Communicating sexual health

An estimated 250 million or more sexually transmitted infections occur annually. They can cause anything from disfigurement to brain damage and even death. AIDS is one of them. We have to talk about that. We have to make people recognise the implications, for themselves, their families and their communities.

This issue of AIDS action includes simplified management guidelines on STDs and looks at ways of promoting safer sex. But the issue does not refer to safer sex only in its technical sense—i.e. what you can and cannot do sexually without transmitting HIV, or other STDs (see box). Nor does it focus only on the clinical consequences of unsafe sex.

What is sexual health?

As the article on page two illustrates, safer sex is a concept, not a technical term. It is a vital aspect of the broader subject of sexual health, which is described by the World Health Organisation as 'the integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are enriching and that enhance personality, communication and love.'

Sexual health enables an individual to enjoy and control sexual and reproductive behaviour, without limiting the enjoyment and control of another. This means freedom from fear, guilt, and other psychological, political and economic factors which inhibit free choice in sexual relationships. Sexual health, including safer sex, is a community development issue.

How can we promote this?

To promote sexual health, we must promote a better understanding of sex, sexuality, STDs and the social factors which influence behaviour. To do this, we must start talking. As Calle Almedal, AIDS Co-ordinator at the Norwegian Red Cross, explains: 'In most communities worldwide, sex is already discussed in one setting or another. Often 'sex talk' happens among individuals of the same sex and similar age. Sex is also talked about in certain social settings, such as at marriages, births, circumcisions or even at funerals.'

Once it is known who talks to whom about sex and in what setting, safer sex discussion groups can easily be formed.

'Group facilitators must overcome their own embarrassment. This can be done in a variety of ways, such as group training exercises which start with participants saying all the sexually taboo words they can think of, and then discussing how they feel about these words and why.'

Group discussion must move beyond society's sexual taboos and prejudices—because effective education on safer sex is based on what people really do, not what society says they do.

Practising safer sex

Practical guidelines on how to have sex with reduced risk of HIV transmission should be based on the following facts:

- if person A is infected with HIV (the virus that causes AIDS) he or she contains sufficient quantities of HIV in their sexual fluids (i.e. semen or vaginal fluids) and their blood to infect their sexual partner, person B. (The virus is also found in other bodily fluids, such as saliva, but not in sufficient quantities to cause infection in person B, for example, through mouth to mouth kissing.)
- in order to cause infection in person B, the virus in A's sexual fluids and/or blood has to enter the bloodstream and/or pass through the mucous membranes (e.g. inside the penis or vagina) of person B.
- the virus that causes AIDS, as well as other sexually transmitted viruses, cannot pass through unbroken skin or through unbroken condoms of good quality. It is therefore safer to use condoms during penetrative sex (where the penis enters the vagina or anus).

In this issue . . .

- Community based education on safer sex
- Sexually transmitted diseases: management guidelines

The international newsletter on AIDS prevention and control: 174,000 copies worldwide in five languages
Safer sex as a concept was developed in New York, USA, by the Gay Men’s Health Crisis (GMHC) in 1983, a time when gay men were becoming increasingly aware that this new disease was killing their friends and lovers. There was an urgent need for guidelines on what men could and could not do sexually without passing HIV (the virus that causes AIDS) from one sexual partner to another. No one knew for sure who was or was not infected with HIV. In order to stop further spread of the virus, individuals took the responsibility of not only protecting themselves, but of protecting others from possible infection.

Safer sex was born out of a caring society of gay men who wanted a future where sexual relationships could still be a choice, but where no person was excluded because of their HIV status. The term should be ‘safer’ as opposed to ‘safe’, as the risk of HIV transmission can be reduced, but not entirely eliminated.

Before the GMHC safer sex guidelines were developed, research was carried out among 800 gay men who, through questionnaires and focus group discussions, expressed what they thought about sex, their experiences and how they viewed the threat of AIDS. These guidelines included a range of sexual activity and were not solely based on using condoms. Nevertheless, making condoms erotic has been an innovative and important part of safer sex education among gay men.

More than condom culture
In many countries safer sex has now become a technical term referring to condom use. Within the gay community, it is not simply a technical term, but one which embraces an individual’s sexual health. It means, for example, to get together and discuss each other’s feelings about sex, sexuality and relationships in the era of AIDS.

In Scandinavia, groups of gay men hold a series of discussions called Six Times Safer Sex, meeting once a week for six weeks, together with two facilitators. During these sessions, participants’ sexuality is reaffirmed and adapted in ways that make it possible to go on with an active sex life, but with reduced risk of HIV transmission. The aim is to make one’s existing sex life safer.

Caring talk saves lives
Calle Almedal and Roy Carlegård are registered nurses who worked for two and a half years in a maternal and child health clinic in North Yemen. They have been involved in HIV prevention since the start of the epidemic in the early 1980s. Drawing on the experiences of the gay (homosexual) community in Scandinavia and North America, they outline valuable lessons to be learned about promotion of safer sex, of relevance to heterosexual communities worldwide.

Safer sex is about communication – not just condoms
These discussions reflect a philosophy of safer sex which includes an understanding that people still take risks at one time or another, regardless of their knowledge of HIV transmission. Safer sex takes into account the complexity of human nature, while enabling individuals to have more control over their sexual relationships.

Safer sex discussions include much more than ‘conventional’ forms of penetrative sex (where the penis enters the anus or vagina). ‘Non-penetrative’ sex can be a new and difficult concept for gay men as well as heterosexuals. There are many who perceive penetration as the one and only true form of sex. But this is riskier sex, because condoms can sometimes break. Promoting more creative sexual communication is of vital importance. In this way, safer sex is a positive expansion of human sexuality, putting emphasis on what you can do more safely (as well as what you cannot do) and reaffirming sexual communication as one of the most important things in life.

Speaking louder than words
Before the era of AIDS, it was just as difficult for gay men to talk seriously about sex as for heterosexuals. But the epidemic meant that many had to overcome shyness and fear of ridicule to discuss safer sex in order to learn how to continue with a sex life. There are signs that HIV infection rates among men who have sex with men are declining; a significant number of gay men have adopted safer sex in practice. They may have done this for a variety of reasons:

- because they have attended organised safer sex sessions
- because they have learnt about having safer sex with lovers who practise it (this kind of direct education is often underestimated and is rarely researched or evaluated in educational programmes)
- because they have been deeply affected by the death of friends and lovers through AIDS.

Most significantly, some feel safer sex is how sex is supposed to be and think that everybody is doing it. This perception is vital if behaviour change is to be sustained. It is very difficult to know precisely what has caused behavioural change in the gay community; probably it is a combination of all the above, and more. But if there is one lesson to be learned from a community which has been so affected by AIDS, it is this: teach people to talk about sex! For many heterosexuals time is fast running out.

Calle Almedal, AIDS Co-ordinator, Norwegian Red Cross, PO Box 6875, 0130 Oslo, Norway and Roy Carlegård, Oslo City Health & Environment Department, AIDS Unit.
Bekele and the bar women

Before the 1977 Ethiopia–Somali war Bekele Teferra was a midwife. Now employed as a nurse in South Wolo by Save the Children Fund (SCF), Bekele and fellow community health nurse Sister Workwuha have developed an AIDS education programme with local bar girls. Mike Bailey, SCF's AIDS advisor, talked to Bekele in his home town of Dese.

Where do you hold these education sessions?

In the bars where the girls work. We get the permission of the bar owner beforehand and we do the education during the quiet time of the early afternoon. About 15-25 girls come from the surrounding bars.

Are they embarrassed or scared?

At first they are quiet and a little shy but we soon reassure them by our informal approach. We ask: 'What do you know about AIDS? Where did you hear about it? Have you used condoms?' As they hear each other’s answer they realise that it is the same for all of them and they get more confident. We give them a short questionnaire to fill out and we collect it later.

Do you give them a lecture?

No. That would send them to sleep! Sister Workwuha and I act a play for them. We set up a stage with a bar, table and chairs, some bottles and glasses and some music, of course. Sister Workwuha plays the part of a bar girl and I play a truck driver.

Does the play have a script?

No, it follows a natural story that all the girls are familiar with because it is the story of their lives.

How does the story go?

Well, the man sits down at the table and the girl brings him a drink. He invites her to sit with him and offers her some beer. She asks where he is from and he says from a town five hours' drive away and he has to drive even further away the next day. She asks him if he misses his family. He nods and says that he only stays at home one or two nights a week but he has to have a job and driving pays quite well, so his family can eat and have a house, and he can have a beer in the evening to while away the time.

As they relax together she eventually asks: 'Have you heard about AIDS?' 'What is that?' he replies. 'I think I heard something about it on the radio but it was about people in the capital or prostitutes. Surely it's nothing to do with me.'

'AIDS is about everyone,' she says. 'I heard about it at the family planning clinic. It's caused by a germ which is caught during sex. You can have the germ for years and not know it but you will still pass it on.'

The man gets up to go. 'Well, that's it, then, I think I will stay by myself tonight.' The girl catches his arm and says, 'Wait, it's not so alarming if you know what to do.'

'What can we do?' he asks. She looks shy and says, 'Well, the health workers have said that reducing the number of sexual partners and using condoms will help.'

The man has another drink and then suggests that they go somewhere quieter together. The girl says, 'What about a condom?' He says, 'I have only just heard about them. I wouldn't know where to get one or how to use one.'

'Come on,' she says, 'I'll treat you this time, but you should go to the pharmacy tomorrow and get some of your own. It's quite simple to use, I'll show you.' She takes a condom out of a packet and rolls it onto a beer bottle very gently and seductively.

'Why don't you try?' she says. Reluctantly he does and finds it easy enough.

'That wasn't so bad, was it?' she says. 'No,' he admits, 'but it doesn't seem much fun.'

She takes his arm and says, 'Condoms can be a lot more fun in private. Come on and I'll show you, we can eat later.' She leads him off towards the rooms...

What happens then?

The girls are usually full of chatter and giggles. We let them calm down and then ask them what they think happened in the bedroom. Someone at the back usually says that she has a regular customer who got angry and asked if she thought he was infected. Sometimes the girls are beaten for suggesting condoms. The girls say that they get the blame for everything.

What do they suggest?

They say that AIDS education should be given to the men as well, and that prostitutes should not be blamed. We have given talks to the military, to school teachers — even to 200 Christian clergymen.

What else do the girls say about the condoms?

They say they are not always good quality and sometimes they break. This is after they have taken great trouble to persuade their partners to use them. They also say that sometimes there are too few condoms to go round. This is a problem for the health educators. After one session in a town all the girls got their men to go to the health centre for condoms. There was a big queue and the centre quickly ran out. Those at the back of the queue were very angry. The girls blamed us and we will have a hard job to get their trust back in the future.

Do you think that your HIV education helps?

Yes, but it's only a start. Of course most of the girls would like to leave the bars but they can't afford to. Most aren't called shermuta (prostitute) but setegna adari (woman of independent means). At the moment, with so many men away from home and prices high, women often have little choice about needing an independent income.

Further information from: Mike Bailey, AIDS/HIV advisor, Save the Children Fund, 17 Grove Lane, London SE5.
Faith, Hope and Chastity

Dr Mazuwe Banda, co-ordinator of AIDS prevention programmes in church hospitals in Zambia, describes the social context of programmes which focus on chastity outside marriage, and faithfulness within polygamous or monogamous marriages.

In many African societies, communities have promoted chastity before marriage and marital faithfulness through a number of traditional beliefs and practices. These include:

- **Initiation ceremonies** — practised in nearly all African cultures and, among other things, a time when young people were taught about the responsibilities of adulthood including the issue of sex and family life. Emphasis was often put on avoiding sexual activity before marriage and staying faithful in marriage.

- **The practice of marriages being arranged by parents or families** — often when those involved were still very young. This encouraged young people to wait only for the one to whom they were promised and discouraged the sexual advances of others. Families often looked for those who were known by the community not to be sexually promiscuous as future partners for their sons and daughters.

- **Proof of virginity** — looked for just before or during the first sexual encounter in marriage. If a future bride was found not to be a virgin, either the marriage was dissolved or the bride-price (payment made by the groom’s family to the bride’s family) was very much reduced.

- **Punishment of those found to be unfaithful in marriage or young people found to be unchaste** — adultery often resulted in the payment of heavy fines (in the form of animals such as cattle or goats, or enforced labour) or the dissolution of marriages. Men or boys who made unmarried girls pregnant were either forced to marry the girls or to pay fines.

- **Polygamy** — in a polygamous marriage a man had as many wives as he desired (and could afford). The man would continue to have sexual relations with his other wives if one wife was pregnant or ill. The husband was expected to be faithful to his wives and the wives to their husband.

**Influence of Christianity**

Where the idea of chastity before marriage and marital faithfulness already existed, Christianity reinforced this idea, teaching that sex outside marriage was not only bad for the community but was also a sin against God. The Church, however, also discouraged traditional polygamous marriages, and this may have had a negative influence on traditional sexual relations. A man whose cultural expectation was to have more than one wife, but who married only once to satisfy the church, was still very likely to seek sexual partners outside marriage — in relationships less stable than a polygamous marriage.

**Changing morality**

In more recent times it appears there have been some changes in sexual attitudes and practices. More ‘liberal’ attitudes towards sex in towns and cities can be directly attributed to the effects of industrialisation and the influence of Western culture.

Rapid urbanisation has weakened community influence on the lives of individuals. Traditional ways of providing instruction on sex and married life often do not exist; grandparents or other extended family members are less readily available. More stressful lives and the influence of alcohol has also contributed to a change in sexual relationships.

An emphasis on the need to maintain stable, faithful sexual relationships is now re-emerging in view of the threat of AIDS. In Zambia, soon after the recognition in 1986 that AIDS was a serious public health problem, a vigorous AIDS awareness campaign was launched, with the main theme: AIDS kills. One man or woman for life. Numerous posters and other educational materials and programmes, urging people to prevent the spread of AIDS by sticking to one sexual partner were produced by the Ministry of Health. Condom promotion was only a
part of the government campaign.

Two years later, Zambian church leaders representing all church denominations in the country issued a pastoral paper Choose to live, which stated that the most effective and acceptable way of limiting the spread of AIDS is through chastity before and outside marriage.

A number of indigenous NGOs have participated in the campaign to promote premarital chastity and marital faithfulness, such as the Family Life Movement of Zambia (FLMZ), which works to promote natural methods of family planning; the Copperbelt Health Education Project (CHEP) of Kitwe, and the Anti-AIDS Project, which runs Anti-AIDS Clubs in schools throughout the country (see AIDS action issue 8).

Conclusion

In Africa, faithful monogamous or polygamous relationships are widely considered to be the most acceptable means of limiting the spread of AIDS. Promotion of condoms is more likely to meet with cultural antagonism or logistical difficulties. However, the impact of encouraging traditional moral values in limiting the spread of HIV is as yet uncertain.

Dr Mazuwe Banda, Churches Medical Association of Zambia, Ben Bella Road, P O Box 34511, Lusaka.

Preparing for that ‘big day’

Dr Lillian Kimani, a Kenyan psychologist, makes some suggestions for starting community education on safer sex.

Safer sex education is not only about making sex safer, but about improving the quality of sexual relationships. As Dr Lillian Kimani explains: ‘Social intercourse takes up time — sex doesn't. Especially for young people, who have to work, go to school and compete, it is only on Friday night they relax. They are so keen to have pleasure, it takes two seconds to have sex. And then the following morning the girls start to chew their nails and say ‘Oh, my God...’ Many are still waiting for that big day when they can really spend time making love.’

Irrespective of knowing what safer sex is, most people still have unsafe sex at one time or another. Safer sex behaviour needs to become ‘normal’ behaviour in society in order for behavioural change to be sustained. To achieve this, it is absolutely necessary to find ways of speaking more openly about sexual behaviour in a language that people will accept and understand.

Before beginning to educate a community or group of individuals about safer sex, we must first understand the social context in which unsafe sex takes place.

The next step is to help individuals to recognise the risks involved in what they are doing, and to identify the most acceptable safer sexual options both for themselves and their partners.

Some useful general guidelines on planning safer sex education in the community include:

- start from trust rather than fear. Safer sex education should aim to help people protect themselves and their partners from HIV infection rather than passing judgement on particular sexual needs or practices.
- promote discussion around the most common sexual activities in any given community/society, including people’s views about sexual satisfaction, expectation and pleasure.
- encourage people to evaluate the negative and positive factors influencing their own sexual behaviour. For example, what motivates sex outside marriage? What stimulates or motivates sexual desire for another?
- discuss various social factors that lead to individuals having unsafe sex, e.g. crowded living conditions, lack of economic support and other factors which can cause negative emotions like anger, low self esteem, and bitterness.
- encourage any form of sexual expression in which the risk of HIV transmission is minimised (see page one). There are many options for safer sex and individuals will make a choice based on what is most pleasurable and acceptable to them.
- try to promote an understanding that insisting on safer sex is not a sign of mistrust within a relationship, but of mutual care.

Community discussion groups on safer sex are vital if we are to confront some of the major barriers to successful education on AIDS prevention such as people’s belief that they are not at risk, and that condoms lessen the pleasure of intercourse. Perhaps through greater social communication about sex we can encourage better communication between the individuals practising it.

Dr Lillian Kimani, The Personal Growth Services Centre, P O Box 40808, Nairobi, Kenya.
Guidelines for management

AIDS is primarily a sexually transmitted disease (STD). The control of AIDS is dependent on the control of STDs. It is known that infection with, and transmission of, HIV is facilitated by ulcerative genital conditions and possibly by urethritis and cervicitis. The recommendations and guidelines given here apply to persons with STDs and STD-associated syndromes, regardless of whether or not they also have HIV infection.

More than 20 micro-organisms are known to be transmissible through sexual intercourse. Pathogens cause a wide variety of different clinical manifestations of STDs. However, sexually transmissible pathogens cause particular patterns of clinical features (syndromes) and these may be easily recognised.

In many countries, expert personnel and accurate laboratory diagnostic facilities may not be available. Under these circumstances, the clinical approach to the diagnosis of STD associated syndromes is a simplified method for the management of STDs. STD-associated syndromes are common presenting signs of STDs. These include:

**Urethral discharge in men** - this may be indicative of gonorrhoea, chlamydia, trichomoniasis or candidiasis.

**Vaginal discharge in women** - this may be indicative of gonorrhoea, chlamydia, trichomoniasis, anaerobic vaginosis or candidiasis.

**Genital ulcer disease in men and women** - this may be indicative of gonorrhoea, chlamydia, trichomoniasis, anaerobic vaginosis or candidiasis.

**Acute inguinal lymphadenitis** - this involves inflammation of the lymph nodes in the groin and may be indicative of chancre, chlamydia, or secondary bacterial infection of genital ulcers.

**Acute epididymo-orchitis** - this may be indicative of gonorrhoea, chlamydia, or other agents such as pyogenic bacteria and viruses.

**Pelvic inflammatory disease** - this may be indicative of gonorrhoea, chlamydia, or a number of aerobic and anaerobic bacteria.

The treatment regimens outlined below have considered the availability of drugs at the various levels of health care.

- **Level A** refers to the primary health care centre
- **Level B** provincial hospital level
- **Level C** central hospital or referral centre

### Management of STD associated syndromes

**Urethral discharge in men**

- **Level A**
  - Cotrimoxazole 10 tablets daily for three days; if patient is not better in seven days give tetracycline 500mg po q6h for seven days; if patient is not better in seven days refer to Level B.
  - Give benzathine penicillin 2.4 Mu im plus either cotrimoxazole 10 tablets po daily for two days or erythromycin 500mg po q6h for seven days; if patient is not better in seven days refer to Level B.

- **Level B**
  - (i) For smear positive gonococcal urethritis give kanamycin 2g im plus metronidazole 2g po; if patient is not better in seven days give thiamphenicol 2.5g po daily for two days; if patient is not better in seven days refer to Level C.

- **Level C**

**Vaginal discharge**

- **Level A**
  - Cotrimoxazole 10 tablets daily for three days plus metronidazole 2g po; if patient is not better in seven days give tetracycline 500mg po q6h for seven days; if patient is not better in seven days refer to Level B.

- **Level B**
  - Carry out a speculum examination and perform a gram stain and wet prep on vaginal discharge.
  - (i) Frothy discharge with or without trichomonads: give metronidazole 2g po.
  - (ii) offensive discharge with or without clue cells: give metronidazole 400mg po q8h for seven days.
  - (iii) White discharge with or without plaques and with or without yeasts and hyphae: apply 1% aqueous gentian violet or povidone iodine or give nystatin pessaries 100,000 units to be inserted q12h.
  - (iv) Purulent discharge emanating from the cervix: give gonorrhoea and chlamydia treatment.

If patients treated on any of the above regimens are not better in seven days refer to Level C.

- **Level C**
  - Perform culture and sensitivities and treat according to pathogen isolated.
Sexually transmitted diseases

for three weeks; if not better in ten days refer to Level C.

- **Level C**
  Give ceftriaxone 250mg im or chloramphenicol 500mg po q6h for ten days **plus** metronidazole 400mg po q8h for ten days or treat according to sensitivities.

**Acute inguinal lymphadenitis**

- **Levels A and B**
  (i) **Bubos with genital ulcers**: treat as for genital ulcer disease (above).
  (ii) **Bubos without genital ulcers**: treat as for lymphogranuloma venereum, i.e. tetracycline 500mg po q6h for 14 days or erythromycin 500mg po q6h for 14 days. Refer to Level C if patient is not better in 14 days.

- **Level C**
  Treat according to results of investigations.

**Acute epididymo-orchitis**

- **Levels A and B**
  Exclude other causes of acute testicular swelling such as hernia, torsion. Give kanamycin 2g im **plus** tetracycline 500mg po q6h for 14 days; if patient is not better in seven days refer to Level C.

- **Level C**
  Exclude other causes of acute scrotal swelling and treat.

**Pelvic inflammatory disease**

- **Level A**
  Give cotrimoxazole 10 tablets po daily for two days **plus** tetracycline 500mg po q6h for ten days **plus** metronidazole 400mg po q8h for ten days; if patient is not better in ten days refer to Level B.

- **Level B**
  Give chloramphenicol 500mg po q6h for ten days **plus** metronidazole 400mg po q8h for ten days; if patient is not better in ten days or if there are abdominal masses or evidence of peritonitis refer to Level C.

- **Level C**
  Treat according to sensitivities.

**Note**: metronidazole should be avoided in the first three months of pregnancy.

Professor Ahmed Latif, Department of Medicine, University of Zimbabwe Medical School, P O Box A178, Avondale, Harare, Zimbabwe.

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**Table 1:** Signs and symptoms of specific STDs

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<th>Description</th>
<th>Symptoms</th>
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<td>Gonorrhea</td>
<td>Caused by the bacterium <em>N. gonorrhoea</em>. Clinical features in males include:</td>
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<td>- infertility</td>
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<td>- infection of the eyes - this is rare in adults and is a result of self-</td>
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<td>In females, the clinical features include:</td>
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<td>- purulent vaginal discharge</td>
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<td></td>
<td></td>
<td>- pain on passing urine - inflammation of urethra</td>
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<td></td>
<td></td>
<td>- inflammation of the cervix (asymptomatic in 70 per cent of women)</td>
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<tr>
<td>Syphilis</td>
<td>Caused by the bacterium <em>T. pallidum</em>. This disease occurs in two forms -</td>
<td>- Early (primary and secondary stages which involve firstly a genital</td>
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<td>- early (primary and secondary stages which involve firstly a genital ulcer</td>
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<td>Refer to <em>AIDS action</em> issue 6 for diagnosis and treatment.</td>
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<td>Chlamydia infection</td>
<td>Caused by <em>C. trachomatis</em>. Chlamydia has exactly the same signs as</td>
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<td>- Give chloramphenicol 500mg po q6h for ten days <strong>plus</strong> metronidazole 400mg po q8h for ten days; if patient is not better in ten days or if there are abdominal masses or evidence of peritonitis refer to Level C.</td>
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<td><strong>Level C</strong></td>
<td>- Exclude other causes of acute scrotal swelling and treat.</td>
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<td>In females, the clinical features include:</td>
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<tr>
<td></td>
<td></td>
<td>- purulent vaginal discharge</td>
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<tr>
<td></td>
<td></td>
<td>- pain on passing urine - inflammation of urethra</td>
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<tr>
<td></td>
<td></td>
<td>- inflammation of the cervix (asymptomatic in 70 per cent of women)</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Caused by the bacterium <em>T. pallidum</em>. This disease occurs in two forms -</td>
<td>- Early (primary and secondary stages which involve firstly a genital</td>
</tr>
<tr>
<td></td>
<td>- early (primary and secondary stages which involve firstly a genital ulcer</td>
<td>ulcer and then a non-titch rash on the body) and late syphilis which is</td>
</tr>
<tr>
<td></td>
<td>- and then a non-titch rash on the body) and late syphilis which is an</td>
<td>often fatal progression where the heart and brain may be affected.</td>
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<tr>
<td></td>
<td>- often fatal progression where the heart and brain may be affected.</td>
<td>Refer to <em>AIDS action</em> issue 6 for diagnosis and treatment.</td>
</tr>
<tr>
<td>Chlamydia infection</td>
<td>Caused by <em>C. trachomatis</em>. Chlamydia has exactly the same signs as</td>
<td>- Chlamydia infection is one of the most common causes of genital ulcer</td>
</tr>
<tr>
<td></td>
<td>gonorrhea. Diagnosis can only be made with specialised laboratory tests.</td>
<td>- Chlamydia infection is one of the most common causes of genital ulcer</td>
</tr>
<tr>
<td>Pelvic inflammatory disease</td>
<td><strong>Level A</strong></td>
<td>- Give cotrimoxazole 10 tablets po daily for two days <strong>plus</strong> tetracycline 500mg po q6h for ten days <strong>plus</strong> metronidazole 400mg po q8h for ten days; if patient is not better in ten days refer to Level B.</td>
</tr>
<tr>
<td>Pelvic inflammatory disease</td>
<td><strong>Level B</strong></td>
<td>- Give chloramphenicol 500mg po q6h for ten days <strong>plus</strong> metronidazole 400mg po q8h for ten days; if patient is not better in ten days or if there are abdominal masses or evidence of peritonitis refer to Level C.</td>
</tr>
<tr>
<td>Pelvic inflammatory disease</td>
<td><strong>Level C</strong></td>
<td>- Exclude other causes of acute scrotal swelling and treat.</td>
</tr>
</tbody>
</table>

Note: metronidazole should be avoided in the first three months of pregnancy.

Professor Ahmed Latif, Department of Medicine, University of Zimbabwe Medical School, P O Box A178, Avondale, Harare, Zimbabwe.
Safe sex or marriage?

I have just read AIDS Action issue 8 and I believe your publication is promoting promiscuity. I work at a hospital in a rural area serving a population of approximately 60,000 Zulus. AIDS has begun to manifest itself in our community. The Zulu community that I serve was known to have a high standard of morals up to relatively recent times. For various reasons, including colonialism, apartheid and migrant labour, these standards have steadily been eroded with the result that we now have a very high rate of illegitimacy, promiscuity, sexually transmitted diseases and worst of all, broken marriages and families.

AIDS is one of the more serious problems associated with promiscuity, but it is by no means the only one. My appeal to you is not to do away altogether with promoting the use of condoms, but alongside these things, please emphasise the fact that marriage is the place for a proper sexual relationship. Dr R C Morcom, Mosvold Hospital, P/Bag X2211, Ingwavuma 3968, South Africa.

Ed: AIDS Action agrees that preventing the spread of AIDS does not depend only on promoting safer sex and the use of condoms, but may also include promoting faithfulness in marriage (see article page 4). But chastity and/or faithfulness may not be possible for everyone. We therefore need to consider a range of approaches appropriate to the situations of different individuals and cultures.

We asked Refiloe Serote of the Township AIDS Project in Soweto to reply: Faithfulness within marriage is not always possible for everyone. Young people do have sex before marriage and people do have sexual partners outside marriage for various reasons. For example, in South Africa, where husbands and wives may be separated for much of the time, men say, 'How can I be expected to go without sex for ten or eleven months of the year?' As educators we cannot tell people what to do or how to live their lives; we can only give them the information to enable them to make informed choices.

HIV transmission

I refer to issue 11 where a reader asked whether AIDS could be caught by eating food contaminated with infected blood. My questions are: Can the virus survive on a needle or other inanimate objects (e.g. urinals, bedpans, toothbrushes, razors, bedding)? If so, for how long? If it can, then surely the same applies to the virus in food, and its consumption could lead to spread of HIV. Also, if people with AIDS have oral complications such as thrush or herpes or which cause bleeding in the mouth, can a person get AIDS from sharing contaminated with infected blood. My questions are: Can the virus survive on a needle or other inanimate objects (e.g. urinals, bedpans, toothbrushes, razors, bedding)? If so, for how long? If it can, then surely the same applies to the virus in food, and its consumption could lead to spread of HIV. 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