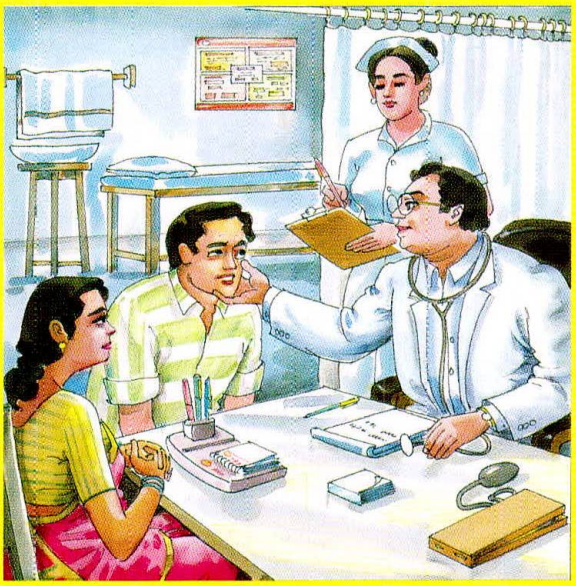
QUALITY STD CARE
TRAINING MODULE



FOR PRIVATE MEDICAL PRACTITIONERS

APAC project is administered by Voluntary Health Services, Chennai with financial assistance from United States Agency for International Development under bilateral agreement with the Government of India.

APAC-VHS
Chennai

TRAINING MODULE

For Private Medical Practitioners

October 1998

AIDS Prevention And Control Project
Voluntary Health Services

CONTENTS

FOREWORD

Acquired Immuno Deficiency Syndrome is a disease of late 20th century and the universal consensus is that sexually transmitted diseases form an important co-factor in the transmission of HIV. While HIV/AIDS do not have a cure now, sexually transmitted diseases are curable. The AIDS Prevention and Control Project (APAC) sees this linkage between STD and HIV as the basis for developing intervention strategies for the prevention and control of HIV/AIDS.

Research studies conducted by APAC and others reveal that there exist great variations in the treatment of STD conditions, and minimal contributions towards preventing sexually transmitted diseases. Therefore there is a need to orient General Practitioners on quality STD care to enable them to recognise their crucial role in this context. APAC has planned to organise massive training programme to train medical and paramedical persons in "Quality STD Care". APAC's strategy to develop a Module to strengthen the skills of the General Practitioners is an attempt in this direction. The Module contains epidemiology, clinical features and guidelines for prevention and control of sexually transmitted diseases. This module is primarily designed to be used during the training programmes for General Practitioners. It can also be integrated with any other training programme for the Allopathic medical practitioners.

The Training Module is a joint effort of APAC and the Chennai School of Social Work. We wish to record our appreciation for the assistance provided by experts from Christian Medical College, Vellore, Government Rajaji Hospital, Madurai, PSG Institute of Medical Science & Research, Coimbatore, General Hospital, Chennai, Tamil Nadu State AIDS Control Society, Family Planning Association of India, Madras University as well as the Training Institutions. It is hoped that the Training Module will be a valuable technical tool in STD/HIV/AIDS prevention and control to those working in this field and will be of benefit to the community.

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Project Director,
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Chennai,
29.10.98

INTRODUCTION

Need and purpose

This Training Module is aimed at General Practitioners (GP) in Tamil Nadu. A recent STD Health Facility Survey for Chennai city, conducted by the Tamil Nadu AIDS Control Society, indicates that a majority of patients with STD (90.23%) avail private medical care, while only 9.75% avail government hospital facilities. Therefore the need to train General Practitioners to diagnose STD early and to treat them appropriately is critical in this context. Evidence from some research studies demonstrates that there exists a great degree of variation in treatment of STD conditions. The Training Module is directed at standardising treatment of various STD conditions.

The Training Module has been initiated in Tamil Nadu due to the concerted efforts of Central Government and donor organisations to tackle the HIV/AIDS problems in this State. It is well known that Tamil Nadu is the State with the highest reported prevalence of HIV/AIDS, with the largest number of AIDS deaths. Further, Tamil Nadu is relatively more open to innovative approaches.

The main goal of the Training Module is to provide a standardised learning aid to General Practitioners. The Training Module recognises the crucial role of General Practitioners in intervention strategies for the prevention and control of STD and HIV/AIDS. The Training Module aims to strengthen the present skills of general practitioners and develop newer and more appropriate skills for the delivery of quality STD services using a standardised treatment pattern.

Users and target audience

The target audience is General Practitioners who are within the formal sector of private medical care.

The module is to be used as a training tool by qualified trainers and resource persons of medical institutions. The manual can be used to train groups of 15-25 participants, this range being the best for training. The trainers should be :

- Well versed in Training Methodologies in general and participatory training approach in particular
- Experts in Public Health, Epidemiology and STD/HIV/AIDS
- Specialists in STD care
- Skilled in adopting communication techniques

General objectives of the training module

- To make General Practitioners aware of the need for quality STD care and the important role they play in this
- To introduce General Practitioners to the concept of Syndromic Case Management
- To enable General Practitioners to acquire skills in using Syndromic Case Management for STD treatment
- To encourage General Practitioners to develop a positive attitude towards preventive STD care aspects such as Partner treatment, Follow-up, Counselling and Condom promotion
- To introduce General Practitioners to ethical, social, and legal issues related to STD/HIV/AIDS practice

Organisation and contents

The training module is broadly divided into four sub-modules giving a vivid description on epidemiology and public health issue of STD/HIV/AIDS, problems in managing STD and quality STD care through syndromic case managements, prevention of STD and AIDS through condom promotion and behaviour change communication, managements of HIV/AIDs and importance of universal barrier precautions in general practice, values of ethical practice while caring for STD and AIDS patients and the need for documentation and recording.

Module I

Epidemiology of HIV/AIDS and STD

Session 1

EPIDEMIOLOGY OF HIV/AIDS

General objective

The trainees should be able to appreciate the various aspects of the HIV/AIDS problem in order to realize the Private Medical Practitioner's role in its prevention and control.

Learning objectives

At the end of the session, the trainees should be able to :

- Recognize the magnitude of HIV/AIDS problem and appreciate the need for preventive measures
- Describe the epidemiology of HIV/AIDS and the natural history of HIV infection/AIDS
- Identify and list out the risk behaviour for STD/HIV to prevent/control HIV/AIDS

The magnitude of HIV/AIDS problem

The global context

The number of AIDS cases reported to the Global Programme on AIDS (GPA) in adults and children rose to 1,169,811 by mid-1995 from 985,119 in 1994. This represents almost a 20% increase in one year. But GPA believes that the true number of cases may be four times this, in the region of 4.5 million. The estimate takes into account under-diagnosis, under-reporting and delays in reporting.

The number of AIDS cases is only a fraction of the number of people estimated to have been infected with HIV who, in turn, are likely to go on to develop AIDS. According to GPA estimates, about 18.5 million adults and more than 1.5 million children have been infected with HIV since the beginning of the pandemic in the late 1970s/early 1980s.

Fig. 1 shows that next to Sub-Saharan Africa, South and South East Asia has the largest number of HIV positive individuals - 5 million out of the global total of 27.9 million.

Future Projections

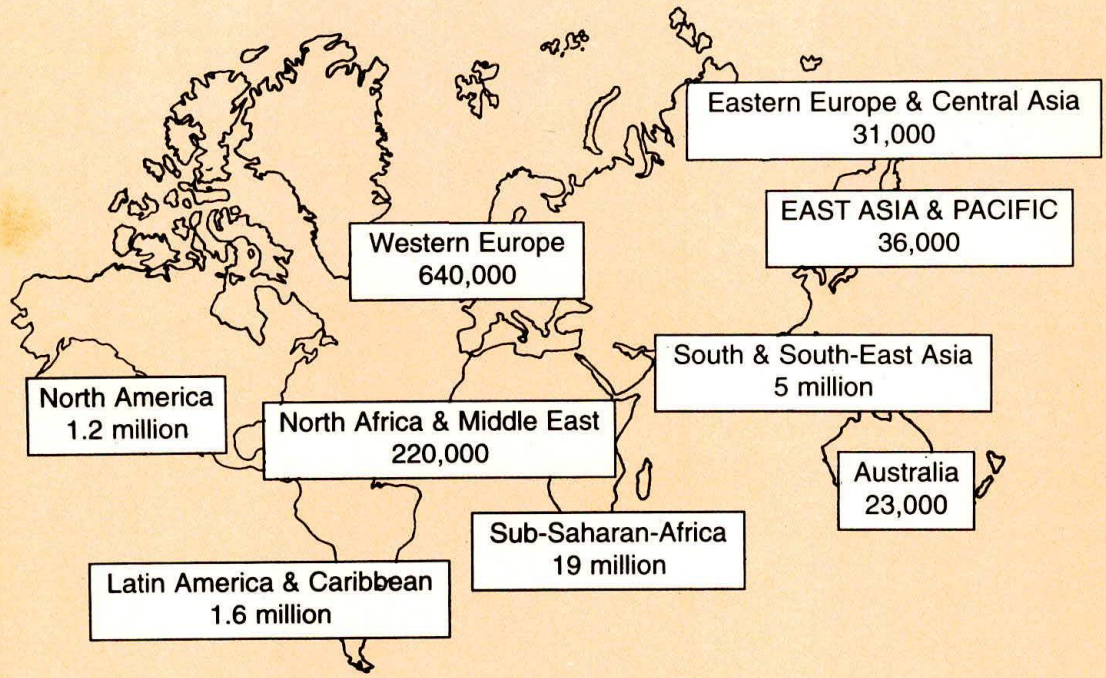
Table 1 : Estimated Adult Population and HIV Prevalence in mid-1993 and by 2000.

Mid 1993			2000	
"Macro" region	Estimated HIV Prevalence	Estimated Population aged 15-49 years (1990)	Projected HIV Prevalence	Projected Population aged 15-49 years
Australia, Europe & North America	> 1.2 million	646 million	1 million	675 million
Latin America & Caribbean	> 1.3 million	227 million	> 2 million	282 million
Africa	> 6.5 million	289 million	> 9 million	397 million
Asia	2 million	1527 million	8 million	1843 million
Global Total	> 11 million	2689 million	> 20 million	3197 million

Fig.1

ESTIMATED DISTRIBUTION AS OF MID 1996, OF ADULTS AND CHILDREN INFECTED WITH HIV SINCE LATE 1970s

(GLOBAL TOTAL : 27.9 MILLION)



Source : NACO Country Scenario

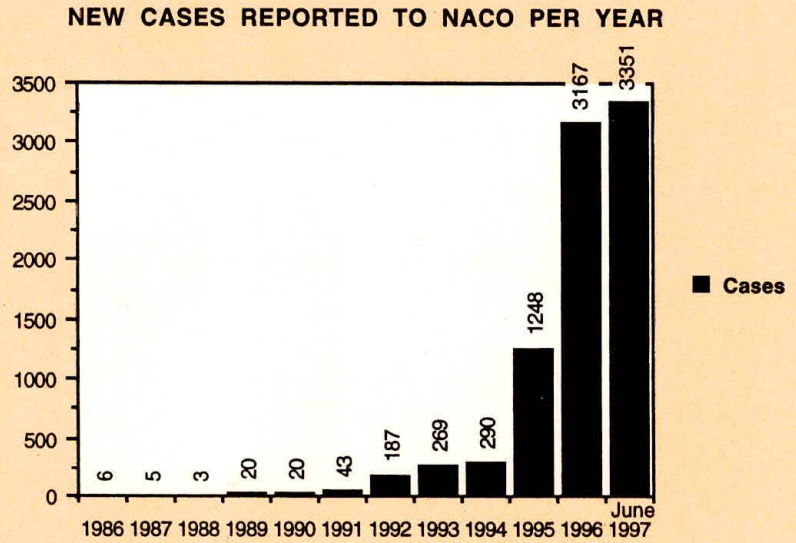
December 1996

Table 1 gives the future projection about the HIV prevalence by the year 2000, when more than 20 million people will be HIV Positive globally. And the WHO projection is that there will be a cumulative total of 30-40 million HIV infections in men, women and children, of whom more than 90% will be in developing countries.

AIDS situation in India

Since the first AIDS case was registered in Mumbai and HIV positive reported in Chennai in 1986, 5167 cases of AIDS have been reported to the Ministry of Health and Family Welfare from the 32 States and Union Territories till 28th February, 1998. Much of the increase is attributable to better case finding and reporting which have resulted from various intervention activities, but it is still highly probable that the epidemic continues to increase.

Fig.2 : AIDS SITUATION IN INDIA



Reported cases of AIDS and HIV positives are only the tip of the iceberg. Table 2 shows the reported number of AIDS cases in different States of India :

Table 2 : AIDS CASES IN INDIA (Reported to NACO)

(As on 28th February, 1998)

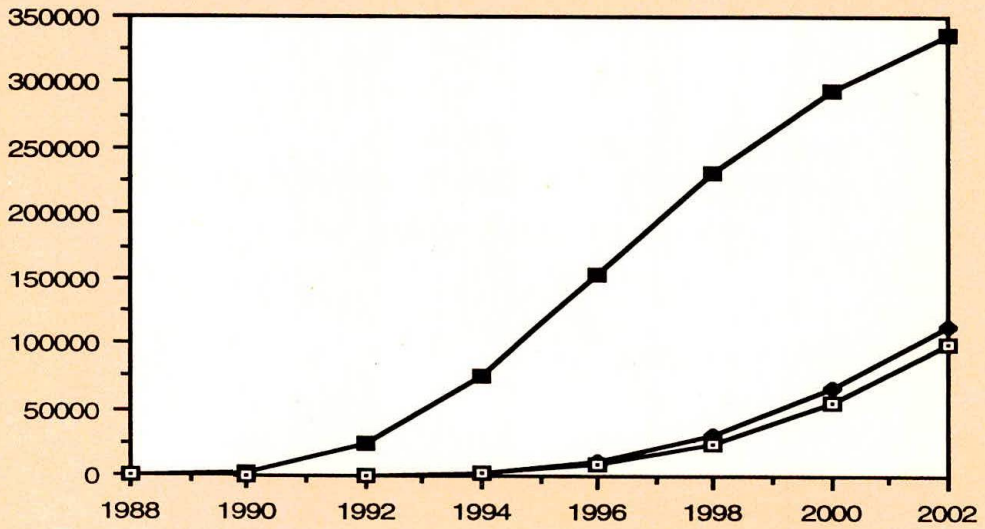
State/Union Territory	AIDS Cases (Indians)
Andhra Pradesh	42
Assam	22
Bihar	3
Daman & Diu	1
Dadar Nagar & Haveli	0
Delhi	212
Goa	12
Gujarat	134
Haryana	1
Himachal Pradesh	9
Jammu & Kashmir	2
Karnataka	120
Kerala	105
Madhya Pradesh	134
Maharashtra	2513
Manipur	301
Nagaland	10
Orissa	2
Pondicherry	132
Punjab/Chandigarh	100
Rajasthan	54
Tamil Nadu	1092
Uttar Pradesh	109
West Bengal	57
All India Total	**5167**

AIDS situation in Tamil Nadu

India adopts a policy of not screening all suspects for HIV. Also, it is impossible to test every individual to determine his positivity status and is not warranted either. Therefore effective methods of estimating HIV positives, AIDS cases and their deaths have been developed. Using such methods, it is estimated that in Tamil Nadu, there are 2,32,141 HIV positives and 25053 deaths due to AIDS as of June 1998 (Fig.3).

Fig.3

HIV/AIDS TRENDS IN TAMIL NADU



YEAR		1988	1990	1992	1994	1996	1998	2000	2002
HIV	■	43	3014	23721	76589	153566	232141	294996	337108
AIDS	✦	0	7	243	2362	10793	30968	65781	113474
DEATHS	⊡	0	4	147	1608	8111	25053	56158	100897

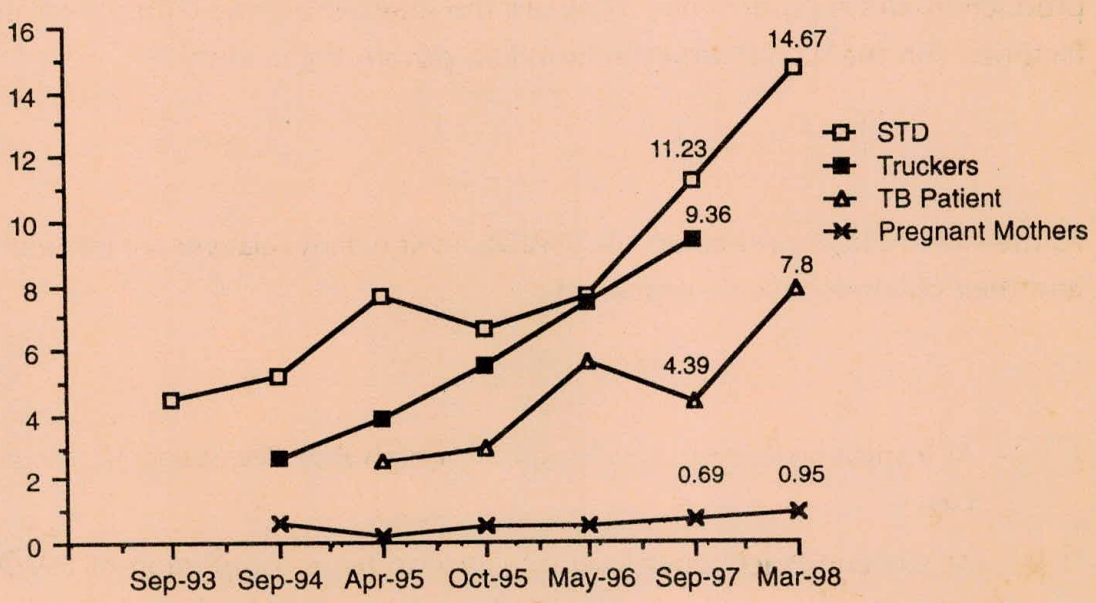
It should be noted that the magnitude of the problem (AIDS cases are not so high even in 1998, but in the next two to three years, the number of deaths will increase enormously and by 2002 more than 1 lakh people might die due to AIDS) will continue for many more years, until the already infected HIV Positive people will die of full-blown AIDS.

HIV epidemic progression in Tamil Nadu

In Tamil Nadu HIV epidemic progression (1993 - 96) in various population groups indicates a rising trend of HIV positivity status among the high risk groups such as STD patients and truckers as related to the general population. The present low prevalence among pregnant women will also go up in the next 2 or 3 years because the infection will spread to the general population (Fig.4).

Fig.4

TRENDS OF HIV POSITIVITY AMONG HIGH RISK GROUPS IN TAMIL NADU 1993 - 1998



Need for preventive measures

The increasing trends of HIV positivity and its later conversion to AIDS cases and deaths due to AIDS itself warrant the need for urgent action. In addition, the following issues related to the problem also reinforce the need to start preventive measures urgently.

The impact of AIDS

Effect of the pandemic on population

During the 1990s, the impact of AIDS will be the greatest in large urban areas of Saharan Africa, especially in Eastern and Central Africa where, today, in some cities as many as a quarter to one-third of all adults aged 15-49 will be infected with HIV. In such cities, AIDS deaths in youths, children and in those aged 15-49 may reduce expected population growth by over 30% and the adult mortality rate may be upto three times.

AIDS and socio-economic development

AIDS strikes the economically productive population on whom society relies for production and reproduction. They are the ones who grow crops, work in mines and factories, run the schools and the hospitals, govern the country.

AIDS and its effect on family

As the earning family members die of AIDS, their elderly relatives are left without support and their children become orphaned.

AIDS and its effect on medicare

- At institutional level, it will result in a high Bed Occupancy & Medicare cost
- At General Practitioner level it will mean larger proportion of HIV/AIDS cases than in routine practice and need for routine universal precautions

Natural history of HIV infection/AIDS

The natural history of any disease refers to the stages through which a disease passes, in the absence of any intervention. Clear knowledge of natural history of a disease helps in identifying the stages at which appropriate intervention for prevention or control of the disease can be undertaken.

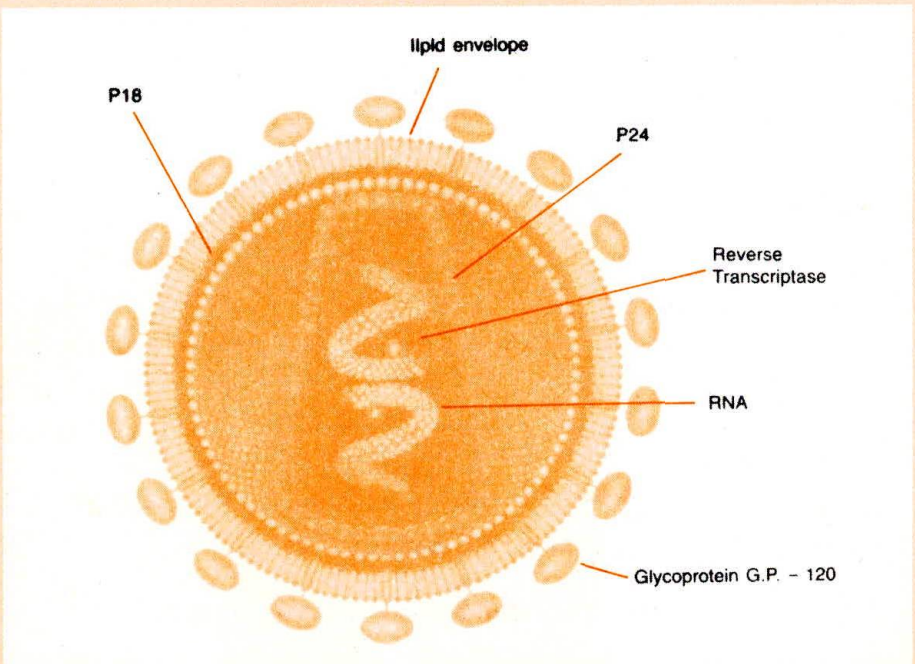
Pre-pathogenesis period

Human Immuno-deficiency Virus (HIV)

- HIV belongs to the family of Retro viruses
- There are two types of HIV Virus : HIV Type 1 and Type 2
- Both Types are prevalent in India, Type 1 is more frequently reported
- HIV Type 1 is a more virulent pathogen than Type 2

Fig.5

STRUCTURE OF HIV VIRUS



Host factors

Age & Sex

The spread of HIV infection occurs most frequently in the age group of 20 to 50 years. Globally, out of one million newly infected cases, 50 per cent are females. In India according to NACO, however, the male to female ratio is 3:1. APAC sponsored community prevalence study in Tamil Nadu shows almost equal ratio between males and females.

Susceptibility of infection vis-a-vis sexual practices

- The receiving partner is at a greater risk than the insertive partner, in both vaginal and anal intercourse. The risk of transmission from male to female is higher than transmission from female to male because female is the recipient partner in sexual intercourse.
- Anal sex carries a higher risk than vaginal sex
- Oral sex and deep kissing carry low risk relatively
- A good degree of protection is provided to persons using condoms. The safety depends upon the type of condom and its correct and regular use

High Risk Behaviours

Based on the epidemiological characteristics of HIV infection, certain high risk behaviour groups, who are likely to be harbouring infection more frequently than the general population, have been identified.

- People with multiple sex partners (commercial sex workers, men who are away from their families for long periods, as they are likely to have extra-marital sex) and homosexuals
- Injecting drug users, because they share needles and syringes

- People requiring frequent transfusions of blood e.g. haemophiliacs, thalassemics etc

Routes of transmission

- Sexual intercourse (heterosexual or homosexual), when one of the partners is infected
- Transfusion of infected blood
- Use of contaminated needles / syringes
- From an infected mother to her baby

Fig.6

PROBABLE SOURCE OF INFECTION (NACO Dec. '96)

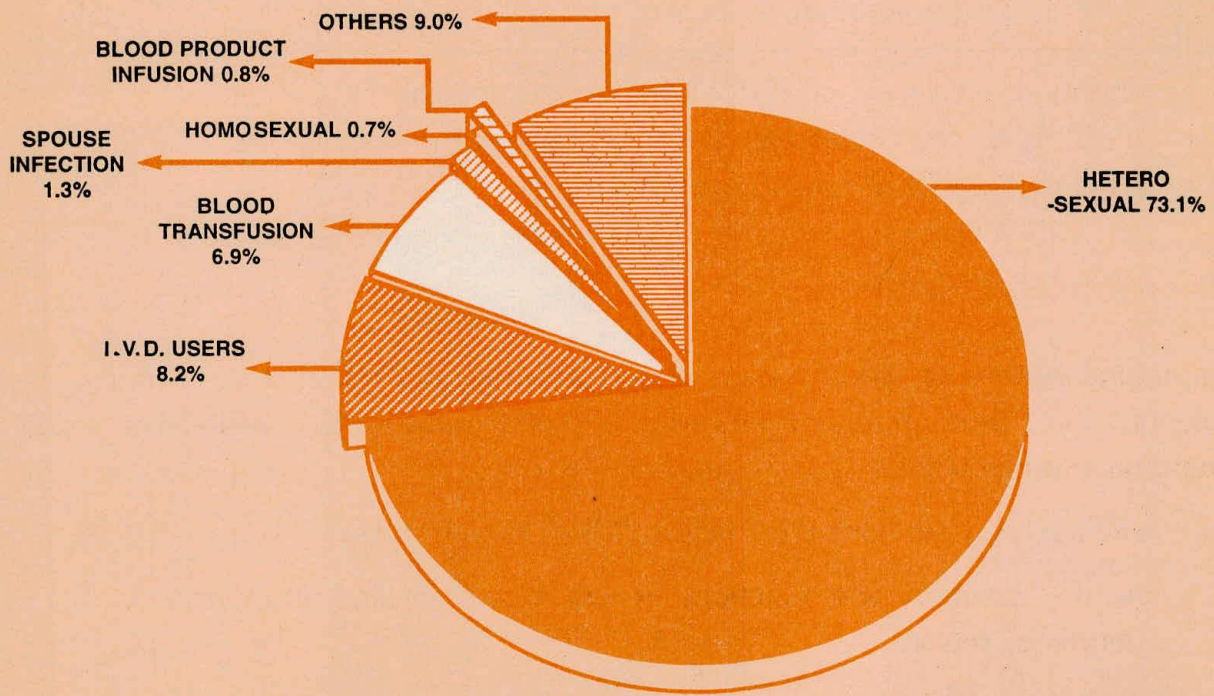


Table 3 : INTENSITY OF DIFFERENT MODES OF TRANSMISSION

S. No.	Modes of transmission	Intensity
1.	Sexual intercourse* - Vaginal - Anal	0.1 – 1.0 %
2.	Blood transfusion	90 – 95 %
3.	Perinatal	20 – 40 %
4.	Injecting drug use	0.5 – 1.0 %
5.	Needle type exposure (health care settings, needle stick injury, tattooing etc.)	0.5 %

* Although efficiency of this mode of transmission is low, it accounts for the commonest mode of transmission because the absolute number of risk intercourse is more.

Pathogenesis period

The natural history of HIV infection begins as soon as virus enters the body of a susceptible host through any of the routes of transmission as discussed earlier (sexual, parenteral and perinatal).

- HIV infects predominantly T helper (CD 4) Lymphocyte
- As the numbers and functions of CD 4 cells decline, immune deficiency sets in
- As immune deficiency progresses, the subject develops secondary (opportunistic) infections and malignancies and further constitutional signs and symptoms of the diseases contracted

Window period and period of latency

6 weeks – 3 months	From 3 months upto 2-10 years	After 2 to 10 years
HIV antibodies reach a high titre approximately 3 months after the virus has entered the body	Anybody who has the virus is a carrier and can infect others	Signs and symptoms of a disease manifest
If the tests like ELISA & Western Blot are performed within three months, they may be reported as negative. This is known as the Window Period	He/she has no symptoms of the disease at this stage. The person is considered HIV positive as revealed by a positive test.	These can be grouped under major and / or minor conditons
However the patient will be in a carrier state transmitting the disease to others by all routes mentioned	A person can be an unknown carrier for many years before the virus has destroyed much of the immune system that he/she falls ill.	Dies due to opportunistic infections and / or AIDS
Window Period	HIV Positive	
Period of Latency for AIDS from the time of HIV infection		AIDS Case

Diagnosis

- HIV infection is diagnosed by blood tests for antibodies
- HIV antibody tests usually done are : 1. ELISA test 2. Western Blot test

- ELISA test is also specific and less expensive. Commonly used for screening at blood banks, voluntary testing etc.
- Western Blot test, though more specific, is costly. Confirmation can also be done by using results from 3 consecutive ELISA tests from different kits
- HIV antigen can be detected through PCR test and viral load assessment tests. Using these tests has shrunk the Window Period but these two tests that can detect presence of HIV virus early are available in few places at Chennai

How HIV infection is not spread?

HIV infection will not spread through casual contact, such as

- At work place or schools
- Coughing or sneezing
- Sharing cups, glasses, plates and other eating utensils
- Through water or food
- Handshakes
- Touching or hugging
- Mosquitoes and other insect bites
- Wearing clothes of infected persons
- Going to swimming pools or public baths
- Using telephones
- Using toilets

How can transmission of HIV infection be prevented?

- By observing the **ABCs** of safe sex viz. **A**bstaining from sex or practising safer sex by not exposing a partner or oneself to body fluids such as semen and vaginal secretions; **B**e faithful to your sexual partner; **C**ondom use: when used properly, prevents semen, vaginal secretions or blood from entering the body
- Not sharing contaminated needles, syringes or other skin-piercing equipment with others, since they may be contaminated with blood
- Not reusing contaminated needles and syringes employed for medicinal purposes before properly autoclaving them
- Screening blood and blood products for HIV
- Autologous blood transfusion

FACTS SHEET

Epidemiology of HIV/AIDS

Global Problem : There is a global problem of AIDS/HIV which is increasing alarmingly (more than 20 million by the year 2000 AD).

Largest number of AIDS cases in India next to Maharashtra is in Tamil Nadu.

Positive Cases : There are 4,50,000 estimated HIV positive cases in Tamil Nadu (1998). (Refer STD prevalence study of APAC)

Deaths : 1 lakh people are expected to die due to AIDS by the year 2002.

High Risk Behaviour includes having multiple sex partners, sex with casual partners and not using condoms, injectable drug uses and homosexuality.

Route of transmission : Sexual intercourse, infected blood transfusion, contaminated needles / syringes, infected mother to baby.

Window Period upto 6 weeks to 3 months from HIV contact.

Tests to be done only after counselling : detect antibodies - ELISA and more specific, the Western Blot test.

Normal Carrier : HIV positive person, outwardly normal and can live normally for 5 to 10 years, is infective, but not through casual contact.

End stage of HIV infection is AIDS, the body succumbing to opportunistic infections.

Care and Counselling : Both HIV positive and AIDS cases require counselling for family care and support.

Session 2

STD AND HIV/AIDS

General objective

To understand the magnitude of STD and the relationship between STD and HIV/AIDS for Prevention and Control of HIV/AIDS.

Learning objectives

At the end of the session, the participants will be able to :

- Understand the magnitude of STD in India
- Recognize the role of STD in transmission of HIV/AIDS
- Recognize the special problems of STD in women

STD - the problem

In answering problem, we need to explore three issues :

- The extent of STD in the population, and
- The complications caused by STD when patients are not treated effectively,
- The link between STD and transmission of HIV.

STD, including HIV, are caused by the same high-risk sexual behaviour.

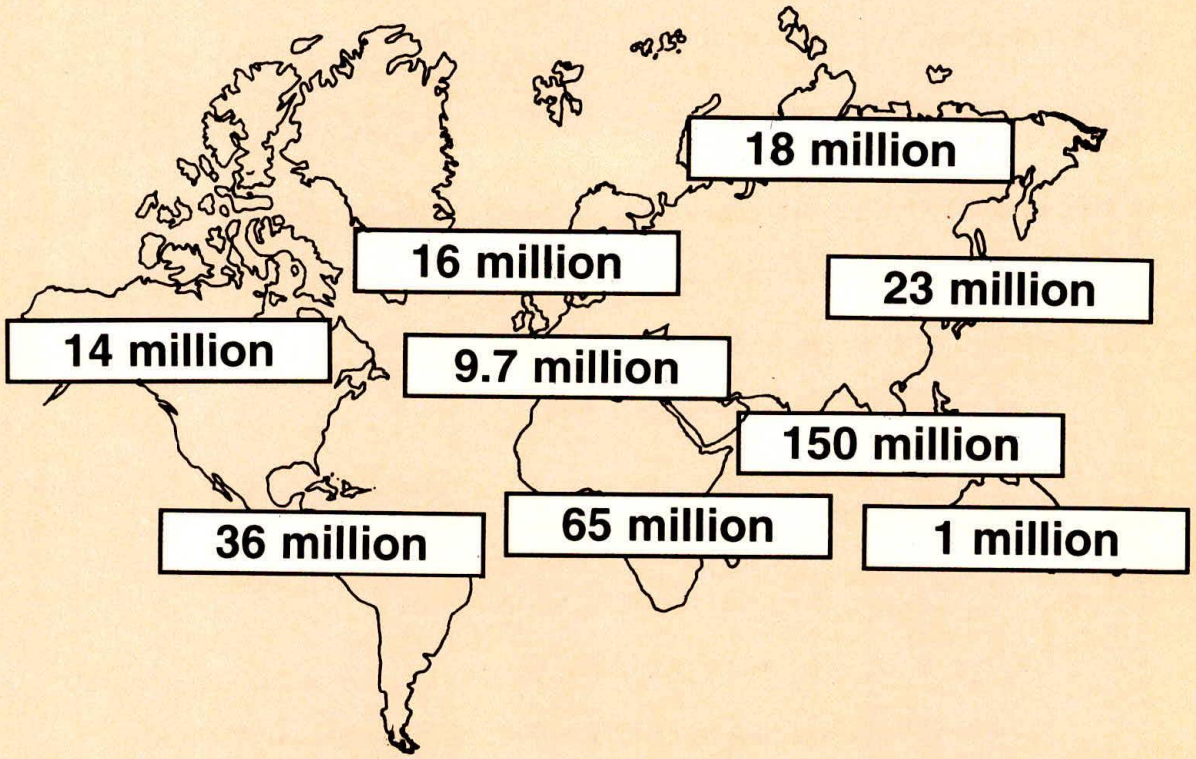
Having multiple partners and changing partners often are risky and expose people to STD.

Extent of the problem of STD

Worldwide in 1995, the World Health Organization estimated that there were over 330 million new cases of curable STD (Gonorrhoea, Syphilis & Trichomoniasis)

Fig.7

ESTIMATED NEW CASES OF CURABLE STD AMONG ADULTS, 1995 (WHO)



GLOBAL : 333 MILLION

Magnitude of problem in India

The total annual incidence of all STD in India is estimated at around 5 per cent (TNSACS/NACO). Thus, it is estimated that each year approximately 40 million new infections with STD occur. They must be tested and kept under surveillance for HIV. Prevalence of STD in Tamil Nadu was 15.8% in the age group of 15 - 45 years as per a research study conducted by APAC in 1997 (includes HIV and hepatitis 'B').

Who is affected?

STD including HIV Infection, are widespread throughout the world. They affect sexually active people of both sexes. So STD occur in both males and females. However, statistics rarely show an equal distribution between men and women, nor do they show an equal distribution between different age groups.

Distribution of STD by age and sex

For both males and females, rates of STD tend to be the highest in the 15-30 age group, decreasing in later ages.

Most large studies show that, after the age of 19, cases occur more or less equally in both sexes. However, there is usually a slight male preponderance. There are several possible reasons, some perhaps more obvious than others:

- Sexually transmitted infections often produce no symptoms or only mild symptoms in women. So, fewer women come forward for treatment and therefore they fail to appear in statistics;
- Services in general may be more accessible to men than women. For example, where men migrate to urban services and therefore are more likely to appear in statistics;
- Cultural and economic constraints might also prevent a proportion of women from attending for treatment;
- A large number of men might be infected after practising unsafe sex with a small number of sex workers;

- Older men in the later part of reproductive age group may be more sexually active than women of the same age;
- Men are more likely to change partners than women

However, it must be remembered that the problem of STD in women is hidden as revealed by surveys undertaken at antenatal, family planning and gynaecological clinics. They show a high prevalence of STD among the women and mostly they are asymptomatic.

STD transmission

In many developing countries throughout the world, sexually transmitted diseases (STD) rank among the top five conditions for which adults seek health care (WHO/UNAIDS). These diseases are important for two reasons: their magnitude and their potential for causing serious complications.

The advent of the human immunodeficiency virus (HIV), another sexually transmitted infection, has drawn attention to the urgent need for prevention and control of STD.

This section will help you to answer three questions:

- How are STD transmitted?
- What types of behaviour increase the risk of transmission?
- What biological and social factors influence transmission?

Mode of transmission of STD

As the name implies, the main mode of transmission of STD is through unprotected penetrative sexual intercourse (vaginal or anal). Other modes of transmission include:

- mother-to-child: during pregnancy (HIV and syphilis), at delivery (gonorrhoea and chlamydia) or after birth (HIV)
- Transfusions or other contact with blood or blood products (syphilis, HIV)

Behaviours influencing transmission

If the main mode of transmission of STD is through sex then the following factors increase risk of infection:

Risk behaviours

- Having more than one sex partner
- Having a partner who has other partners
- Having sex with 'Casual' partners, commercial sex workers or their clients (partners whose other contacts are not known and whose status in terms of STD is not known)
- Continuing to have sex with person having symptoms of STD

Not using a condom in any of the above situations exposes both partners to a high risk of infection.

Social factors that influence transmission

- Failure to follow 'safe sex' measures, such as using condoms
- Approval of multiple partners by social acceptance like 'Devadasi System'
- Delay in getting STD treatment
- Not taking the full prescribed course of treatment for STD
- Failure to bring in sexual partners for treatment for STD
- Myth that having sex with a virgin young child cures STD

Biological factors that influence transmission

Apart from behavioural and social factors, certain biological factors also increase transmission of STD

- **Age**

  The nature of the vaginal mucosa and cervical tissue in young women makes them very susceptible to infection. Young women are specially at risk in cultures where they marry or become sexually active during their early teenage.

- **Gender**

  STD are primarily transmitted to women through vaginal intercourse. It is easier for a woman to be infected by a man than for a man to be infected by a woman in this way. This is because women have a larger surface exposed (i.e. the vagina) during penetrative sex as well as the fact that the infected semen stays longer in the vagina.

STD - a Cofactor in transmission of HIV/AIDS

AIDS is an STD

AIDS is an STD because the primary mode of transmission is through the sexual route. The individual and social environmental facors for sexual behaviour are the main cause for both infections. Whereas most of the STD will present with one symptom or the other, AIDS is almost totally asymptomatic until in the later stages.

Link between STD and AIDS

- Both STD and HIV predominantly have the same route of transmission, i.e. the sexual route
- Risk behaviour in individuals predisposed to STD and HIV is just the same

- Other STD make it easier for HIV to be transmitted from one partner to the other. For instance, the mere presence of chancroid, chlamydia, syphilis and trichomoniasis may increase HIV transmission, maybe three to nine times in heterosexual men
- Infection with HIV affects other STD by making them more resistant to treatment, e.g. single dose treatment for chancroid fails at least six times more often in HIV infected individuals than in others
- STD clinic / General Practitioner's clinic provides an important access point for people at high risk, for both STD and HIV infection, not only for diagnosis and treatment of STD but also for education and prevention
- Trends in STD incidence and prevalence can be used as indicators of change in sexual behaviour and thus to measure the trends in HIV transmission and impact of AIDS control interventions based on behavioural change

STD as a Co-factor

Even though the sexual route is the main mode of transmission of AIDS, HIV is not so readily transmitted (Table 3 in Session 1). In fact compared to diseases like Hepatitis 'B' and Syphilis, HIV is far less infectious. It is estimated that the risk of infection with HIV through sexual route is between 1 in 1000 (0.1%) and 1 in 100 (1%) exposures. Nevertheless, the large size of population and the frequency of exposure account for this route as the most important method of spread.

But in the presence of other sexually transmitted diseases, especially those that produce genital ulcers, there is a five-fold increase in the risk of transmission of HIV. This is explained by the fact that a co-existing ulcerative disease makes it easier for HIV to gain entry into the body through the ulcerated area. In addition, the virus accumulation and shedding is more in ulcerated areas in the HIV carrier. Exposed blood vessels like during menses make it easier for it to be transmitted. It is also proved that even non-ulcerative

STD conditions in females result in T4 lymphocyte accumulation in the cervix, thus rendering them more vulnerable for HIV infection.

Commercial sex workers, long distance truck / van drivers and cleaners, travelling men, construction workers, rickshaw-pullers and hostel based students are relatively more prone to sexual promiscuity and therefore to STD. This is also confirmed by the HIV sero-prevalence corresponding to similar behaviour pattern.

The enhancing role of other STD on HIV transmission explains the need for prevention and early treatment of other STD as an effective measure to contain the HIV pandemic. Due to this reason, WHO has an integrated STD programme in the Global Programme on AIDS (GPA). This has already borne results as shown by the experience in developing countries like Tanzania which, through effective control of STD, has decreased the incidence of HIV by 42%.

Women and STD

Past observations have shown that STD are more easily transmitted to women from men than vice versa. This being so, HIV also should be more easily transmitted to women from men than the reverse. In Tamil Nadu, the data from the Department of STD, Government Rajaji Hospital, Madurai, shows that in the period between 1986 and 1992 as many as 78.5% of women infected with HIV were Commercial Sex Workers (CSWs) with more than 70% of them having one or more STD conditions as a co-factor. But in 1993-94, an increasing trend for HIV infection among housewives (whose only risk factor is a promiscuous husband with frequent STD infections) has been observed. Most of these women never knew that they had an STD.

Sexually Transmitted Diseases (STD) have implications which are rather more serious in women than in men. The symptoms and sequelae of STD vary from men to women and the latter experience a greater psychological stress.

Asymptomatic STD are more frequent in women. Very often the disease presents at a concealed site, not visible to the female patient. Moreover, the common symptom of STD in a woman, namely, 'the discharge' is exhibited by many common and non STD

conditions, and masks early recognition of STD in such women and so there is delay in seeking treatment or is not treated at all.

The long-term complications of STD are far more serious in women than in men. The important complications are risk of cancer, infertility, miscarriage, stillbirth, risk of ectopic pregnancy and inadvertent transmission of pre-natal infection with a high rate of morbidity and mortality.

Their access to special treatment centres like a STD clinic is less. This is due to several social and cultural factors including non availability of appropriate health service.

FACTS SHEET

STD and HIV/AIDS

Each year 40 million new infections with STD occur in India.

Risk behaviour includes multiple partners, having a partner who has other partners, sex with casual partners, homosexual behaviour, non use of condoms.

Commercial Sex Workers, long distance truck drivers, travelling men, construction workers and hostel based students are relatively more prone to promiscuity and therefore to STD.

Social factors that influence transmission are, not following "safe sex", delay in getting treatment, not taking full course of treatment, failure to bring partners for treatment.

AIDS is an STD, as the primary mode of transmission is sexual.

HIV transmission risk is increased by STD because of the same risk behaviour and because of presence of ulcer and other reasons.

Women and STD : easily transmitted, mostly asymptomatic, delay in seeking treatment and long term complications are more serious.

Problems in STD care include shortage of trained personnel, delay in diagnosis and treatment, lack of compliance to treatment of patient and partner, no counselling.

Quality care for Prevention of STD cases will prevent / control AIDS Pandemic.

Module II

Quality STD Care

Session 3

PROBLEMS IN MANAGEMENT OF STD

General objective

The General Practitioners will be able to know and tackle the complexities of giving 'total' treatment for STD patients and to understand the special problems in providing STD services to women.

Learning objectives

At the end of this session, the participant will be able to :

- Adopt "total treatment" for STD patients
- Understand the problems in ensuring treatment compliance, partner treatment and follow-up of STD cases
- Be aware of clinical issues specific to women and STD including the need to look out for asymptomatic cases and their management
- Be aware of the need to maintain records of STD case management

"Total treatment" of STD patients

For Quality Care of STD, the following important aspects of management should be taken into account :

- Compliance with treatment
- Partner treatment

- Follow-up
- Referral for treatment failure or complications

Problems in STD case management

In a treatment setting where STD patients are managed, certain problems are often encountered. The common and important problems are :

- Delay in seeking treatment
- Compliance with treatment
- Partner management
- Follow-up
- Referral of cases with complications
- Maintenance of case records

Delay in treatment

It is well known that most STD patients delay seeking treatment. A study conducted at a Madurai STD clinic revealed that the average duration of symptoms prior to attending STD clinic was 13 days for men and 30 days for women. It is not the patient taking treatment who spreads the disease, but it is the one who does not initiate treatment.

Reason for delay in treatment

The major reasons for delay in seeking treatment are the stigma and ignorance associated with STD. Many men and women want to conceal their disease as long as possible; women in particular are slow to recognise the symptoms of STD and to avail of treatment. Attending public STD clinic is a painful experience for many men and women.

Feeling of shame, guilt, anxiety and fear further adds to their difficulties. Again the negative attitude of the health providers, the inaccessibility of the clinic, the inconvenient

working hours of the clinic, long waiting time, lack of privacy in certain set up, too many hospital procedures and frequent change of physician etc. add to the delay in seeking treatment.

Compliance with treatment

Non-compliance with treatment of STD affects the outcome of management, leads to complications, produces inestimable costs, both economic and human, and also results in frustration of the treating physician.

The factors pertaining to the patients are ignorance, fear of being identified in a STD clinic, anxiety / fear of tests and treatment, financial constraints, distance from residence to clinic and patient's own beliefs.

In a treatment setting, factors leading to non-compliance are negative attitude of some healthcare providers, inconvenient working hours, prolonged waiting time, delayed treatment, complicated treatment regimens, lack of privacy, inadequate time spent with the patient, insistence of clinic personnel to bring the partner(s), frequent change of physician and too many hospital procedures.

The 'stigma' associated with STD, societal ignorance of STD/HIV/AIDS and social disapproval of promiscuity, prostitution and homosexuality also hinder the treatment compliance of STD patients.

REMEDIAL MEASURES for Non-compliance are :

- For the Patient
  - ☞ Education and counselling of the patients
- In the treatment setting
  - ☞ Providing a treatment setting with privacy
  - ☞ Convenient working hours
  - ☞ Minimal waiting time
  - ☞ Personnel with non-judgmental and empathetic attitude and

☞ Facilities for early diagnosis and treatment through use of simplified treatment regimens, as suggested in the flowcharts for syndromic management of STD, will achieve a better compliance with treatment of STD patients

Partner management

Partner management is an essential component of total treatment of STD; otherwise the patient is very likely to acquire re-infection from the untreated partner(s). A general practitioner should aim at the "simultaneous treatment" of partners of STD patients. In a clinic-based study at Madurai, the partner treatment rate was as low as 30%. Among the married patients only 28% brought their spouses for treatment. The reasons for low partner treatment rate were :

- The fear of the disease will become known to partners
- Inability to bring the 'Primary contact' who was CSW
- Fear of being identified in the STD clinic by others
- Strained marital relationship
- Unwillingness of partners to attend STD clinic
- More often, it was the asymptomatic status of STD in the partners

Follow-up & referral

Follow-up is essential to assess the outcome of the treatment and whether total treatment is achieved.

In case of treatment failure, health provider should find out whether failure is due to non-compliance of the treatment or due to complication. In this process he can initiate action to retreat or to refer the patient to a specialist or to higher centre for further management. Certain problems include treatment failure, drug resistance, complications or late sequelae like sterility, neuro-syphilis, eye complications, stricture urethra etc.,

Maintenance of case record

Maintenance of records for STD case management services is 'the tool' for follow-up. It should be done whenever possible even though it may be too difficult for a busy general practitioner to maintain extensive records. STD record should have details such as name, age, sex, correct and complete address, complaint and duration of treatment given, history of drug allergy, previous STD and partner treatment. Patient counselling and condom usage details should also form an essential feature of any recording system.

Due to the importance accorded to the need for maintaining records, a separate session is earmarked elsewhere in this module.

Special problems in providing STD care to women

Sexually Transmitted Diseases (STD) have implications which are rather more serious in women than in men, and the symptoms and sequelae of STD vary in women and the latter experience a greater psychological stress.

Challenges in Diagnosis and Management of STD in women

- Asymptomatic STD are more frequent in women. Very often the disease presents at a concealed site, not visible to the female patient. Moreover, the common symptom of STD in a woman, namely, 'the discharge' is exhibited by many common and non-STD conditions, and masks early recognition of STD in such women
- The long-term complications of STD are far more serious in women than in men. The important complications are risk of cancer, infertility, miscarriage, stillbirth, risk of ectopic pregnancy and inadvertent transmission of pre-natal and peri-natal infections with a high rate of morbidity and mortality

  The important STD like syphilis, gonococcal infection, chlamydial infection, herpes simplex infection, trichomoniasis and human papilloma viral infection pose special problems for women

- While many of these STD manifest as overt diseases in men who seek early treatment, in case of women the symptoms are not so well defined and are often similar to those of other diseases. Therefore, women with STD delay seeking treatment or seek treatment from a variety of health providers like traditional health care deliveries
- Syphilis in pregnant women has a special connotation with many deleterious effects. It is associated with foetal wastage. Apart from miscarriage and stillbirth, late manifestations like malformation of teeth interstitial keratitis may persist throughout the life of the infected child with resultant 'stigma'
- In gonorrhoea, the commonest primary site of infection is endocervix and most women are asymptomatic. Detection of gonococcal infection in women is both cumbersome and costly. It requires a 'culture', the result of which can be available after a delay of a minimum of 24 hours, and which requires special 'selection media' and handling. A common and serious sequele of gonococcal infection in women is the spread of infection to the endometrium and fallopian tubes, leading to Pelvic Inflammatory Disease (PID). The sequelae of PID include peritonitis, tubal abscesses, ruptured ectopic pregnancy, infetility and chronic or recurrent infection necessitating hysterectomy. Gonococcal PID is not easily diagnosed as there is no standard laboratory test and the criteria for diagnosis of PID vary widely. The treatment of PID is also complex and controversial. The treatment regimens for PID have high failure rates
- In sexually transmitted Chlamydial infection, the commonest presentation is 'asymptomatic endocervicitis' in women, while it is symptomatic urethritis in men. Like gonococcal infection, untreated chlamydial cervical infection can ascend to the fallopian tubes and cause PID. Although chlamydial infection of the cervix is expected to be common in women, it is rarely

diagnosed. This is due to the fact that it is often 'symptom free' and a confirmatory test like Chlamydial culture is technically difficult and expensive. This diagnostic facility is available only in a few selected laboratories. Under these circumstances, treating the female partners of men with Non-gonococcal Urethritis (NGU), a common aetiological agent of which is chlamydia, would be the correct epidemiological approach but this is not routinely done

- Herpes Simplex Virus (HSV) infection in women, too, poses special problems
  - ☞ Infected women have increased risk of developing cancer in cervix
  - ☞ Inadvertent transmission of the virus to the newborn during delivery can lead to a life threatening neonatal herpes

  In view of this, women with recurrent episodes of disease are advised to have a routine Pap smear done every year to detect pre-cancerous change at the earliest. The infection of the neonate can be prevented by Caesarean section for women with HSV infection in the birth canal at term.

- Trichomoniasis is the commonest cause of vaginal discharge in women. In fact, trichomoniasis is the commonest STD in women. Though not serious, trichomoniasis is an annoying disease causing much mental and physical distress. Though the disease is frequently associated with copious, frothy vaginal discharge with an unpleasant odour and itching, it is at times asymptomatic, the disease being diagnosed by a routine microscopic examination of wet film of the vaginal discharge. Asymptomatic cervical infection has been found to be associated with abnormal Pap smears

- Human Papilloma Virus (HPV) causes warts. In women, warts may be too large or extensive and are often difficult to treat. Warts increase in size enormously during pregnancy and severe

infection may complicate vaginal delivery. It is possible that a woman may harbour the 'wart virus' without an overt disease but may have Cervical Intra-epithelial Neoplasia (CIN)

To summarise

- The consequences of STD are more serious in women than in men
- The signs and symptoms for many STD are not well defined and are often similar to those of other diseases
- Also for various reasons, women delay seeking treatment
- Their access to special treatment centres like STD clinic is less

These are challenging issues that need to be addressed by the General Practitioner and for this the initial step is to be aware of these special problems in women and be on the lookout for them to be able to reduce missed opportunities for treatment.

Session 4

SYNDROMIC CASE MANAGEMENT

General objective

The trainee should be able to acquire clinical knowledge and skills in the use of standardised treatment regimens for STD syndromes in primary health care settings.

Learning objectives

At the end of this session, the participant will be able to :

- Describe the advantages of syndromic case management
- Classify the main causative agents responsible for different clinical syndromes
- Use flow-charts for Syndromic Diagnosis and Management
- Prescribe Standardised Treatment regimens for STD Syndromes

STD management approaches

In general there are two approaches in the management of STD, one is based on aetiological diagnosis and the other is clinical.

Aetiological diagnosis poses several problems, namely, to identify as many as 20 STD causative organisms requires skilled personnel and sophisticated laboratory.

eg: Gonococcal & Chlamydial infections - require facilities like culture, which are non-existent in many a laboratory setup.

Primary and secondary syphilis needs dark-field microscope. Tests for other STD like herpes etc. are even more complicated.

Majority of patients with STD seek treatment from general practitioner's clinic or ill equipped STD clinics which lack required facilities and skilled personnel. Laboratory services are both expensive and time consuming. Similarly clinical diagnosis has limitations. It is difficult to differentiate between various types of infections especially in the presence of mixed infections.

For example, clinical distinction cannot always be made between gonococcal infection and chlamydial urethritis. There are chances of misdiagnosis, hence syndromic approach.

In syndromic approach the symptoms and signs are grouped to identify the syndrome.

Advantages of syndromic management of STD

- Classifying the main aetiological agents by clinical syndrome
- Using the flow charts the treatment for each syndrome is prompt and can be instituted at any first line health facility
- There is wider access to treatment catering to a large needy population
- There are ample opportunities for preventive measures and promotion of condom use

Syndromic case management is

- Scientific
- Simple to treat with good drug compliance
- Free from errors in clinical judgment
- Effective against mixed infections
- Cost effective in the long run and does not require laboratory tests

Now health care providers are able to appreciate that the syndromic approach is very effective. Indeed it is the only approach that meets the main need to control the spread of STD by offering immediate treatment at the first visit. In view of difficulties in aetiological and clinical diagnosis of STD, a third approach to STD management is introduced which is called Syndromic Case Management.

The main features of syndromic case management

- Classifying the main causative agents by clinical syndrome they produce
- Using treatment flow chart for each syndrome
- Treating the patients for all important causes of the syndrome and
- Ensuring that partners are treated, patients educated, and the use of condom promoted

Even though STD are caused by different organisms, these organisms give rise to only a limited number of syndromes. A syndrome is simply a group of symptoms complained of by patients and the sign found on examination.

Responding to criticisms of the syndromic approach

The syndromic approach isn't scientific

On the contrary, it is based on epidemiological studies conducted throughout the industrialised and developing world. A number of validation studies have been done comparing syndromic diagnosis with laboratory assisted diagnosis. These studies found syndromic diagnosis to be similar to laboratory-assisted diagnosis, and hence accurate. As a result, syndromic diagnosis of STD has been adopted in many settings all over the world.

Syndromic diagnosis is too simple for a physician to use - it can even be used by nurses

Simplicity does not prevent physicians from using other tools, such as a thermometer or a stethoscope! It is a great advantage for STD control if other service providers, in addition to doctors, can use the syndromic approach to make a diagnosis. Simplified diagnosis and treatment also frees more time for health care providers to offer education for behaviour change.

The syndromic approach does not use a service provider's clinical skills and experience

Many clinicians rely heavily on their own clinical judgement. They find it difficult to accept that using a clinical judgement alone could be a problem. Not only do studies show that clinical diagnosis is accurate for only 50% of STD cases, but clinical diagnosis also misses mixed infections.

It would be better to treat the patient first for the most common cause and then, if the symptoms don't improve, treat for a second cause

Patients who are not cured by the first treatment may not return to the health centre and may even seek further treatment elsewhere, resulting in an inappropriate course of treatment. They may also become asymptomatic but still have an untreated STD, and if they have unprotected intercourse, they may spread the infection further.

The syndromic approach wastes drugs, because patients are being over-treated

In fact studies have shown that the syndromic approach makes STD care less expensive in the long run. The technology, skills and infrastructure needed to make an aetiological diagnosis are expensive. Failed treatment or a wrong clinical diagnosis that results in inappropriate or incomplete treatment then makes the cost of treating a patient higher because he has to be treated again and may develop complications and further spread the infection.

The syndromic approach promotes the development of antibiotic resistance

Antibiotic resistance emerges if people do not take enough antibiotic(s) to cure their infection(s) completely. With the syndromic approach, providers are encouraged to give standardised treatment using the most effective medications available for a given syndrome. Providers are also encouraged to use single dose therapy whenever possible thereby avoiding problems with patient compliance. Better communication between providers and patients makes it more likely that the patients will continue to take their medication as required after they leave the health centre.

Good, simple laboratory tests, such as Gram stain, should be included in STD diagnosis

When you include laboratory tests in the process, patients must wait for the results and may not return for treatment. Also, while they are waiting, they remain infectious and complications can occur. Gram stain is only justified when microscopy is readily available, quick and consistently accurate.

Identifying the Syndromes in STD

Even though STD are caused by different organisms, these organisms give rise to only a limited number of Syndromes. A Syndrome is simply a group of symptoms complained of by patients and the signs found on examination.

The Syndromes in STD are grouped as

- Genital Ulcer
- Urethral discharge in males
- Vaginal discharge
- Inguinal swelling
- Lower abdominal pain in females
- Scrotal swelling

The aim of syndromic management is to identify one of these six syndromes and manage it accordingly.

It includes only those syndromes that are caused by organisms which both respond to treatment and lead to severe consequence if left untreated. Other STD syndromes, such as vesicular lesions (herpes), genital warts and dysuria in women, are not included in this programme.

Using syndromic flow-charts

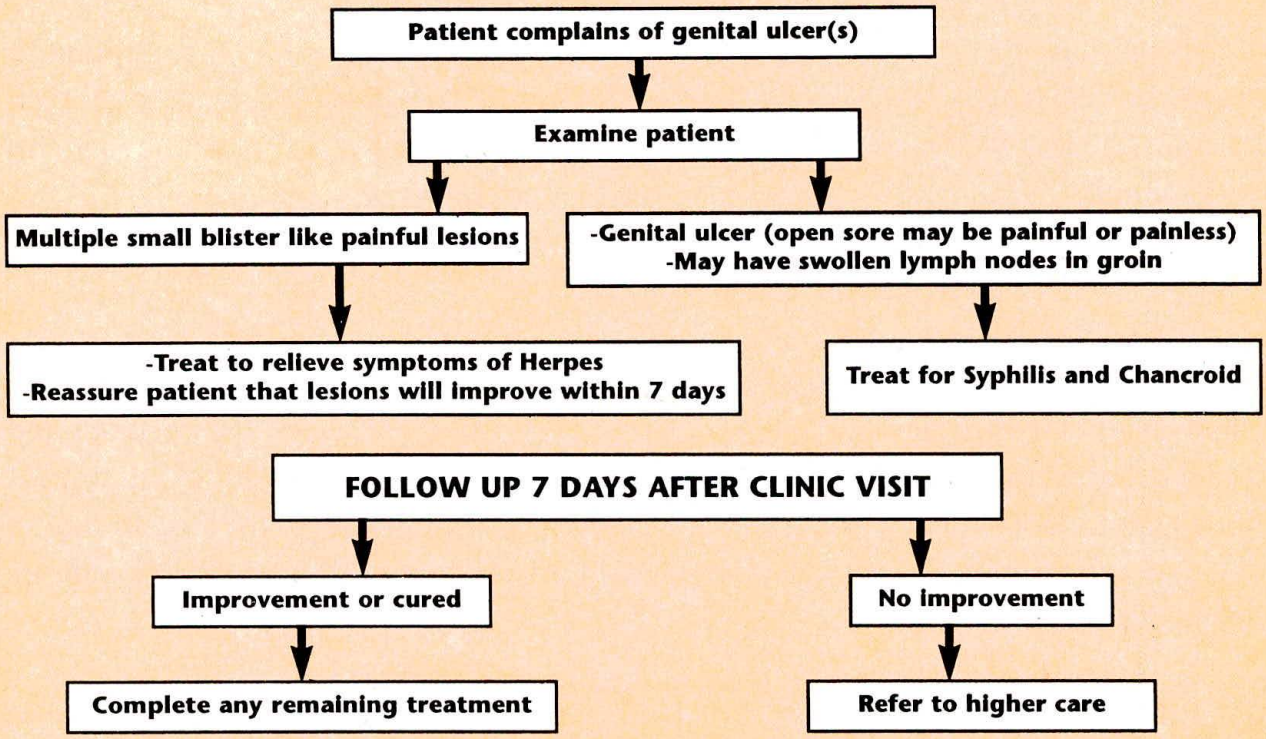
Because the above six syndromes are easy to identify, it has been possible to devise a "flow-chart" for each one. Each flow-chart takes us carefully through the decisions and actions that we need to take, leading to guidance on the condition(s) for which to treat the patient. Once trained, the service providers will find the flow-charts easy to use; so it is possible for non-STD specialists at any health facility to manage STD cases with the following benefits:

- Promptness of treatment, patients treated on their first visit
- Wider access to treatment, treatment being available at more centres
- Opportunities for introducing preventive and promotive measures such as education and distribution of condoms

Treatment for all the causative agents for the syndrome

While a clinical or aetiological diagnosis tries to treat just one causative agent, syndromic diagnosis includes immediate treatment for all the important causative agents thus quickly making the patient non-infectious and taking care of the mixed infections that are common in STD.

GENITAL ULCER



TREATMENT

SYPHILIS

Benzathine Penicillin G 2.4 million units in 2 injections (give one injection in each buttock)

OR

Aqueous Procaine Penicillin G 1.2 million units IM injection daily for 10 days

For men and non-pregnant women sensitive to Penicillin

Doxycycline 100 mg orally 2 times daily for 15 days

OR

Tetracycline 500 mg orally 4 times daily for 15 days

For pregnant women sensitive to Penicillin

Erythromycin 500 mg orally 4 times daily for 15 days

(Advise those women to bring the child within 7 days of birth for screening)

CHANCROID

Erythromycin 500 mg orally 4 times daily for 7 days

Alternative Treatment

Ciprofloxacin 500 mg orally as a single dose (do not give to pregnant women)

OR

Trimethoprim 80 mg/Sulphamethoxazole 400 mg 2 tablets 2 times daily for 7 days

OR

Ceftriaxone 250 mg in a single IM dose

HERPES SYMPTOMATIC THERAPY

- Apply topical antibiotic ointments. Advise patient to wash genital area regularly with soap and water.
- First episode - Acyclovir 200 mg orally 5 times daily for 7 days
- Recurrent episodes - Acyclovir 200 mg orally 5 times daily for 5 days

N.B. : Tetracycline and Doxycycline should not be used during pregnancy and lactation.

STEPS FOR STD PREVENTION AND MANAGEMENT

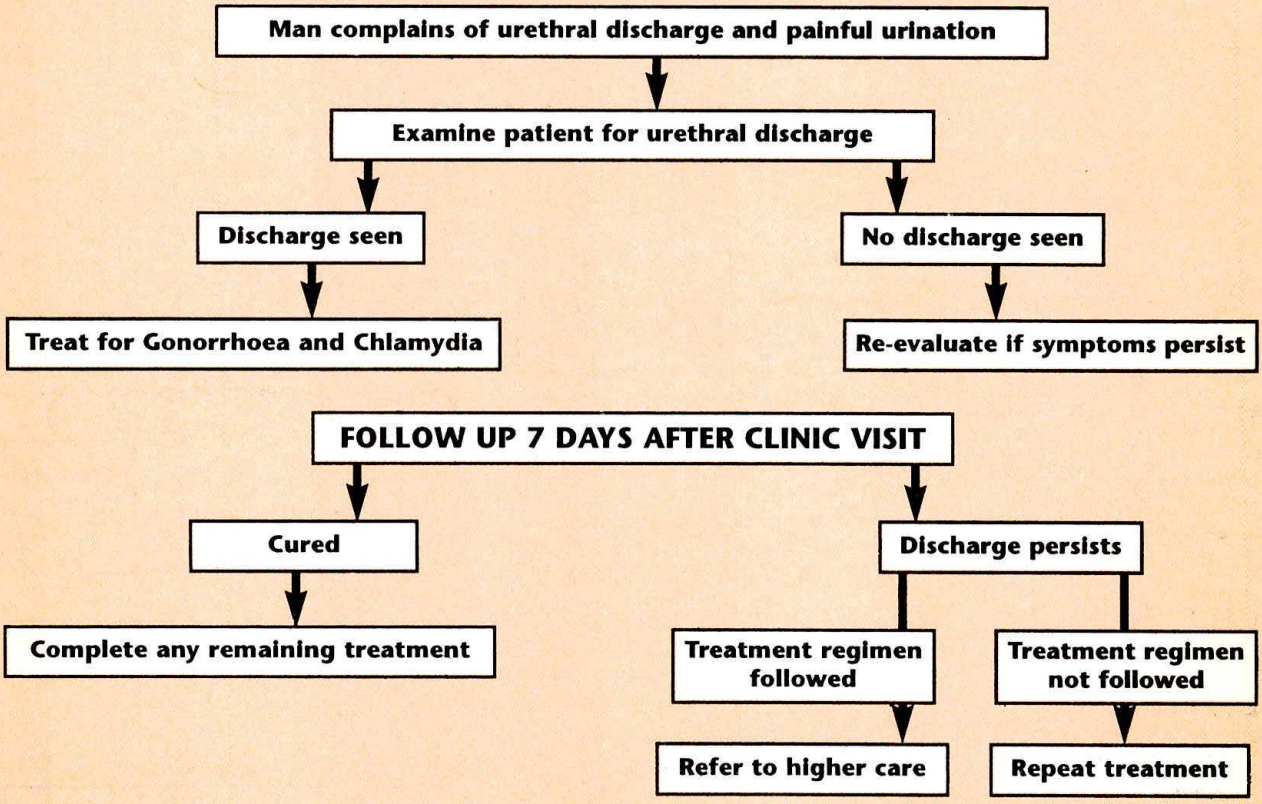
Give all patients

1 Treatment
2 Instructions for medication and follow up
3 Education and counselling
4 Condoms

Education and Counselling for patients

1 Cure your infection
2 Do not spread STD
3 Help your sexual partners to get treatment
4 Come back to make sure you are cured
5 Stay cured with condoms
6 Keep safe by staying with just one sexual partner
7 Protect yourself against AIDS
8 Protect your baby - ask your wife to attend ANC during pregnancy

URETHRAL DISCHARGE



TREATMENT

GONORRHOEA

Ciprofloxacin 500 mg orally in a single dose (contraindicated in pregnancy)

OR

Norfloxacin 800 mg orally in a single dose

OR

Kanamycin 2 g IM as a single dose

CHLAMYDIA

Doxycycline 100 mg orally 2 times daily for 7 days

OR

Tetracycline 500 mg orally 4 times daily for 7 days

OR

Erythromycin 500 mg orally 4 times daily for 7 days (pregnant women)

STEPS FOR STD PREVENTION AND MANAGEMENT

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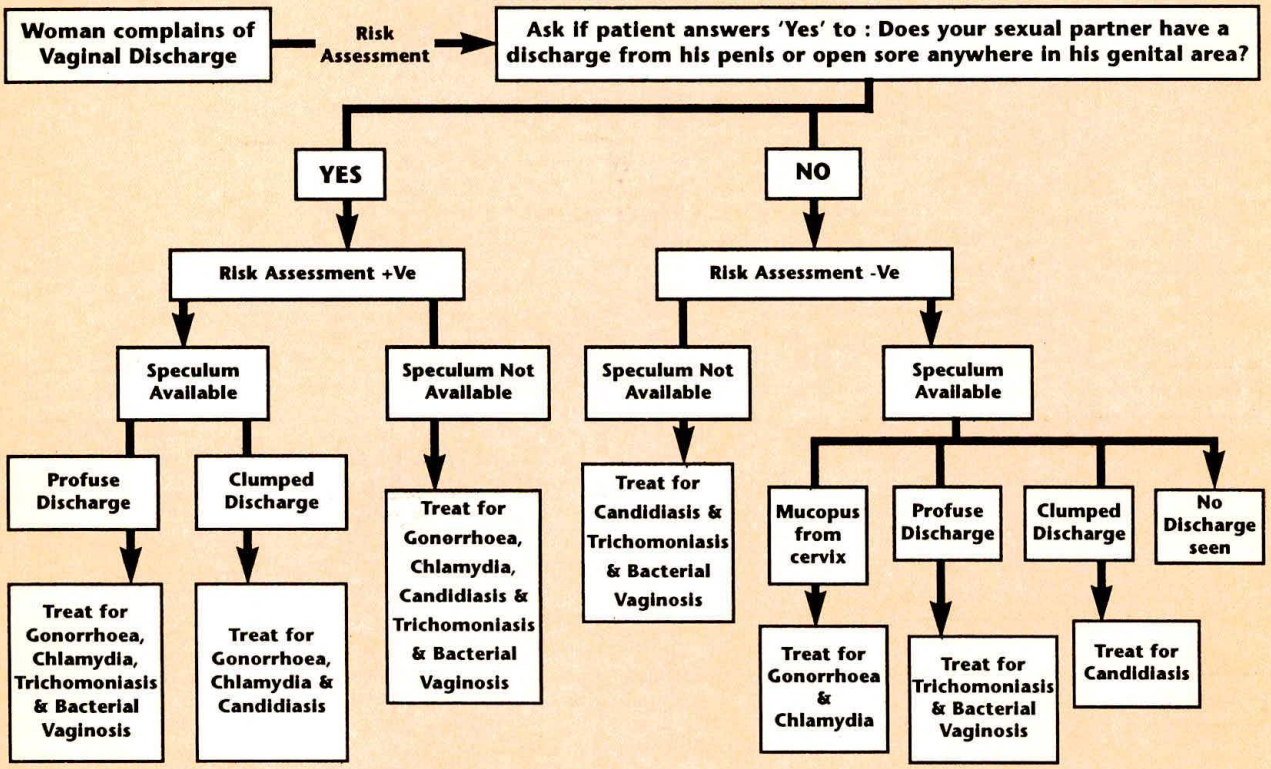
VAGINAL DISCHARGE



TREATMENT

Cervical discharge on speculum examination:

Treatment for Cervicitis includes treatment for both Gonorrhoea and Chlamydial infection.

Recommended regimen (non-pregnant women):

Ciprofloxacin 500 mg in a single dose orally

and

Doxycycline 100 mg orally twice daily for 7 days.

Alternative regimen :

Azithromycin 1 g single oral dose under supervision (effective both for Gonorrhoea and Chlamydial infection)

In case of pregnancy :

Inj. Ceftriaxone 250 mg single IM dose

and

Erythromycin stearate 500 mg orally four times a day for 7 days

Vaginal discharge on speculum examination

Recommended regimen :

Metronidazole 400 mg thrice daily for 7 days

and

Miconazole or Clotrimazole 200 mg intravaginally once daily for 3 days

or

Clotrimazole 500 mg intravaginally once only

or

Fluconazole 150 mg orally as a single dose

During the first trimester of pregnancy no Metronidazole must be given, and treatment is by Miconazole only.

N.B. : Tetracycline and Doxycycline should not be used during pregnancy and lactation.

STEPS FOR STD PREVENTION AND MANAGEMENT

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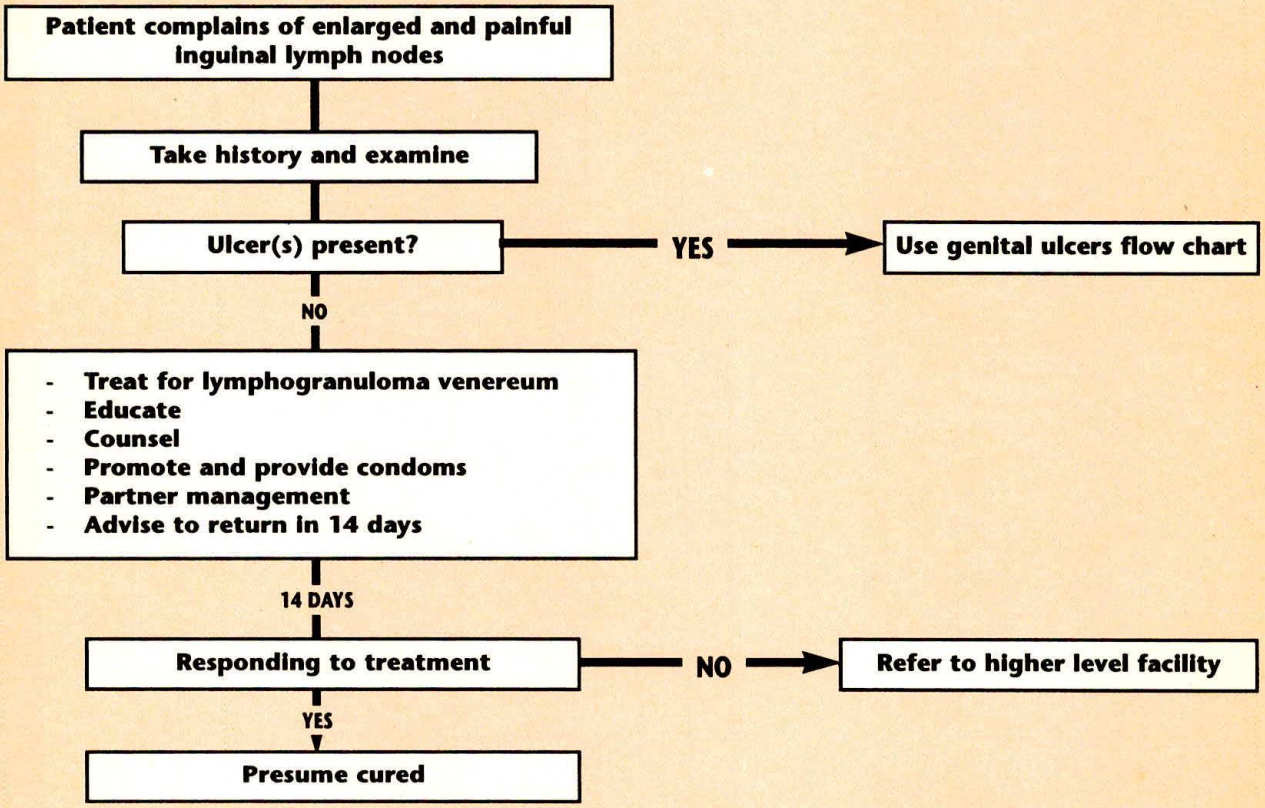
INGUINAL BUBO



TREATMENT

Doxycycline 100 mg orally twice daily for 14 days or
Tetracycline 500 mg orally four times a day for 14 days

Alternate regimen:
Erythromycin stearate 500 mg orally four times daily for 14 days.

If a bubo becomes fluctuant, pus should be aspirated with a wide-bore needle and syringe every second or third day, until there is no aspirate. The entry into the bubo should be made through normal healthy skin. Under no circumstances should a bubo be incised.

N.B. : Tetracycline and Doxycycline should not be used during pregnancy and lactation.

STEPS FOR STD PREVENTION AND MANAGEMENT

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Education and Counselling for patients

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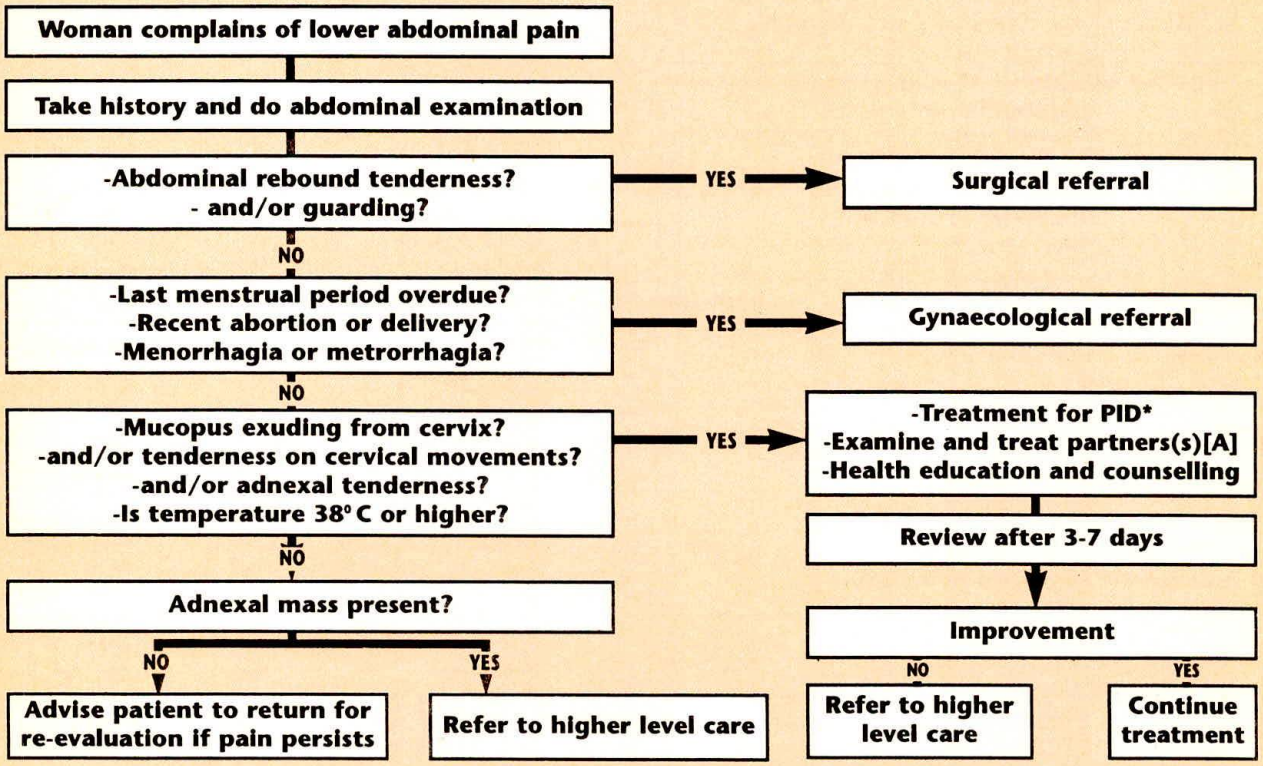
LOWER ABDOMINAL PAIN

(Speculum and bimanual examination possible with or without microscopy)



*For patients with IUD, remove IUD 2-4 days after starting treatment

TREATMENT FOR P.I.D.

(Gonorrhoea+Chlamydia+Anaerobic infection)
Use this regimen only if patient is well enough to take food and liquids. walk unassisted. take her medication, and return for follow up. Otherwise, refer to higher level care.

Single dose treatment for Gonorrhoea

Ciprofloxacin 500 mg orally as a single dose

OR

Norfloxacin 800 mg orally as a single dose

OR

Ceftriaxone 250 mg IM as a single dose

OR

Cefixime 400 mg orally as a single dose

OR

Kanamycin 2 g IM as a single dose

Alternative treatment if single dose treatment is not available

Trimethoprim 80 mg/Sulphamethoxazole 400 mg 10 tablets once daily for 3 days.

Plus Treatment for Chlamydia

Doxycycline 100 mg orally 2 times daily for 14 days

OR

Tetracycline 500 mg orally 4 times daily for 14 days

Plus Treatment for Anaerobic infection

Metronidazole 400 mg twice daily for 14 days

N.B. : Tetracycline and Doxycycline should not be used during pregnancy and lactation.

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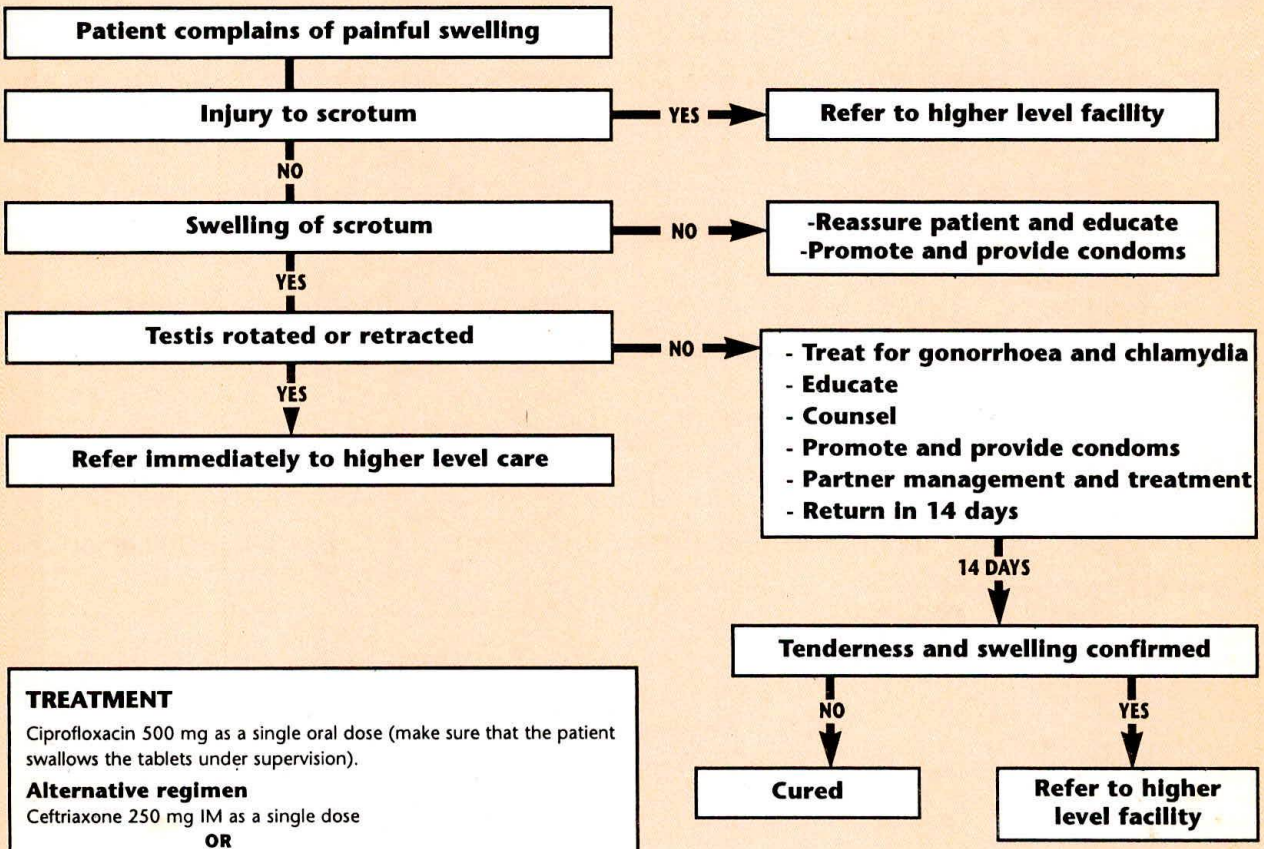
SCROTAL SWELLING



TREATMENT

Ciprofloxacin 500 mg as a single oral dose (make sure that the patient swallows the tablets under supervision).

Alternative regimen

Ceftriaxone 250 mg IM as a single dose

OR

Cefixime 400 mg in a single oral dose

OR

Kanamycin 2g IM as a single dose

Recommended regimen for Chlamydial urethritis :

Doxycycline 100 mg orally twice daily for 10 days (make sure that the patient receives 20 tablets or capsules with instructions to take one tablet in the morning and one in the evening).

Alternative regimen

Tetracycline 500 mg orally 4 times a day for 10 days or
Erythromycin 500 mg orally 4 times a day for 10 days or
Sulfisoxazole 500 mg orally 4 times a day for 10 days (equivalent doses of other sulfonamides may also be used).

Supportive therapy

This is a painful condition and supportive therapy with

- Bed rest
- Scrotal elevation with a scrotal support and analgesic is essential part of management
- Advise the patient to take all his tablets and inform him about the mode of transmission of STD and the possible complications of infection and, in particular, epididymo-orchitis.

N.B. : Tetracycline and Doxycycline should not be used during pregnancy and lactation.

STEPS FOR STD PREVENTION AND MANAGEMENT

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Case Studies

Dear Participant

Here are some case-studies. Work on them using flow-chart and decide on the management.

Case Study 1

Mr. A. says that he has a discharge from his penis. When you ask him to milk his urethra, you notice a slight discharge at the meatus. He has no other lesion.

Case Study 2

Mr. B. reports with complaint of sore penis. On examination, you see an ulcer on the penis but no discharge.

Case Study 3

Twentyfive year old Miss C. tells you that she has a genital discharge for the past four weeks.

Case Study 4

Mrs. D., a housewife, complains of pain in her lower abdomen. Her periods are normal and she is not pregnant. A week later, she returns along with her husband saying that she feels no better after taking the drugs you gave her. This time she also has high fever.

Session 5

PREVENTIVE COMPONENTS OF QUALITY CARE OF STD

General objective

The General Practitioner should be able to appreciate the role of prevention in control of transmission of Sexually Transmitted Diseases.

Learning objectives

- Identify the four preventive components of Quality Care of STD, namely partner treatment, follow-up, compliance and condom use and
- Describe at least two approaches for partner treatment, compliance and follow-up of STD patients

Total Treatment for STD

There are many measures of preventing STD conditions like being faithful to one partner, reduction of sex partners and use of condoms. However, ensuring quality treatment for STD is also one equally important way of controlling STD infection. We will discuss briefly in this chapter the role of ensuring quality in rendering STD treatment and how to achieve the same.

Roles And Responsibilities of the General Practitioner in rendering Quality STD care for prevention of STD

- To ensure that the patient has taken full course of treatment prescribed by the GP, i.e. comply with the drugs prescribed

- Treatment of partners for the same STD condition and initiate the treatment of the partner at the same time as the patient
- Do follow-up of the patient to ensure that there is total cure of the condition, not only disappearance of syndromes
- Refer the patient to an STD specialist if there is no improvement after treatment OR development of complications such as superadded infection or sequel of the condition

The General Practitioner should be able to appreciate the role of prevention in the care of STD. Since STD spread rapidly and need extra care during treatment for preventing re-infections, the GP has to assure that there is

- Completion of treatment by the patient. This will prevent patient from developing drug resistance
- No opportunity for re-infection of the patient during treatment by blocking the other natural sources of infection i.e. treating partners concurrently
- Adequate response to treatment by following up the patient to ensure that the patient is totally disease free
- No recurrence of symptoms or non-response even after completion of treatment and that no complications such as urethral stricture or tubal block are developed by the patient subsequently

Advantages of prevention

- Compliance with treatment will prevent patients from developing drug resistance to common STD drugs
- Partner treatment will break the cycle of infection-re-infection from and to the patient and spouse. In the case of non-regular sex partners, if treatment of such partners is possible, it will prevent the infection from spreading to other sexual partners of the non-regular partner, e.g. in the case of commercial sex workers to the clients

- Follow-up will ensure that there is total elimination of the organisms, especially if the diagnosis can be clubbed with appropriate laboratory testing for the presence of the organism
- Referral to higher centres for sequels of STD or for resistant cases will help in patient s developing confidence in the treatment of the GP

Problems in implementation of prevention measures

These have been described under the chapter of problems in STD case management. To reiterate, the most important problem relates to partner treatment (how to inform the partner of the STD condition without arousing suspicion, how to convince the asymptomatic partner about the need for treatment).

Other ones are pertaining to follow-up since the patients, for reasons of anonymity, prefer to travel long distances to seek treatment and may therefore be not willing to come back for a follow-up again.

Problems in compliance relate to the high cost of drugs and to the disappearance of symptoms even within a few days of treatment and the patients being not convinced of the need to complete the treatment.

Referral to higher centres may prevent patients from losing confidence in the GP.

Conclusions

To summarise, prevention through the above measures will ensure reduction in transmission of STD and consequently HIV infection to a large extent.

Module III

Condom Promotion and Behavioural Change Communication

Session 6

CONDOM PROMOTION

General objective

- To motivate medical practitioners to promote preventive measures in STD quality care

Learning objectives

- To appreciate their opportunities for condom promotion and educate the patient for correct and consistent use of condoms
- To equip medical practitioners with basic counselling, and Behavioural Change Communication (BCC) knowledge to use in diagnostic and treatment procedure and to have a non-stigmatized approach

Role and Responsibilities of General Medical Practitioners

- To utilise counselling and communication skills in STD quality care
- To motivate patients to accept and adopt preventive behaviour
- To promote the use of condom as part of treatment

The need

Just as we search for administering ways for preventing diseases, at present one of the most important ways for preventing STD is to promote the use of condoms. It is a fact, anyone who is having STD and who has had multiple sex partners is said to have high risk behaviour. Behaviour or habits cannot be changed overnight, and it is not easy to motivate people with high risk behaviour to abstain from sex or stick to one partner. They will not follow the advice of even a doctor. Hence, it is essential to advise use of condoms if we have to control STD and prevent HIV spread.

What is condom?

It may be surprising to know that there are many who have not seen, touched, or used a condom. Even doctors and paramedical workers are ignorant about the qualities of condom. They fail to recognise importance of correct and consistent use of condoms. This makes it imperative that doctors must explain about condom and demonstrate how to use condom to the patient and should not take it for granted that people know about it.

Condom is a rubber sheath, easy to use on the erect penis. While having an intercourse semen is collected in its tip. So fertility cannot happen and infection cannot be transmitted both ways.

Why should one use a condom?

- To prevent unwanted pregnancy
- To protect oneself and partner against sexually transmitted diseases (STD) including AIDS

Why people do not use condom - Misconception

Reasons for not using Condom and Misconceptions about using condom

Belief	Reason	How to overcome
1. Using condom during sex is irritating	• Not knowing how to use the condom	• Eradicate wrong belief and demonstrate how to use condom
2. Condom will tear during intercourse	• If one uses old condom this could happen	• Show different condoms, new and old (one with expiry date passed)
3. Condom is sticky and oily	• Sexual intercourse also is sticky due to the semen. The feeling that condom is an outside thing not part of body makes it so.	• Educate
4. Condom reduces sexual pleasure	• Lack of enough practice of using condom	• Educate and demonstrate
5. Women do not like it	• Women like what men like	• Ask women to educate
6. Erection goes before using condom	• Ignorance in using condom	• Educate and demonstrate

Who should use condom?

Condoms are meant for the people in their reproductive age group to use it either as a contraceptive or as a protection from contracting STD/HIV. Condom must be used by a person who is involved in multipartner sex, or who goes to sex workers. Multipartner sex means one having sex with different partners at different times like a sex worker.

How to use a condom?

Care should be taken while using condoms because improper use can damage the condom resulting in contracting the virus or unwanted pregnancies. The following instructions need to be followed while using a condom.

- Do not open the packet until the penis is fully erect
- Open the packet carefully without damaging the condom
- Do not unroll the condom before putting it on
- Place the condom at the glans of the erect penis and while still holding its tip unroll it over the full length of the erect penis. The tip has to be pressed tightly to squeeze out the air before unrolling over the penis
- During intercourse make sure the condom stays in place
- Immediately after ejaculation, the penis must be withdrawn when it is erect by holding the ring of the condom at the base of the penis
- The condom should be carefully slipped off the penis with the reservoir tip aimed downwards to avoid spillage
- Dispose it off promptly by making a knot at the base and throwing it into the garbage, flushing it into the toilet or burying it. DO NOT REUSE THE SAME CONDOM

There are many who have had experience of failure in using a condom. They need motivation and encouragement in using condom. Dispel all myths attached to the use of condoms.

Doctor's role in condom promotion

Health education needs to be a part of treatment with following information

- Explain the need for use of condom as a part of treatment
- Prescribe condom to overcome embarrassment

- Distribute condom, if possible
- Display condom and information on STD prevention
- Explain and demonstrate how to use the condom, if the person is ignorant about it
- Casually speak openly about it
- Explain need for correct and consistent use of condom in STD treatment

Information needs to be displayed as well as distributed - information on STD, condom etc.

Other information on condom

To be given to the patients, this could be displayed -

- By posters / charts
- Given in hand bills
- Shown in flash cards
  - ☞ Who should use condoms
  - ☞ Different types of condoms
  - ☞ Where can one get condoms
  - ☞ When to use condoms
  - ☞ Quality control of condom

How does one know if a condom is of good quality?

This is very difficult to assess individually for each condom. Use the condom before the expiry date and within two years of the manufacturing date.

At the time of use, check for any visible tears, nicks, or melting, and if present, do not use that condom. When you buy a condom check for expiry date.

Can a condom be reused?

No. Each condom is for one use only. After use, a condom must be disposed off promptly and properly.

Does the use of a condom reduce sexual pleasure?

Condoms do not reduce sexual pleasure, because sexual pleasure is a perceived pleasure. Psychologically some people perceive a loss of pleasure when using a condom. Ribbed/Dotted/Scented/Flavoured condoms, for example, are known to increase sexual pleasure. Main problem is lack of practice and perceived uneasiness in using condom.

How should condoms be stored?

Condoms should be protected from heat, direct sunlight, pressure, and mechanical damage. Unused condoms should be discarded if they have crossed the expiry date.

One should have one or two condoms available to use it when having sex. Women who have multipartner sex may always keep a few ready and motivate their male partners to prevent the spread of STD/HIV.

Use another condom if it

- Is torn or its packaging is damaged
- Has crossed the date of expiry
- Is uneven or has changed in colour
- Feels brittle, dried out, or very sticky

Where condoms can be obtained?

Condoms are available at Primary Health Centres (PHCs), shops and with NGOs. However, due to shyness many do not dare to ask for one. Now costly condoms are available in many brands. But many do not know that low cost condoms are also

available. People would freely buy condom if there is a sanction from the society, or if it is available liberally everywhere.

What are the different brands of condoms available in India and how much do they cost?

The condoms available in India are Nirodh, Delux Nirodh, Kamasutra, Fiesta, Kohinoor, Moods, Mejestic Midnight Cowboy, Adam and many others. The price of these ranges from Rs. 2 to Rs. 10. There are also a number of imported condoms available in India which cost more than Rs. 10.

Nirodh - 3 for 50 paise, Delux - Five for 2 Rupees, Super Delux Nirodh - Four for Three Rupees and others are from Rs. 6 to Rs. 20 depending on the quality, quantity and brand.

Is it okay for an HIV infected person to have sex using a condom?

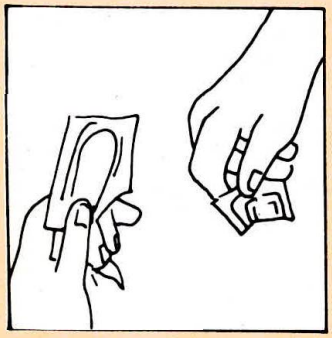
Yes, it is okay. When a person who is HIV positive, decides to have sex, it is that person's responsibility to insist on the use of a good quality condom for every sexual act, as this reduces the risk of spreading the infection.

Are there condoms for women?

Yes. There is a condom called Femidom. At the moment, it is very costly. It is not yet marketed in India. Improvements on it are being worked out for universal acceptability.

CORRECT USE OF CONDOMS

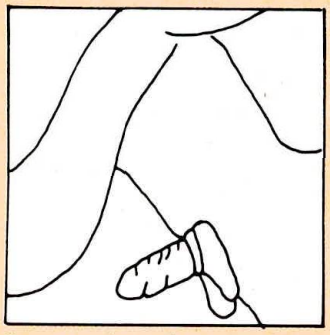
Fig.8



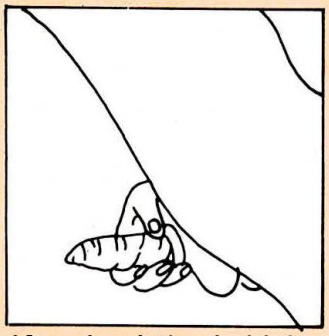
1 Open the pack carefully without damaging the condom. Wear the condom only after penis becomes fully erect

2 Press the tip of the condom and fix it on the erect penis

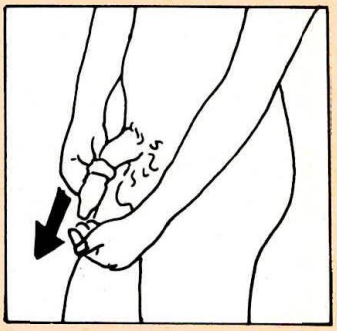
3 Hold the tip of the condom and slowly unroll it to full length so that the penis is completely covered



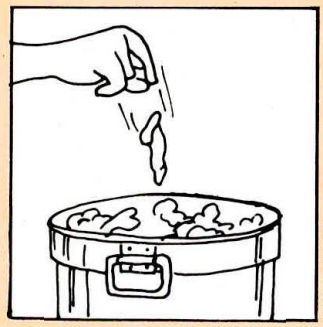
4 Ensure that the condom is in position before commencement of sexual intercourse



5 After ejaculation hold the bottom of the condom and gently withdraw the penis



6 Remove the condom carefully without spilling the semen



7 Dispose off the used condom in the garbage bin. Do not reuse

- ☞ Always use condom during sexual intercourse
- ☞ Dispose off used condoms and do not reuse them
- ☞ Use condoms within the expiry date
- ☞ Before use ensure that the condom is intact and undamaged

Session 7

COUNSELLING AND BEHAVIOURAL CHANGE COMMUNICATION (BCC)

General objective

- To motivate medical practitioners to promote preventive measures in STD quality care

Learning objectives

- To equip medical practitioners with basic counselling, and Behavioural Change Communication (BCC) knowledge to use in diagnosis and treatment procedure and to have a non-stigmatised approach.

Role and Responsibilities of General Medical Practitioners

- To utilise counselling and communication skills in STD quality care
- To motivate patients to accept and adopt preventive behaviour

Introduction

Taking patient's history, diagnosing the disease and prescribing treatment are routine work of any medical practitioner. While this is easy for most diseases, for certain stigmatised diseases like sexually transmitted diseases (STD), getting history and motivating patient to follow treatment needs slightly more careful approach. These diseases are influenced by many cultural, social norms and beliefs and therefore patients coming for treatment or even completing treatment feel inhibited. It is a very sensitive and personal topic with several social and psychological barriers specially when we

discuss about sex. To overcome this problem medical practitioners have to act not only as doctors but also as motivators (for partners to seek treatment), supporters and counsellors for continuing treatment and completing the same. This needs careful handling and for this, counselling and behavioural change communication methods provide information and skills to the health providers.

Why doctors?

Doctors have a unique position in people's life. Even in these modern days doctors' words are equal to God's words, because of the respect and belief people have in them. It is also a fact that most STD patients go to general practitioners and less than 20% only go to STD specialists. Also people are careful in choosing their doctor and have chosen you among others for their own reasons. They want care and are worried. They tend to trust the doctor and try to follow his/her advice and are grateful. So it is the duty and social responsibility of the doctor to give the best full treatment. Doctors could utilise this opportunity and motivate them to complete treatment as well as change behaviours for preventing re-infection and spread of STD/HIV/AIDS.

Counselling and BCC as a part of treatment process

Medical practitioners, in order to have maximum number of patients, find it difficult to spend reasonable time with patient. So the aim of this training is not to produce counsellors but effective health providers who could use counselling and communication skill while diagnosing and discussing with the patients.

Counselling is defined as a therapeutic communication (dialogue) between patient and the doctor, aimed at enabling the patient to understand the nature of his/her illness, causes, options for treatment, to take personal decision relating to their life style.

ATTENTION to patients and LISTENING to their doubts, fears and giving appropriate RESPONSE are the core of counselling, besides observing confidentiality.

Behaviour Change Communication (BCC)

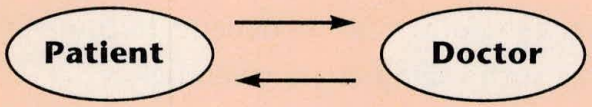
Behaviour change communication helps the patient to understand the role of behaviour (life style) in promoting health and the need to change it as a part of treatment.

- Brief intervention studies in general practice have shown that five to ten minutes of simple advice by a general practitioner and a leaflet can motivate patient to change behaviour and follow healthy life style.

As illustrated an iron rod be bent easily when it is red hot. In the same way a STD patient when he comes to the doctor is "red hot", he needs treatment, and he can easily be influenced by the doctor. All that the doctor has to do is to give a few tips, a few helpful words. These not only awaken the person to facts but motivate him to change his behaviour.

These could be imparted through

- Communication skills - forming relationship
- Building concern for change in the patient



☞ Attend

☞ Listen

☞ Understand

Doctor - Patient relationship

The doctor has to build a fruitful relationship with the patient by spending sufficient time for attending, listening and understanding the need of the patient, if a change is expected.

By listening to the fears and doubts expressed by patient, identify them and respond empathically if needed. Some tips on effective and non-effective responses :

Verbal and Non Verbal Responses

Effective Responses	Non Effective Responses
Tone : Positive, assured, receptive, encouraging, accepting **Facial expression :** Open, caring, pleasant Look directly with concern Show attention to what is being said, nod, acknowledge **Verbal expression :** Answer clearly to the question Open-ended questions, summarizing, Encouraging Repeating the message	**Tone :** Unpleasant, cynical, judgemental, making fear **Facial expression :** Looks away, frowns, yawns, looks at watch Controlling, commanding **Verbal expression :** Speaking too quickly Directing question Advice labelling and moralising

Non-stigmatised approach

Some of the attitudes of health provider can block the communication and the doctors need to be aware of their own attitudes that can both motivate patients to come as well as turn away the patients from them. Some such examples are given below :

- "STD is a disease like any other disease"
- "Anyone with STD is a sinner. There are many innocent victims of STD"
- "I will not treat an STD patient, I am not like that"
- "Women never follow Doctor's instructions"

Only through non-stigmatised approach could a doctor encourage patients to come and complete the treatment.

Health providers feel that treating STD patient will stigmatise them.

When treating a patient with confidentiality there is no need for others to know about the disease being treated. The health providers need to realise this and change the attitude in view of the fact that in the coming years STD will be one of the highly prevalent diseases in our country.

Giving information

- Provide only relevant factual information
- Give the information clearly with simple language
- Do not give unwanted or controversial issues
- Create concern for the disease. It is stated that people will change and adopt preventive practices when they realise that they are susceptible to a serious disease.

Motivate them with encouragement and support to change risky behaviour

"Harm Reduction" is a part of STD control method. When patient is ready to change he needs support which is not available in the environment, e.g. accessibility to STD clinics.

The patients need knowledge and skill to use a condom and also how to buy it without feeling embarrassed. Doctors' few words of encouragement can embolden them to buy and use condom.

Medical practitioners should follow up the patient over a period to sustain these changes.

Who needs special attention

- Patients who come for the first time for treatment
- Patients who come for second time with STD (no change in behaviour)

- Persons who are young, have a life style or a job that promotes risky behaviour
- Women who come with STD/RTI (Reproductive Tract Infection) problems
- Before and after lab testing for STD/HIV (suspected persons)
- Women who come for ANC/PNC or FP - whose husbands may have high risk behaviour

Information to be given and counselling

1. Basic information on STD - transmission, link HIV/AIDS and need to control
2. Treatment procedure
   - Drugs compliance
   - Prevention of reinfection
   - Follow up of treatment
3. Compliance to treatment regimens (to explain to patient)
   - Importance of taking full treatment
   - Adverse effect, if not followed
   - Possible drug resistance
4. Prevention of Reinfection of STD (to explain to patient)

   Safe sex behaviour
   - Abstaining from sex till full cure
   - Not having penetrating sex
   - Use of condom - correctly and consistently
   - Concurrent partner treatment

5. Partner treatment - Importance of concurrent treatment of partners who may also be infected. So to prevent reinfection both persons should be treated concurrently.
   - Problems of partner treatment
   - Compliance with treatment of partners

6. Follow up : The importance of follow-up and coming back to doctor
   - To clarify doubts
   - To assess the prognosis of disease
   - To reinforce prevention practices
   - To check any reinfection

7. Testing for STD/HIV/AIDS
   - Blood test is not available for all STD conditions
   - Blood test is available for HIV, but only with informed consent
   - Pretest counselling, a requirement for HIV/AIDS testing - this involves the following
     - ☞ Giving full information about STD/HIV/AIDS to the patients - its consequences
     - ☞ Consequence of test result, if it is positive and negative (Window period)
     - ☞ Need for prevention of reinfection
     - ☞ Need for change in behaviour
     - ☞ Who will help the person if he/she is HIV positive
     - ☞ Partner treatment
     - ☞ Opportunistic infection of HIV/AIDS, Psycho-Social consequences and need for support
   - Referral - In case counselling or treatment is not possible the doctor is responsible to refer the patient to another doctor, viz.
     - ☞ Specialist centre
     - ☞ Counsellors/Psychologists/Psychiatrists for the treatment

Module IV

HIV/AIDS in General Practice

Session 8

CLINICAL FEATURES AND MANAGEMENT OF HIV/AIDS

General objective

To acquaint the General Practitioners with medical, social and ethical aspects of HIV/AIDS in the medical practice.

Learning objectives

At the end of the session, the participant will be able to

- List clinical features of HIV/AIDS; and
- Describe general principles of management of HIV/AIDS

Role and Responsibilities of G.P.

- To be able to identify the clinical presentation of HIV/AIDS
- To take responsibility for clinical management of HIV/AIDS
- To manage HIV positive patients including preganant women in their families in an empathetic and responsible way

Present prevalence studies conducted periodically by the State AIDS Control Society (TNSACS), Chennai, suggest that HIV prevalence among patients attending STD clinic could be between 14 - 15 percent. APAC conducted community prevalence study of STD including HIV and the result is that HIV prevalence in the society is 1.8% among 15 - 45 age group which also means that one or two out of 100 people in our society

are likely to be a carrier of HIV infection. A general practitioner treating around 2000 patients a month could have attended, without ever knowing, on some HIV sero positives. But this need not cause any alarm. The G.P. should keep his/her mind open for this possibility and should suspect HIV disease as a possibility in certain clinical presentations beside following certain precautions to prevent spread of infection in the hospital/clinic setup.

It is important for General Practitioners to note the following points :

- To recognize STD as a possible co-factor for easy spread of HIV infection in the society and hence treat the patients as early as possible (including the spouses)
- To follow universal precaution in dealing with open wounds, body fluids, skin piercing or invasive techniques
- To speak about HIV and promote condom usage to those who are likely to be at risk due to their behaviour
- To minimize blood transfusion to the barest minimum to encourage voluntary donors and to insist on testing every unit of blood for HIV before transfusion
- To suspect HIV infection as a possibility in certain clinical presentations
- To know when and how to call for a HIV test as well as when not to test for HIV

Clinical spectrum of HIV infection

Infection runs a very prolonged clinical course, ranging from "Acute Syndrome" associated with primary infection to asymptomatic state and onto advanced immuno-compromised state.

According to the CDC classification, HIV infection is divided into :

Group I Acute HIV Syndrome

Group II Asymptomatic Infection

Group III Persistent Generalised lymph-adenopathy

Group IV Advanced disease presents as

- Constitutional diseases
- Neurological diseases
- Secondary infectious diseases
- Secondary neoplasm and
- Opportunistic infections

The acute HIV syndrome may be present in 50 to 70 percent of people with infection, usually 3 to 6 weeks after primary infection. The patient may have fever, pharyngitis, headache or myalgia with occasional skin rashes or lymph-adenopathy. All these are transient and self-limiting.

In India, a G.P. coming across these complaints is likely to mistake them for other common ailments. Besides, HIV test may not yet be positive at this stage (Window period).

They make a spontaneous recovery, and hence testing is not indicated.

The asymptomatic stage (clinical latency) ranges between 3 and 7 years or more. While active viral replication with associated T4 lymphocyte depletion is going on one side, the patient enjoys apparent health. Because the patient looks and feels healthy and also this being the most prolonged part of the disease spectrum, virus spreads from this patient to others most efficiently during this period. Sexual activity, drug addiction, with

needle sharing, blood donation as well as marriage and conception all take place during this period and the only way to know patient's infective status is through blood tests.

Stage of generalised lymph-adenopathy : This is indicated by the presence of enlarged lymph nodes (>1c.M) in 2 or more extra inguinal sites for more than 3 months without any obvious cause. It should be remembered that HIV infected patients with generalised lymphoma, are also not uncommon in HIV disease. Persistent Generalised Lymph-adenopathy is actually an immunological response by the reticulo-endothelial system to HIV infection with an attempt to arrest the virus in the lymph nodes. PGL actually means that patient is immuno-competent. But when immunity fails, it is preceded by regression of the lymphnodes. Thus, in HIV disease spectrum, regression of lymphadenopathy is not a good sign.

Advanced Disease Stage

This may present with major or minor signs.

The common major signs are

- Unexplained weight loss of more than 10 percent of known original body weight
- Recurrent or persistent diarrhoea of more than a month's duration
- Persistent or intermittent low grade fever of more than a month's duration
- Unusual respiratory diseases - either chronic or recurrent
- Neurological disorders - particularly dementia

Common minor signs are

- Oral candidiasis - Characterised by glossitis with whitish plaques in mouth and even in oesophagus
- Oral Hairy leukoplakia (OHL) characterised by vertical whitish striations on the sides of the tongue

- Preuitic dermatoses without specific cause
- Multi-dermatomal Herpes Zoster
- Extensive bacterial or fungal infections of the skin

According to NACO (National AIDS Control Organisation), New Delhi, a HIV seropositive person having two or more major signs with at least one minor sign can be considered as suffering from AIDS.

This is not a very scientific way of diagnosing AIDS, but in the absence of more sensitive and specific scientific technologies in India, this principle appears more suitable.

Besides the above so called major and minor signs, disseminated tuberculosis as well as extra pulmonary tuberculosis should be viewed with suspicion.

Kaposi's sarcoma is very rare in India and diagnosis of Pneumocystis Carini Pneumonia is also very difficult. Hence these points are not stressed in our set up.

Management

General

The most important component of Mangement is counselling. Patient should be reassured at the same time, as he is being informed of his condtion. Sympathy, confidentiality as well as reassurance go a long way in helping the patient face his plight.

Medical

This is directed toward HIV infection as well as opportunistic infections. Among the three drugs that are of some effect against HIV (Azidothymidin (AZT) DDI and DDC) only AZT is available in India. Given alone, it can lead to bone marrow depression while it only temporarily suppresses HIV replication. Severe interaction with other common drugs is also known. Hence one should consider the advantages and disadvantages in a given case before venturing to prescribe this drug. Close monitoring is necessary for the patient while receiving the drug.

The better method of management is addressing the opportunistic infections, most of which are treatable.

- Diarrhoea responds well to rehydration and administration of common anti diarrhoeals.
- Respiratory infections are best managed by Tab. Cotrimoxazole while antituberculosis therapy takes care of tuberculosis (as effectively as in HIV negative patient).
- Candidal glossitis is best controlled by clotrimoxazole mouth paint or oral ketoconozole/fluconazole tablets.
- Pruritic dermatoses respond to oral anti-histaminics and external application of calamin lotion/liquid paraffin.
- Infections are treated by appropriate antimicrobials and suitable topical applications.

AIDS patients should not be refused treatment and can also be managed as outpatients.

Claims about cure of AIDS made by certain Traditional/Siddha Physicians in India are not yet substantiated scientifically. Some practitioners misuse the opportunity and exploit AIDS patients of magic cure.

Good balanced nutrition appears to prolong life. Rest and relaxation have improved the condition of the AIDS patients. Meditation and Yoga were found to be useful in controlling emotional stress and in confidence building.

Session 9

UNIVERSAL BARRIER PRECAUTION IN GENERAL PRACTICE

General objective

To acquaint the General Practitioners with medical, social and ethical aspects of HIV/AIDS in their medical practice.

Learning objectives

At the end of this session, the participant will be able to

List Universal Barrier Precautions to be taken against all routine cases in their General Practice.

Risk of HIV transmission in a health care setting

Transmission of HIV in a health care setting can occur from patient to health care worker, between patients, or from health care worker to patient.

- Patient to healthcare worker transmission. HIV transmission from patient to health care worker can occur when the health care worker is exposed to the blood of an HIV-infected person. An example of this is parenteral exposure, such as a needle stick injury. HIV transmission can also occur through mucous membrane contact, such as a splash of blood into the health care worker's eye or mouth. Non intact skin contact can be a point of HIV entry such as a splash of blood onto open wounds or broken skin due to dermatitis, acne or chapped skin

- Patient-to-patient transmission. Patient-to-patient spread of HIV infection is usually by an indirect route. This transmission can occur through blood-contaminated needles, syringes or other equipment which have not been properly sterilized or disinfected before use. Patients can also be infected when they receive a transfusion with contaminated blood or blood products
- Health care worker-to-patient transmission. Transmission of HIV from health care worker to patient appears remote and has only been suggested in one instance

Universal precautions

Purpose

The purpose of universal precautions is to prevent transmission of infection from body fluid and blood-borne pathogens. All health care workers should adopt universal precautions with blood and body fluids of all patients when there is a risk of direct exposure to any blood or body fluids, regardless of whether HBV, HIV or any other infection has been diagnosed in the patient. Universal precautions should be applied because the healthcare worker may not know who is and who is not infected.

Why "Universal"?

Althouth the actual number of asymptomatic HIV infected persons is not known, it is much larger than the number of reported cases of AIDS. Patient history-taking and examination cannot identify the majority of patients infected with HIV, HBV or other body fluid or blood borne pathogens. However, even though there are no signs, infections can still be transmitted. Also, a person when tested may be negative (in the "window period") but infective. It is, therefore, essential to implement a programme of infection control precautions that is used consistently with all patients and in all healthcare settings.

UNIVERSAL BARRIER PRECAUTIONS

PROTECTS PERSONNEL	PROTECTS PATIENT	PROTECTS COMMUNITY

Universal blood and body fluid precautions involve

- Wearing gloves if there is a risk of contact with blood and body fluids
- Wearing eyeglasses or goggles, mask and / or gown if there is a risk of splashing of blood or body fluids; and
- Always washing hands before and after patient contact and on removal of gloves

Infection Control precautions are intended to isolate the virus and the body fluids, not the patient.

Hand washing

- Use running water
- Liquid soap preferred to solid soap

30 seconds washing in running water - removes transient flora

Work surfaces

- Sodium Hypochlorite 0.5 to 1 % for surface disinfection

Other precautions

- Cover-cuts, abrasions with water proof dressings
- Do not pass sharp instruments hand to hand
- Do not use hand needles

- Do not guide needle with fingers
- Do not resheath needles

Disposal of hospital waste/disposables

- **SHARP INSTRUMENTS** INTO APPROVED CONTAINERS
- **CLINICAL WASTE**
- **DISPOSABLES** → INTO **WASTE BAGS** → SENT FOR **INCINERATION**

Disposal of infectious waste

Infectious wastes divided into the following two categories and disposed off as mentioned below :

SHARPS	NON SHARPS
Into puncture-resistant Non-Collapsible container	Organic Waste 1) Dressings Tissues Placenta, Umbilical cord Blood bags IV lines, other catheters • **ALL INCINERATED** 2) Blood, Urine, Stool • **DOWN DRAIN**

Session 10

SOCIAL AND ETHICAL ISSUES IN HIV/AIDS

General objectives

To acquaint the General Practitioners with medical, social and ethical aspects of HIV/AIDS in their medical practice.

Learning objectives

At the end of this session, the participant will be able to

Recognise Social and Ethical issues arising in Diagnosis and Management of HIV/AIDS

Role and responsibilities of G.P.

- Willingness to treat HIV/AIDS patients
- To be aware of the need for counselling before HIV testing
- To maintain confidentiality
- To protect patient's rights

Social, Ethical and legal issues in HIV/AIDS control

What are the Social Issues in relation to HIV infected persons?

HIV/AIDS infection is more than a medical problem. Its association with sexuality, illness and death often produces strong feelings. The social issues or the problems generated in the society are mostly due to ignorance (myths and beliefs), cultural background and indifference to issues affecting health in general. Taboo in relation to sexuality, I.V. drug use, selling blood for earning livelihood, sex with partners other than marriage partners often lead to disease and stigma. People infected with HIV or suffering from AIDS have

the same dignity and human rights as any other person. As medical officer or in private practice one should be aware of social, ethical and legal issues related to the HIV infection and AIDS so that you can educate the community regarding the need to promote confidentiality of the affected. It is also important that one should educate the society to avoid stigmatizing and discriminating against the affected individuals. It will also help to protect one from being penalized against consumer rights.

Emotional problems of those infected with HIV/AIDS

- Fear of dying, particularly alone
- Loss of livelihood and ambitions and physical distress
- Grief – losses they have experienced or are anticipating
- Guilt of having infected others, sadness of family
- Depression – Absence of cure
- Denial of status and social responsibility
- Anxiety – prognosis, rejection, concern about confidentiality
- Anger – unlucky to catch the infection
- Suicidal activity – way to avoid pain
- Loss of self esteem – rejection by colleagues, family memebrs
- Spiritual concerns – impending death, loneliness etc.

How to protect Human Rights, Discrimination and Isolation of HIV/AIDS cases?

Worldwide, many people infected with HIV or who have AIDS are denied of their human rights. Some are put into quarantine, imprisoned or forcibly tested. People have been deported or denied entry into countries. There are instances where people have been denied housing, employment or schooling or have not received care and treatment. It has also been seen that details regarding HIV positive individuals have found prominent place in media coverage exposing them to social identification and have also been subjected to these abuses. A major challenge to the AIDS epidemic is to stop these abuses.

It is, therefore, important that respecting, promoting and protecting human rights are as important as providing care to HIV positive persons.

In what way human rights are interfered with?

The form in which the human rights get interfered with is :

Discrimination and isolation: It has been seen that people are unfairly treated, because of fear, ignorance or prejudice or may experience discrimination, because they are poor or disadvantaged. The other great problem is that some risk groups like commercial sex workers, injecting drug users and professional blood sellers come from sections of population belonging to low income or poor classes. The addition of poverty and discrimination due to their disease status induces a phenomenon of "Double discrimination". This leads to stigmatization and additional social consequences.

The other discrimination could be in the nature of denial of housing, employment, education.

Being socially isolated can produce psychological feelings. This has been documented in many cases.

What are the important ethical issues in HIV?

The most important area in relation to ethical issues has been in terms of testing for HIV status.

The development of a test in 1985 to detect HIV infection in individuals for blood donation who showed no signs of disease was an important landmark in AIDS epidemic. It opened the way to protect the blood supply and allowed the identification of people, who while apparently healthy could transmit the infection to their sexual partners and needle sharing partners and in case of women to offspring. It did not take long to understand that this technical advance had two aspects. One - it could make an immense contribution to slowing the infection spread. Another - it could expose HIV infected to stigmatization, discrimination and even loss of freedom.

This has resulted in a variety of official policies on HIV screening as part of national AIDS programmes. For example in Swedish bylaw, sexual contacts of HIV positive individuals are to be tested. In U.S.A though the policy is that there should be specific informed consent of patient for HIV testing, testing is carried out even without consent.

Should premarital HIV testing be done?

This cannot be made mandatory as it would undermine confidentiality as a pre-requisite for testing. But if individuals request consent to voluntary testing, it should be encouraged.

If a husband and/or wife is HIV positive, should the couple have a child?

It is better that they do not, as it is possible that the child born to them will also be HIV positive (although this is not always the case). They could instead be advised to adopt a child.

Can two HIV positive people get married?

Yes, surely, if they wish to. They must, however, practise safer sex using condoms to prevent re-infection with HIV.

What are the laws concerning the official policy in India with regard to testing?

There are variety of laws concerning the official policy with regard to testing varying from

- Mandatory testing of blood and blood products for transfusion
- Testing only in high risk groups with consent
- Unlinked anonymous screening for research purpose
- Testing for people demanding voluntarily with pretest counselling

Are there other ethical issues, in relation to HIV/AIDS?

Yes - the other issues are :

- Confidentiality about revealing the test results to patient, spouses, employer etc.
- Exclusion of HIV positive individuals from occupations involving high risk practices like health care workers with procedures
- Testing of new drugs and discoveries being claimed to cure the disease
- Conducting behaviour and intervention research into, and revealing the identity expose them to social stigmatization

All these issues must be kept in mind while dealing with HIV/AIDS cases to avoid stigmatization, discrimination and isolation.

How can medical personnel / medical institutions be held responsible in ensuring that uninfected blood / blood products and equipment are used?

Multipronged measures would be required.

- Medical personnel / medical institutions should be increasingly made aware of their responsibilities
- It must be made mandatory for all manufacturers to screen blood products for HIV
- Consumer awareness and activism should be developed and encouraged
- Resorting to litigation in cases of negligence and malpractice would lead to accountability of medical personnel and institutions

Exercises for group work

Case Study - 1

Mr. X is a leading businessman in Bangalore. His only son is married and looking after the business establishment. He has a lovely wife. Daughter-in-law is a nice girl and lives with the family. The grandson is aged 2 years and very much attached to Mr. X. He spends considerable time playing with him. In general his home is like heaven and everybody is peaceful and happy.

Suddenly he falls ill and doctors after detailed investigations, recommend by-pass surgery of the heart. He undergoes surgery and recovers. Every member of the family looks after him very well and he becomes normal. He continues to support his son in the business and leads a happy family life. During one bout of illness, he is tested for HIV and is declared by the doctor that he is suffering due to AIDS. He is shocked and every member of the family is informed of his positive status. The grandson is not allowed to come near him. Food is served at a distance. He feels extremely bad and hates himself. One day the in-laws come and want to take away their daughter and grandson. His son looks helpless for which he blames his father. No relatives visit their house and a few of them speak ill of his character. He wants to die. Somebody tells him to confirm the results at Chennai. He gives the blood for testing Western Blot. After a couple of days, he and his wife go to get the results. They are asked to give some more blood for some other detailed blood tests.

A week later when they go to collect the results they are asked to see the counsellor. The counsellor, after a briefing says that he is not positive for AIDS but that he is suffering due to some type of blood cancer and he may not live long. His wife exclaimed "Thank God, he is only suffering due to blood cancer; he is not having AIDS; I am relieved".

- List the social issues and suggest remedial measures.

Case Study - 2

Mr. X is 45 years old and an exporter of garments, a very busy businessman. He tours a lot and has all vices. He has some problem in the stomach and is admitted to a five star

hospital in Chennai. Investigations are done and doctors recommend abdominal surgery. They fix up the operation for Friday and advise him to be prepared with empty stomach etc. Anaesthetist certifies him O.K. Suddenly on Thursday afternoon a doctor comes and says that he really does not require the operation and that he can be cured with medicines and gives a list of medicines. Mr. X is a shrewd man and suspects something fishy. He enquires further and comes to know that he was discharged due to HIV positive status, but he definitely needs the surgery.

The same day he goes to another big hospital in Chennai and requests them to perform the operation the very next day. His story of urgency was believed and operation was done on the very next day. After 10 days he was fully recovered and discharged from the hospital. While leaving the hospital he met the Director of the hospital and said that he was HIV positive. The doctor was stunned and shocked. Then he narrated his experience in the previous hospital and said he alone need not be blamed for this and left.

- Briefly state the ethical issues from the above case study and how you will rectify it.

Case Study - 3

It is a big maternity hospital in that city. An officer working in AIDS prevention activities visits the hospital and is casually inquiring his friend about testing for HIV. He is surprised to know that every pregnant mother is tested for HIV and if found positive it is prominently recorded in the case sheet. He was also told that none of the mothers who tested positive has come back for further care or delivery. To the question whether the hospital authorities know what was their fate, the answer was in the negative.

The officer took two addresses of recent positive cases and went to their houses. A lady aged 55 answers him, stating that her daughter-in-law is a worst woman, uses all abusive languages against her and adds that the daughter-in-law has been thrown back to her parent's place.

The officer traces the address of the girl and reaches the house. He is received by the daughter-in-law who is pregnant. She is a graduate and she narrates about the happy

life of hers, with her husband till the result of her positive status was made known. She loved her husband who is also subsequently tested and found positive. She cries and tells about the abuses she, her husband and her family members met with. She said that she went to the hospital with lot of dreams about the baby to be born, but all her dreams have been shattered. She was accusing the doctor who did the test without her knowledge and that he alone is responsible for destroying her family and her life. She is knowledgeable about the difference between HIV positive status and AIDS. She feels that without knowing her positive status, she would have lived happily till the inevitable death came or if they had told her alone, she would have managed to live respectably. The doctor and the hospital are responsible for destroying her life and family.

- Briefly state the ethical issues from the above case study and suggest how you will overcome them.

Session 11

DOCUMENTATION AND FOLLOW-UP

General objective

The trainees should be able to appreciate the need for Documentation about STD Syndromes for its "Total Treatment" in their clinic and understand the items to be documented.

Learning objectives

At the end of the session, the trainees would be able to :

- List Advantages of Recording for Follow-up and Partner treatment
- Recognize their Social obligations and role as a documentor for Control of STD in the Community
- Be familiar with the Reporting and feedback mechanism

The need for documentation

General Practitioners generally do not maintain a detailed record of the diagnosis and treatment of routine cases while attending their practice. Various reasons like lack of time, acute cases mostly seen or cases not coming back for treatment to the same practitioner etc. are responsible for this.

But, for STD and other chronic diseases, recording for proper follow-up

- Is essential for quality care

- The patient with chronic suffering will also appreciate the special care and attention being given to him.
- When the patient comes regularly for follow-up, the doctor is also impressed

Advantages of recording for follow-up and partner treatment

Follow-Up-Recording

One of the common problems with care of the STD case is patients do not come for follow-up. Thus it is important to devise mechanisms for overcoming this problem. One such mechanism is proper documentation of the STD case and its follow-up.

The following are the advantages of recording for follow-up; it facilitates :

- Assessment of clinical cure
- To look for treatment failure and development of drug resistance
- Record of Referral - when treatment fails or complication arises
- Evaluation of effectiveness of counselling - Risk behaviour change - condom usage

Recording of partner treatment

Similarly, another problem commonly encountered in treatment of STD is treatment of partner without which the case is likely to get re-infected. In this regard, for Quality Care of STD, beside counselling patient and partner for treatment, it is also important to document partner treatment.

The following are the advantages of recording for partner treatment; it helps :

- Identify and list partners who require treatment
- Identify what method has been followed to ensure partner treatment - (Patient Referral or Physician Referral)

- Record status of compliance of treatment by partner
- Record clinical cure of partner when partner is seen

Social obligations as documentor

Documentation by the Doctor of cases of STD seen, in addition to the above advantages for delivery of Quality Care of STD to his/her client also helps the Regional and National Agencies monitoring the progress of the control programme against STD and thus against HIV/AIDS in the area served by the Doctor. Thus, documentation and reporting of STD cases and care given is considered a social obligation on the part of the Doctor for a National cause.

Documentation and reporting by the treating Doctor provides the following information by studying the trends over years for particular STD syndromes in a particular area.

Information derived from documentation and reporting :

- Helps assess impact of programme in the local area
- Helps review strategy for control of STD in the area
- Helps plan effective Health Education Campaigns in that area
- Helps liaise with other agencies (N.G.Os) in the area that could help fight against STD in the area

Feedback from the Regional agencies to whom reporting is made can provide valuable information back to the Doctor.

- Antibiotic sensitivity/resistance
- STD trends in the region
- Plan human and material resources (eg. Drugs, Condoms) locally
- Need for special campaigns/co-ordination with other agencies
- Need for further research

Reporting and feedback mechanism

When you start maintaining individual record for case and partner treatment and follow-up, it becomes easy for the practitioner to analyze and report the particulars required for decision making at the clinic-level as well as at the regional level.

Reporting is to be done either through mail on a monthly or a bi-monthly basis to the Training Institution which will in turn compile it and send it to APAC Project, Chennai, for compilation at the regional level.

Feedback will then be given by APAC to both the Training Institution as well as the Doctor who will then have the overall view of the situation in the region and the common problems faced by others involved in the programme.

Thus it is envisaged that through proper documentation, reporting and analysis of the STD Case Mangement by the reporting Doctor and feedback received from the co-ordinating agency, will result in Quality STD Care and thus control HIV/AIDS.

QUALITY STD CASE MANAGEMENT RECORD

NAME OF CLINIC

Reg. Number : Date of Registration :

Name of Patient : Age : Sex : M/F

Complete Postal Address

Complaints (Syndrome)	Duration	Name of Partner(s)

History of Drug Allergy :

Details of Case Treatment	Follow-up 1 Date, Remarks	Follow-up 2 Date, Remarks	Follow-up 3 Date, Remarks
Counselling Topics			
1.			
2.			
3. for Condom use			

Partners Treatment	Partner 1	Partner 2	Partner 3
Method to ensure Patient treatment	Patient Referral/ Physician Referral	Patient Referral/ Physician Referral	Patient Referral/ Physician Referral
Treatment given			
Partner Follow-up dates & Remarks			

Referral (if any) Name of Doctor :

Reason for Referral :

Feedback from Doctor :

APAC PROJECT

for

QUALITY CARE OF STD

Mailed Questionnaire

To

Dr. .....

..... Ref. : Batch No .....

.....

Dear Doctor,

Kindly spare 2 minutes of your valuable time to fill in this questionnaire and send it by post immediately to us. This will enable us to guage the success of the Training Programme we have conducted for you as well as to identify your practical problems and devise solutions to ensure Quality Care of STD that will contribute to prevention and Control of HIV/AIDS.

1) Your workload of STD cases per month : <1/1-2/3-4/>4

2) Percentage STD cases treated using Syndromic Case Management : None/25/50/75/100

3) Percentage of STD cases recommended condom use for Case/Partner : None/25/50/75/100

4) Percentage of STD cases where partner treatment was undertaken : None/25/50/75/100

5) Percentage of STD cases who returned for follow-up : None/25/50/75/100

6) Percentage of STD cases given Behavioural Change Communication : None/25/50/100

- Kindly list any problems faced in following "Quality STD Care" :
- Any specific information you want us to send you :
- Any other comments you want to make :

Thank you for filling up this feedback cum follow-up Questionnaire. We will immediately respond to your requests/send our Social Worker to you.

A self-addressed stamped envelope is enclosed to send your response immediately.

With warm regards,

Yours truly

CHIEF CO-ORDINATOR

Format for follow-up of Allopathic Private Medical Practitioners

Month : Year : Name of the Doctor :

The information below will help us to strengthen the training programme that you received in Quality STD Care and to provide you with a follow-up. Kindly co-operate with us by filling out this form and handing it over to the social worker who comes to meet you from your training centre.

Number of STD cases treated :

1. Number of cases treated by Syndromic treatment

Genital Ulcer		**Urethral Discharge**	**Vaginal Discharge**	**Lower Abdominal Pain**	**Others** (Specify)	
M	F	M	F	F	M	F

2. Number of Partners treated by syndrome
3. Number of cases followed up and ensured completion of treatment
4. Number of STD cases counselled for condom use
5. Number of STD cases counselled for reduction of partners and other safe sex options.

Signature

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Training Institutions

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II. **PSG Institute of Medical Science & Research**
Coimbatore - 641 004
1. Dr. Surendran 2. Dr. K. Selvaraj 3. Dr. Thomas V. Chacko 4. Dr. Marina Thomas

III. **Meenakshi Mission Hospital & Research Centre,**
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1. Mrs. Beena Sivaprakash 2. Dr. Indira Athappan 3. Mr. Jacob C. Varghese
4. Dr. Lakshman Marvarkat

IV. **Rajah Sir Muthiah Medical College,**
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1. Dr. Annie J. Mani 2. Dr. Biswajit Chakraborthy 3. Dr. S. Gopalakrishnan
4. Dr. Vijaya Bhushanam

V. **Tanjore Medical College**
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