infections include sexually transmitted infections and others due to, for example, unsafe abortion or child delivery techniques and lack of access to good hygiene. Some STDs, such as syphilis, hepatitis B and HIV, can affect other parts of the body, for example, the eyes, mouth, nervous system, rectum or urinary tract.

More than 20 disease-causing organisms are transmitted through sexual contact. A few are viruses, like HIV, and cannot be treated with antibiotics. But common STDs such as syphilis, gonorrhoea, chancre and chlamydia are caused by bacteria and can be cured.

Common STD problems include vaginal and urethral discharge, genital itching, pain when urinating and during sexual intercourse, painful genital and/or anal sores (ulcers), painful swelling in the lymph glands in the groin and scrotum, and lower abdominal pain.

STDs can affect the fetus during pregnancy, causing maternal ill-health and infant death throughmiscarriage, stillbirth and premature birth. Syphilis often infects infants during the birth process, causing severe eye infections which can lead to blindness.

Serious complications can result if these infections are not treated. Women may be at greater risk of cervical cancer. Untreated infections of the lower reproductive tract (the external genitals, vagina and cervix) can rise to affect the upper reproductive tract (the uterus, fallopian tubes and ovaries). This may be linked with unhygienic IUD insertion, and unsafe abortion and childbirth techniques.

These complications are known as pelvic inflammatory disease (PID). PID results in chronic pelvic pain and discomfort, infertility and ectopic pregnancy (in the fallopian tubes), which can cause the woman’s death through internal bleeding.

In men, untreated STDs, especially gonorrhoea and chlamydia, can cause painful inflammation of the testes, and infertility by blocking the sperm ducts.

All about STDs continued.

In the past, STD control was less effective because it relied on treating the few people (mostly men) with symptoms who decided to seek medical attention. Staff still sometimes lack training in STD care, or people decide not to go to special STD clinics because they feel embarrassed or ashamed. People often visit private doctors, pharmacists or traditional practitioners, rather than specialised STD services. Many, especially women, may not realise that they have an STD, because they do not have, or do not recognise, the symptoms.

Prevention and care at the primary level

The sexual transmission of all STDs (including HIV) can be prevented by having safer sex – using condoms or having non-penetrative sex. Prevention and education programmes are an essential part of STD control, aiming to raise people’s awareness about STDs and the importance of early treatment, to reduce stigma, and to provide affordable condoms.

Another key aspect of STD control is the early diagnosis and treatment of disease, preferably during the person’s first visit to their health worker. This prevents the development of complications, limits the spread of infection, and provides a valuable opportunity for one-to-one HIV/STD education. Ideally STD care should be integrated into the most accessible and well-used health services: local dispensaries and health centres, and family planning and ante-natal clinics, as described on pages 6 and 7.

Resources are often limited and it can make good sense to provide services for people who may be more at risk, and who have limited access to care. For economic, cultural or social reasons, many people – young men and women, sex workers, men away from home or with male sexual partners – lack access to, or feel unable to use, STD services. The needs of women in stable relationships (often infected by their male partners) are also much ignored, unless they are using family planning or ante-natal services that provide STD education and care.

WHO and other international agencies are now promoting a new and effective approach called syndromic management which is enabling health workers to diagnose and treat most STDs at the primary level (see pages 3, 4 and 5). Staff are also trained to provide health education about STDs, and the need for partners to be treated. One of the reasons for the failure to control STDs has been the increasing resistance to drugs by the bacteria that cause gonorrhoea and chancroid. Standard management guidelines also help to ensure correct treatment with effective drugs, and hence delay the development of resistance.

Drs Monir Islam and Peter Piot, WHO/GPA, Geneva.
STDs are most easily diagnosed using laboratory tests. But these tests require sophisticated equipment that is too expensive for most settings, and obtaining results can take a few days. In most places, a sample has to be sent away to be cultured or the person referred to a hospital or special STD clinic. Often people may decide not to return for test results and treatment, or take up a referral, and their infection remains untreated.

**Syndromic approach**

Ideally, primary level health workers – nurses, midwives, clinical officers or medical assistants – need to be able to diagnose and treat people with an STD on their first visit at an affordable cost, without laboratory tests. Drugs need to be highly effective, free of side-effects, available at the clinic, and ideally given by mouth in a single dose. Patients also need information about STD prevention, and the importance of treating partners.

STD care at the primary level is being achieved with a strategy called 'syndromic management'. This has been researched and tested in many countries during the last eight years, and is recommended by WHO and other international agencies. The approach is based on identifying the main groups of symptoms and signs (syndromes) commonly associated with certain infections. Health workers diagnose and treat on the basis of these syndromes, rather than for specific STDs.

Simple standard guidelines in the form of flow charts for each syndrome can be developed for health workers to use at the primary level, after training. To develop these guidelines, STD control programmes need to find out the common syndromes in the area, the organisms responsible for them, and identify effective antibiotics. Treatment is prescribed to deal with the infections commonly associated with the syndrome in the region.

Syndromes vary considerably from region to region. For example, it does not make sense to advise that all patients with genital ulcers should be treated for syphilis and chancroid, if another infection such as granuloma inguinale (donovanosis) is a significant cause of ulcers (such as in India and Papua New Guinea). Overall, the cost of treating for more than one organism is less than setting up and running on-site laboratory facilities.

The syndromic approach can be used only for people with signs or symptoms. It works very well for urethral discharge in men, and genital ulcers in men and women. However, it is sometimes not so successful for women with vaginal discharge and/or PID symptoms. To overcome this, health workers are being advised to ask a series of questions based on risk factors for gonorrhoea and chlamydia. Less expensive and more convenient diagnostic tests are being developed.

**Common STD syndromes**

- Genital ulceration in men and women (syphilis, chancroid and granuloma inguinale)
- Urethral discharge in men (gonorrhoea and chlamydia)
- Vaginal discharge in women (gonorrhoea, chlamydia, candidiasis, trichomoniasis, bacterial vaginosis)
- Lower abdominal pain (PID) in women (gonorrhoea, chlamydia, anaerobic bacterial infections)

**Primary level health workers need classroom and clinic-based training to enable them to manage STDs using the syndromic approach.**
Guidelines for STD care

Effective STD care means more than just diagnosis and treatment, and includes health education and follow-up. The following steps should be followed with all patients.

1. First take the person’s history, asking them what symptoms they have, how long they have had these and whether they feel any pain, especially while urinating or having sexual intercourse. It is also useful to know when they last had intercourse, if they noticed signs of an STD in their partner and if they have had any previous treatments for STDs. Question the person in a sensitive and respectful manner, using words they understand. Carry out the consultation in private, and reassure them that whatever they say will be kept confidential. Ideally the health worker should be the same sex as the patient.

2. If possible, and after explaining what is going to happen and asking for the person’s agreement, carry out a physical examination of their genitals, anal area and groin. Look for STD signs such as unusual discharge, or sores and swellings. Ask a male patient to retract his foreskin (if necessary) and look for discharge from the urethra. If none is present, give the penis a gentle squeeze, and massage it forward to expel any discharge. Examine the skin of the person’s abdomen, buttocks, and chest for rashes and sores. If gloves are unavailable, do not touch the person’s genitals, but decide which syndrome is present on the basis of the person’s history and symptoms, and by looking for any signs.

3. After deciding which syndrome(s) are present, follow the appropriate flow chart(s). Prescribe the treatment, stressing the importance of completing the treatment course correctly.

4. Give the person clear information on how STDs are transmitted, and the importance of treating partners, prevention methods and the proper use of condoms (see box below). Give the person partner notification cards to pass to their most recent sexual partner(s). They need not give you their partners’ names.

5. Ask the person to return after seven days for a follow-up appointment, if possible. During this visit, ask them about symptoms, sexual activity and condom use, examine them for signs of STD, and remind them about prevention methods. If signs and symptoms are still present, and if you think they have followed treatment advice correctly, refer them for further diagnosis and treatment.

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One-to-one advice for every patient includes:

- giving information about STDs and HIV, and about how they are spread and prevented
- showing the person how to use a condom correctly, giving them a supply, and telling them where to obtain more
- advising women to visit an ante-natal clinic within the first three months of pregnancy for a check-up

Key messages for the person are:

- Take all prescribed medicines and make sure you complete the treatment, even if you feel better. Do not take medicines from other sources.
- Make sure that you do not pass the infection to anyone else, and do not have sexual intercourse until you are completely cured. If you do, use a condom.
- Come back for a follow-up visit to make sure you are cured.
- Encourage all recent sexual partners to have a check-up, even if they have no symptoms.
- Prevent future infections, including HIV, with condoms.

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Genital ulcer

Genital ulceration is due to chancroid and syphilis in most African countries, causing painful or painless open sores. Treatment for both is always recommended because it is not possible to distinguish them by clinical examination, and infection with both is common.

**Treat for syphilis and chancroid**

<table>
<thead>
<tr>
<th><strong>SYPHILIS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzathine penicillin G: 2.4 million units by intramuscular injection during one visit (inject half of dose in each buttock); or aqueous procaine penicillin G: 1.2 million units, by intramuscular injection daily for 10 days; or doxycycline: 100mg by mouth twice daily for 15 days (NOT pregnant women); or tetracycline: 500mg by mouth 4 times daily for 15 days (NOT pregnant women); or erythromycin: 500mg by mouth 4 times daily for 15 days (pregnant women allergic to penicillin)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CHANCROID</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Erythromycin: 500mg by mouth 3 times daily for 7 days; or ceftriaxone: 250mg intramuscular injection as a single dose (but may not be effective for people with HIV); or ciprofloxacin: 500mg by mouth as a single dose (NOT pregnant women, and may not be effective for people with HIV); or trimethoprim 80mg/sulphamethoxazole 400mg: 2 tablets 2 times daily for 7 days (only in areas where effectiveness is proven and monitored)</td>
</tr>
</tbody>
</table>

Ideally drugs should be ones that are given orally in a single dose.

If the same drug is needed to treat two infections (such as erythromycin for syphilis and chancroid) do not give a double dose but give the longer, higher dose.

**PREGNANT WOMEN** should be asked to bring their babies to the clinic for screening within seven days after birth.

Treatment for DONOVANOSIS should also be included if it is common (as in some parts of Asia-Pacific).

**GENITAL HERPES** (numerous fluid-filled painful blisters, 2-4mm in size) is increasingly common, often causing persistent ulceration in people with HIV. The person should be advised to wash the area regularly with soap and clean water. The drug treatment for herpes is acyclovir. It is not included in most syndromic management guidelines because it is very expensive, and not fully effective or widely available.

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An example of a flow chart for genital ulcer syndrome.

**GENITAL UL CER**

Patient complains of genital ulcer or pain

Examine patient

Genital ulcer (open sore – painful or painless, and person may have swellings in groin)

Treat for syphilis and chancroid

Follow up 7 days after clinic visit

Improvement

Complete any remaining treatments

No improvement

Refer to higher-level care
ome abnormal vaginal discharge is caused by trichomoniasis, candidiasis or bacterial vaginosis, which cause inflammation of the vagina (vaginitis). Abnormal vaginal discharge can also be due to gonorrhoea or chlamydia, which is more serious, causing inflammation of the cervix (cervicitis), and may lead to pelvic inflammatory disease. However, it is impossible to tell from a clinical examination whether a woman with vaginal discharge has cervicitis or not.

Risk assessment
Treating every woman for all possible infections means unacceptable over-treatment. However, studies have shown that gonorrhoea and/or chlamydia are the likely cause of vaginal discharge if:

- the woman’s partner has a discharge from his penis or genital sores; or
- if any two of the following are true:
  - if she is under 20 years old;
  - if she is single;
  - if she has had sex with more than one partner in the previous three months;
  - if she has had a new sexual partner (including being newly married) in the previous three months.

The health worker asks questions (risk assessment) based on the above factors. The woman is treated for vaginal infection only, if she answers no to the questions above. If the risk assessment is positive, she should be treated for both vaginal and cervical infection.

CERVICAL INFECTION: Treat for both gonorrhoea and chlamydia
Use same treatments as for urethral discharge. Ciprofloxacin, doxycycline and tetracycline should NOT be prescribed to pregnant women. Also treat for vaginal infection (see below).

VAGINAL INFECTION: Treat for candidiasis, trichomoniasis and bacterial vaginosis

- **CANDIDIASIS**
  - miconazole or clotrimazole: 200mg inserted in the vagina once daily for 3 days; or
  - nystatin: 100,000 units (one pessary) inserted in vagina once daily for 14 days; or
  - clotrimazole: 500mg inserted in vagina as single dose; or
  - gentian violet: 1% aqueous solution applied to vulva and vagina each night for 5 days

- **TRICHOMONIASIS AND BACTERIAL VAGINOSIS**
  - metronidazole: 2g by mouth as a single dose; or
  - metronidazole: 400-500mg by mouth 2 times daily for 7 days

PID occurs when infections spread up from the vagina to affect the uterus, fallopian tubes, ovaries and lining of the pelvic cavity. Women with PID may have symptoms of lower abdominal pain, painful and heavy menstruation, irregular and painful vaginal bleeding, painful urination and sexual intercourse, vaginal discharge and sometimes fever, diarrhoea and vomiting.

PID can also be the reason for ectopic pregnancy, infection in the pelvic cavity or perihepatitis (inflammation of the abdominal lining). These conditions are life-threatening and should be suspected if the woman has the above symptoms and a recent delivery or abortion, is pregnant or has a missed or overdue period. There may also be signs of muscle tensing with pressure on the abdomen, tenderness when pressure is released from the abdomen or the presence of a tender pelvic lump. The woman should be referred immediately to hospital.

The commonest causes of PID are gonorrhoea, chlamydia and anaerobic bacterial infection (overgrowth of certain bacteria normally living in vagina).

**Treat for gonorrhoea, chlamydia and anaerobic bacterial infection**
If a woman with PID is treated at primary level, she should be reassessed in 72 hours, and if there has been no improvement, she should be referred.

- **GONORRHOEA:** see urethral discharge box (single dose treatments for gonorrhoea if possible).
- **CHLAMYDIA:** doxycycline: 100mg by mouth 2 times daily for 14 days (NOT pregnant women); or tetracycline: 500mg by mouth 4 times daily for 7 days (NOT pregnant women); or erythromycin: 500mg by mouth 4 times daily for 7 days.
- **ANAEROBIC BACTERIAL INFECTION:** metronidazole: 400-500mg by mouth 2 times daily for 7 days.

The health worker asks questions (risk assessment) based on the above factors. The woman is treated for vaginal infection only, if she answers no to the questions above. If the risk assessment is positive, she should be treated for both vaginal and cervical infection.

- **CERVICAL INFECTION:** Treat for both gonorrhoea and chlamydia
- **VAGINAL INFECTION:** Treat for candidiasis, trichomoniasis and bacterial vaginosis

**TREATMENT STRATEGIES**

Treatment depends on syndromes present, the recommended, easily available drugs and certain conditions, such as pregnancy.

- **A man with urethral discharge and genital ulcer syndromes could be prescribed treatments as follows:**
  - ciprofloxacin: 500mg as a single dose to treat gonorrhoea (discharge) and chancroid (ulcers); and
  - benzathine penicillin G injection to treat syphilis (ulcers); and
  - doxycycline: 100mg by mouth 2 times daily for 7 days to treat chlamydia (discharge)

However, if he is allergic to penicillin, the same doxycycline dose for 15 days will cure syphilis, as well as chlamydia.

- **A pregnant woman who is allergic to penicillin and has genital ulcers should be prescribed:**
  - erythromycin: 500mg by mouth 4 times daily for 15 days (syphilis and chancroid)
About 5 per cent of pregnant women in Kenya have syphilis, although many do not know that they are infected or feel too afraid and ashamed to seek treatment from STD clinics. But most women visit ante-natal clinics for a check-up during their pregnancy, providing an opportunity for STD care and prevention.

A programme has been launched in 10 clinics in Nairobi which is enabling nurses to diagnose syphilis using signs and symptoms, take a confirmatory blood test, and to provide treatment and counselling. In the past blood samples were sent to a central clinic, and women were referred for treatment.

All pregnant women are tested for syphilis as part of routine ante-natal check-ups. When a woman is diagnosed with syphilis, the nurse, using a flipchart with simple drawings, explains that syphilis is an STD and is a risk to the child and woman, but that it can be treated very easily. The nurse answers any questions, and uses appropriate language. For example, advice about sticking to one partner is not helpful because many men have several partners, often including a long-term relationship with a 'co-wife'.

The nurse also emphasises the importance of treating the woman's sexual partner. Many women feel that their partner should know, but are frightened that they will become violent. They often decide to tell them to come to the clinic without telling them why. The nurse gives each woman several 'partner notification cards' – asking partners to come to the clinic without mentioning syphilis. When the man comes to the clinic, he is told that his partner has syphilis, and how this may affect the unborn baby. Men usually show concern for the unborn baby, but sometimes get angry and accuse their wives of being unfaithful. Some men do not want to go to the same clinic as their partner and are referred elsewhere if they wish. Education about taking responsibility and using condoms is focused on men, because they are seen to have control over sexual activity. The men often say that they do not use condoms because they do not like them, know where to obtain them, or how to put one on.

Options for prevention
People often confuse syphilis with other diseases, especially HIV infection. They do not know that syphilis is spread through sexual contact or that condoms can help prevent infection.

Although both men and women are advised not to have sex for one week after treatment, some men say they would find it difficult. The nurse discusses options with both women and men, such as using condoms for sex with all sexual partners. Many women find it difficult to suggest using condoms or having only one partner, because they feel that it is men who make decisions about sex.

If a woman wishes, she learns how to use a condom, and discusses ways to persuade her partner. If he says: 'You never asked me to use a condom before!' she could reply: 'We have to be responsible for ourselves and our baby now.' Some women decide to try to sleep in a different bed if their partner tries to insist on having sex, or even return home to their families in order to protect the health of the baby.

The success of the programme is striking. During the first year, all new ante-natal clinic attenders were screened for syphilis. Nearly all women with syphilis were cured, and their partners notified. Over half of those notified were treated successfully at the clinic. The nurses have reacted very positively to the programme, feeling that they can do something for their clients, and that their new communication skills are valuable.

Fenniskens, E Obwaka and M Temmerman, PO Box 20923, Nairobi, Kenya.
The project is supported by USAID/Mothercare Project and EC/DGVIII and DGXII.
‘All part of the service’

AIDS Action reports on how two projects are successfully providing STD care at health centres.

Integrating care

STD control has been integrated into the urban and rural primary health care system in Mwanza, a district in Tanzania. Using locally adapted syndromic management guidelines, medical assistants now carry out the initial examinations and prescribe treatment, referring where necessary to the medical officer. Nurses dispense prescriptions, and provide health education, condoms and partner contact cards.

During a three week training course, health workers learn how to diagnose and treat the most common STDs, and to be aware of people’s concerns and problems. The first week takes place in the classroom, followed by two weeks of supervised practical work in an STD clinic. The participants are helped to understand the need for confidentiality and how to organise the clinic layout to improve privacy. The training includes discussion about local attitudes and beliefs about STDs, links with HIV, and health education techniques.

The programme was first run at the main hospital in Mwanza town, and has now been extended to rural areas.

At first, drugs were sometimes used for treating other diseases or the health workers sold drugs to patients instead of supplying them free. The project now emphasises the need for monthly supervision visits to each health centre by the STD regional officer. The tablets are counted and checked against the patient register.

Some health workers found the flow charts difficult to use. Regular in-service training has led to successful treatment of the three main syndromes (urethral discharge, vaginal discharge and genital ulcers).

About 10 per cent of the trained health workers were transferred to other jobs. After liaison with health centre managers the number of staff transferred shortly after training has been reduced.

Many people with STDs do not seek treatment at health service clinics or buy drugs from other sources. Public education programmes help to promote safer sex and improve the use of health services.

Source: Drs Gina ka-Gina, Heiner Grosskurth and Philippe Mayaud, AMREF-Mwanza, PO Box 1482, Mwanza, Tanzania.

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7
More opportunities for youth

When I first heard of the HIV/AIDS peer education training programme I was in my third year at high school. At first I thought it was a joke - what could adults teach us young people about sex? But as time went on I became more interested and was invited to a training course.

By the end of the first workshop I started seeing the world through different eyes and realising how little I really knew in terms of living. It was sometimes difficult to stand up for what I believed when I saw the mockery in my peers’ eyes. But as my friends saw that I was more sure of myself, more assertive and better informed about things like sex, STDs, periods and AIDS they started to rely on me for information.

It was difficult to learn to stop telling people what to do and to listen more. It was frustrating to see them doing the opposite of what I hoped they would do. But with time I learnt that people have different values and like to do things their own way. I learnt to be who I am, and not to try to be too perfect. When I tried to hide my real self people could see that I was being fake.

It is important for us peer educators to meet frequently. I learnt a lot from the other young people I worked with. I have gained from the process and will continue to do so, and hope the opportunity is given to more of us.

Matlhagonolo Mogapi, Gabarone, Botswana.

RESOURCES FOR STD CARE

Caring for people with sexually transmitted diseases, including HIV disease is designed to help nurses, midwives and other health workers provide care for people whose lives are affected by STDs.

In English for £25.00 from English National Board Publications, Victory House, 170 Tottenham Court Road, London W1P 0HA, UK.

Color atlas and synopsis of sexually transmitted diseases contains colour photographs and syndromic management information for clinicians.

In English for £20.00 from McGraw-Hill Publishers, Health Professions Division, Shoppenhangers Road, Maidenhead, Berks SL6 2QI, UK.

Genital tract infection guidelines for family planning service programs provides information for clinicians on STDs which commonly appear in family planning settings.

In English and French for US$6 from JHPIEGO Corporation, Materials Control Division, Brown’s Wharf, 1615 Thames Street, Suite 200, Baltimore, MD 21231, USA.

All about STDs: information on sexually transmitted diseases provides information in simple language on how STDs are contracted, prevented and treated.

Free in English from STD Foundation, PO Box 9074, 3506 GB Utrecht, The Netherlands.

The culture of silence: reproductive tract infections among women in the Third World discusses the importance of STD in women’s health and possible strategies to reduce infections.

Free from International Women’s Health Coalition, 24 East 21st Street, 5th Floor, New York, NY 10010, USA.

Understanding STDs is a teaching pack for secondary school students designed for use in the Pacific Islands, containing exercises and illustrations.

Free in English or French from South Pacific AIDS Commission, BP DS, Noumea Cedex, New Caledonia.

STD educators’ guide to AIDS and other STDs is a very popular and adaptable resource for trainers working with young people.

In English and Spanish for $50 from Health Education Consultants, 1284 Manor Park, Lakewood, OH 44107, USA.

Counselling & sexuality: a training resource is a pack of four videos and training guide designed to help counselling programmes cover sexual health, including one video, ‘I’ve got gonorrhoea’ where a woman discovers she has contracted an STD from her husband.

In English and Arabic for $35 per video and guide or $10 for guide on its own or $100 complete set from IPPF, PO Box 759, Inner Circle, Regent’s Park, London NW1 4LQ, UK.

Sexually transmitted diseases: recognition and treatment is a 24-slide set on STDs with accompanying script in versions for Africa and Asia-Pacific. Available for £6.20 (mounted) from Teaching-aids At Low Cost (TALC), PO Box 49, St. Albans, Herts AL1 4AX, UK.