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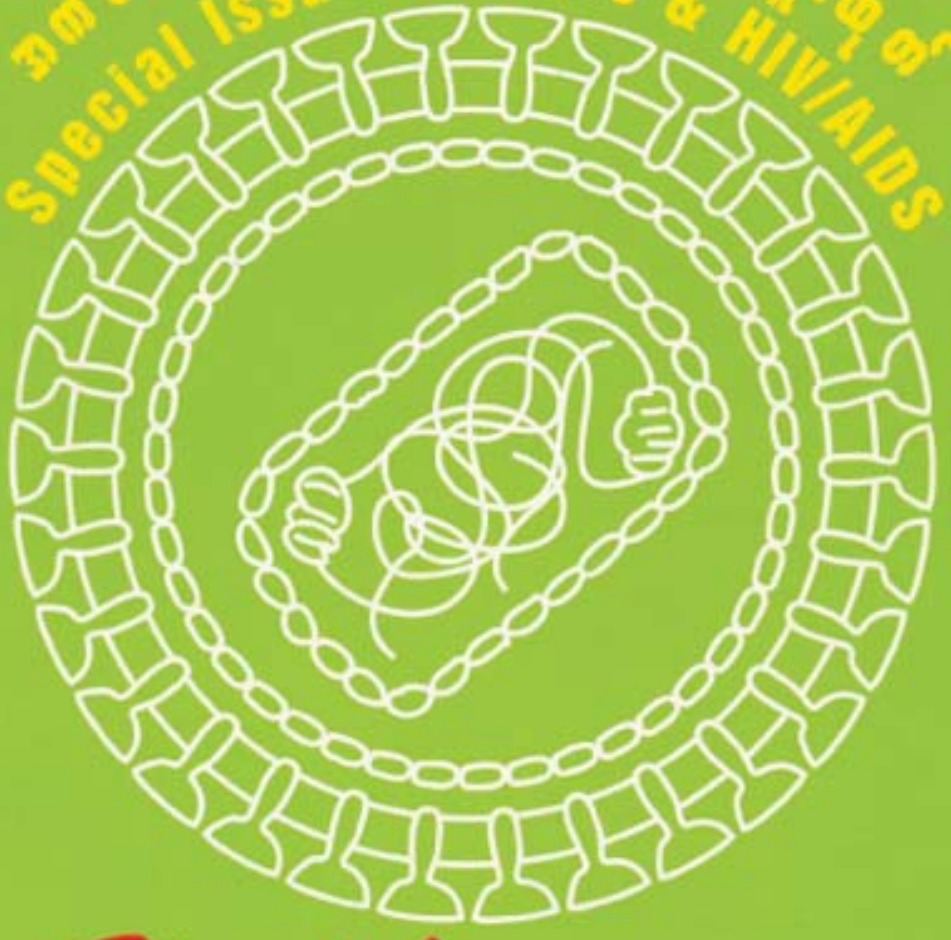
Special Issue on STDs & HIV/AIDS



Health Messenger

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CONTENTS

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The procedure, explanations and treatment given in this publication are based on research and consultation with medical and nursing authorities. They all reflect accepted medical practices. Nevertheless they cannot be considered absolute and universal recommendations. The authors, the editor and the publisher disclaim responsibility for any adverse effects resulting directly or indirectly from the suggested procedures, from any undetected errors, or from the reader's misunderstanding of the text.

Cover: Diagram of AIDS virus. t wpa&m*¦ Ai;&ypy;?

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Editorial

AIDS is taking a great toll of lives every year. Although great progress has been made in the understanding of the disease and the treatment of some of its complications, we still do not have a vaccine or any treatment capable of curing this fatal disease.

As there is no cure for AIDS, the combination of information-prevention wil still be our prinicipal way of fighting against AIDS. AIDS and STDs are related to certain risky behaviors (unprotected sex, sharing of needles and syringes, etc). By avoiding drugs and by following safer sex practices, we can protect ourselves against this disease including STDs. It is also necessary to diagnose STDs at an early stage and treat them accordingly as the presence of an STD can aggravate the infection by HIV.

This special edition on STDs and HIV/AIDS will focus mainly on diagnosis and treatment of the diseases, and include information on how to prevent their spread.

I hope it will be useful to you. Enjoy your reading!!

Best regards.

Dr. Seerat Nasir
Editor

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STD and HIV/AIDS in Thailand and Myanmar

Dr Ying-Ru Lo, WHO
Mrs Laksami Suebsaeng, WHO

Introduction

The Human Immunodeficiency Virus (HIV) has a long incubation period and the infection usually is not noticeable before causing the Acquired Immunodeficiency Syndrome (AIDS). In many cases the period can last more than 10 years. During that period HIV can be transmitted by an infected but symptomless individual to other people, who can carry the virus for further years and ensure its wider spread.

The epidemiological and biological correlation between curable Sexually Transmitted Diseases (STDs) and the sexual transmission of HIV infection is well established. Young people are at highest risk to acquire both infections. There is substantial evidence that STDs increase the risk of transmission and infection of HIV, and that genital-tract infections increase spreading of the virus.

• HIV and STD affect largely young people.

• Prevention and control of STD is one of the main strategies for the prevention of HIV transmission.

Global estimates for HIV/AIDS

By the end of 1999, according to new estimates from the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) the number of people living with HIV will have grown to 33.6 million. Virtually every country in the world has seen new infections in 1998 and the epidemic is frankly out of control in many places.

• More than 95% of all HIV-infected people live in the developing world

HIV came relatively late to Asia. No country in Asia had experienced a major epidemic until the late 80's. By the beginning of the 90's, however, a number of countries, led by Thailand, observed an increasing number of infections. By 1998, the epidemic was well established across the continent. Estimated HIV prevalence in 1999 was highest in Cambodia (3.7%), followed by Myanmar (1.92 %) and Thailand (1.78%).

Many countries have low reporting rates for HIV and AIDS. This is due to limited capacity for diagnosis, weakness of the reporting system and confidentiality issues. The rate of reporting for HIV and AIDS is estimated to be lower than 10% in some countries in Asia. Therefore, Ministries, WHO and UNAIDS have to rely on estimates, which are based on the analysis of the data collected.

HIV/AIDS and STD in Thailand

Reporting of STD from government STD clinics since 1967. The six reported diseases are syphillis, gonorrhoea, non-gonococcal urethritis, chancroid, lymphogranuloma venereum and granuloma inguinale.

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Sexually Transmitted Diseases (STD)

The number of reported STD cases began to decline in 1986. The initial decline between 1986 and 1989 is due to the decline in gonococcal infections after introduction of effective treatment. The more dramatic decline after 1989 is due to changes in sexual behaviour and increased use of condoms in clients visiting sex workers and expanded STD treatment and counselling services in the community.

HIV and AIDS

The first AIDS case in Thailand was reported in September 1984 in men having sex with men. Three years later the transmission of HIV shifted to infection among intravenous drug users, and later, to female commercial sex workers (CSWs). This was followed by another wave of infection in clients of commercial sex workers and, subsequently, girlfriends of men who visited CSWs. With increasing infection

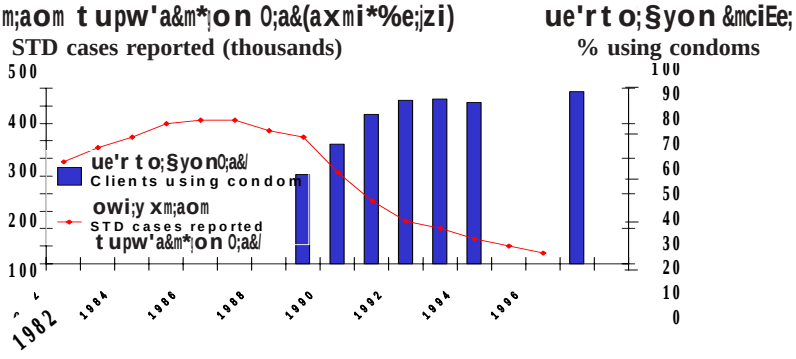

Figure 1. Clients Using Condoms and STD Cases Reported-Thailand

AZG/MSF-Holland Myanmar

rates in pregnant women, more infection in children born to HIV infected women is occurring.

Additional data on route of transmission, age as well as opportunistic infections provide valuable information for health planners. Thailand is currently reporting up to 40% of it's AIDS cases. About one million people are infected with HIV in Thailand, out of a population of 61 million. There are 30 000 to 50 000 new HIV and AIDS cases each year. More then 80% of AIDS cases are transmitted by sexual transmission, followed by approximately 5 % of infections through IDU and 5 % through vertical transmission. Transmission through

Thailand (estimates for 2000)

• Cumulative number of HIV infections	1.3 million
• Cumulative number of AIDS cases	470,000
• Cumulative number of AIDS deaths	440,000
• Cumulative number of AIDS orphans under 13 years of age	85,663
• New HIV/AIDS cases each year	30,000 to 50,000

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donated blood has been reduced to nearly zero due to screening for HIV of all donated blood units since 1989. About 30 % of AIDS cases are reported from the upper northern region.

The age distribution shows highest number of AIDS cases reported in young adults. The number of cases in the under 5 age group is of serious concern.

from 1 % to 13 % depending on the area. HIV prevalence among IV drug users in Rangoon had already reached 73% by 1989. Since that time HIV infection among IV drug users tested in Rangoon and Mandalay has ranged from over 50% to 85%. In Myitkyina, HIV prevalence among IV drug users tested had reached 90% by 1993 and remained at that level through 1996.

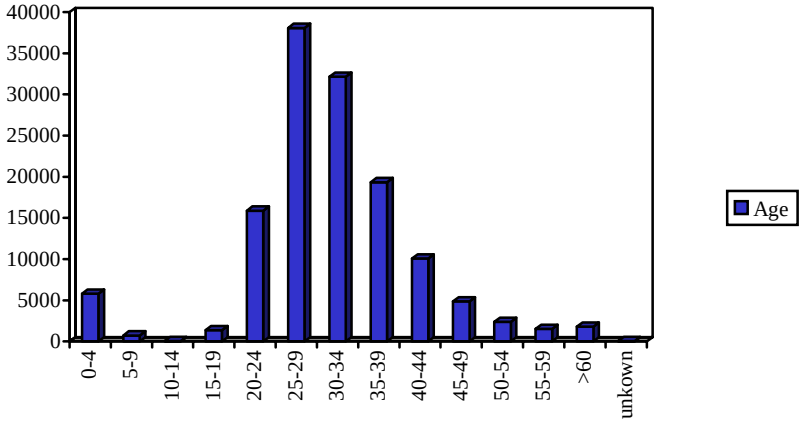

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Figure 2. Number of reported AIDS cases by age, Thailand 1984-1999

Due to prevention efforts HIV infection was found to be decreased after blood tests in selected population groups as in pregnant women and military recruits. But in intravenous drug users the proportion is still increasing; 51 % of IVDU were HIV infected by the end of 1999.

HIV/AIDS in Myanmar

In Myanmar the epidemic is still on the rise and has now bypassed Thailand. In the end of 1997 the estimated number of adults and children living with HIV/AIDS was 440,000. The HIV prevalence in pregnant women ranges

HIV prevalence among sex workers tested in Rangoon and Mandalay has increased from an average of 4 percent in 1992 to 21 percent in 1996. The average HIV prevalence from the latest surveillance in 1999 among sex workers reached 47%. Since 1992, HIV testing has been conducted among antenatal clinic attendees. HIV prevalence among antenatal clinic attendees tested in Rangoon and Mandalay increased from no evidence of infection in 1992 and 1993 to 0.8% in 1996. The latest national surveillance data from 1999 report 1.92% prevalence among pregnant women a 2.5 fold increase in 3 years compared to the 1996 Rangoon/ Mandalay data.

Population group	HIV prevalence %
Male STD	9.09
Direct commercial sex workers	18.84
Indirect commercial sex workers	6.55
IVD Users	51.14
Pregnant women	1.76
Blood donors	0.44
New military recruits	1.60

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Glossary:

Seroprevalence: existing widely in serum

Sentinel surveillance: a survey done within a certain block of time

Myanmar (estimates as end of 1997)

• Cumulative number of HIV infections	440,000
• Cumulative number of AIDS cases	100,000
• Cumulative number of AIDS deaths	86,000
• Cumulative number of orphans	14,000
• HIV seroprevalence among IV drug users	50 –85%

Over 80% of AIDS cases are reported in men.

Sentinel Surveillance data from September to October 1999 from the latest report of the National AIDS Programme in Myanmar:

Population group	HIV prevalence %	Range
Male STD	8.09	0-24
Female STD	9.66	1-17
CSWs	47.00	37-57
IVDUs	56.64	13-92.31
Pregnant women	1.92	0-6.5
Blood donors	1.19	0.98-1.27
New military recruits	2.67	0.67-4.7

How much STDs and HIV is there in our community?

A survey at Mae Sot Hospital on HIV in 1997 resulted in the following positivity rates for HIV:

Sex-workers: 25%; Drug users 33%; Blood Donors 0.3%; Pregnant women 2.0% and the Anonymous HIV Testing Clinic 56%.

Screening for STDs has been carried out with consent in pregnant women in Maela Refugee camp in 1998. The results showed low rates of STDs: syphilis and gonorrhoea <1% and chlamydia <3.3%. Testing for HIV in most of the refugee camps on the border is not routinely offered, however all blood donors should be screened for HIV and Hepatitis B. The STD results are encouraging but because they are not ZERO, health workers should always be ready to diagnose an STD in their community. The experience of the Karen HIV/AIDS Education Working Group, who is currently helping patients and families in community based care of people with AIDS, in Maela and Umpiem Mai camps and in some Thai Karen villages around Mae Sot, also reminds us that HIV and STDs are present. So, STDs and HIV/AIDS are REAL risks for people living on the Thai-Burmese border.

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Blood Donor	317	1.6%	1.3%	11.2%
ao;v|&i	317	1§6§	1§3§	11§2§
Abortion Complication	71	4.2%	4.2%	8.2%
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Courtesy: Dr. Rose McGready, SMRU

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The link between STDs and HIV/AIDS: the medical and social causes

Health Messenger

Why the increase of STDs?

Sexually Transmitted Diseases (STDs) are now a big problem in developing countries. The underlying conditions which explains this increase include:

- Population explosion with increase in the number of young people.
- Rural-to-urban migration.
- Wars.
- Poverty and prostitution, etc.
- Lack of access to treatment which includes lack of medical facilities, trained health workers and effective drugs.
- Lack of awareness and education on risky sexual behaviors.

WEAVE

These factors are related in one way or other. If there is increase number of young people, they will look for jobs, which may lead to increase population movement - rural to urban or cross border. On the other hand, wars can displace people from one place to another and families can be scattered. These factors may give rise to poverty, which may push the young people to search for work and may push girls into prostitution.

Moreover, young men or women, while working in another town or country, may find freedom where they are free from social restrictions. This may create premarital or extramarital sex, multiple sexual partners, drug addiction or homosexuality. All these are high risk behaviors for STDs or HIV transmission.

STDs affect people's health and also induce economic loss. The greatest impact can be seen among women in whom severe complications include:

- pelvic inflammatory disease (PID)
- chronic pain, and
- adverse pregnancy outcomes like ectopic pregnancies, endometritis (inflammation of the lining of the uterus), spontaneous abortions, still births and low birth weight babies.
- STDs are a major cause of infertility in both men and women.

Congenital infections in the newborn include:

- congenital syphilis.
- ophthalmia neonatorum.
- pneumonia.

The most dangerous of all STDs is HIV/AIDS, which causes death of men, women and children and is not curable. People with STDs have a great chance to be infected by HIV, as any inflammation can aggravate the infiltration of the virus. As there are many lymphocytes at the inflammation site, the virus can easily spread all over the body within a short time. This will be discussed later in detail.

Can STDs be cured?

Some STDs can be cured and other have no cure. But medicines should only be taken according to the advice of a doctor or health worker. To be cured of STDs totally, the doctor/health worker's instructions must be followed strictly. If not, the disease will not be totally cured and the germs will remain in the body causing damage inside. There will be reinfection by the same STD which will be more difficult to cure.

BUT REMEMBER AIDS HAS NO CURE.

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STDs and HIV/AIDS: The social problem

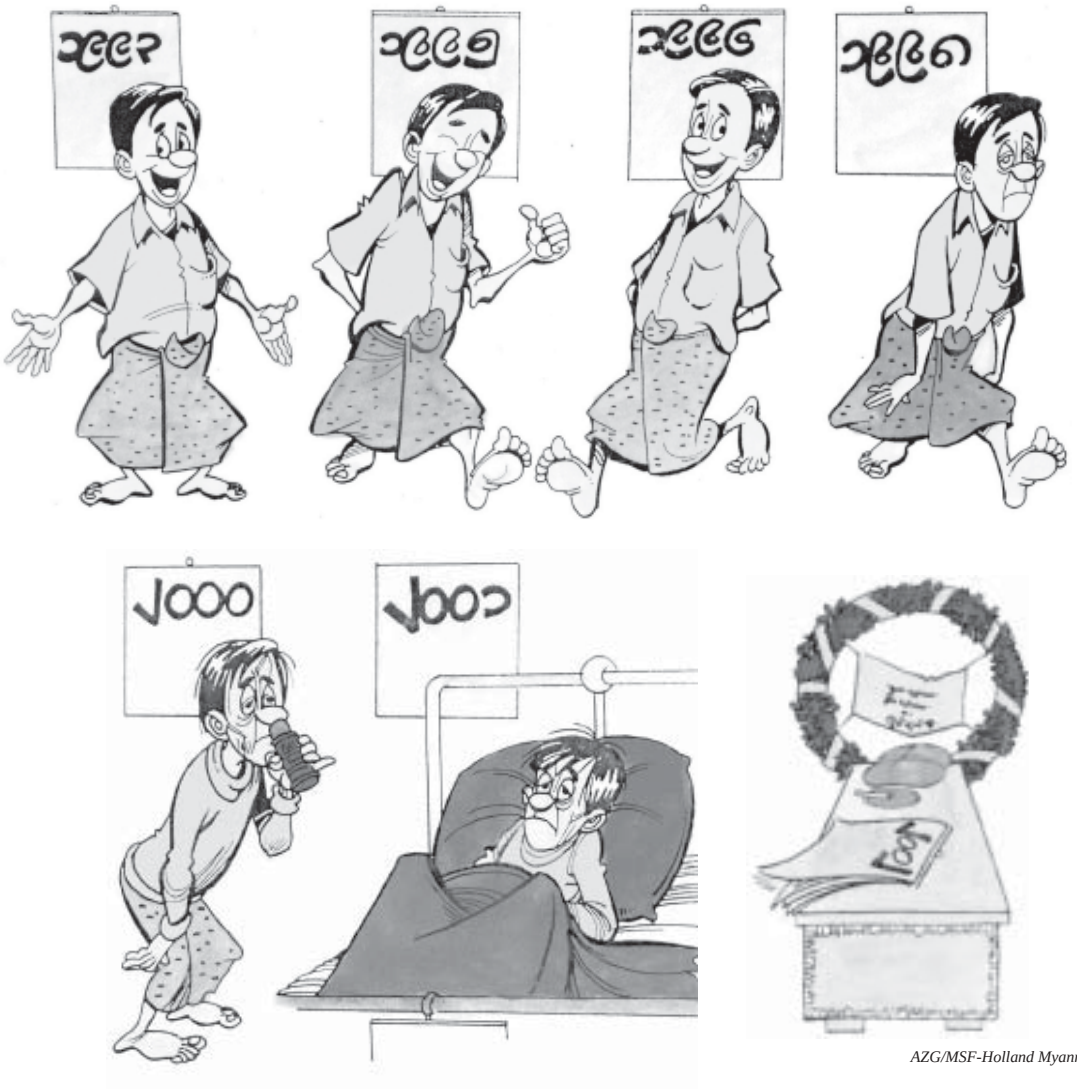
Some STDs may damage the internal pelvic organs and cause infertility. Infertility can be a social problem in the Asian countries, couples failing to produce offsprings as may face criticism by their relatives.

HIV/AIDS usually attacks the young and economically productive group of population. The death of the young people affects the productivity and therefore the economy of a country. The cost of AIDS patient care is very high which also cause economic loss.

Death of people from AIDS leaves behind orphans. These orphans are a burden on society. As the number of HIV infected people are increasing, there is more and more a shortage of caregivers.

STDs not only cause physical pain, but can also cause mental and social damage. People with STDs are shy to seek treatment in fear of being socially humiliated. This leads to self-treatment, incomplete treatment or failure to seek any treatment and therefore complications. Stigmatisation and misconception about AIDS is another cause that prevents people from taking care of their infected relatives. This might cause complete abandonment. Hospitalisation of AIDS patients costs more as it is a chronic illness which requires longer stay in the hospitals.

Keeping this in mind we have to take care of any signs or symptoms of STDs and change any risk behaviours as a preventive measure to keep ourselves safe from the deadly disease AIDS.



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Syndromic Management Approach : An Effective Way to STD Case Management

Health Messenger

Sexually Transmitted Diseases (STDs) mostly goes unidentified by the patient and therefore they do not seek treatment. There remains a big gap between the number of cases diagnosed and those treated for STDs.

Presence of an STD can accelerate the infection by HIV. So it is important to diagnose and treat STDs properly. Prevention and care of Sexually Transmitted Diseases (STDs) is an intervention which improves the health status of the population and is a plan for prevention of HIV transmission.

Besides primary prevention, the main basis of STD control, is prompt, effective and comprehensive treatment of all individuals with symptomatic curable infections.

The traditional method for STD management has been through laboratory diagnosis of the germs that cause diseases. But this process is expensive and most health centres and dispensaries in developing countries do not have access to reliable laboratory facilities. Considering the cost of laboratory diagnosis and many errors in clinical diagnosis for patients who attend the first level of primary health care (PHC), the WHO has developed and advocated the syndromic management approach.

Syndromic management for treatment of STDs depends on groups of symptoms (patient complaints) and signs (patient and medic observations) which can be explained by one or more infection. These groups are called syndromes. One example of syndromic management is painless genital ulcers that can be caused by chancroid or syphilis. A health worker using the syndromic management approach would treat patients for both germs.

The selection of drugs for treatment of STD's should be guided by the following:

- Prefer drugs that can treat more than one organism.
- Prefer single dose treatments to help compliance.
- Consider the cost of different drugs.
- Use drugs with a long shelf life and easy storage requirements.
- Use drugs recommended by the national STD program.
- Avoid using drugs for which resistance has been established.

Remember in some situations, for example, drug resistant gonorrhoea, the cheapest drug is not the best choice.

There are six major syndromes:

(1) Urethral discharge in men
(2) Testicular pain and swelling
(3) Genital ulceration
(4) Genital bubo
(5) Lower abdominal pain in women
(6) Abnormal vaginal discharge

What is a syndrome ?

A syndrome is simply a group of ***symptoms*** of which a patient complains, and ***signs*** observed during examination. Each set of symptoms/signs is called a syndrome.

Once a syndrome has been identified, antibiotics can be given for the majority of pathogens responsible for that syndrome according to the STD treatment guidelines for Thai-Burmese border.

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- "wcce;axmuyru tpm;x;ajymi;ap on?
- use;rma&;pep.uortqitm;v;u pnatmi§yvyon?
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- a&m*vu%mrjyaomvemrsm;tay:to; r§yEijci;?(trsdor;rsm;twu tE&m, &r/ tujzwrrwy;)
- use;rma&;apmia&mujznqn;ay;orsm; taejzi§i;w.aq;buqi&mtawt bursmtm;to;r§y&ontwupwr ouromcpm;&jci;ponwjzpon?

Advantages of the Syndromic Approach

- Reduces probability of incorrect clinical diagnosis
- Alternative to laboratory support
- Standardizes treatment at all levels of the health system
- Allows patients to be treated effectively at their first visit
- Can be used even at Primary Health Care level
- Easy training of the health care providers
- Simple and easy to follow
- Cost effective

Disadvantages of the Syndromic Approach

- Over treatment
- Undue exposure to potential side effects
- Cannot be used for asymptomatic patient (except upon risk assessment for females)
- Health care providers feel uncomfortable not to use his/her clinical experience

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The problem of drug resistance in Asia

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"aq;rw;on Eipm&; , m;/ *E&; , m;a&m*¡y; rs{ursm;" rm use;rma&;vyom; rsm;twu rnon t"y¡ , &y¡oen;? u|Eyw on xi;-jrerme , pywi*Ea&m*¡(vit*¡tjzLqi;a&m*¡) uo&mY tarmuppvi or[w ux&armupmaZm pon aq;rsm;u to;§yvi vemrsm;a&m*¡raysmub rsm;jy;a&m*¡a0'emuom , m , ou omaprmjzpon? xa}umivem. vit*¡tpwtyi;rsm;u}um&nysuq;apEirjriwuvmapjy;a&m*¡ysEr tcitvr;uvn; jriwuvmapy¡on?

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Many health workers on the Thai-Burmese border are very experienced with the treatment of multi-drug resistant *P. falciparum* malaria. Some of the older healthworkers on the border will remember when chloroquine, fansidar, MSP, quinine or mefloquine alone, were useful to treat malaria. The STD called gonorrhoea caused by the bacteria *Neisseria gonorrhoea,* is also resistant to many antibiotics. South-East Asia is thought to be where the drug resistant *Neisseria gonorrhoea strains* first appeared although the reasons for this are not understood.

What does "drug resistant *Neisseria gonorrhoea strains*" mean for the health-worker? If we use drugs such as amoxycillin or cotrimoxazole to treat gonorrhoea (urethral discharge) on the Thai-Burmese border we have a high chance that the patient will not be cured or will only get temporary relief of symptoms. This increases the chance of long term damage to the genital organs of the patient and increases the chance of spreading the disease.

The drug resistant strains of Neisseria gonorrhoea also means an increased cost to the community.

It is very worrying that there are increasing reports of Neisseria Gonorrhoea from South East Asia being resistant to ciprofloxacin.

Courtesy: Dr. Rose McGready, SMRU

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STD Treatment Guidelines Based on Syndromic Approach for Thai-Burmese Border

a&m*¦vu%mp **Syndrome**	rnona&m*¦twu **Treat for**	aq;0¦;rsm; **Drugs**	aq;aomu§x;en; **Dosage**	vemw0;vi&&&rn aq;t&ntwu **Quantity / Patient**
vit*¦wi;jynwn temay¦ujci;/ temay¦ujci;/	Syphilis and Chancroid or Donovanosis	Benzathine Penicillin G, 2-4 million units plus either Ciprofloxacin, 500mg[1] or Doxycycline, 100mg[2]	IMI w}urom aomuaq;w}ur wae 2}ur/14&u	1 v; 1 v; 28 v;
ar;vr;a}umi;rt&nqi;jci;/ tjzLa&mi/(o)t0¦a&mijyn/ om;trvnwemjci;/	Gonorrhoea and Chlamydia	Ciprofloxacin, 500mg[1] plus Doxycycline, 100mg[2]	w}urwn;aomuy¦/ wae 2}ur/14&u	1 v; 28 v;
ar;vr;a}umi;twi;y;0ijci;/ t§ryxaeaomt&nqi¦jci;/r;c;- pr¦a&mixaeaomnont&nrsm; qi¦jci;/t&njzLqi;jy;,m;,jci;/	Trichomononas[4] Gardnerella[4] Candidiasis[4]	Metronidazole, 2g[3] Metronidazole, 2g[3] Nystatin 50,000 units	aomuaq;w}urom aomuaq;w}urom ar;vr;a}umi;twi; wnvi¦wjym;7nxny¦?	5x400 mg v; 5x400 mg v; 7 jym;
0r;Auatmuyi;ten;i,emjci;/ 0r;Auatmuyi;vepmemjci;/ atmuy¦a&m*¦rsm;ry¦-ttwuay¦ujci;/ om;trjyiywi oaEwnjci;/ Amoeboma 0r;c¦yjci;/	Gonorrhoea and Chlamydia and Bacterial Vaginosis Gonorrhoea and Chlamydia and Bacterial Vaginosis	Ciprofloxacin, 500mg[1] plus Doxycycline, 100mg[2] plus Metronidazole, 2g[3] Ciprofloxacin, 500mg[1] plus Doxycyline, 100mg[2] plus Metronidazole, 400mg[3]	w}urwn;aomuy¦? wae 2}ur/14&u w}urwn;aomuy¦? }uuom;wi;x;y¦ wae 2}ur/14&u wae 2}ur/7&u	1 v; 28 v; 5x400 mg v; 1 v; 28 v; 14 v;

1? u,0e&vi¦iray;&y¦-§i;tpm;Ceftriaxone, 250mg w}urx;ay;y¦?
2? u,0e&vi¦iray;&y¦-§i;tpm;Erythromycin, 500mg aomuaq;w&u 4-}ur/14&u]56 v;/
3? u,0eyxr3vwiray;&y¦-§i;tpm;Nystatin 50,000 units ar;vr;a}umi;twi;wnvi¦wjym;/7nxny¦/
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STD Treatment Guidelines Based on Syndromic Approach for Thai-Burmese Border

a&m*¦vu%mp **Syndrome**	rnona&m*¦twu **Treat for**	aq;0¦;rsm; **Drugs**	aq;aomu§x;en; **Dosage**	vemw0;vi&&&rn aq;t&ntwu **Quantity / Patient**
ay¦ijctuswa&mijci;	As for Chlamydia	Doxycycline, 100mg[2]	wae 2}ur/14&u	28 v;
a0;apa&mijci;	Gonorrhoea Ei Chlamydia	Ciprofloxacin, 500mg plus Doxycycline, 100mg	w}urwn;aomuy¦? w&u 2}ur/14&u	1 v; 28 v;
q;vr;a}umi;rt0¦a&mi(o) tjzLa&mijynrsm;qi;jci;	Gonorrhoea Ei Chlamydia	Ciprofloxacin, 500mg[1] plus Doxycycline, 100mg[2]	w}urwn;aomuy¦? wae 2}ur/14&u	1 v; 28 v;
uav;rsuprjynxujci;	Neonatal Gonorrhoea Ei Chlamydia	Ceftriaxone, 125 mg vial Erythromycin syrup, 120ml	50mg§kg (125mg trsm; q;w}ur IMI) 50mg§kg§day aomuaq;wae 4}ur14&u	1 v; 2yvi;
vit*¦wiuwway¦ujci;	Condyloma Accuminata	Tincture Podophyllin 25%[5]	wywvi 2-5aq;&wivm vr;ci;y¦?	1yvi;
vit*¦tar;trirsm;wioe;wujci;	Pediculosis Pubis	Gamma benzene hexachloride 1%	vit*¦ay:wivr;ay;y¦[6]	1 yvi; 50cc

1? u,Oe&vi ray;&y¦-§i;tpm; Ceftriaxone, 250mg w}urx;ay;y¦?
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3? u,Oe&vi ray;&y¦-§i;tpm; Nystatin 50,000 units, ar;vr;a}umi;twi;wnvi wjym;Ee;jzi 7nxny¦?
5? u,Oe&vi ray;&y¦-§i;tpm; Trichloroacetic acid wywvi 3-4}ur aq;rxnci&mvum&nxn (Acetic Acid)jci;jzi uwwu aumi;pmjriEion?
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1. WHO. "STD Treatment Based on Syndromic Approach." Chart. Page 41. Inter-agency Field Manual: Reporductive Health in Refugee Situatuions1995.
2. Ministry of Health, Thailand. "Treatment Guidelines of Sexually Transmitted Diseases in Thailand. Thailand Medical Council Journal, 1995.

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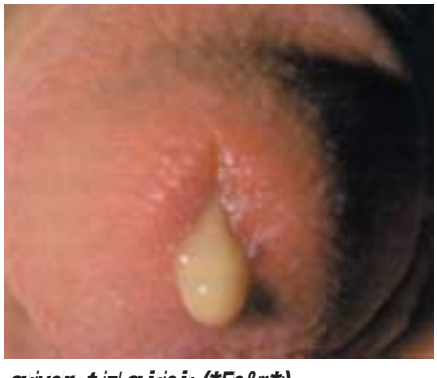

y(1) q;¶yer tjzLqi;¶jci;(*Ea&m*)
Fig 1. Urethral Discharge (Gonorrhoea)

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Syndromic approach to identifying common STDs

Dr. Rose McGready, SMRU

This article will explain the symptoms that a sexually active person may complain of when they have a STD (and / or HIV). It is important for the medic to remember that NOT ALL STDs cause symptoms, especially in women. As well, the AIDS pandemic has taught us that HIV spreads fastest in conditions of poverty, powerlessness and social instability. These conditions prevail on the Thai-Burmese border. So health-workers must be able to identify and treat correctly all STDs to reduce the transmission of STDs and HIV/AIDS.

1. STDs that cause urethral discharge (men)

A discharge from the penis is the most common symptom of STDs for men. It is caused by an infection in the urinary passage (the urethra). The discharge appears 2-21 days after infection, which can be milky, whitish, yellowish, brownish, green or blood-stained in colour depending on the organism that caused the disease. The discharge may be itchy and the man may also complain of a burning sensation when he passes urine.

It could be the result of gonorrhoea, chlamydia, genital herpes, or non-specific urethritis, trichomonas or candida. If the infection is not treated it can lead to blockage of the urinary passage, damage to the testicles and infertility.

2. STDs that cause vaginal discharge (women)

Vaginal discharge is normal for every woman who is menstruating. Glands lining the uterus, and in the cervix and vagina respond to the monthly changes in hormones and sometimes produce little or no discharge, and at other times (e.g. at ovulation, during sexual intercourse) can produce quite a lot of discharge.

Normal females have vaginal discharge BUT it is not itchy or painful and does not have a bad smell.

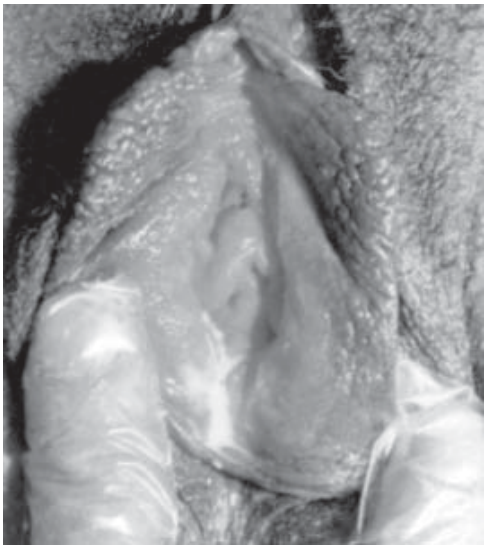

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Fig 2. Vaginal Discharge (Gonorrhoea)

Abnormal discharges from the vagina are a sign of a STD. They can be white, brown, yellow or milky with or without an offensive smell. The woman may also complain of itching, a burning sensation or pain when passing urine or during sexual intercourse or even bleeding with intercourse. Vaginal discharge can be caused by gonorrhoea, chlamydia, candidiasis, trichomoniasis, or bacterial vaginosis. These STDs can lead to infertility, abnormal pregnancies, miscarriages, still-births, abnormalities / eye discharge in newborn infants.

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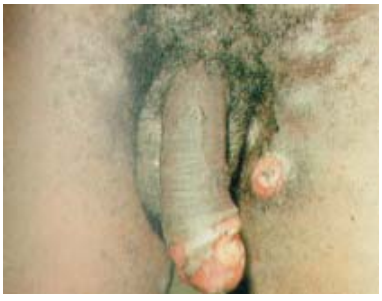

y(3) ay¥i&i;Y tu&way¥uaom umvom;a&m¥/ay¥ijcwi temtr&;tpm;u¥jyoaeon?*

Fig 3. Granuloma inguinale, showing a typical ulcer on the inner thigh.

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(see page 34)

Candidiasis, bacterial vaginosis and trichomoniasis can occur in women and men with stable partners. Candidiasis, bacterial vaginosis are not usually STDs and trichomoniasis can also be found in women who have not had sexual intercourse. Patients seeking treatment for discharge (vaginal or penile) should all be treated with care and respect. The health worker is there to make the correct diagnosis, treat the disease if they can and give the patient advice to prevent the disease from occurring again to the individual and for the community members.

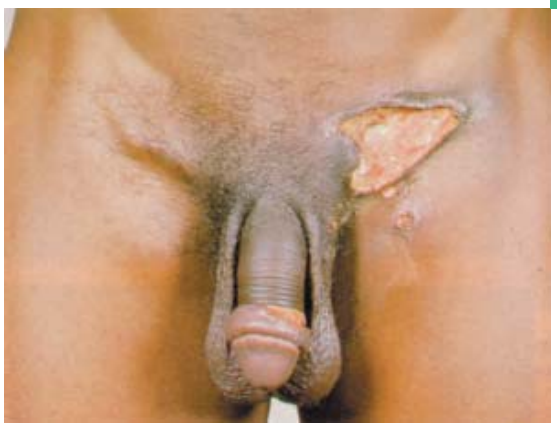

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Fig 4. Lymphogranuloma venereum (note the enlarged lymph nodes or buboes in the right inguinal region, and an ulcerated inguinal bubo in the left groin).

3. STDs causing genital ulcers (men and women)

Genital ulcers are sores on the surface and inside the male or female sex organs. There could be one or more ulcers, smooth or ragged, clean or full of pus, painful or painless. Ulcers may also occur with lumps in the lymph nodes in the groin.

The STDs that cause them are syphilis, genital herpes, lymphogranuloma venereum, chancroid or granuloma inguinale. The ulcers result from damage to the skin from germs. They can lead to damage to the genital organs, delivery of abnormal babies and sometimes brain damage, like in the final stage of syphilis.

Genital ulcers are very serious and can

An example of syndromic management

The syndromic treatment of urethral discharge

Examine male patients complaining of urethral discharge and/or pain during urination for evidence of discharge. If none is seen, massage the urethra gently and see if any discharge is produced. Then proceed following the instructions in the flow chart.

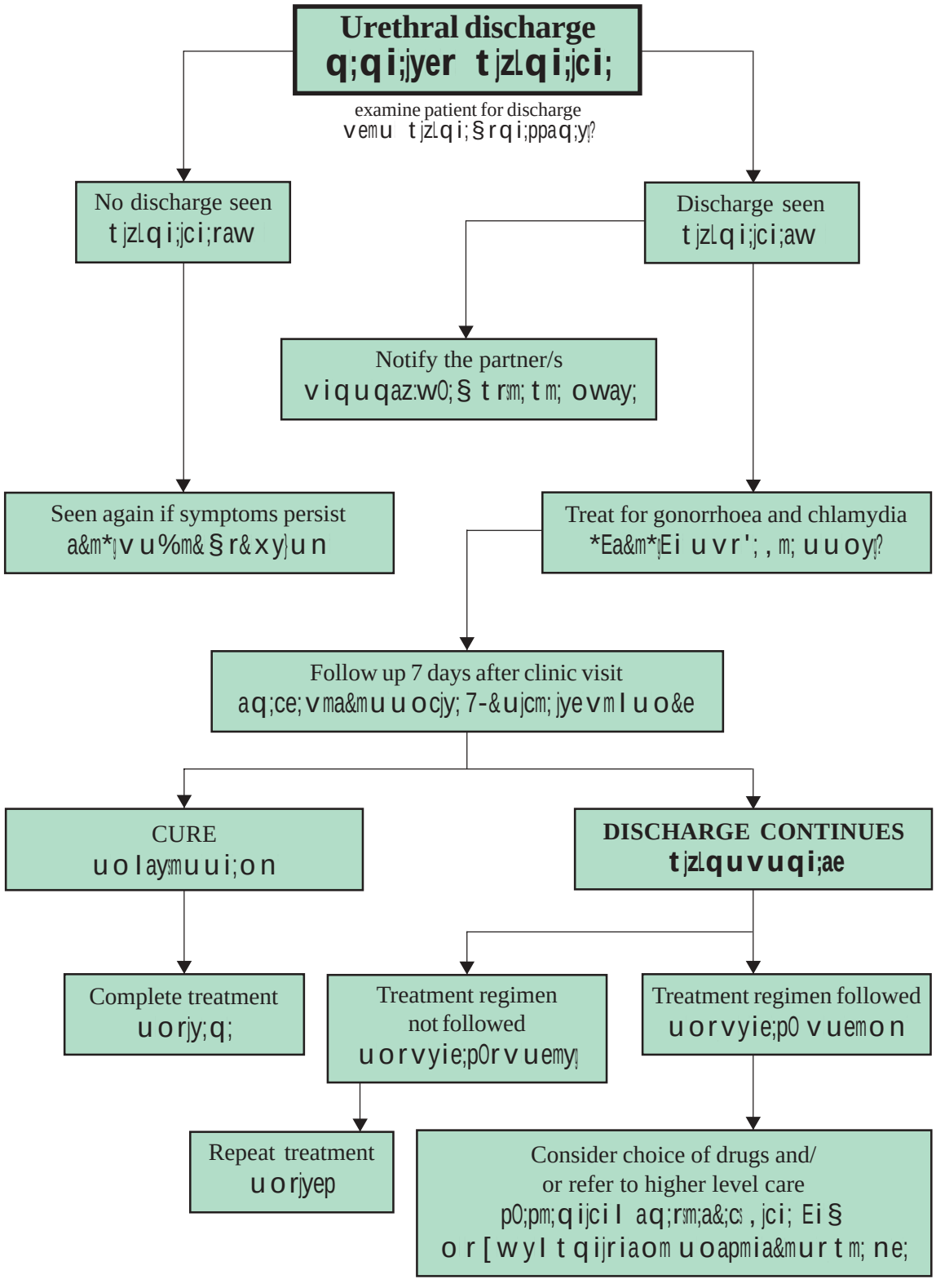
Presumptive Diagnosis: gonorrhoea and chlamydia

If your lab is capable of doing gram stain you might detect gram negative intracellular diplococci and confirm the diagnosis of gonorrhoea.

Treatment:

Use ciprofloxacin 500mg stat (immediatel) dose plus doxycycline 200mg OD (or 100mg BD) for 14 days.

Explain to the patient the importance of completing the full course of treatment, notifying the partner/s and not having intercourse until the patient and partner have completed the treatment and any symptom has disappeared.


Urethral discharge
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examine patient for discharge
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No discharge seen
tjzLqi;jci;raw
Discharge seen
tjzLqi;jci;aw
Notify the partner/s
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Seen again if symptoms persist
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Treat for gonorrhoea and chlamydia
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Follow up 7 days after clinic visit
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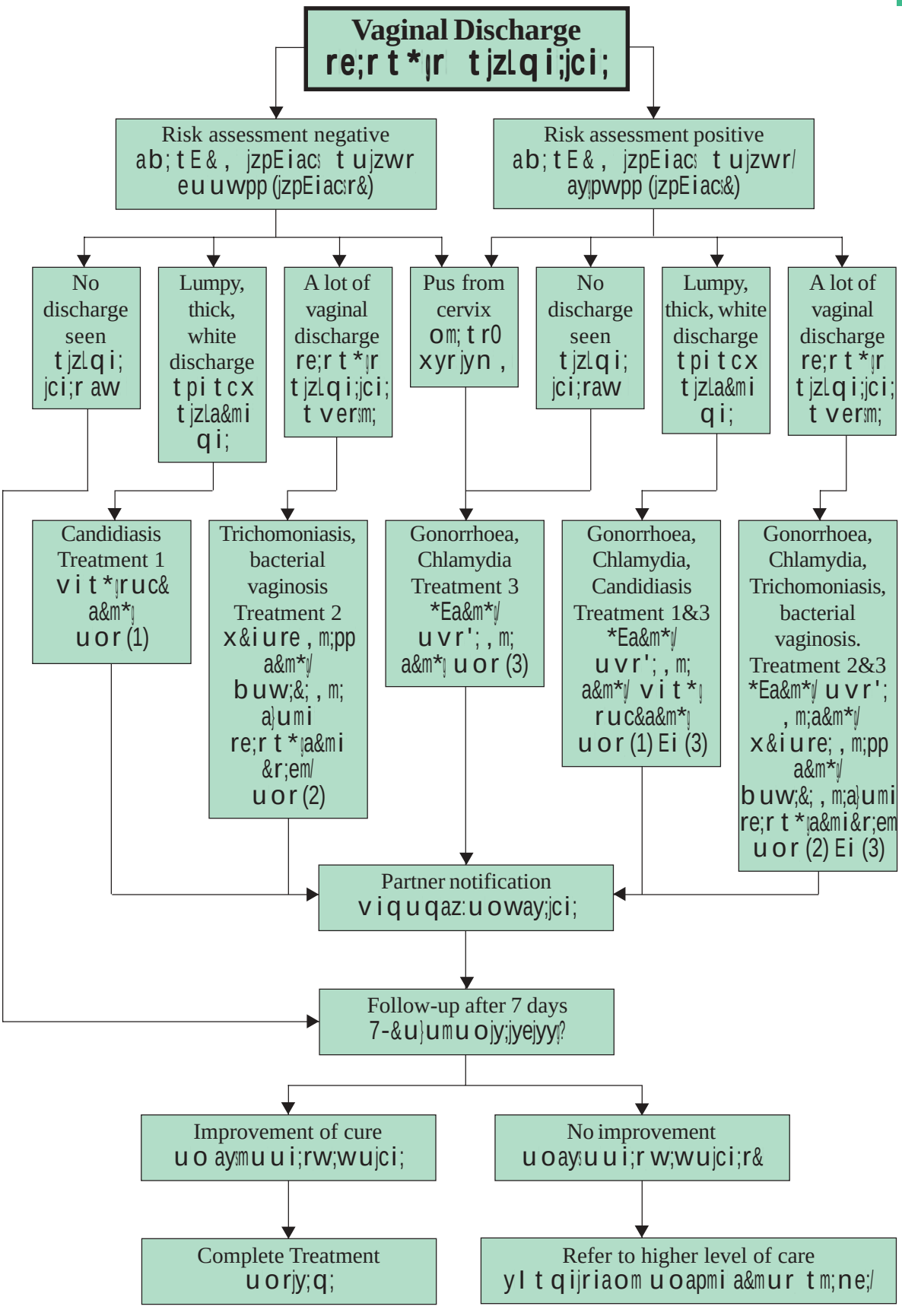
Vaginal Discharge
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Risk assessment positive
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No discharge seen
tjzLqi; jci;raw
Lumpy, thick, white discharge
tpitcx tjzLa&mi qi;
A lot of vaginal discharge
re;rt*¡r tjzLqi;jci; tver:m;
Pus from cervix
om;tr0 xyrjyn,
No discharge seen
tjzLqi; jci;raw
Lumpy, thick, white discharge
tpitcx tjzLa&mi qi;
A lot of vaginal discharge
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Candidiasis Treatment 1
vit*¡ruc& a&m*¡ uor (1)
Trichomoniasis, bacterial vaginosis Treatment 2
x&iure, m;pp a&m*¡ buw;&;, m; a¡umi re;rt*¡a&mi &r;em/ uor (2)
Gonorrhoea, Chlamydia Treatment 3
Ea&m¡ uvr';, m; a&m*¡ uor (3)
Gonorrhoea, Chlamydia, Candidiasis Treatment 1&3
Ea&m¡ uvr';, m; a&m*¡ vit*¡ ruc&a&m*¡ uor (1) Ei (3)
Gonorrhoea, Chlamydia, Trichomoniasis, bacterial vaginosis. Treatment 2&3
Ea&m¡ uvr';, m;a&m*¡ x&iure;, m;pp a&m*¡ buw;&;, m;a¡umi re;rt*¡a&mi&r;em uor (2) Ei (3)
Partner notification
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Follow-up after 7 days
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Improvement of cure
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No improvement
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Complete Treatment
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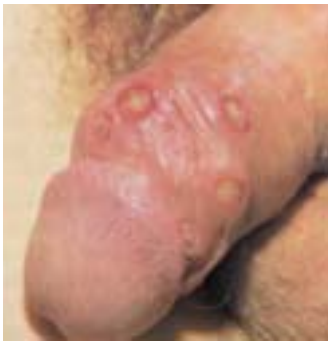

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Fig 5. Chancroid, showing typical multiple ulcerating lesions.

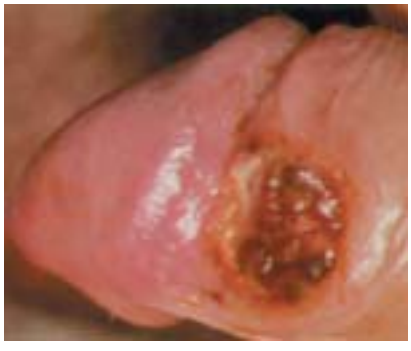

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Fig 6. Syphilis - typical primary chancre of the penis

The syndromic treatment of vaginal discharge

Perform an STD Risk assessment and proceed according to the chart. Performing a speculum examination should be part of every STD exam for women. You don't know if you don't look!

STD Risk assessment

To assess if the woman is at risk of STD, ask the following:

- Does her sexual partner have symptoms or has he had symptoms in the last 3 months (e.g. urethral discharge, pain on passing urine, open sores on the genitals)?
- Is there any possibility that her partner recently had sexual intercouse with someone else?
- Has she had sexual intercourse with someone else?
- Has she had more than 1 sexual partner in the last 4 weeks?
- Has she recently started a new sexual relationship?

If the answer to ANY of these questions is YES or if the woman is uncertain, then she should be considered at risk of having an STD

1. **Suggested treatment for candidiasis**:
   Nystatin 100,000 units in the vagina for 7 nights.
2. **Suggested treatment for trichomoniasis and bacterial vaginosis**
   Metronidazole 2 grams orally as a single dose or Tinidazole (Fasigyn) 2 grams is better if it is available) or Metronidazole 400-500mg two times daily for 7 days. *Do not prescribe during the first 3 months of pregnancy. Caution the patient to avoid alcohol while taking metronidazole.*
3. **Suggested treatment for gonorrhoea and chlamydia**
   Ciprofloxacin 500mg stat and doxycycline 100mg BD for 14 days. Doxycycline can be substituted by Erythromycin during pregnancy 500 mg 4 times per day for 7 days.
4. **Suggested treatment for candidiasis, gonorrhoea and chlamydia**
   Use treatments 1 and 3
5. **Suggested treatment for trichomoniasis, bacterial vaginosis, gonorrhea and chlamydia**
   Use treatments 2 and 3.

Explain to the patient the importance of completing the full course of treatment, notifying the partner/s and not having intercourse until the patient and partners have completed the treatment and any symptoms have disappeared.

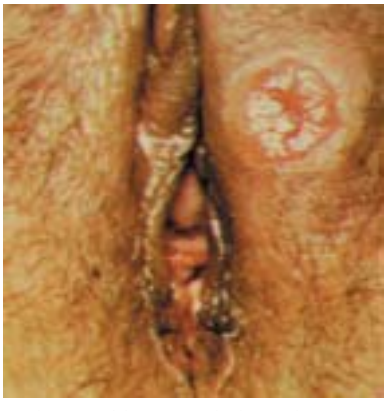

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Fig 7. Syphilis - typical chancre of the labium majus

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greatly increase the risk of getting HIV.

4. STDs causing lower abdominal pain (women)

This can be caused by pelvic inflammatory disease (PID) and be a result of infection with STDs such as gonorrhoea and chlamydia. However other factors that are not STDs can also cause this including complications of pregnancy, abortion, intestinal obstruction and appendicitis. So a careful examination is needed before a STD is diagnosed.

5. STDs causing swelling of the inguinal area or scrotum

This can be caused by chlamydia, gonorrhoea and lymphogranuloma venereum or granuloma inguinale. Again other factors can cause swelling in these areas such as herniation of the bowel, filariasis, hydrocoele, and testicular cancer. This should remind the health worker to make a good history and physical examination on the patient.

Genital warts tend to cause growths, either as isolated lumps or in large clumps and do not fit into the syndrome of ulcers or swellings. Applying a cotton swab soaked in vinegar to the lesion can be very helpful in confirming a lump as a wart as it becomes very white as the vinegar dries.

6. Diseases of the blood

Hepatitis B and HIV can both be transmitted through unprotected sexual intercourse, sharing needles / using unsterile needles, blood transfusions (if not screened) and from infected mothers to their infants. For both of these infections the person may look and feel completely well even though they carry the virus and can transmit it to others. Hepatitis B can cause liver cirrhosis and liver cancer (hepatocellular carcinoma) and the HIV virus can result in death.

Let's have a practice with the syndromic approach

Case 1.

Saw Arthur comes to the clinic because he has a yellow, pus-like, urethral discharge. He is 22 years old and has burning pain when he passes urine.

Question 1. What is the most important question for the health worker to ask to determine the cause of Saw Arthur's discharge?

a) Saw Arthur have you had unprotected intercourse (unsafe sex/sex without a condom) in the last few weeks?
b) Saw Arthur are you using IV drugs?

c) Saw Arthur have you ever used a condom?
d) Saw Arthur are you married?

Question 2. What are the possible STDs that can cause Saw Arthur's discharge?

a) Genital warts
b) Syphilis, genital herpes, lymphogranuloma venereum, chancroid and granuloma inguinale
c) Gonorrhoea and chlamydia
d) Hepatitis B

Question 3. What treatment (antibiotic) would you use for Saw Arthur?

a) Cotrimoxazole
b) Erythromycin and Doxycycline
c) Metronidazole
d) Ciprofloxacin and Doxycycline

Question 4. What other advice and counseling

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does the health worker need to explain to Saw Arthur?

a) How to use a condom.
b) Saw Arthur should ask his sexual partner/s to come to the clinic for treatment.
c) Saw Arthur may have acquired HIV and Saw Arthur should come back if he has problems.

Case 2.

Naw Paw Paw is a 24 year old single woman who comes to the clinic with vaginal discharge and complaining of a lump in her inguinal area. She is very quiet and does not want to talk much. She does not want you to look, she just wants some medicine, but because you are the good health worker you explain to her that you cannot give a treatment if you don't know what you are treating. You explain to her very carefully that the examination and what you find are confidential. On examination you find she has a vaginal discharge and a swelling of 2 or 3 big lymph nodes on her right inguinal area. You explain to her this problem can be treated.

Question 1. What are the possible STDs that can cause Naw Paw Paw's discharge?

a) Genital warts
b) Syphilis, genital herpes, lymphogranuloma venereum, chancroid and granuloma inguinale
c) Gonorrhoea and chlamydia
d) Hepatitis B

Question 2. What is the treatment for this woman?

a) Start with Cotrimoxazole and if not better come back
b) Nystatin 50,000 unit nightly for 7 nights
c) Ciprofloxacin 500mg stat dose plus Doxycycline 100mg BD for 14 days
d) Check if the patient is pregnant. IF the patient is not pregnant use Ciprofloxacin 500mg stat and Doxycycline 100mg BD for 14 days. If the patient is pregnant use Ceftriaxone 250mg IM single dose and Erythromycin 500mg 4 times daily for 14 days.

Question 3. What else does this patient need?

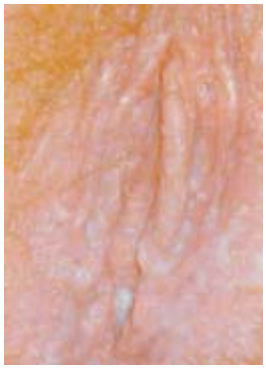
a) To go and marry the person who gave her the STD
b) HIV test
c) An explanation on how to use condoms and counseling about HIV and to come back if there are any problems and to advise the partner to come in for treatment
d) No further advice

Question 4. When you start to explain to Naw Paw Paw that the partner will also need treatment Naw Paw Paw starts to cry. She tells you there has been many partners in the last 1 months. She tells you her mother has died 5 months ago and her father is alcoholic and that she has been trying to find work to look after the 6 children of her mother. She was always helping her mother at home, so she never went to school and the only job she could get money for was to work as a sex-worker.

AZG/MSF-Holland Myanmar

What is your advice for Naw Paw Paw now?

a) Don't tell me your troubles, I have enough of my own
b) She must use condoms for this work or she too may end up dying from HIV
c) Tell her father to stop drinking and do some work
d) Leave home and don't worry about her brothers and sisters, they're not her



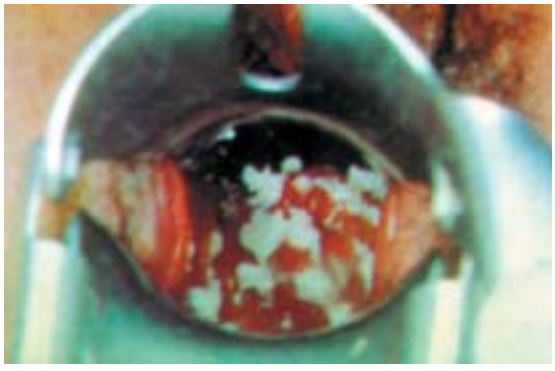


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Fig 8 & 9. Vaginal discharge (Candidiasis)

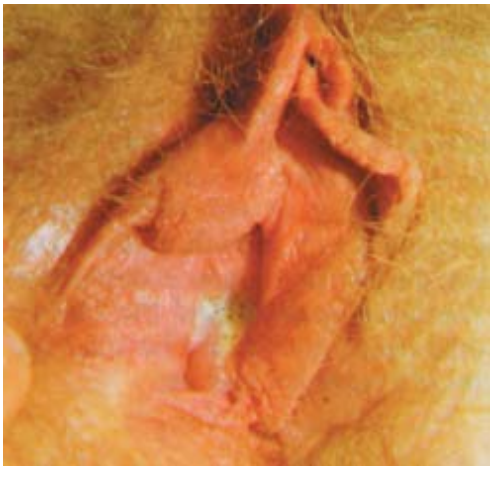

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Fig 10. Vaginal Discharge (Trichomoniasis)

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Fig 11. Granuloma inguinale of the vulva.

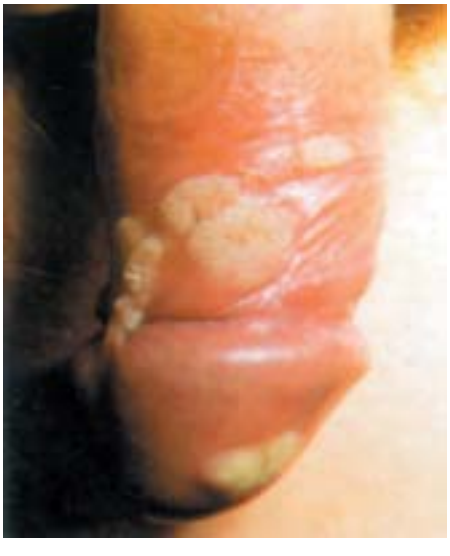

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Fig 12. Genital warts (condyloma accuminata) of the penis.

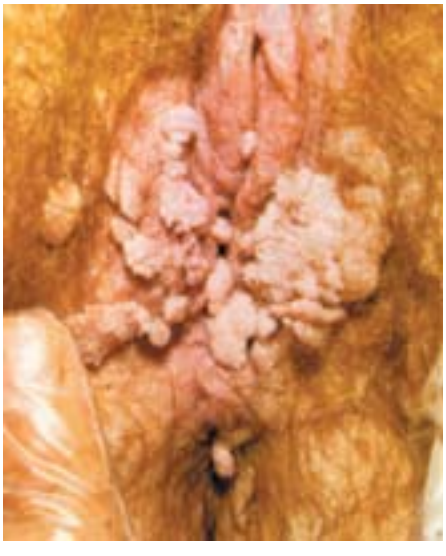

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Fig 13. Genital wart of the labia.

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Answers

Case 1

Question 1. The correct answer is a). There has to be a history of a 'risky' sexual contact without a condom to get urethral discharge. A risky sexual contact simply means sexual contact (penis-vagina, penis-anus, penis-mouth) without a condom. Are there any other diseases (apart from STDs) that can cause a pus discharge from the urethra? Yes but rarely– TB, infection after certain types of circumcision

Question 2. The correct answer is c).

Question 3. Using the STD Guidelines the correct answer is d).

Question 4. All of the answers are correct and need to be discussed with Saw Arthur. STD services have to be user friendly so that people will come for treatment and their partness will also come for treatment. If the health worker is judgmental or scolding in any way people will not come for help. Health workers have an important role in reducing HIV transmission by making sure all STDs are accurately diagnosed and correctly treated.

Case 2

Question 1. The correct answer is c).

Question 2. The correct answer is d).

Question 3. The correct answer is c).

Question 4. The correct answer is b).

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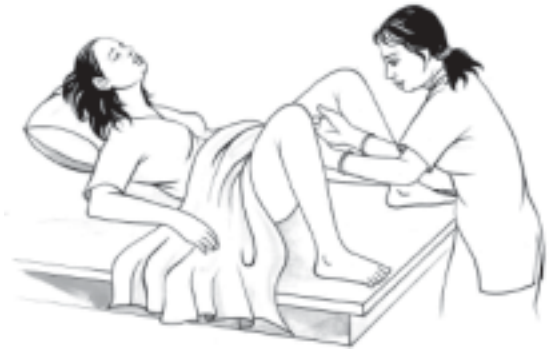

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Neonatal Conjunctivitis

Dr. Jerry Vincent, IRC

This article will discuss the causes and treatment of the eye infection of the newborn caused by sexually transmitted diseases of the mother.

What is neonatal conjunctivitis?

Neonatal conjunctivitis or infection of the conjunctiva of the newborn, ophthalmia neonatorum, and blennorrhea neonatorum, and inclusion blennorrhea are some of the many terms used in the medical literature to describe conjunctivitis of the newborn.

The World Health Organization defines conjunctivitis of the newborn as any conjunctivitis with discharge occurring during the first 28 days of life.

In nearly all cases, neonatal conjunctivitis is caused by exposure to bacteria or other pathogens in the vagina. Numerous bacteria have been cultured from eyes of neonates with neonatal conjunctivitis and in many cases, multiple pathogens are identified.

The incidence of neonatal conjunctivitis among live births varies greatly from area to area and country to country. Where data exists, incidence rates vary from 0.1 per 1,000 live births to over 60 per live births.

In the developing countries, up to 75% of neonatal conjunctivitis is attributable to *Neisseria gonorrhea* followed by *Chlamydia trachomatis* infections and other causes. In industrialized countries *Chlamydia trachomatis* is responsible for up to 50% of all cases of neonatal conjunctivitis followed by *Neisseria gonorrhea* and other causes.

Neonatal conjunctivitis from Neisseria gonorrhea

Much of the world's neonatal conjunctivitis and most all the cases of blinding neonatal conjunctivitis are due to exposure of the newborn to *Neisseria gonorrhea.* This infection occurs when the mother has unrecognized or inadequately treated gonorrhea. Approximately 30% of infant born to mothers with untreated gonorrhea can be expected to develop gonococcal neonatal conjunctivitis. Left untreated, this infection will often lead to blindness.

The typical case becomes clinically evident between day 3 and day 6 although occasional reports are found of delayed onset of 2-3 weeks.

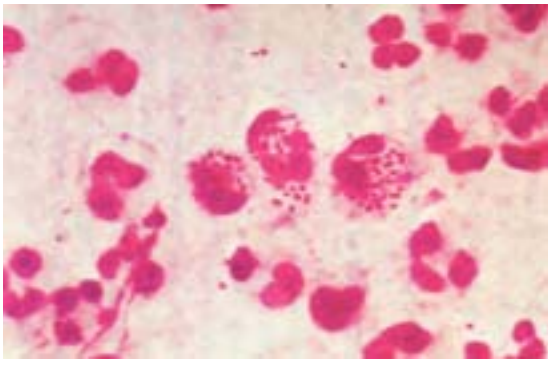

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Fig 1. Intracellular gonococci in a smear of urethral discharge

The clinical signs include:

- swelling of the eyelids
- swelling of the conjunctiva
- copious purulent discharge
- both eyes involved in about 75% of cases
- corneal ulcer and possible cornea perforation if not treated

These clinical signs are usually very severe. The eyelids may be swollen enough to make it very difficult to open the eyes. The conjunctiva may be swollen enough to balloon out between the eyelid margins and there is a large amount of pus discharge. This discharge sometimes contains blood. Blindness occurs with this

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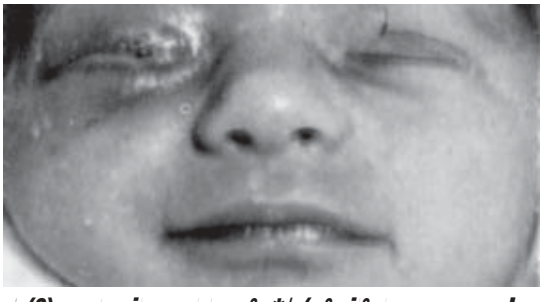

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Fig 2. Ophthalmia neonatorum (note the swollen right eyelid)

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Information for the Health Workers

Great care must be taken in examining these infants. The discharge from the eyes of these patients is very contagious (infectious) and all attempts should be made to avoid or minimize contact with this discharge.

The pressure created by the large amount of inflammation and edema of the eyelids and conjunctiva can cause the discharge to shot out or spray from the eye when the examiner is trying to open the eyelids to examine the eyes. To avoid having discharge spray your own face, gently clean away as much of the discharge as possible with saline moistened cotton before you attempt to examine the eyes. ***Do not put your face close to the face of the infant when you are initially pulling the eyelids back to examine the eye. If possible, follow universal precautions and use gown, gloves and goggles.***

It is very easy for the hands of the examiner to become a source of infection for their own eyes or for the eyes of other patients. To prevent this from happening, *wear gloves if available and wash your hands very thoroughly as soon as you complete your examination.*

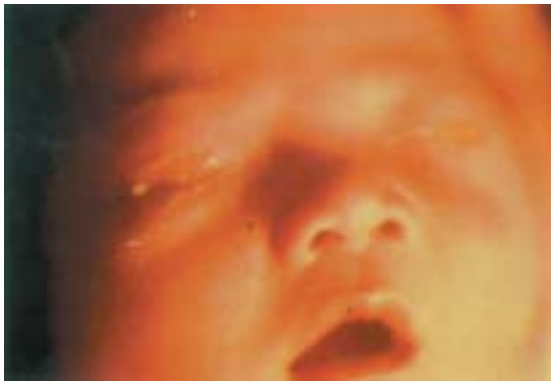

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Fig 3.Ophthalmia neonatorum (purulent conjunctivitis)

disease when the cornea becomes infected resulting in an ulcer with blinding scarring or perforation and loss of the eye.

Any delay in treatment not only increases the chance of blindness; it also increases the danger of a more generalized infection. The conjunctiva may become the entry point for *Neisseria gonorrhea* or *Neisseria meningitis*, leading to septicemia or meningitis.

Treatment of gonococcal conjunctivitis

In most areas, the current World Health Organization recommended treatment for gonococcal conjunctivitis is benzylpenicillin. Due to resistance in many areas, including Thailand, alternative drugs are used.

For the border area, a single dose of ceftriaxone 50mg/kg given IM is the treatment of choice. If this antibiotic is not available, alternatives such as a single-dose cefotaxine (125 mg intramuscularly) or single-dose kanamycin (75 or 15mg) can be considered.

The treatment plan also includes tetracycline ointment given hourly the first day and every 3 hours until swelling and discharge subside, then 4 times a day for 10 additional days.

[Note that there is some concern for ototoxicity with kanamycin. Erythromycin ointment or gentamycin drops can be substituted if tetracycline ointment is not available.]

The eyes should be cleaned of discharge before applying ointment or drops to the eye as the discharge prevents the ointment from having good contact with the eye and reduces the effectiveness of treatment.

Infected infants are highly contagious, and it is possible to infect others via the secretions and discharge from the eyes of these infants. If possible, isolate newborns for at least 24 hours after the start of therapy.

The mother and her partner should also receive treatment using the recommended regimen used locally for sexually spread gonorrhea infections.

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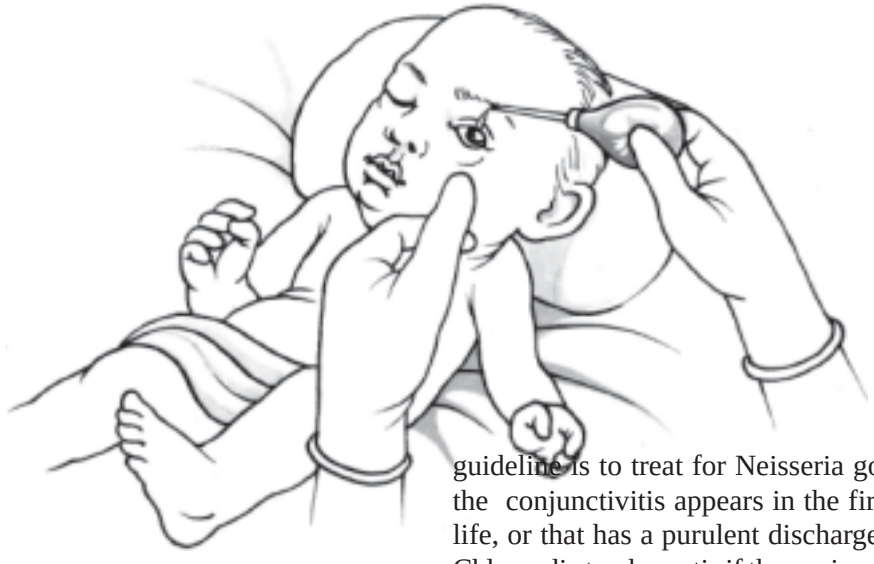
Neonatal conjunctivitis from Chlamydia trachomatis

Neonatal conjunctivitis from Chlamydia will usually become clinically evident on day 7 or day 8. An onset as early as the first day life is possible, and may be due to prolonged rupture of membranes. Delayed onset also is seen, with some infants developing clinical signs as late as weeks 5 to 6. The average, infection will last 4-5 months, if left untreated, but occasionally it persists for as long as 2 years.

Over half of the time, only one eye will be affected with much less discharge than seen in gonorrhea conjunctivitis. Although *Chlamydia* causes neonatal conjunctivitis rarely causes blindness, this infection can also infect the respiratory and gastrointestinal tracts of newborns. Late pneumonia occurs in 10% to 20% of newborns exposed to *Chlamydia* at birth.



Treatment of Chlamydial conjunctivitis

For infants with presumed chlamydial conjunctivitis, systemic therapy with erythromycin is more effective than topical therapy alone and it helps the removal of concurrent nasopharyngeal carriage, which may predispose to the development of pneumonitis. The dose is:

- 50mg/kg per day of erythromycin syrup should be given by mouth in 4 divided doses for a minimum of 14 days.
- Tetracycline ointment (or erythromycin ointment) should be given 4 times a day for 14 days.

The eyes should be cleaned of discharge before applying the ointment.

The mother and her partner should also receive treatment using the recommended regimen used locally for sexually spread Chlamydia infections.

Differential diagnosis

Ideally, a laboratory work up would be used to determine what pathogen is responsible for the conjunctivitis. Because this is not usually possible in the field, the suggested guideline is to treat for Neisseria gonorrhea if the conjunctivitis appears in the first week of life, or that has a purulent discharge. Treat for Chlamydia trachomatis if the conjunctivitis occurs after the first week of life. If you are uncertain about the cause of the in*fection, you should treat for both gonorrhea and chlamydia*.

Prophylaxis for neonatal conjunctivitis

Prophylaxis can prevent most cases of neonatal conjunctivitis and should be considered in areas where sexually transmitted disease's (STD's) are common. Prophylaxis for neonatal

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conjunctivitis includes the careful cleaning of the eyes immediately after birth and the application of tetracycline eye ointment, erythromycin eye ointment or 1% silver nitrate drops. When cleaning the eye, secretions and blood should be cleaned from the face with the eyelids closed. The ointment should then be installed and not flushed from the eye.

Many cultures use traditional "medications" (e.g., lemon juice, cooking oil, etc.) to apply to the eyes of newborn infants. Some of these substances are irritants and may cause eye damage. Along the Thailand – Burma border, many apply breast milk to the newborn's eyes. Although this is probably not harmful and might be helpful, it is not know to what extent breast milk or other traditional medications are effective against *Neisseria gonorrhea* and *Chlamydia trachomatis*.

With twenty to forty percent of the admissions to European blind schools being attributed to neonatal conjunctivitis at the turn of last century, this disease was at one time, a major cause of blindness. Although the incidence of this form of blindness has been greatly reduced during this century, there is reason to believe that neonatal conjunctivitis will become more significant in the future as a cause of blindness. The prevalence of sexually transmitted diseases has been increasing throughout the world for the past three decades. Strains of *Neisseria gonorrhea* resistant to penicillin have become widespread in some areas, making treatment more complicated. These trends will unfortunately probably contribute to an increase in the incidence of neonatal conjunctivitis and health workers should be aware of the current WHO guidelines for diagnosis and treatment.

Summary of Treatment Plans for Neonatal Conjunctivitis

Suggested treatment for ***Neisseria gonorrhea*** conjunctivitis in the newborn
Ceftriaxone 50mg/kg single dose IM
AND
Tetracycline ointment every hour for first 24 hrs.
8 times a day thereafter until swelling and discharge subside,
then 4 times a day for 10 additional days

Suggested treatment for ***Chlamydia trachomatis*** conjunctivitis in the newborn
Erythromycin syrup, 50mg/kg daily in four divided doses by mouth for 14 days
AND
Tetracycline ointment 4 times a day for 14 days

Glossary:

Conjunctivitis: inflammation of the conjunctiva
Ototoxicity: poisonous effect on the eighth nerve or upon the organs of hearing and balance
Concurrent: occurring or existing together or side by side

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Counseling, Information and Partner notification for Patients

Dr. Rose McGready, SMRU

Patients normally find it very difficult to talk about STDs and their sexual activities, especially if the health worker is hesitant or embarrassed. Health workers must have the necessary communication skills and attitudes to feel comfortable when asking patients about sexual activity. In addition the following guidelines are specific for STD counseling:

- Behave in a way that is sensitive to the patient's feelings, and avoid being judgmental.
- Reassure clients about confidentiality; otherwise they may withhold information because they fear what they say will be revealed to others.
- Explain to patients why you are asking personal questions
- Allow enough time for the consultation, especially if the patient is embarrassed.

Counsel patients who have an STD on the importance of future protection.

It is also necessary to discuss the need of treating the sexual partner. Since this is a delicate matter and most patients find it difficult to talk about this topic, it should be discussed elaborately. Make sure the patient is aware that not all infections of the genitals are transmitted sexually, but that treatment of the partner is essential to avoid being re-infected.

Partner Notification

The purpose of notifying the patient's sexual partner(s) is to treat people who are very likely to have STD and to prevent the patient from becoming re-infected. Notifying partners may be difficult for several reasons:

- The concept of notification may be very threatening to the patient. It is essential to respect the patient's wishes and maintain her/his trust. Health workers must recognize that many clients are so scared to notify their partner (s) that they will provide information only if the health worker has earned a reputation for maintaining confidentiality.
- Many patients, especially women , find it very difficult to discuss the problem with their partner/s.
- Some partners do not believe they have a disease, especially if they have no symptoms, so they refuse to come for treatment.
- Some partners may not know the name and addresses of their partners or they may give false names and addresses (as in case of CSWs). Some addresses may be hard to

locate.On a case by case basis, health workers can choose one of the following approaches:

Patient led system of notification and referral

Some patients may have the confidence to talk to their partner(s) directly and refer them for STD management. Ask patients to bring or send in their partner (s) to the clinic.

Patient led system of treatment

Patients know their partner will not attend for STD treatment, but they are willing to take treatment to their partner. Give the patient enough medicine for their partner(s).

Health worker led system of notification

Some patients may prefer that the health worker contact their sexual partner(s). Ask for

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the name and address of the partner(s) and try to contact them by visiting them.

Combined approaches

More than one approach may be required. For instance if a client offers to notify sexual partners you may wait a reasonable amount of time (about a week) then try another approach if the partner has not appeared for treatment.

When a partner comes to the clinic or to see the health worker, treat him/her for the same STD that the initial patient had.

Health worker led notification can bring up to 3 times more partners for treatment than patient led notification and referral, but it needs enough staff to make the visits.

FOLLOW-UP CARE

When patients return for follow-up ask the following:

- Do they have any symptoms of STD?
- Have they completed their course of treatment?
- Have their partner(s) been treated?

Counsel patients about prevention of STDS in the future.

When patients return for follow-up ask the following:

- Do they have any symptoms of STD?
- Have they completed their course of treatment?
- Have their partner(s) been treated?

TREATMENT FAILURE

STD management and treatment may fail for the following reasons:

The patient may have failed to take the full course of treatment

The patient may have been re-infected because the partner was not treated

Bacteria or strains are resistant to the treatment.

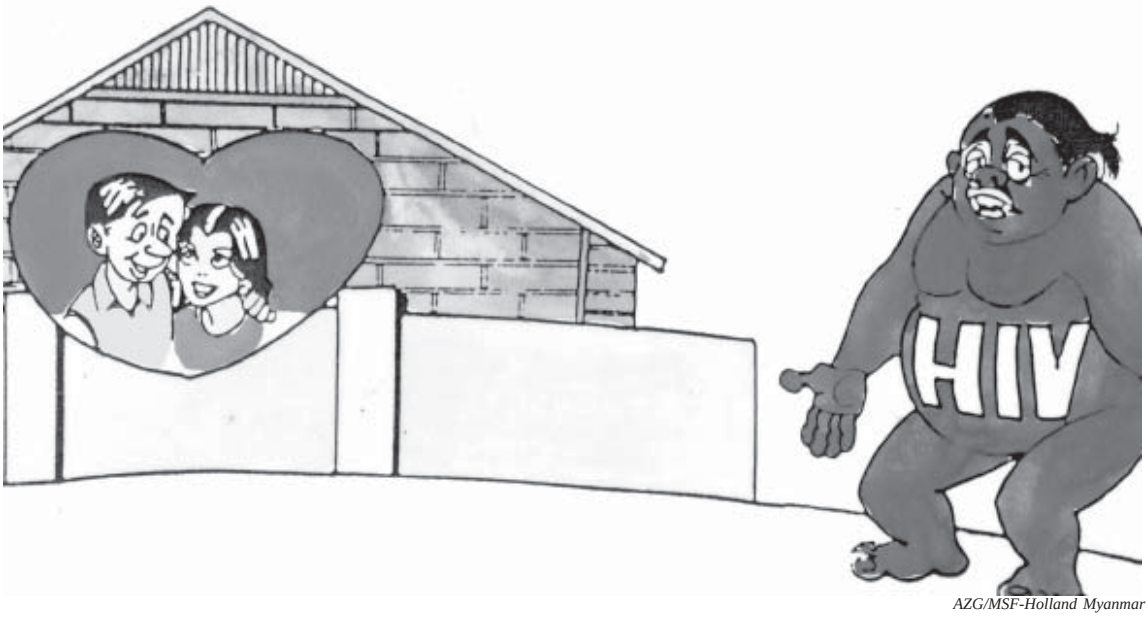
The treatment was not correct. Syndromic management does not cover all causative organisms as in the case of uncommon infections (e.g. lymphogranuloma venereum and donovanosis that cause ulceration).

If the patient has not followed the course of treatment, provide further treatment and counseling.

If the patient has been reinfected by the partner, provide further treatment and re-emphasize the importance of treating the partner. Offer the patient any possible assistance for treating the partner.

Condoms are the best method to protect against STD, including HIV, when used correctly and consistently.

Condoms do not protect against infection from groin lesions that are not covered.



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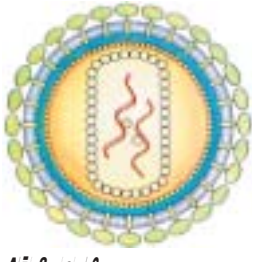

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Fig 1. Digram of AIDS virus

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An introduction to HIV/AIDS

Health Messenger

What is AIDS?

AIDS means:
Acquired - not hereditary but due to an (acquired) virus encountered by the patient during his or her lifetime.
Immune - major collapse of the immune system.
Deficiency **S**yndrome - the group of symptoms and signs.

What is HIV?

Human
Immune Deficiency
Virus

AIDS is due to the progressive destruction of the immune system by a virus.

What is the immune system?

The immune system protects the body against aggression by my microbes which are present in the environment.

The immune system acts throughout the body in the form of certain types of white blood cells called lymphocytes, which permanently guards the body against infection using the lymphoid organs as their bases (e.g. thymus, lymph nodes, spleen etc.). There are two main families of lymphocytes: T lymphocytes and B lymphocytes, which have different actions.

One variety of ***T lymphocytes***, the T4 lymphocytes act as a coordinator of the defence operations and consequently play a very important role.

T lymphocytes directly attack the invaders. The B lymphocytes attack by means of chemical substances called antibodies, which bind to the germ and destroy it. So, if there is an antibody against the HIV in the body during serological tests, it means that the body of that person has been attacked by HIV.

Where does the AIDS virus come from?

There are two types of AIDS virus found in humans till now.

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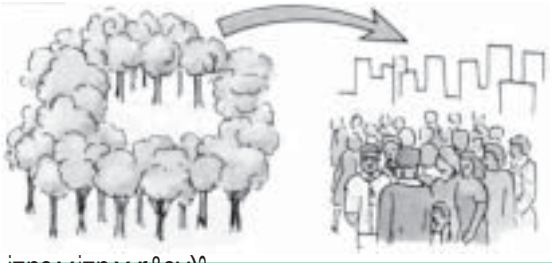

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HIV1

HIV1 is the major virus responsible for AIDS. It is ***possible*** that it is derived from a ***virus affecting chimpanzees***. HIV1 appears to have existed for a long time in few isolated human populations, and appears to have been well tolerated by these populations.

HIV2

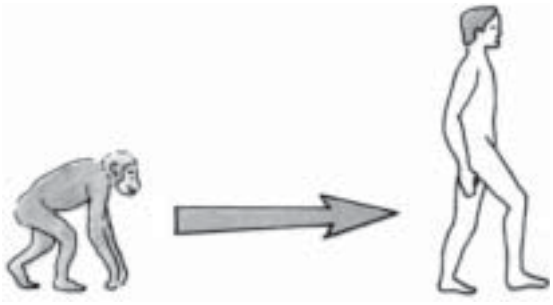
HIV2 is a fairly close relative to ***African monkey virus*** (Mangabey monkey).

It is thought that***, transmission*** of this virus from the monkey to man occurred a relatively long time ago. But it was well tolerated in the ***monkey*** but in ***man*** it caused AIDS. Its transmission is more difficult. Once it is transmitted, it causes disease ***less frequently and less rapidly*** than HIV1.

WHO IS AT RISK FOR INFECTION?

EVERYBODY
Everybody who is exposed to the infection. But especially:

- Persons with STDs and sores on their genital parts.
- Persons who have many sexual partners.
- Commercial Sex Workers (CSW) or Prostitutes (male/female).
- Patients receiving injections with non-sterile equipment.
- Patients receiving untested blood from unknown donors.



How to recognize a person with AIDS?

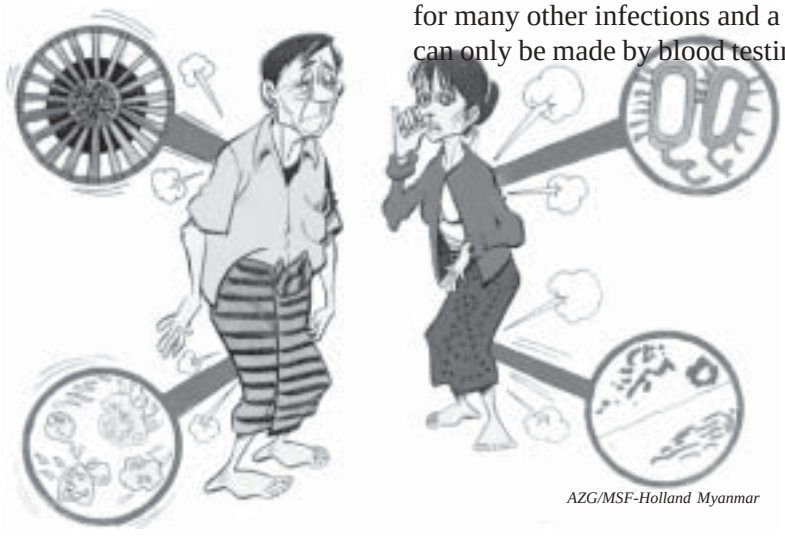
Some persons pass through a first stage with fever and throat infections like a bad cold. They can then be without symptoms during a long period.

For some time before the final diagnosis can be made, the person might suffer from different symptoms of infection. They are grouped into what is called ARC (AIDS Related Complex).

The disease appears differently around the world.

Some signs and symptoms are more common in certain parts of the world than in others. "Slim disease", stressing the weight loss, is more common in Africa, while pneumonia is more common in the USA.

The symptoms of AIDS are the same as for many other infections and a final diagnosis can only be made by blood testing.



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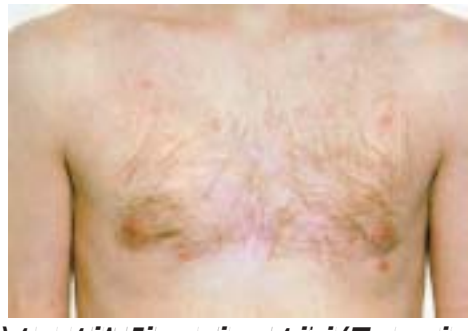

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Fig1. HIV-related rash (in this patient the blood test for HIV was negative, but turned positive after 5 weeks).111

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Diagnosing AIDS

Diagnosing an adult with AIDS

To make the diagnosis the person should show at least 2 major and 1 minor sign.

Major signs

- Loss of more than 10% of body weight
- Prolonged fever for more than 1 month
- Chronic diarrhoea for more than 1 month

Minor signs

- Persistent cough for more than 1 month
- Recurrent herpes zoster (a virus)
- Chronic, generalized herpes simplex (a virus)
- Loss of memory
- Peripheral nerve damage
- Generalized itchy skin disease
- Swollen glands
- Thrush (fungal infection by candida) in mouth and throat
- Loss of intellectual capacity

AIDS should be suspected, if the symptoms persist, especially in an area with many people with AIDS.

Diagnosing a child with AIDS

To make the diagnosis, the infant or child should show at least 2 major and 1 minor sign.

Major signs

- Weight loss or slow growth
- Prolonged fever for more than 1 month
- Chronic diarrhoea for more than 1 month

Minor signs

- Generalized swollen glands
- Repeated common infections
- Generalized skin disease
- Thrush in mouth and throat
- Persistent cough

Attention: many children have these symptoms. The diagnosis is confirmed if one of the parents or both are also ill.

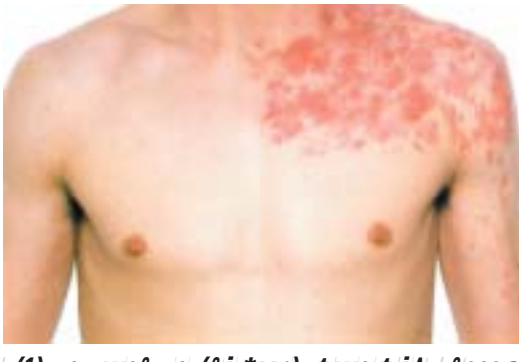

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Fig1. Herpes zoster (shingles) is often the first manifestion of immunosuppression in HIV positive patients.

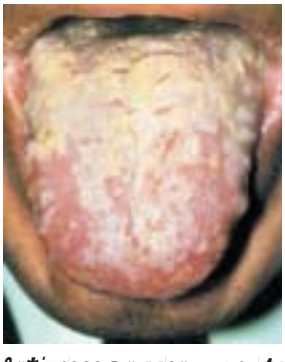

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Fig2. Extensive oral infection with candida albicans in an AIDS patient.

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HIV/AIDS Transmission and Non-Transmission Routes

Andrea Menefee, IRC

There is a variety of confusions regarding the transmission of HIV/AIDS which plays an important role in stigmatizing the AIDS victims. This article will focus on how HIV/AIDS are transmitted and not transmitted.

Most people are afraid of HIV and AIDS. But, the good news is that HIV/AIDS does not spread very easily from person to person. HIV is different than viruses that cause the common cold or influenza. Those viruses are very tough, are very infectious, and can be carried through the air. But AIDS virus is not airborne and is weaker than the other viruses.

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HIV/AIDS transmission routes

Most health workers are very familiar with how HIV/AIDS is transmitted. There are only **THREE WAYS HIV/AIDS CAN BE TRANSMITTED**:

Transmission of HIV\AIDS by sexual transmission is the most common way for HIV to be transmitted, worldwide.

It can be spread between two people when one person is carrying the virus, either through vaginal ,anal or oral sex.

By body fluids

HIV/AIDS can spread through sexual relations with an infected person.

For example, HIV/AIDS can spread by:

- having sex with a man who has HIV/AIDS without using a condom (from semen or blood).
- having sex with a woman who has HIV/AIDS without using a condom (from vaginal fluid or blood).

By blood

HIV\AIDS can spread though direct blood-to-blood contact with an infected person.

For example, HIV/AIDS can spread by:

- sharing needles with HIV infected person for drug injections
- sharing needles or razors with HIV infected person for ear piercing and tattooing, or shaving

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- from blood transfusions if the transfused blood contains HIV and has not been tested for the virus

From mother to child

HIV/AIDS can spread from mother to child by:

- transmission from an HIV infected mother to the foetus through the placenta.
- transmission from an HIV infected mother to the baby during delivery.
- transmission from an HIV infected mother to the baby through breast milk.

(Note: transmission rates through breast milk are low, and HIV-infected mothers are encouraged by the World Health Organization to breast feed, since breast milk is the best food for babies)

Health workers and teachers must understand that there are **FOUR CONDITIONS** that must be fulfilled in order for HIV to be transmitted from one person to another. These four conditions are:

1. HIV MUST BE PRESENT in a person's body fluid

2. HIV MUST SURVIVE during the time it is outside the person's body. The time that HIV can survive outside of the body is very short (approximately 30 minutes depending on the environment of the virus)

3.HIV MUST GET INTO A PERSON skin makes a barrier that HIV cannot get through - therefore, HIV can only enter when the skin is damaged, or where there are delicate membranes that do not protect the body as well, such as in the anus or vagina.

4. ENOUGH HIV MUST BE TRANSMITTED to another person for them to become infected. This means that if only a small amount of HIV is transmitted, it may not be enough to cause infection.

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HIV/AIDS non-transmission routes

Most health workers know how HIV is transmitted. But, it is just as important to **KNOW HOW HIV/AIDS IS NOT TRANSMITTED**, so that people do not unnecessarily fear HIV/AIDS and do not avoid people who have HIV/AIDS.

HIV/AIDS IS NOT SPREAD BY:

- **holding hands**
- **playing sports**
- **bathing together**
- **sharing food**
- **mosquitoe bites**
- **massage**
- **sneezing or coughing**
- **sharing clothes**
- **breathing**
- **hugging**
- **faeces or urine**

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Health workers and teachers may get asked difficult questions from the community and from their students about different ways HIV/AIDS might be transmitted. Some questions can sometimes be confusing, and the answers may not be so obvious or may depend on the situation.

However, questions will be easier to answer if health workers and teachers remember:

1) there are only three transmission routes for HIV/AIDS;

2) the four conditions that must be fulfilled for HIV/AIDS to be transmitted.

For example...

1. QUESTION:

....since HIV/AIDS is transmitted by blood, how come mosquitoes do not transmit HIV/AIDS?...

ANSWER:

...mosquitoes do NOT transmit HIV because the blood that the mosquito takes up is too small an amount to transmit the infection. Remember, one of the conditions for HIV/AIDS transmission is that there must be ENOUGH HIV TRANSMITTED TO CAUSE INFECTION IN ANOTHER PERSON....

...HIV directly affects the young and sexually active people. If mosquitoes carried the virus, everybody would have been infected

...Mosquitoes can transmit malaria but not HIV because malaria germs stay and grow inside mosquitoes but HIV does not

2. QUESTION:

...if I play football with someone who has HIV/AIDS, will I get it?....

ANSWER:

...skin is an excellent barrier to HIV infection, and HIV cannot pass through healthy skin. Remember, HIV/AIDS must get into a person's body for infection to occur....

3. QUESTION:

...if I use someone's toothbrush and that person has HIV/AIDS, will I get infected?...

ANSWER:

...infection is possible because blood from bleeding gums can get onto the toothbrush, but infection is unlikely, since the virus would have to survive on the toothbrush, and both the person with HIV/AIDS and the person using their toothbrush would have to have sores or infection in their mouth or gums. However, it is advised to avoid sharing toothbrushes with someone infected with HIV/AIDS.

4. QUESTION:

...Suppose that I play football with someone who has AIDS and they have a cut on their arm and it touches a cut on my arm?...

5. QUESTION:

...If I use a spoon that a person with HIV/AIDS uses and they have a cut on their mouth, will I get sick?...

6. QUESTION:

...What if a child gets a nosebleed and anther kid falls over on that spot and cuts his knee?...

7. QUESTION:

...What if a dog bites a person who

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When answering difficult questions about HIV/AIDS transmission, remember the three transmission routes of HIV/AIDS...

...TRANSMISSION IN ANY OTHER WAY IS EITHER IMPOSSIBLE OR VERY UNLIKELY!

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Children and HIV/AIDS

Health Messenger

This article describes the impact of HIV and AIDS on young children and the extent of the problem. It also provides an overview of how HIV is transmitted to infants and young children.

HIV and AIDS can affect infants and young children in one of three ways. They may be:

- infected with HIV.
- affected by HIV.
- vulnerable to HIV.

Children infected with HIV

KEY POINTS

- Children can be infected with HIV through mother-to-child transmission, contaminated blood transfusions, unsterile medical equipment, or sexual abuse.
- A third of babies born to HIV-infected mothers will become infected.
- Children are most affected by HIV in settings where women are most affected by HIV.
- HIV is predicted to significantly increase infant and child mortality.

At the beginning of the AIDS epidemic, children were not considered to be at risk of HIV infection. This changed as it became clear that infants and young children had been infected with HIV by contaminated blood transfusions and by use of unsterile medical equipment. It also became clear that the virus could be passed from an infected mother to her baby during pregnancy, birth or breastfeeding.

How are children infected?

Children can be infected with HIV through:

- pregnancy, birth or breastfeeding if the mother is infected with the virus
- receiving infected blood transfusions
- treatment with unsterile medical equipment such as needles, syringes or surgical instruments
- sexual abuse involving penetrative vaginal or anal sex

Globally, the majority of infected children - about 90 per cent - are thought to acquire the virus through transmission from an HIV infected mother, either during pregnancy, birth or breastfeeding. Contaminated blood transfusions and medical equipment are thought to be responsible for about 10 per cent of HIV infection in young children.

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Photo by Dr. Seerat Nasir

Children affected by HIV

KEY POINTS

- Many children, who are not themselves infected, are affected by HIV and AIDS.
- Loss of a parent or parents affects the emotional, physical and mental health of young children, their security, and educational prospects.
- Children from families affected by HIV/AIDS may be stigmatised and suffer discrimination.

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The lives of many children who may not have HIV themselves are affected when family members have HIV and AIDS. Families face increased poverty and stress when adults are too sick to continue with their work to earn money or to farm their land. Mothers who are ill find it more difficult to care for young children, and young children themselves may end up caring for younger siblings (brothers or sisters) or sick parents.

In addition to children whose parents are infected with HIV and are sick or dying, there are many whose parents have died of AIDS. They may have lost a mother or a father or both. It is estimated that:

- nine million children in the world have already lost a mother because of AIDS.
- at least 30 million children in the world are living with HIV-positive parents and are at risk of being orphaned in the future.
- by 2010 over 40 million children under five year of age in Asia, Africa, and Latin America will have lost one or both parents because of AIDS. By 2020, it is predicted that the largest number of AIDS orphans will be in South and South-East Asia.

Loss of a parent or parents can affect young children in many ways. The effects vary from country to country and depend on culture, social and family structure, and legal systems. For example, in some countries, children may lose their rights to property or land. In others, where many children have lost their parents, family support systems are under great strain. Young children may be cared for by grandparents or older siblings who are unable to cope or to afford extra food and clothing, or they may be cared for reluctantly by relatives who already have too many demands. In these circumstances, young children are less likely to be sent to school and more likely to be expected to work at a very young age to earn money. As well as having to cope with loss, grief and confusion, children from families affected by HIV and AIDS may be stigmatised and rejected and not allowed to play with other children.

SEAPRO Forum

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Center for babies infected or affected by HIV/AIDS, Chiangmai

Children vulnerable to HIV

KEY POINT

Children without parents and displaced children are more vulnerable to rape and sexual abuse, and the associated risk of HIV infection.

Children without parents or who are not living with their parents because of war or economic reasons, are more vulnerable to sexual abuse and exploitation. Refugee and displaced children are particularly vulnerable.

There is a growing evidence of very young children being infected with HIV and other STDs following sexual abuse and rape. Although it is usually older children, especially girls, who are most at risk of sexual exploitation, younger children are also vulnerable to sexual abuse.

One study in Zimbabwe found that, in 1990, 907 children aged under 12 years had been treated at a clinic in the capital city Harare, for STD. In another study in the same country done among 54 sexually abused children in Bulawayo, one girl was only two years old. Twelve of these 54 children were tested for HIV and four were found to be positive.

Without family support, education or skills, orphaned children from families affected by AIDS may themselves grow up to be more vulnerable to HIV infection through starting sexual activity at a young age to support themselves. If orphans themselves become HIV infected, they have no parents available to care for them when they are sick.

***Vulnerable**: capable of being physically or emotionally wounded or hurt.

Adopted from ***"Caring with confidence: Practical information for health workers who prevent and treat HIV infection in children". AHRTAG briefing paper.***

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Health and Human Rights

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The Universal Declaration of Human Rights (UDHR) was written in 1948. It is an international document, which upholds all of our human rights. Every nation in the world is responsible for ensuring that the rights described in the Declaration are respected and promoted in their country.

Article 1 of the UDHR says that all people in the world are born equal in dignity and rights and that these rights are guaranteed to everyone. Everybody has human rights. It is important to always respect a person's dignity whether they are healthy or sick, no matter what kind of disease or illness they have. The health worker should always treat a person who is living with HIV with dignity and make sure that person feels comfortable to seek medical care when he/she needs it.

Article 19 says that everyone has the right to express himself or herself freely — to talk openly about whatever subject they want. It is important to be able to speak freely about HIV/AIDS to people in the community so everyone knows what it is and how to prevent it.

Article 25 says that everyone has the right to a standard of living (enough food, shelter, and medical care) that will allow them to keep good health and well being. Health workers can use their position and their voice in the community to call on their governments to provide these basic human needs, in the interest of helping their community members to stay healthy. People with HIV are often suffer discrimination in their communities. It is especially important that health workers also make sure that people living with HIV are also given their basic human needs.

These are just some of the many examples of how the Universal Declaration of Human Rights can be used by health workers to help their patients and members of their community not only to get quality health care and health education when they need it, but also to stay healthy.

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The Karen Education Working Group

Ms. Honey Moon, KEWG

The Karen Education Working Group (KEWG) is a non confessional, non political group. It was organized by Karen volunteers in 1996 when a survey in 4 camps revealed that more than 70% of pregnant women (Karen refugees and Thai Karen) had never heard of HIV/AIDS and less than 1% of women had any knowledge of prevention of HIV. None of the NGOs working with refugees was in a position to do anything about this quasi-absence of information in the camps, more than 10 years after the beginning of the AIDS epidemic.

The KEWG took on the responsibility to coordinate HIV/AIDS education and awareness activities among the Karen population in the camps. It is the first time that an independent group of Karen takes the responsibility to inform the population in the camps on such sensitive issues as sexuality, STD and HIV/AIDS. Like in many other cultures, these questions are taboo in the Karen society. That is why it is essential that the information process is being done by Karen themselves, so that the communities will not be antagonized by ideas and principles coming from elsewhere and not always adapted and applicable to their own culture.

The specific objectives of KEWG are:

- To raise the awareness of the refugee population on HIV and AIDS.
- To train community members to work as educators on HIV/AIDS
- To set up information centers in the camps providing materials on HIV/AIDS
- To organize the community care for the patients suffering from HIV/AIDS in the camps
- To provide a framework for the policy regarding HIV/AIDS in the camps

KEWG designs activities and programs in Karen (and Burmese) languages specifically targeting awareness and prevention to allow Karen people to know how to protect themselves from this deadly virus. The KEWG is composed of Karen members with various backgrounds (medics, teachers, clergymen, and community leaders). The KEWG consists of a panel of volunteers with a chair person, a secretary, 10 senior members and 15 camp delegates. Some senior members and camp delegates also belong to local medical NGOs working in the camps. In addition, there are forty other volunteer community leaders from the camps (Maela and Umpiem Mai) who have already received training organized by KEWG. Previously the KEWG received limited support from Medecins Sans Frontieres (MSF), the Shoklo Malaria Research Unit (SMRU) and the British Embassy in Bangkok and AUSAID.

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AIDS NEWS

Health Messenger

Oral Sex is no more safe: new finding by AIDS researchers, USA
The Nation, Thursday, February 3, 2000

A significant number of gay and bisexual men are becoming infected with the AIDS virus through oral sex — an activity that was believed by many to be safe.

A study found nearly 8 per cent of recently infected men in the San Fransisco area was infected through oral sex. "This was higher than we expected," said Dr. Frederick Hecht, who helped lead the study.

The study was done jointly be Dr. Hecht's team from the University of California in San Fransisco and a group at the Centres for Disease Control and Prevention (CDC). They surveyed 102 gay and bisexual men recently infected with HIV and found oral sex wa the oly risky behaviour that eight of the men had engaged in. Dr. Ronald Valdiserri, deputy director of CDC's HIV prevention centre referred to it as a serious news.

"We've known .... that there was a risk of HIV transmission through oral sex. Of course scientists indicated that they thought it was a much smaller risk compared to anal or vaginal sex." Dr. Hecht said many of the men who were interviewed did not know about the risk of oral sex. "Even though oral sex might be low-risk, it it not without risk," he said. And if people do it often enough it can cause HIV infection. Some gay men consciously substitute oral sex for anal sex. Dr. Hecht said, " They think they are being careful,". The study showed this could be a deadly mistake. The researchers did not consider a man as having been infected through oral sex if he said he had engaged in any other risk behaviours. This may cause the underestimation of transmission through oral sex in this group.

Sharp drop in VD cases
Bangkok Post, Thursday, March 30, 2000

Fear of AIDS has led to a sharp drop in reported cases of venereal disease (sexually transmitted disease) in Thailand, according to the government.

In 1999, there were 16,398 cases of venereal disease reported by the ministry, compared with 361,229 in 1989, the Public Relations Department said.

"The ministry attributed this positive sign to the fear of AIDS, which resulted in more frequent use of condoms by people who had many sex partners," it said.

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Prevention

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Dr. Rose McGready, SMRU

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Prevention is the most important strategy for the control of STD, including HIV. This is done through education. The spread of STDs is influenced by several factors including sexual behaviour and attitudes, availability of early diagnosis and treatment and contact tracing (to find out the sexual partner/s of the patient). It is important that these factors be remembered so that effective programmes aimed at preventing the spread of STDs can be designed and implemented. Family planning programmes are well placed to disseminate information on the risks and complications of STDs and to promote low risk behaviour. They can also encourage the use of condoms, not only for pregnancy for prevention but also for prevention of STDs.

People need information on the symptoms and signs of STDs and confidence to seek early treatment when required. Education on the prevention of STDs can be included in the educational activities of family planning programmes inside and outside clinics.

There is no evidence that contraception increases the incidence of STDs; rather increased incidence is more likely due to changes in sexual behaviour . What is evident is that condoms provide protection against STDs.

Most effective ways of preventing STDs including HIV infection
A = Abstinence (from sex)
B = Be faithful (to your partner)
C = Condom (Correctly used)

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AIDS SONGS

Written by Karenni Health Department Community Health Educators, Karenni Camps, Mae Hong Son, 1999. These three songs about AIDS were written and recorded for AIDS Day, 1999, by Community Health Educators (CHEs). The songs were played by the CHEs during AIDS Day events in the camps, and were aired by the local MHS radio station on AIDS Day and are still being aired on occasion. For tapes of the songs you may contact Ms.Andrea Menefee, IRC, Mae Hong Son.

(1)
During the time we are alive in the world, we see so many things. Especially, in the place we live, we hear about AIDS. We have seen people who enjoy their time with women. But, because of that behavior, AIDS can spread among us. There is no medicine for AIDS, so we must protect against that terrible disease.
AIDS will kill people. If you get AIDS, it cannot be treated.

(2)
AIDS weakens the immune system. How does AIDS spread and infect others? Some ways of infection are; Having sex with someone who has the disease, and sharing needles. Let fight against AIDS! How can AIDS be prevented?
Some ways of prevention are; Sleep only with your loving partner, and don't share needles.

(3)
AIDS is a very frightening disease.
AIDS can kill people.
There is no medicine for AIDS.
AIDS is a frightening disease.
Let all of us fight against the AIDS.

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viquq

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owxujy; viwjyexwp0 ue'rtm; aocmpmuixm;y?

ue'ro;&e wiyijy; oabmwnr,y?

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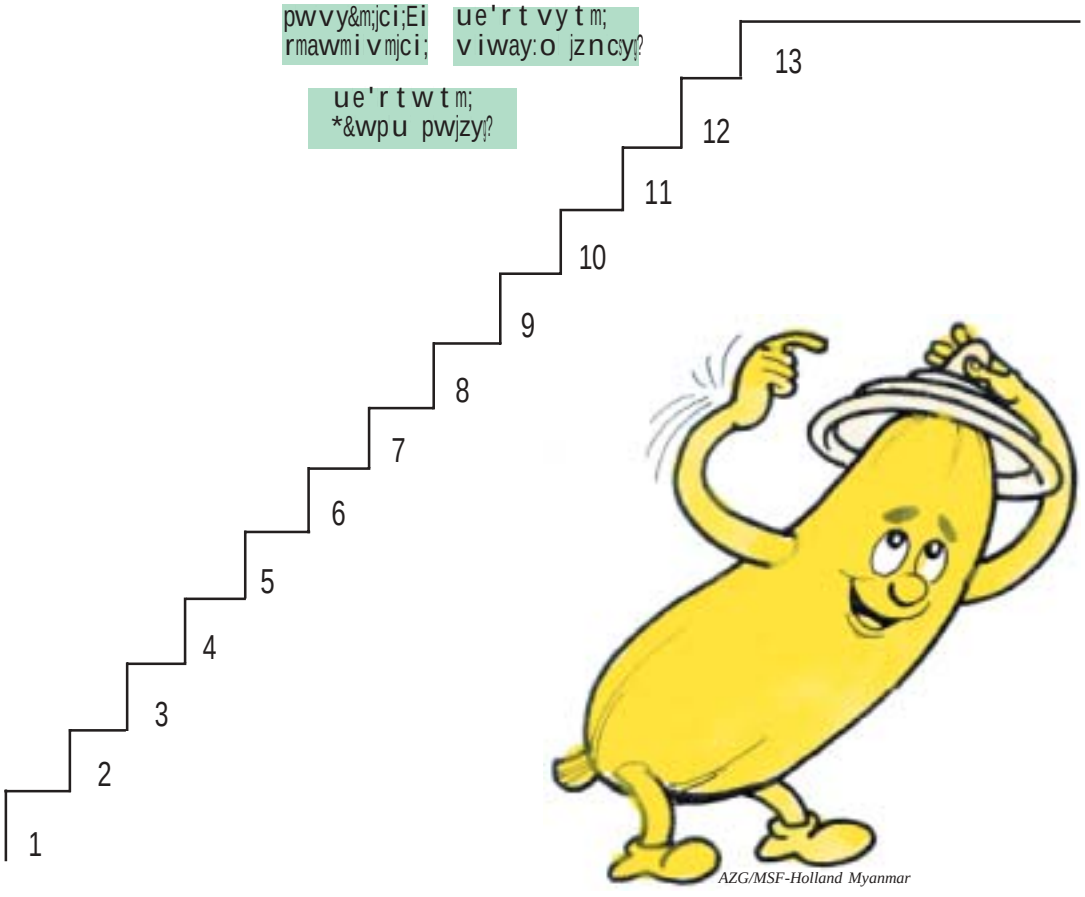


AZG/MSF-Holland Myanmar

Adopted from AHRTAG

CONDOM USE STAIRCASE

Group: Any size, 12 years-adult

Time: 15-30 minutes

Materials: Large sheet of paper with the condom staircase drawn on it and 13 large cards with the steps written on to them. (You could draw pictures representing the 13 steps.

- Explain to the group that they have to put the 13 steps for condom use on the staircase in the right order. Distribute the 13 cards among the group.
- Follow this game by asking the group members to demonstrate how to put on a condom using a model or an object such as a banana.

pinch tip of condom

slide condom off penis

throw away used condom carefully

sex (intercourse)

check expiry date on condom package

check that the condom is correct way round before it is unrolled

withdraw penis after ejaculation carefully holding condom

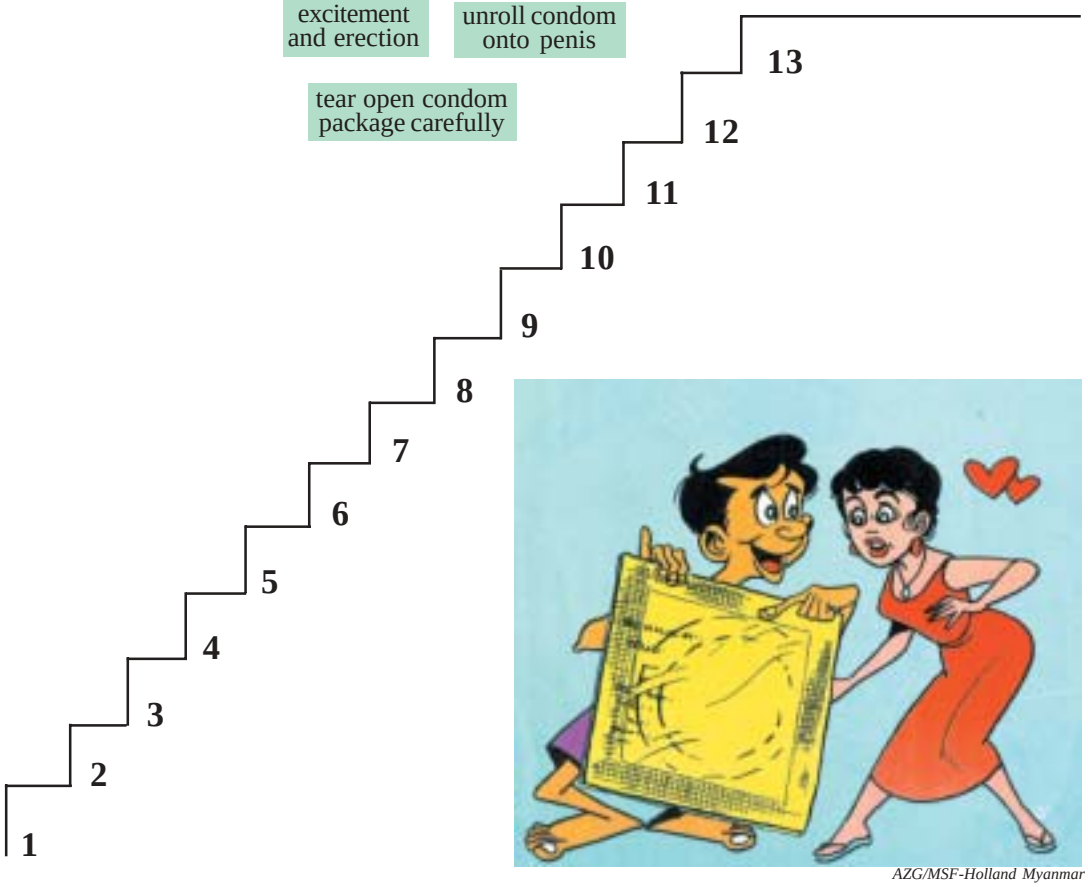
discuss and agree to use condom

male orgasm (ejaculation or coming)

excitement and erection

unroll condom onto penis

tear open condom package carefully



AZG/MSF-Holland Myanmar

Adopted from AHRTAG

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STD QUIZ	
1. What does STD stand for?	
2. Name four sexually transmitted diseases.	
3. Are all STDs curable?	
4. Give three possible symptoms of an STD.	
5. Why are some STDs dangerous?	
6. Is AIDS an STD?	
7. Name two most effective way to protect yourself from an STD infection.	
8. Your doctor prescribed you medicine to be taken for 10 days. After five days can you stop taking medicine?	

Tick the right box **Questions**	**True**	**False**
9. You can be infected with an STD without realizing it.		
10. If a woman has an STD which is not treated correctly, she may have difficulties having children later on.		
11. STDs are a great danger to young people.		
12. As soon as the symptoms of an STD have disappeared, you can stop taking the medicine.		
13. If you have an STD and you are taking medicine prescribed by your doctor, your partner should be treated as well.		
14. A person who has an STD is more liable to get infected with HIV.		
15. Women who take the birth control pill are not at risk from being infected with STD.		
16. Men who have an STD infection can be cured by having sex with a virgin.		
17. You can buy medicine from the pharmacy to treat STD without going to the doctor.		
18. You can not shake hands with an AIDS patient as you might get HIV infection.		
19. Mosquito bite can transmit HIV.		
20. You can get vaccinated against HIV.		

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SAW PAING AND NAN WAI

Zmwvr;o§yaz: a*:'e (WEAVE u¡e;rma&;prue;)

Gordon Sharmar, WEAVE

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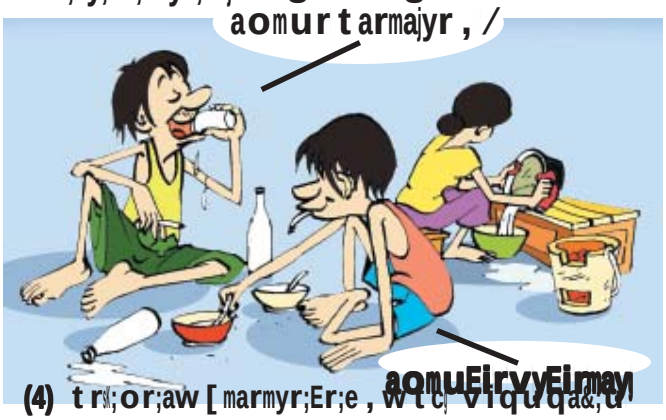

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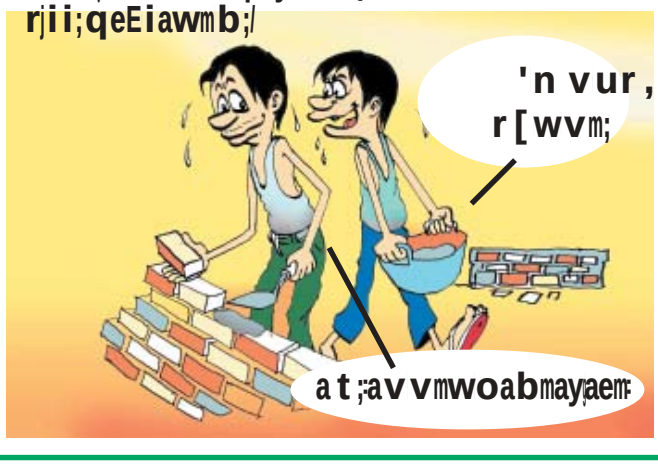

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SAW PAING AND NAN WAI, *Gordon Sharmar,* WEAVE

1) Saw Ping and Nan Wai do not have to worry about hunger as they have got a job in a construction project. Although the future cannot be predicted, it can be said that everything is fine for the time being.

2) After a day's work, in the evenings, Saw Paing relaxes drinking and chatting with his co-worker Maung Kyaw.
"Drink to relieve tiredness"
"Drink so that we can work"

3) As for Ma Nan Wai, taking rest is impossible, as she has to do the housework incessantly — cooking, sweeping the floor, bathing the baby and so on – almost everything.
"You all get tired, but for me as if am not tired"

4) For women when they are tired, they are not interested in sexual intercourse, but for men naturally they are not alike women and when time comes, they yearn for sex. The sexual behavior of man and woman is no the same as the animals like cats and dogs. When you watch carefully they are not in the same gesture.
"Hello my Darling! Let's start doing the exercise for health tonight"

5) Ma Nan Wai has fallen asleep and Saw Paing alone gives up doing something with her. The work is very tiring everyday and it will be like this all along.
"Oh! Hopeless".
"I think it'll be like this every night……."

6) Like everyday before going to work, Maung Kyaw jokingly ask Saw Paing to join in an undertaking and visit those places. This time Saw Paing does not refuse like any other times.
"Won't you come tonight?"
"Yes, I'll come just to see how things are going on."

7) On that night, Saw Paing makes a false excuse by telling Ma Nan Wai that he is going out with his friend for a drink. Mg Kyaw takes his friend to the place where he frequents. On that night Saw Paing gets drunk and seek pleasure.
"Oh! What a fair-skin beauties are they."
"That's why I call you frequently".

8) Three months later Saw Paing fell sick. Sometimes he had terrible headache, he had diarrhoea or dysentery, vomiting, coughing and felt very exhausted.
"You'll became healthy if you take medicine regularly. You always said that when I fell sick".

9) Mg Kyaw frequently got sick and he was infected with AIDS and he ultimately died as the disease progressed. Saw Paing was shocked by hearing about his friend's death.
"He got this disease a long time ago. I'm afraid, am I having this disease?"

10) When he often got sick, he went to see the doctor at the hospital to get proper treatment. After all check-ups had been finished, the doctor decided to explain to the patient about the truth.
"You have HIV positive signs. But this is not a strange thing. Don't worry too much. You must eat nourishing foods, sleep regularly, must take rest and regular exercise for health and you should avoid liquor, cigarette and narcotics for health. Indulge in the doctrine regularly what you believe or read, teach your kid, go fishing, play sport…
"Go to the movies or take part in whatever hobbies you like".

11) In sexual intercourse, if you do not use condom, you can be infected with HIV. Through mother, HIV virus is transmitted to the foetus. Then sharing needles with HIV infected persons can transmit the infection. But mosquitoes bites, eating together with an infected person or sharing the cup for drinking or using the same bath soap can not transmit the virus. It means you should not be afraid of the disease and you should not separate the infected person from his family. You should treat him normally. Avoid carefully not to deject the patient.

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Prevent STDs & HIV/AIDS

UNDP/WHO/UNOPS

oi. taz:re(vi§r ,m;) tay:oPm&y?
Be faithful to your partner

ue'ruo;y?
Use condom

AZG/MSF-Holland Myanmar

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Use sterile syringe & needle

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Be healthy & Happy

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Glossary:

Gonorrhoea: Gonorrhoea is caused by *Neisseria gonorrhoeae*.

Trichomoniasis: Caused by *Trichomonas vaginalis*.

Candidiasis: Caused by *Candida albicans*.

Syphilis: This is caused by *Treponema pallidum*. In the pri mary stage, single painless ulcerated lesion **(chancre)** develops at the site of introduction of the germ, usually on the genitals. The ulcer is rounded with a well-defined edge and indurated base. Often accompanied by inguinal lymphadenopathy.

Chancroid: *Haemophilus ducreyi* causes chancroid. It present assingle or multiple ulcers on the genitals. The ulcers \are usually deep, painful, dirty with pus (not always)and a soft irregular margin. Inguinal lymph nodes may become enlarged.

Lymphogranuloma venereum: This STD is caused by *Chlamydia trachomatis*, which affects mostly men (often latent in women). Inguinal lymphadenopathies develop resulting in a matted mass of nodes that becomes fluctuant and suppurative. Fis tulas develop.

Granuloma inguinale (Donovanosis): This disease is caused by *Calymmatobacterium granulomatis*. It is a rare disease. An indurated papule usually forms on the penis, labia or anal margin but extragenital lesions are common on the face, lips and neck. These primary lesions may be tender and produce a foul-smelling discharge. Inguinal lymphadenopathy is usual.

Genital warts (Condyloma acuminata): This is caused by a virus called *Human papilloma virus (HPV).*They occur commonly on external genitals, but perineum, anus and rectum can be in volved and in women vagina, cervix and urethra. The warts are usually multiple and they often grow together and might become infected.

Indurated: hardened.

Inguinal lymphadenopathy: disease of the inguinal lymph nodes.

Fluctuant: conveying the sensation owing to liquid contents.

Suppurative: producing pus.

Fistula: an abnormal passage of communication, usually be tween two internal organs, or leading from an internal organ to the surface of the body.

Papule: a small, circular, superficial, solid elevation of the skin.

Note:

Distance Learning Health Magazine