

The objectives of any activity in the area of sexually transmitted diseases (STDs), including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), should be to prevent and treat STDs, reduce the transmission of HIV/STD infections, and help care for those affected by AIDS.

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CHAPTER FIVE

Sexually Transmitted Diseases, Including HIV/AIDS

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Sexually Transmitted Diseases, Including HIV/AIDS

Introduction

STDs, including HIV/AIDS, spread fastest where there is poverty, powerlessness and social instability. The disintegration of community and family life in refugee situations leads to the break-up of stable relationships and the disruption of social norms governing sexual behaviour. Women and children are frequently coerced into having sex to obtain basic needs, such as shelter, security, food and money. In a refugee situation, populations that have different rates of HIV/AIDS prior to becoming refugees may be mixed. Also many refugee situations are like large urban settings and may create conditions that increase the risk of HIV transmission.

STDs, which are a major public health problem in most parts of the world, were largely neglected until the appearance of HIV/AIDS. Now, more attention is focused on conventional STDs (such as gonorrhoea, syphilis, chlamydia, etc.). They are among the most common, although undiagnosed, causes of illness in the world; and they have far-reaching health, social and economic consequences. STDs substantially increase the risk of HIV infection. Preventing and controlling STDs are key strategies in controlling the spread of HIV/AIDS.

The vast majority of HIV infections are sexually transmitted. Between five and ten per cent of HIV infections world-wide are estimated to be transmitted through infected blood and blood products, though this percentage is decreasing as blood for transfusions is more regularly tested for HIV. In refugee situations, it is essential to ensure that all blood for transfusion is tested and that universal precautions are enforced.

Mother-to-child transmission of HIV (MTCT), also called "vertical transmission", is the most common mode of HIV transmission in children. More than 90 per cent of HIV-infected

infants acquire their HIV infection from their mothers during pregnancy, delivery or during breastfeeding. When there is no intervention, the risk of MTCT ranges from 15 to 25 per cent in industrialised countries and from 25 to 45 per cent in developing countries. Transmission is affected by a number of factors, not all of which have been fully examined. These factors include:

- high viral-load level in the mother's blood,
- in cervio-vaginal secretions and, in breast milk, decreased maternal immune status,
- prolonged rupture of membranes (greater than four hours),
- the mode of delivery, and
- intra-partum haemorrhage.

Studies show an additional 7 to 22 per cent risk of HIV transmission through breastfeeding. Late postnatal transmission after six months of age has been described in a number of studies. (See Annex 2 on MTCT and HIV and Infant Feeding.)

Interaction between refugee and local populations is likely to occur. It is therefore vital to liaise with host countries to ensure that comparable services are provided to local populations. Failure to do so would not only be counterproductive in the effort to prevent the spread of STDs and HIV, it could also result in conflict between the two populations.

Mandatory HIV testing of refugees is sometimes requested in the mistaken belief that this will help prevent HIV transmission. Under no circumstances should mandatory testing be pursued. Mandatory testing for HIV represents a violation of human rights and has no public health justification. (See Annex 1 on HIV testing in refugee situations.)

Establishing STD/HIV/AIDS Programmes

As described in Chapter Two (Minimum Initial Service Package [MISP]), three activities should be conducted prior to any assessment in any new refugee situation (including an emergency):

- Guarantee availability of free condoms
- Enforce universal precautions against HIV/AIDS transmission in health-care settings
- Identify a person who will coordinate RH activities.

Comprehensive prevention, treatment and care services for STDs, including HIV/AIDS, should be made available to refugees at the earliest opportunity. By taking the following steps, you will ensure that the services you provide are effective.

Assessment

Conduct a situation analysis as soon as possible to help plan an appropriate and comprehensive prevention and treatment service.

The following information should be collected:

- the prevalence of STDs and HIV in the host and home country, region or area (this information is available from the national AIDS programmes, UNAIDS and WHO);
- the location of specific risk areas within the refugee community (for example, where sexual services are bought and sold, high alcohol-consumption areas, bars), to be targeted as priorities for specific activities; and
- the cultural and religious beliefs, attitudes, and practices concerning sexuality, reproductive health, STDs and AIDS. This information can be obtained through qualitative research using focus groups, interviews and, if possible, KABP (Knowledge, Attitudes, Behaviour and Practices) surveys.

It will also be necessary to:

- liaise with local health authorities to define a management protocol for STDs; and
- identify people in the refugee community who have been trained in HIV/STD prevention.

Implementation

The situation analysis will indicate what STD and HIV/AIDS interventions are required and what is feasible. The following should be included as basic elements of response to every refugee situation: universal precautions in health-care settings, safe blood transfusion, access to condoms, access to STD care, information, education and communication (IEC) activities, and comprehensive care for people with HIV/AIDS.

Universal Precautions in Health-Care Settings

Universal precautions are part of the MISP (Chapter Two) and are essential to prevent the transmission of HIV from patient to patient, health worker to patient and patient to health worker. Because people working under pressure are more likely to have work-related accidents and to cut corners in sterilisation techniques, infection-control measures adopted during crises must be practical to implement and enforce.

The guiding principle for the control of infection by HIV and other diseases which may be transmitted through blood, blood products and body fluids is that **all should be assumed to be potentially infectious**.

The minimum requirements for infection control are as follows:

- Facilities for frequent **hand washing**. Hands should be washed with soap and water, especially after contact with body fluids or wounds.
- Availability of **gloves** for all procedures involving contact with blood or other po-

tentially infected body fluids. Gloves should be discarded after each patient, or else washed or sterilised before re-use. Heavy-duty gloves should be worn when materials and sharp objects are taken for disposal.

- Availability of **protective clothing**, such as waterproof gowns or aprons. Masks and eye shields should be worn where there is a possibility of exposure to large amounts of blood.
- **Safe handling of sharp objects.** Puncture-resistant containers for sharps disposal must be readily available, close at hand and out of the reach of children. Sharp objects should never be thrown into ordinary waste bins or bags.
- **Disposal of waste materials.** People, particularly small children, struggling to survive will scavenge. It is therefore vital to make waste disposal safe. All medical waste materials should be burnt. Those items that still pose a threat, such as sharp objects, should be buried in a deep pit at least 10 metres from a water source. Medical waste should not be disposed of in communal dumps.
- **Cleaning, disinfecting and sterilising.** Pressure-steam sterilisers are recommended for cleaning medical instruments between use on different patients. If sterilisation is not available, or for instruments that are heat sensitive, instruments must be cleaned and high-level disinfected (HLD). HIV can be inactivated by boiling for 20 minutes or by soaking in chemical solutions including a five per cent solution of chlorine bleach for 20 minutes or in a two per cent glutaraldehyde solution for 20 minutes.
- **Proper handling of corpses.** It is advisable for relief workers to wear gloves and cover any wounds on hands or arms when handling corpses. The relief worker should wash thoroughly with soap and water afterwards. Special caution should be taken with body fluids as they may be potentially infectious.

- **Treating injuries at work.** In cases of injury with a sharp instrument, the wound should be washed thoroughly with soap and water. Splashes of blood or other body fluid into the mouth or eyes should be rinsed thoroughly with water or saline respectively. Further procedures to be followed after an accidental exposure to blood have been developed by Médecins Sans Frontières (MSF). Prophylactic treatment against HIV transmission, known as Post Exposure Therapy (PET), may be warranted.

Guidelines containing information about potential risks in the environment, how to protect against those risks, and what to do in case of accidents such as needle-stick injuries, cuts or blood splattering should be developed and distributed to field workers. It is equally important to provide clear information about what does not constitute a risk. The guidelines should indicate when it is appropriate to use protective clothing and why. Health workers should also be given guidance on how to avoid unnecessary injections and other procedures involving sharp instruments.

Access to Condoms

If consistently and correctly used, condoms offer effective protection against STDs, including the sexual transmission of HIV. Since many refugees have already been exposed to this message, there may be a demand for condoms in the early phases of a refugee situation. Condoms are contained in the MISP (See Chapter Two) and should be made freely available for those who seek them. Take every opportunity to raise awareness and promote condoms as a method of protection against STDs, including HIV infection. The female condom is not yet widely known; but, if available, it should be used as an additional method of protection.

Procurement of good-quality condoms:

There are many brands of condoms on the market. If an agency does not have experience in procuring condoms, it may be desirable to contact UNAIDS, UNFPA, UNHCR or WHO to facilitate the purchase of bulk quantities of

good-quality condoms at low cost. Annex 3 shows how to calculate the number of condoms required. Good-quality condoms are essential for the protection of the consumer and the credibility of the relief programme.

Condom distribution: To ensure ongoing access in refugee situations, a system of distribution must be in place. The system should include the following:

- Condoms and instructions for their use should be available on request in health facilities (especially where STDs are treated) and distribution centres (such as food and non-food item distribution areas). Staff should be trained in the promotion, distribution and use of condoms.
- Promotional campaigns should be launched at football matches, mass rallies, dance parties, theatres, group discussions, etc., to promote the use of condoms and inform the public on how and where to obtain them.
- Contacts between the refugee and local populations are likely to occur. Therefore, condoms must also be made available to the wider host community. This requires liaison with groups involved in AIDS prevention and family-planning activities in the area.
- Once the situation has stabilised, health workers must decide whether or not to continue free distribution of condoms. The introduction of some form of partial cost-recovery (social marketing) may be considered in situations where this is feasible and appropriate. When possible, the condom-distribution network can be extended to community agents, shops, bars, youth and women's groups, etc. Social marketing strategies in the host country or in the country of origin could be extended into the refugee situation.

Safe Blood Transfusion

Blood transfusions must not be done if the facilities for safe transfusion, including screening for HIV testing, do not exist. Safe blood trans-

fusion can be organised within the refugee settlement in major operations or should be arranged with local health facilities following appropriate discussions with the Ministry of Health. Should local health facilities be used, support to these structures must be assured by the refugee programme.

The likelihood of becoming infected with HIV through transfusion of infected blood is well over 90 per cent. Measures to ensure the safety of blood transfusion in refugee situations are extremely important.

The main recommendations for preventing HIV infection and other blood-borne diseases through blood transfusion are to:

- Transfuse only previously tested blood and only when clinically necessary.
- Use blood substitutes, such as simple crystalloid (physiological saline solution for intravenous administration) and colloids whenever possible.
- Collect blood from donors identified as being least likely to transmit infectious agents in their blood. Selection of safe donors can be promoted by giving clear information to potential donors on when it is appropriate or inappropriate to give blood and by using a blood-donor questionnaire. Voluntary, non-remunerated blood donors are safer sources than paid donors. Personal information given by the donor must be treated as strictly confidential.
- Provide reagents to perform HIV testing of donated blood. Screening for HIV and other infectious agents should be carried out using the most appropriate assays.
- Develop clear policies and protocols/guidelines concerning the appropriate use of blood for transfusion, the recruitment and care of donors and the safe disposal of waste products, such as blood bags, needles and syringes.
- Appoint an experienced person to be responsible for refugee-specific blood transfusion services.

Access to STD Care

Because the risk of HIV transmission is greatly increased in the presence of other STDs, early establishment and integration of STD services within general health care services is a priority. STDs and their complications, such as infertility and congenital syphilis, are a major cause of ill health and are usually grossly under-reported. The prevention of STDs involves the promotion of safer sex as well as early and effective case finding, advise on notification of partners and case management.

STD services should be user-friendly, private and confidential. Special arrangements may be necessary to ensure that women and young people feel comfortable using these services. In many societies, women will not seek treatment if the health professionals at the clinic are all male, particularly if a physical examination is required. In these situations, female health workers should provide services for women.

Appropriate and effective case management involves the following:

- training health care providers
- providing guidelines for case management, including case definition and management protocol
- consistent availability of appropriate drugs
- consistent supply of condoms
- monitoring
- identifying secondary or informal providers of STD care

Training health care providers. Health care providers, including volunteer workers, should receive training in prevention of STD/HIV/AIDS, be provided with information materials and serve as channels for the distribution of condoms. Professional health workers should be trained in the syndromic approach to STD management.

Health worker training should include the following topics:

- syndrome recognition and diagnosis

- effective treatment based on observed syndromes
- importance of confidentiality
- education for prevention/counselling focused on specific population groups
- condom promotion and provision
- partner notification and management
- monitoring

STD Case Management. Treatment of symptomatic cases should be standardised on the basis of syndromes and not dependent on laboratory analysis. A treatment protocol (consistent with national protocols) based on syndromic case management should be prepared and adopted. (See examples in Annexes 4 and 5.) The most effective drugs should be used at the first encounter.

Initial drug requirements should be based on available data from the country of origin or estimated as indicated in Annex 8. Monitoring activities will then serve to review real needs. If IEC efforts are effective, if services are user-friendly and people from outside the camp are attending the health facilities, the need for drugs may increase rapidly.

Partners of patients with an STD are likely to be infected themselves and should be treated. Each patient should be provided with contact slip(s) to be given to his/her sexual partner(s). On the basis of these slips, partners should have access to the same treatment as the patient who presented first. The process should be confidential, voluntary and non-coercive and include all sexual partners of each STD patient.

Applying a syndromic approach to STD case management allows effective care for symptomatic cases without the need for laboratory support. The exception to this is systematic testing for syphilis in pregnant women. This type of testing is cost effective even in sites where the prevalence of syphilis in the general population is as low as one per cent.

Information, Education and Communication (IEC)

Information, education and communication activities are central to a successful HIV/AIDS and STD strategy in all situations. IEC includes a variety of activities at different levels, from intensive person-to-person education to mass dissemination of information. (For further information on IEC, refer to Appendix One.)

Comprehensive Care for People with HIV/AIDS

Comprehensive care for people with HIV-related illnesses should be seen as a component of basic care in any refugee situation. This is especially important when refugees come from an area where HIV-related illnesses are a major cause of morbidity and mortality. (The WHO flow chart for suspected symptomatic HIV infection for the purpose of clinical management is provided in Annex 6.)

The elements of comprehensive care include:

- **clinical management**, involving early diagnosis of HIV-related illnesses, rational treatment and planning for follow-up care;
- **supportive care** to promote and maintain hygiene and nutrition;
- **education** of individuals and families on HIV prevention and care;
- **counselling** to help individuals make informed decisions on HIV testing, reduce stress and anxiety and promote safer sex; and
- **social support**, including information and referral to support groups, welfare services and legal advice.
- A **home-based care system**, to which people with advanced HIV infection/AIDS-related illnesses can be discharged from inpatient care, should be established early in refugee situations.

The introduction of comprehensive care for HIV/AIDS in refugee situations involves:

- sensitising health workers to HIV-related illnesses and AIDS;
- developing a policy on the role of voluntary and confidential HIV tests (with related pre- and post-test counselling) for clinical diagnosis (see Annex 1). If host countries offer voluntary counselling and testing services to the local population, initiate discussions to determine the possibility of extending these services to refugee populations;
- adapting existing clinical and nursing guidelines for case management of HIV-related illnesses in primary and secondary care in refugee settings. This should include guidelines on discharge and referral of people with HIV-related problems, either for more sophisticated care or to home-based care;
- drawing up an essential drug list for care of HIV-related illnesses and establishing mechanisms to ensure the procurement and supply of these drugs;
- training health care workers in the use of the clinical guidelines;
- introducing counselling training for health and lay workers and developing guidelines for counselling. This can be integrated into counselling for other problems related to the refugee situation. It will be helpful if staff involved in this activity are not subject to frequent rotation;
- including those people living with HIV/AIDS in training programmes;
- ensuring that HIV-related care is fully integrated into basic curative services and that prevention components (such as supply of condoms) and STD treatment are provided;
- developing community support for AIDS care by:
 - exploring community potential for stigma and discrimination;
 - exploring community capacities and commitment;

- encouraging the development and training of self-help and other community-based support groups; and
- starting community-based care and support activities, using the self-help groups that have been established.

Monitoring

Data on the number of STD and HIV/AIDS cases presenting for treatment or detected in health services are essential for planning services and as indicators of trends in STD prevalence in the community. Always suspect under-reporting of STDs and HIV/AIDS. Managers of health care programmes may want to check for the presence of informal networks of treatment for STDs, such as in local markets.

STD/HIV/AIDS Indicators

✓ Indicators to be collected from the health-facility level

- percentage of blood screened for HIV before transfusion and per cent found positive for HIV
- incidence of STDs
- practice of universal precautions

✓ Indicators collected at the community level

- outlets for condoms distribution
- knowledge of correct condom use
- condom use

✓ Indicators concerning training and quality of care

- training of health workers in syndromic case management
- quality of STD case management

(Refer to Chapter Nine—Surveillance and Monitoring.)

Checklist for STD/HIV/AIDS Programmes

- From MISDP
- ☐ Guarantee availability of free condoms
 - ☐ Enforce universal precautions
-
- ✓ HIV/STD/AIDS situational analysis is undertaken
 - ✓ Trained people from refugee community are identified
 - ✓ Information, education and communication programmes are in place
 - ✓ Universal precautions in health settings are practiced
 - ✓ Free good-quality condoms are regularly available and accessible
 - ✓ System of condom distribution is in place
 - ✓ Safe blood transfusion services are in place, guidelines disseminated, HIV test kits available, staff trained
 - ✓ Management protocols for STDs are defined and disseminated
 - ✓ Drugs for STD treatment are on hand
 - ✓ Staff are trained/retrained on syndromic case management
 - ✓ System for partner notification and treatment are instituted
 - ✓ Voluntary counselling and testing (VCT) services are in place (as appropriate)
 - ✓ Home-based care for people with AIDS is in place
 - ✓ Counselling and support services for people with HIV/AIDS are in place

ANNEX 1

**HIV Testing
in Refugee
Situations**

HIV Testing in Refugee Situations

Available resources for HIV testing should be devoted, first and foremost, to ensuring a safe blood supply for transfusions. A **voluntary HIV testing and counselling** (VCT) programme is a lower priority in a refugee situation but should not be ruled out if resources are available and if these services are available in the host country or were available in the country of origin.

HIV testing to diagnose HIV-related illness may be indicated, but only if two conditions are met:

- consent, pre- and post-test counselling and confidentiality can be assured; and
- a confirmatory testing procedure is undertaken as outlined in UNAIDS Policy on HIV Testing and Counselling.

People known to be HIV infected or to have AIDS should remain within their communities or within the refugee settlements, where they should have equal access to all available care and support.

UNAIDS/WHO Position on Mandatory HIV Testing in Refugee Situations

Mandatory HIV testing in refugee circumstances, with the single exception of testing blood for transfusion, is not justified. WHO and UNAIDS have determined that such testing should not be pursued as a matter of policy.

- ✓ Identifying people with HIV/AIDS through mandatory testing does nothing to stop the spread of the virus.
- ✓ Mandatory testing is a violation of human rights, and it leaves those who are identified as HIV-positive open to discrimination and persecution.
- ✓ No negative HIV test can be assumed to have excluded the possibility of HIV infection in the person tested. There is a latent period of several weeks following infection, during which the HIV test can come up negative, but the person is still capable of transmitting the infection through unprotected sexual contact or blood. Occasionally, too, tests have shown false negative results.
- ✓ A negative HIV test offers no assurance that the person tested will not be exposed to HIV and become infected soon thereafter.
- ✓ A negative HIV test is, therefore, no reason to relax the universal precautions that health workers need to observe at all times; nor does a negative HIV test give any reason to feel that sterile procedures during medical interventions are any less important. In practice, every patient should be regarded as a potential carrier of HIV, Hepatitis B or other blood-borne infections, since testing removes none of the potential for transmitting these diseases.
- ✓ UNHCR and International Organization on Migration (IOM) issued a joint policy in 1990 which strictly opposes the use of mandatory HIV screening, and any restrictions based on a refugee's HIV status. Nevertheless, some States have adopted mandatory HIV testing for refugees and exclude those who test positive. Other States place restrictions on the admission of persons whom they know to be HIV positive or have AIDS. Although some countries have established waiver procedures, resettlement cases of refugees who are HIV positive or have AIDS are certain to be more complex than most resettlement cases.
- ✓ Resettlement considerations of refugees living with HIV are difficult and must be given special attention to avoid placing these persons at greater risk for discrimination, *refoulement*, and institutionalisation.

Mother-to-Child Transmission and HIV and Infant Feeding

Primary prevention of HIV in girls and women of reproductive age remains the most important component of any strategy or programme to prevent mother-to-child transmission (MTCT).

For women who are HIV negative or of unknown status, breastfeeding should be protected, promoted and supported. (See Chapter Three-Safe Motherhood)

For HIV-infected pregnant women, the only interventions proven to reduce significantly MTCT of HIV are the use of antiretroviral therapy (ARV) and the avoidance of breastfeeding. Women who are known to be HIV positive should be counselled about the possibility of avoiding breastfeeding. They should consider using commercial infant formula, home-prepared formula, or a modified form of breastfeeding, such as expressing and heat treating their own breast milk. They could also breastfeed for a shorter time than usual, or find an HIV-negative wet nurse. However, most of these options are usually impractical. Studies are continuing on the effectiveness and service delivery implications of providing short-course ARV treatment which may represent a feasible intervention in some settings and for some circumstances.

In some settings, consideration could be given to providing HIV-positive mothers with breast milk substitutes and supporting its safe use. The supply of the substitute should be guaranteed for at least six months. The acquisition and distribution of breast-milk substitutes should be in compliance with the International Code of Marketing of Breast-milk Substitutes.

Considerable resources are required to prepare formula, whether commercial or home made. The mother needs water to clean equipment and prepare feeds; she needs adequate fuel to boil water to sterilise equipment and make feeds safe. She must do this six times a day, or prepare six feeds at one time and keep them cool for up to 24 hours to prevent spoilage.

This is not often practical when normal life is disrupted. If feeds cannot be mixed correctly, if equipment cannot be adequately cleaned and sterilised, or if prepared feeds cannot be stored to prevent spoilage, the risks of sickness and death to the infant may be greater than the risk of transmission of HIV through breastfeeding.

Bear in mind these considerations when counselling women. Health care providers should support women and, when possible, their families, in making the best decision on how to feed their infant given their particular circumstances. Breastfeeding may be the most appropriate and safest option.

For more information on HIV and Infant Feeding refer to the "HIV and Infant Feeding Packet" produced by UNAIDS, UNICEF and WHO, Geneva, 1998. Also refer to "Nutrition and HIV/AIDS", Sub-committee on Nutrition News, Number 17, WHO, Geneva, 1998.

CHAPTER FIVE

ANNEX 2

Mother-to-Child Transmission and HIV and Infant Feeding

ANNEX 3

**Formula for
Calculating
Condom
Requirements**

Formula for Calculating Condom Requirements

Condom needs can be calculated if you can estimate the following:

- The size of the target population (i.e., refugee population and adjoining areas). Roughly 20 per cent of this number represents the size of the sexually active male population.
- The percentage of males using condoms. Results from previous knowledge, attitudes, behaviour and practices (KAPB) studies can be used when they exist. If they do not exist, plan from data provided by the most reliable source and adapt according to needs.
- Plan for about 12 condoms per sexually active male per month.
- Add to the above figure 20 per cent for wastage and loss.

✓ **Example:** A baseline calculation for procuring one month's supply of condoms for an estimated refugee and adjoining population of 10,000 people, with 20 per cent of sexually active males using condoms, is as follows:

2,000	sexually active males		2,000		
20/100	20 per cent using condoms	x	0.2	=	400
12	condoms per month	x	12.0	=	4,800
20%	wastage/loss	+	0.2	=	960
total condoms per month					4,800
total wastage/loss					+ 960
Estimated total needs for one month:					<u>5,760 condoms</u>

Condoms usually come in boxes of 144, called a gross. Quantities of follow-on supplies should be modified according to the field situation (demographic profiles in refugee camps may be very different from the normal demographic profile; use rates of condoms may also vary). To avoid shortages, make sure a three-month reserve supply is available.

CHAPTER FIVE

ANNEX 4

STD Treatment Based
on Syndromic
Approach**STD Treatment Based on Syndromic Approach**

Syndrome	Treat For
Urethral discharge	Gonorrhoea and chlamydia
Genital ulcers	Syphilis and chancroid
Vaginal discharge ¹	Gonorrhoea, chlamydia and trichomonas
Lower abdominal pain	Gonorrhoea, chlamydia and anaerobes
Inguinal bubo	as for chlamydia
Scrotal swelling	Gonorrhoea and chlamydia
Neonatal eye discharge	Neonate gonorrhoea and chlamydia

1. If a woman complains of vaginitis (itching)—treat for candidiasis.

ANNEX 5

Drugs for
Treatment
of STDs**Drugs for Treatment of STDs**

(Choice of drugs should be based on antibiotic sensitivity studies in a specific area)

Treat For	Drugs – Depending on Sensitivity Studies	Adult Dose (for uncomplicated or early infections)
Gonorrhoea	Ciprofloxacin ¹ Spectinomycin Cefixime Ceftriaxone Kanamycin Sulfamethoxazole/Trimethoprim	500 mg - single dose - oral 2 g - single dose - IM 400 mg - single dose - oral 250 mg - single dose - IM 2 g - single dose - IM 400mg/80mg - 10 tabs once daily for 3 days
Chlamydia	Doxycycline ¹ Tetracycline ¹ Erythromycin Sulfafurazole	100 mg - twice daily for 7 days - oral 500 mg - four times a day for 7 days - oral 500 mg - four times a day for 7 days - oral 500 mg - four times a day for 10 days - oral
Syphilis	Benzathine penicillin G Procaine penicillin G Tetracycline ^(1,2) Doxycycline ^(1,2) Erythromycin ²	2.4 MUs - single dose - IM 1.2 MUs - daily for 10 days - IM 500 mg - four times a day for 15 days - oral 100 mg - twice daily for 15 days - oral 500 mg - four times a day for 15 days - oral
Chancroid	Erythromycin Ciprofloxacin ¹ Ceftriaxone Spectinomycin Sulfamethoxazole/Trimethoprim	500 mg - three times a day for 7 days - oral 500 mg - single dose - oral 250 mg - single dose - IM 2 gm - single dose - IM 800mg/160mg - twice daily for 7 days - oral
Donovanosis	Sulfamethoxazole/Trimethoprim Doxycycline ¹ Tetracycline ¹ Chloramphenicol	800mg/160mg - twice daily for 14 days - oral 100 mg - twice daily for 7 days 500 mg - four times a day for 7 days 500 mg - four times a day for 2 days
Trichomonos	Metronidazole ³	2 g - single dose - oral
Candidosis	Nystatin pessaries Clotrimazole or miconazole pessaries Miconazole	100,000 IU - twice intravaginally for 14 days 200 mg - once intravaginally for 3 days 500 mg - intravaginally - single dose
Bacterial vaginosis	Metronidazole ³	400-500 mg - twice a day for 7 days - oral or 2 g - single dose - oral

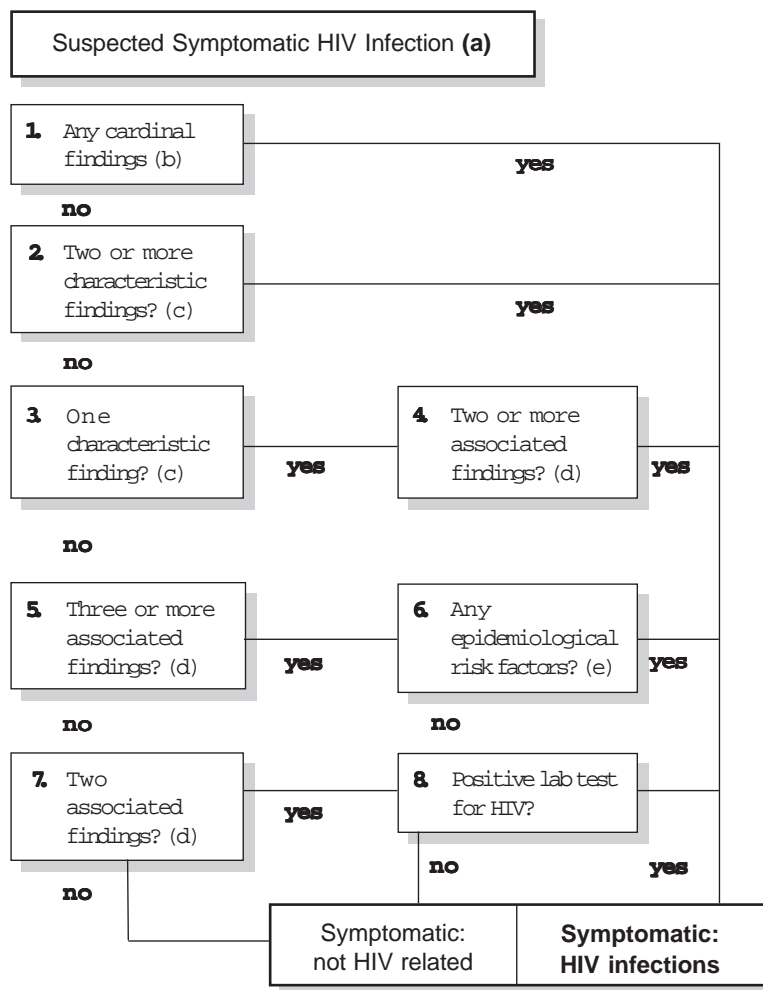
1–Contraindicated in pregnancy
2–For persons allergic to penicillin, but may be less effective. Close follow up is necessary to ensure a cure.
3–Contraindicated in first trimester of pregnancy

NOTE: Drugs for treatment of STDs are continuously revised. Health care providers should rely on the most up-to-date recommendations.

ANNEX 6

Suspected
Symptomatic
HIV Infections

WHO Flow Chart



Annotations:

a) The purpose is to help the health care provider to recognize the patient with symptomatic HIV infection, as an aid to clinical management. HIV testing, when available and affordable, can be used to substantiate the clinical diagnosis.

b) **Cardinal Findings:**

- Kaposi sarcoma¹
- Pneumocystis carinii pneumonia
- Toxoplasma encephalitis
- Oesophageal candidiasis
- Cytomegalovirus retinitis

c) **Characteristic Findings²:**

- Oral thrush (in patient not taking antibiotics)
- Hairy leukoplakia
- Cryptococcal meningitis (may be a cardinal finding in Africa)
- Miliary, extrapulmonary or noncavitary pulmonary tuberculosis³
- Herpes zoster, present or past, particularly multidermatomal, age 50 years
- Severe prurigo
- Kaposi sarcoma (other than as cardinal finding)
- High-grade B-cell extranodal lymphoma

d) **Associated Findings²:**

- Weight loss (recent unexplained) of more than 10% of baseline body weight, if assessable³
- Fever (continuous or intermittent) for more

than 1 month³

- Diarrhoea (continuous or intermittent) for more than 1 month
- Ulcers (genital or perianal) for more than 1 month
- Cough for more than 1 month³
- Neurological complaints or findings⁴
- Generalised lymphadenopathy (extrainguinal)
- Drug reactions (previously not seen), e.g. to thiazetazone or sulfonamides
- Skin infections (severe or recurrent), e.g. warts, dermatophytes, folliculitis

e) **Epidemiological Risk Factors:**

- Present or past high-risk behaviour:
 - drug injecting
 - multiple sex partners
 - sex partner(s) with known AIDS or HIV infection
 - sex partner(s) with known epidemiological risk factor or from an area with a high prevalence of HIV infection
 - males having penetrative sexual intercourse with males
- Recent history of genital ulcer disease.
- History of transfusion after 1975 of unscreened blood, plasma or clotting factor; or (even if screened) from an area with a high prevalence of HIV infection.
- History of scarification, tattooing, ear piercing or circumcision using non-sterile instruments.

1. Kaposi sarcoma is a cardinal finding only when: (i) intraoral lesions are present; (ii) lesions are generalised; or (iii) lesions are rapidly progressive or invasive.

2. If no other obvious cause of immunosuppression is evident.

3. The combination of fever, weight loss and cough is characteristic of both tuberculosis and AIDS.

4. Neurological complaints or findings associated with HIV infection include seizures (especially focal), peripheral neuropathy (motor or sensory), focal central motor or sensory deficits, dementia and progressively worsening headache.

Adapted from WHO/GPA/IDS/HCS/91.6 "Guidelines for the Clinical Management of HIV Infection in Adults", December 1991.

ANNEX 7

WHO Essential Drugs
for HIV/AIDS
ManagementWHO Essential Drugs HIV/AIDS
Management

Indications	Drugs
<i>Dehydration</i>	Oral Rehydration Salts
<i>Diarrhoea</i>	Loperamide
<i>Bacterial Infections</i>	Cotrimoxazole Amoxicillin Ciprofloxacin Ceftriaxone
<i>Fungal Infections</i>	Miconazole Nystatin (oral and ointment) Ketoconazole ¹
<i>Parasitic Infections</i>	Metronidazole (oral)
<i>Palliative Care and Pain Management</i>	Codeine
<i>Tuberculosis</i>	Isoniazid Rifampicin Pyrazinamide Ethambutol
<i>Clinical Depression²</i>	Tricyclics ³ Benzodiazepine Family ⁴

¹ Ketoconazole is expensive, therefore only limited supplies should be considered and only if there are enforceable criteria for its use.

² The appropriate use of anti-depressant medicine should be considered in situations where clinical depression is diagnosed.

³ Given the possibility of overdose, tricyclics should perhaps be prescribed only in 5 or less at a time and by a physician.

⁴ The use of anxiolytics (Diazepam - Benzodiazepine family) may also be considered for temporary management of severe anxiety reactions where respiration is **not** impaired (e.g., pneumocystis carinii pneumonia).

CHAPTER FIVE

Sexually Transmitted Diseases:

Example for estimating of drug requirements
and costs for a population of 200,000

ANNEX 8**Sexually
Transmitted
Diseases**

			Treatment Protocol	Cost per treatment in US\$	Total cost in US\$
Population 15–44 years 50% of total population		100 000			
Expected % of STD (1)	5 %	5 000			
Expected % of genital ulcers	20% of (1)	1 000	benzathine benzyl- penicillin 2.4 MU 1 dose plus erythromycin, 500mg 3/day x 7 days	0.24 plus 1.68 = 1.92	1 920
Expected % of urethral discharge	50% of (1)	2 500	ciprofloxacin, 500mg x 1 plus doxycycline, 100mg 2/day x 7 days	1.72 plus 0.17 = 1.89	4 725
Expected % of cervicitis	5% of (1)	250	ciprofloxacin, 500mg plus doxycycline, 100mg 2/day x 7 days	1.89	473
Expected % of vaginitis	25% of (1)	1 250	metronidazole, 2gr plus nystatin 2p/day x 14 days	0.04 plus 0.50 = 0.79	988
Condoms estimate during STD management		5 000 x 12 = 60 000		US\$5.40 per 144 pieces	2 250
TOTAL US\$					10,356

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Family planning helps save women's and children's lives and preserves their health by preventing untimely and unwanted pregnancies, reducing women's exposure to the health risks of childbirth and abortion and giving women, who are often the sole caregivers, more time to care for their children and themselves.

All couples and individuals have the right to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to do so.

6

CHAPTER SIX

Family Planning

Contents:

- Preliminary Considerations
- Assessment of Needs
- Implementation of Family Planning Services
- Examples of Contraceptive Methods that May Be Provided in Refugee Settings
- Male Involvement in Family Planning Programmes
- Monitoring

