



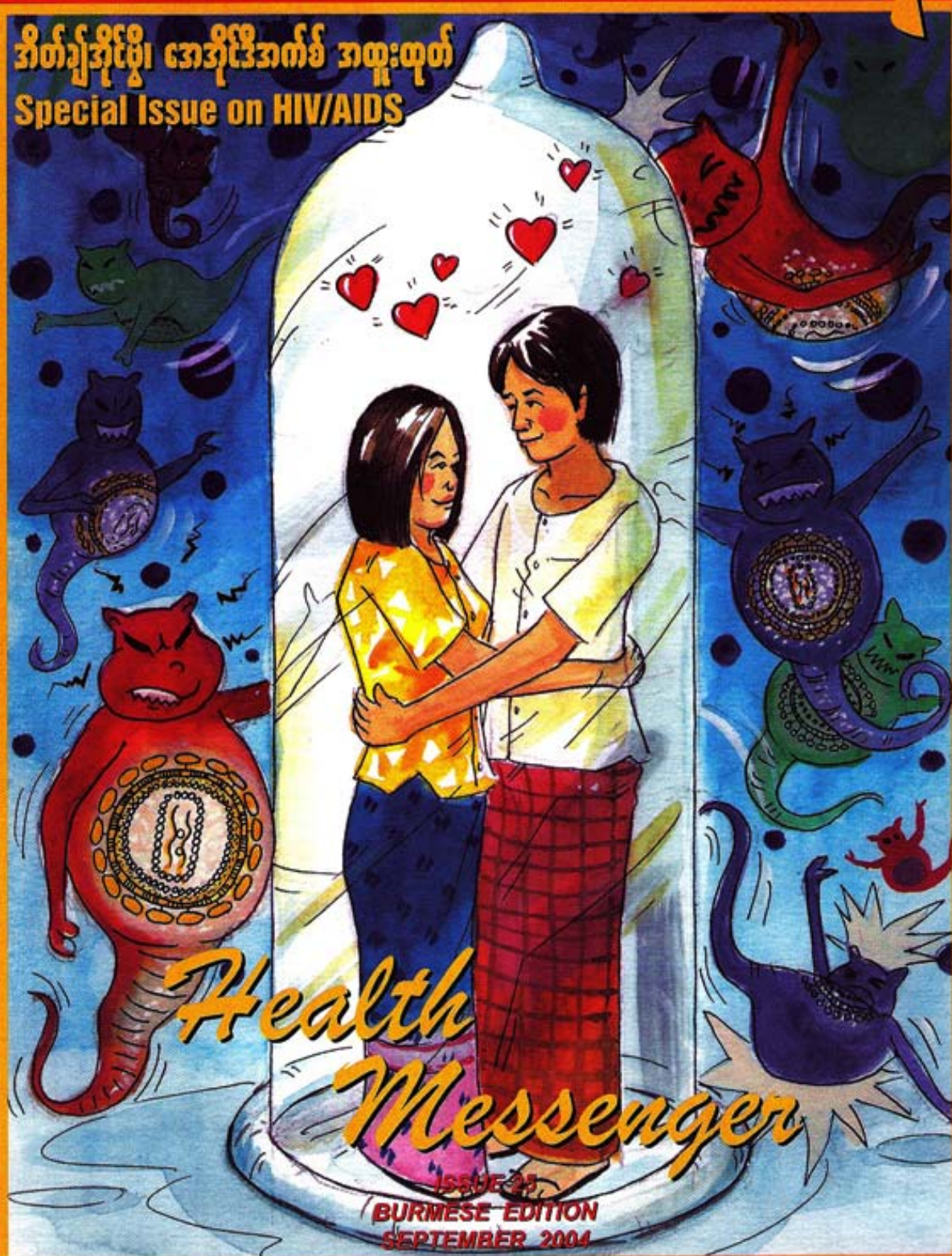
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Special Issue on HIV/AIDS



ISSUE 25

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SEPTEMBER 2004



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

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Editorial

Dear Readers,

XV International AIDS Conference was held in Bangkok during July, 2004. The theme of the conference was *Access for All*, reflecting the need to increase access of developing countries to HIV/AIDS treatments, services, prevention, education and information. Acknowledging that health and social workers have a major role to play in the fight against the epidemic, AMI decided to dedicate this issue of Health Messenger Magazine to HIV/AIDS. The present issue of Health Messenger Magazine will complete the previous special issue on STDs and HIV published four years ago. Readers will find important information on transmission and non-transmission routes of the virus, existing treatments, clinical guidelines and advice for good counselling on HIV/AIDS.

According to UNAIDS, both Thailand (HIV prevalence rate 2.8 %) and Burma (HIV prevalence rate 2.2 %) are the most affected countries in South East Asia after Cambodia (HIV prevalence rate 4.4%). Therefore, we hope this issue of Health Messenger will support health and social workers' daily work on behalf of People Living With AIDS.

Enjoy your reading!!

Warm regards as always,

Dr Than

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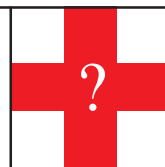
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What is AIDS? A Short Introduction

Health Messenger Team



This article is a short introduction to HIV/AIDS. It will give health workers some ideas to help the people living with HIV/AIDS

The full name of AIDS is **Acquired Immune Deficiency Syndrome**. As the name implies it is a disease caused by a deficiency in the body's immune system. The immune system defends the body against infections and diseases. It is a *syndrome* because there are a range of different symptoms, which are not always found in each case. It is *acquired* because AIDS is an infectious disease caused by a virus which is spread from person to person through a variety of routes (see article page 6). This makes it different from immune deficiency from other causes such as treatment with anti-cancer drugs or immune system suppressing drugs given to persons receiving transplant operations.

In short, AIDS is a medical diagnosis for a combination of illnesses, which results from a specific weakness of the immune system. The

immune deficiency is caused by infection with a virus. A virus is a very small germ.

A cquired	Become infected
I mmune	The immune system is weakened by the virus
D eficiency	
S yndrome	The illness has a variety of symptoms

What causes AIDS?

A virus is an infectious particle that is too small to be seen with the naked eye or even a conventional light microscope. A virus such as HIV is 1/10 000 of a millimeter in diameter and can only be seen with an electron microscope. AIDS is caused by infection with a type of virus called HIV.



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Human Immune deficiency Virus

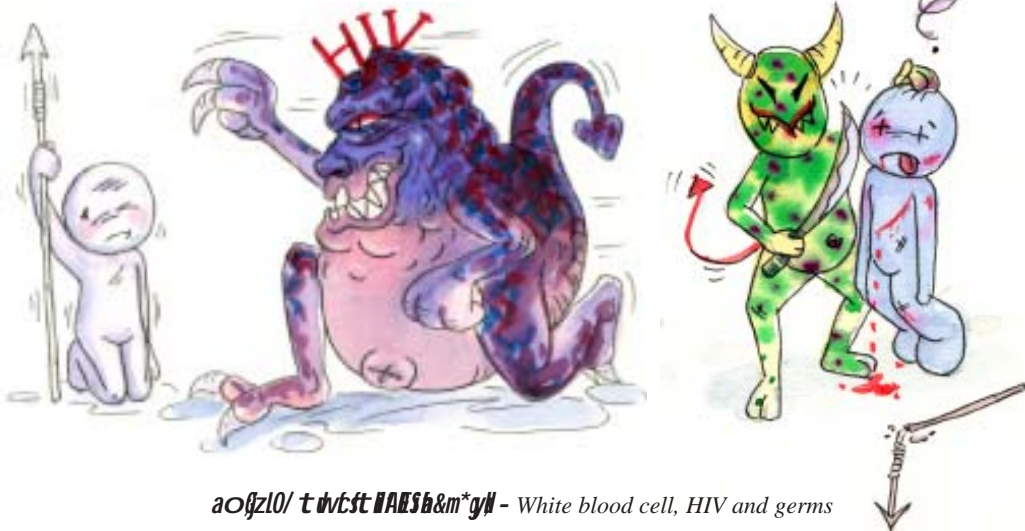
HIV is not one virus, but a family of many similar viruses. For example, HIV 1 is found in most countries of the world while HIV 2 is mainly in West Africa.

How HIV weakens the immune system?

Our blood contains white and red blood cells. Normally the white cells fight off and kill any germs, which enter our bodies. They do this by eating up the germs and by producing chemicals called **antibodies**, which kill them.

In this way our bodies fight off many different germs and we stay healthy. Sometimes we have symptoms of illness when our white cells are fighting the germs, but usually the white cells win and we get better. HIV weakens this immune system by entering and finally destroying our white cells. As more and more white cells are killed, the body becomes less and less able to fight off the many different germs, which live around and in our bodies all the time. Finally, people with AIDS die from one of a number of serious and rare diseases which their bodies cannot resist.

HIV can also attack the brain cells and nervous system directly causing mental and coordination problems.



White blood cell, HIV and germs

Who is at risk for infection?

Everybody

Everybody who is exposed to the infection. But especially:

- Persons with STDs and sores on their genital parts.
- Persons who have many sexual partners.
- Sex Workers
- Patients receiving injection with non-sterile equipment.
- Patients receiving untested blood from unknown donors.
- Injecting Drug Users who share needles.

Transmission of HIV

Health Messenger Team



This article describes the different transmission routes of HIV.

HIV (Human Immuno-deficiency Virus) is present in all body fluids of an infected person but is concentrated (heavily found) in blood, semen and vaginal fluids. It can also be found in tears and saliva although these last two are not considered significant routes of infection.

HIV does not spread from person to person very easily. It is a delicate virus that is easily killed by heat and by drying. A large dose of virus is also needed to spread HIV.

Four critical conditions must be fulfilled if HIV is to be transmitted by a particular route:

1. HIV must be present in a body fluid (in semen, vaginal fluids and blood or blood products).
2. HIV must survive in a situation out of the body
3. HIV must get into a person.
4. Sufficient HIV must be transferred into the other person to make an infective dose.

HIV is spread in three ways:

- ***through sexual intercourse,***
- ***through blood and***
- ***from mother to child.***

Transmission of HIV through sexual intercourse

Vaginal intercourse, where the penis of the male penetrates the vagina of the female is the most common route of transmission of HIV. Anal intercourse, where the penis penetrates the anus of other person, carries a higher risk of transmission than vaginal sex.

A single sexual intercourse can be sufficient



to transmit HIV. However some studies suggest that the risk from a single act of intercourse between a male and female (heterosexual intercourse) can be as low as one chance in one thousand.

Any sores on the penis or the walls of the vagina can increase the chance of HIV transmission. One common reason for this is the presence of a sexually transmitted disease such as syphilis or chancroid. Chlamydia and gonorrhoea, which cause a discharge, are more common than syphilis or chancroid. They may cause no symptoms and so remain untreated for long periods. For this reason they may be relatively more important than ulcerative sexually transmitted infections (STIs). Other infections of the reproductive tract that are not necessarily sexually transmitted are common and easily treatable conditions.

Young women are especially vulnerable to HIV as it is more likely to spread when sexual activity is rough or repeated frequently. There is evidence that uncircumcised men are at greater risk of becoming infected with HIV than circumcised men.

Anal intercourse is the name for sexual intercourse where the penis is inserted into the



HIV prevalence, women in antenatal clinic, major urban areas	2.8 %
HIV prevalence, female sex worker, major urban areas	38 %
HIV prevalence, injecting drug users, major urban areas	47.6 %

Source: UNAIDS 2002

other person's anus. It is common among male homosexuals but also practiced among heterosexuals. It is of particularly high risk for transmission of HIV, and this is because the wall of the lining of the anus is delicate and easily torn when the penis is inserted. There are many white blood cells containing HIV in the blood vessels feeding the rectum. These will become infected when in contact with semen with HIV.

Masturbation involves the handling of the sexual organs. This can be either self-masturbation when a person stimulates his or her own sexual organs or mutual masturbation between two partners. There is no risk of transmission of HIV from self-masturbation because only one person is involved. There is a very low risk of transmission of HIV in mutual masturbation.

During **menstruation**, a woman with HIV will have the virus in her menstrual blood. Sexual intercourse during her menstrual periods will be more risky than outside menstruation. Her sanitary pads or tampons will also contain HIV.

Oral sex can take place in different ways. The tongue of one partner can contact and stimulate the penis or vagina of the other partner. Saliva can come into contact with the genitals of the other partner. Semen or vaginal fluids can enter the mouth of the partner. Infection may occur if there are cuts or sores in the mouth. There is very little evidence on the risks of these different kinds of oral sex. Although the risk is low, it is not absolutely safe and oral sex cannot be recommended as a

safer-sex alternative to other methods of sexual intercourse.

There may be a slight risk from deep **kissing** where the tongues of the persons penetrate each other's mouths. Infection through kissing might take place when one partner has cuts or sores in the mouth. There is no risk from kissing on the cheek.

Condoms reduce the risk of transmission through sexual intercourse.

Transmission of HIV through blood

A **transfusion of blood** from a donor infected with HIV will infect the patient who receives it. Whole blood, red blood cells, platelets, and plasma may contain HIV. Many people have contracted HIV from blood transfusion. Although there is widespread screening of blood transfusion in the developed countries, this is still not the case in many developing countries. The testing of blood does not remove all risk from transmission through donated blood. It takes 3-12 weeks after infection for the body to produce antibodies. If blood is donated during this "(3-12 week) window period" antibodies will not be detected by the HIV test but the blood will still be infectious. **It is important that blood transfusions are given only when necessary.**

Injecting drug use (IDU) is becoming increasingly common in many countries,



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especially in Asia. In South East Asia, especially Thailand, Myanmar, India and Yunnan Province in China, injection by drug abusers is emerging as an important route of HIV infection. In Myanmar, a dramatic increase in HIV seropositivity (Blood test positive) has been found among injecting drug users from 17 percent in 1989 to 59 percent in 1990 and 1991

infected with HIV, they can also transmit the virus to others through sexual intercourse or, when pregnant, to their babies. Many injecting drug users also act as sex workers to pay for their drugs and this was a significant factor in the AIDS epidemic in Thailand.

Needle-stick accidents and blood splashes to the mouth or eyes in the health care setting may lead to the infection of health care workers. The risk is very low and can be reduced further by strict attention to universal infection control precautions.

Piercing the skin with instruments which are not sterilized might lead to transmission of HIV. Acupuncture and tattooing are considered as examples in this case. In Asia tattooing, ear/nose piercing and circumcision are common skin piercing practices. These procedures should be carried out with sterilized instruments, as Hepatitis B and C can be easily transmitted through this route.



r&lf - Source: Care

respectively.

Reports suggest that IDUs in Myanmar were often infected early in their injecting career. Data from national surveillance over recent years show HIV prevalence among IDUs in 1997 at 54%, 56% in 1998 and in 1999 at 51%. In 2000, HIV prevalence rate among IDUs had increased to 63% (Department of Health, 1997; 1998; 1999; 2000; WHO 2001)

Source: *Revisiting "The Hidden Epidemic"* January 2002, Burnet Institute and The Centre for Harm Reduction.

HIV, and Hepatitis B and C, spread very easily between people who inject drugs together and share needles, syringes, and other injecting equipment. Once drug injectors are

Tattooing is not a common route of transmission of HIV/AIDS, as there has never been any documented case of HIV transmission in the world that has been proven to have been due to tattooing. Probably it is extremely rare as the needles are not hollow so no blood collects in them.

Transmission of HIV from mother to child

HIV can pass from an infected woman to her baby ***during the pregnancy (5-10%)***, during ***labour and delivery (10-15%)***, or afterward through ***breast-feeding (5-20%)***. Not all babies born to a mother with HIV



become infected with HIV. When there is no breast-feeding the percentage becoming infected is between 15 and 30. In breast-feeding populations, the percentage of babies that become infected is between 30 and 45. The virus is most likely to pass to the baby during labour or in the first few weeks of breast-feeding, although a small proportion become infected earlier in the pregnancy.

HIV antibodies from the mother cross the placenta to the baby so the HIV antibody test is positive at birth whether the baby is infected



r&i/f - Source: UNOPS

or not. These maternal antibodies stay in the baby for as long as eighteen months, although most babies lose maternal HIV antibodies by nine months of age.

The risk is increased by invasive procedures such as amniocentesis (tapping out the fluid surrounding the foetus) and artificial rupture of the membranes of the foetus. It is possible, but not yet proved, that episiotomy (cutting of the vaginal for easy delivery) and certain practices of traditional midwives, such as abdominal massage, may increase the risk. Caesarean section (delivery by surgical operation) performed before labour begins reduces the risk of transmitting HIV to the baby.

The risk of infection through breast-feeding is increased by inflammation of the breast, such as mastitis or an abscess.

Knowledge about the factors that influence the risk of transmission of HIV is changing rapidly. It is important to keep up to date with changes through newsletters, journal articles, and if possible, the Internet.

Sources:

1. *Protecting the Future*, IRC
2. *Aids Hand Book, Second Edition-Fully Revised* by John Hubley, 1995.
3. *UNDP South East Asia - HIV and Development Programmes*
4. *HIV Transmission through Breastfeeding: A Review of Available Evidence* - WHO

If the mother takes the drug AZT (an antiretroviral drug) during pregnancy, she can significantly reduce the chance that her baby will be infected with HIV. If health care providers treat mothers with **AZT** and deliver their babies by **Cesarean Section**, the chances of the baby being infected can be reduced to a rate of 1 percent.

The study shows that a single oral dose of the antiretroviral drug nevirapine (NVP) given to an HIV-infected woman in labour and another to her baby within three days of birth reduces the transmission rate of HIV by half compared with a similar short course of AZT.



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The HIV/AIDS Situation in Burma

Zaw Winn, Chiang Mai



Articles on HIV/AIDS in Burma are often filled with figures. But it is possible to look beyond the figures to see what has happened to the HIV epidemics in the past and what is happening now.

There is no issue more controversial to start with than the total number of people living with HIV in Burma. To know how many people are infected, we cannot just count people with HIV or rely on reporting of HIV tests or AIDS cases by doctors. Reporting by doctors is rarely accurate. We all have to rely on estimates.

Variations in estimates

Myanmar government reports estimate that there were fewer than 180,000 people living with HIV at the end of 2001. One article written by American academics who did not work in Burma stated there were over 800,000 people infected three years earlier than 2001.

Both kinds of estimators use the same data – obtained from performing HIV tests on the blood of groups of people through the process of sentinel surveillance. But choosing whose blood should be tested is not easy and there are many ways in which the process can be biased. Are rural or urban people tested? Are enough people in each ‘risk group’ included?

Are injecting drug users living in the community and living in drug treatment institutions both tested? Are sex workers working in brothels tested or only those brought for testing by police while they are being taken to prison? Are brothel based sex workers and karaoke bar based sex workers all mixed together in order to get enough women tested? Is the testing in each of the many townships done the same way year after year or does it change?

All of these factors influence sentinel surveillance as it has been practised in Burma over the last several years. Small errors in choosing the people to be tested and false assumptions can lead to big errors when the numbers are multiplied to reflect the situation in the entire country.

The United Nations Joint Programme on HIV/AIDS or UNAIDS estimated in July 2004 that there were 320,000 adults living in Burma with HIV at the end of last year. The UN epidemiologists further state that there is a range of 170,000 to 610,000 people. The government of Myanmar has plans to revise its

How an estimate is made in one location

Imagine there are 1000 injecting drug users in Yangon. 100 of them are caught by the police and undergo mandatory HIV tests. 50 of the 100 or 50% are found to have HIV. This figure of 50% is multiplied by the imagined 1000 injecting drug users to give an estimate of 500 infected injecting drug users in Yangon.

Percentage infected X number of imagined users = estimated number of infected users
 $50/100 \times 1000 = 500$



own estimates with technical assistance from the United Nations later this year.

A serious situation

What is not under debate is that the situation is serious. No one disputes that Myanmar ranks with Thailand and Cambodia in having the highest percentage of its population with HIV in all of Asia.

So let's get on with it. What is important is to see what is driving the epidemic forward in Burma so we can do something about it. There are several sub-epidemics occurring among different groups of people in different parts of the country. Let's look at them:

High Risk Group: Female Sex Workers

One of the most important groups is women sex workers and their male customers. Although sex workers only are officially tested through the sentinel surveillance system in the two sites of Mandalay and Yangon, we know that their customers have infected many of them. Some years in some locations more than half of the women tested are infected. It is much more difficult to know how many of their customers are infected as the police do not arrest or harass men customers as much as they do women sex workers. Young military recruits, some of whom are customers of sex workers, are tested by the military but the results are rarely made public.

What we can know with certainty is that unprotected paid sex between men and women is a major driver of the epidemics. Sex work is common in places where men are far from their homes and have more money and power than women. Truck routes, some border crossing points, and mining areas have these two factors. Sex work is illegal and suppressed so sex workers often move from one city to another. What better way to spread infection than mobile men with more money having unprotected sex with mobile women with less money?

High Risk Group: Injecting Drug Users (IDUs)

Reports suggest there are approximately 150,000 to 250,000 IDUs in Myanmar. Most of them are men. Burma has the distinction of having in the past few years some of the highest rates in the world among injecting drug users. Official Myanmar government sentinel surveillance reports show over 90% of injecting drug users in Myitkyina and over 80% in Lashio and Mandalay have been infected in the past. Sadly, most of these men have died. New sentinel surveillance figures show that the percentage of injectors may be decreasing but it is too early to be sure.

Sharing injecting equipment is a highly efficient method of transmitting HIV. Burma is one of the world's leading countries in the production of high quality heroin. Wherever heroin is made, it is used. And wherever heroin

Serious epidemics

“In South-East Asia, three countries in particular — Cambodia, Myanmar and Thailand — are experiencing particularly serious epidemics.”

Source: HIV/AIDS in Asia and the Pacific Region, World Health Organization, Western Pacific - South-East Asia, 2003

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travels to reach markets far from where it is made, it leaks off the route to be used by people along its path. If more young men with a little money are exposed to high quality heroin in Burma, some of them will begin to inject it and there is a good chance that they will share injecting equipment. We can expect that in the future more women sex workers will begin to inject heroin – this has already happened in Yunnan and other parts of the Greater Mekong Region.

Transmission through Blood Transfusion

It is difficult to know how many people get HIV infection from blood transfusions in Burma. Official records are hard to find. In large hospitals in cities, there is a regular electricity supply so that HIV testing equipment and blood can be kept in refrigerator. 363 out of 745 hospitals in Burma perform blood transfusion but only 38 hospitals have facilities to keep refrigerated blood. Blood for transfusion is more likely to be tested for HIV in facilities with electricity so HIV infected blood can be discarded. At present 0.6% of blood given by new donors has HIV in it.

High Risk Group: Men Having Sex with Men

All savvy people in Burma know that there are men who have sex with men throughout the country. The nat festivals are not the only places where sexual intercourse between men takes place. Unfortunately, little research has



r&lf - Source: PATH

been conducted on sex among men so we cannot say whether unprotected sex among men drives the epidemics.

Mother to Child Transmission

Although we all empathise with children infected by their mothers, these children do not drive HIV epidemics. Children do not usually have sex so they do not transmit the virus.

Although there are officials who will categorically state that today in Myanmar seventy per cent of infections are through sex and thirty per cent are through sharing injecting equipment, there is no scientific evidence for this statement. No one has enough information to say so.

Heresies and superstitions

*“It is the customary fate of new truths to begin as heresies and end as superstitions.”
TH Huxley, Science and Culture*



Misconceptions and Misbeliefs in Burma

Are non-Burmese people, the so-called 'national races', more likely to be infected than Burmese? The HIV epidemics are more mature in Shan State and Kayin State as people who were infected in Thailand returned to these states early in their epidemics. This led to the concept that there was an "East to West gradient" of infection and that infection was more common among non-Burmese people. What was forgotten was that Burmese fishermen from Tanintharyi were also infected, as there were infections among Burmese debt-bonded women sex workers in largely Burmese Kawthaung. These days Burmese female sex workers from Pakokku are travelling to work on the Chinese side of the border near Muse and in the guest houses of Bago where they are infected by their male clients from Mandalay and Patheingyi.

Mandalay is a particularly intense transmission location. By looking at the kinds of HIV that infects people in Mandalay, a team of researchers from the National AIDS Programme and from Japan has reported that the virus in Mandalay is mutating into unique recombinant forms. This can only happen when people with one type of HIV have sex with or share injecting equipment with people with another type of HIV. People from all over the

country are meeting in Mandalay and 'exchanging body fluids'.

People with AIDS

About ten per cent of people infected will need treatment at any one time. So between 17,000 and 60,000 people need antiretroviral therapy today. WHO's 'Three by Five' programme aims at reaching half of these and governmental targets are being formulated. Many more people are going to die before the situation gets better, so prevention and care need to be stepped up – today.



r&if - Source: PATH

Deaths

"annual AIDS deaths may be expected to increase the total number of annual deaths in the 15-49 year-old population by up to 30% - 40%"

HIV/AIDS in Asia and the Pacific Region, World Health Organization, Western Pacific - South-East Asia, 2003



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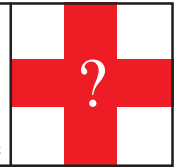
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Clinical Aspects of HIV/AIDS

Health Messenger Team



This article presents major symptoms developed by patients suffering from AIDS and suggests some technics for home-care management.

Acquired Immune Deficiency Syndrome (AIDS) is the final stage of HIV infection. At this stage, disease causing organisms are able to harm HIV infected persons. These infections are classified as “opportunistic”. Tuberculosis, Pneumocystis carinii pneumonia, fungal infections, and cryptococcal meningitis are common opportunistic infections in people living

AIDS within twelve years. A small number of HIV-infected people have not developed symptoms or immune deficiency even after many years. Shorter times between HIV infection and the first signs of illness, and shorter survival times with AIDS, have been reported in developing countries.



with HIV/AIDS. The weak immune system may also allow cancers to develop. Kaposi’s sarcoma, lymphoma, and cervical carcinoma are common cancers. Neurological diseases, due to direct infection of brain cells by the virus, may occur during early or late stages of HIV infection. Women infected with HIV may also suffer from severe genital herpes, candidiasis (thrush) and pelvis inflammatory diseases, characterized by lower abdominal pain.

Following infection with HIV about one-third of those infected will develop AIDS within five years, and about two-thirds will develop

What happens when a person is infected with HIV?

There are three stages of HIV infection.

1) A healthy person infected with HIV

Around the time of infection some people have a short illness similar to glandular fever. After this most people remain healthy with no signs of illness for many years.

However, HIV is still present in the body and the person can infect others without either partner knowing it.

After about three months most people infected with HIV produce antibodies against the virus, but they are not able to kill HIV because it hides in the white cells. A blood test can detect these antibodies.

2) Illnesses associated with HIV infection may begin to appear

A person infected with HIV may begin to show signs of illnesses that cannot be used by



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a t t l f D t u p l a & m * g o , l w l j z p l w w a o m a & m * g s n ; r l n

- & i y l f a c g i f y l f q l l & m u l p u b a & m * g l r s n ; -
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u l l u m ; c s u f - W H O A I D S W e e k l y E p i d e m i o l o g i c a l R e c o r d s , 1 9 8 6 . V o l . 6 1 . p p
 6 9 - 7 3 (p m t l y f t r s l f 6 1 / p m r s u E l n 6 9 r s 7 3)

Clinical signs of AIDS

Major signs	<ul style="list-style-type: none"> - Weight loss greater than 10% of body weight - Fever for longer than one month - Diarrhoea for longer than one month
Minor signs	<ul style="list-style-type: none"> - Persistent severe fatigue - Cough for more than one month - Itchy skin rashes - Cold sores all over body - Shingles - Thrush in the mouth and throat - Swollen glands at two or more sites (excluding the groin) for more than three months.

WHO Guidelines for Clinical Diagnosis of AIDS in Adults

themselves to diagnose AIDS. These diseases are also common in people with immune deficiency, which can be caused in a number of ways apart from HIV infection. For example, malnutrition, cancer and reaction to some drugs. After excluding such causes, a doctor may diagnose AIDS when a person has two or more of the major signs together and at least one minor sign. Major signs are those which are more closely linked with HIV infection. Minor signs are those which occur frequently in other illnesses as well.

If possible people with such symptoms

should also have an HIV antibody blood test. Major and minor signs of AIDS are listed in the table above.

3) *The illnesses in AIDS*

Finally so much of the immune system is destroyed that the person is attacked by serious infections which eventually kill him/her. The diseases vary in different countries, depending on which viruses, bacteria, fungus and protozoal infections are around.

Common diseases that can affect a person with

Epidemiology and Surveillance of HIV/AIDS

UNAIDS/ WHO uses the following classification to describe the HIV epidemic:

- a “generalized” epidemic is one where HIV prevalence has reached at least 1 percent among the general population;
- a “concentrated epidemic is one where HIV prevalence has exceeded 5 percent among certain sub-population; and
- a low prevalence epidemic is one in which infection remains below 5 percent in any given sub-population.

Source: WHO AIDS Weekly Epidemiological Records, 1986. Vol. 61. pp 69-73



AIDS include:

- Chest infections causing pneumonia and shortness of breath (TB is common in people with AIDS)
- Brain infections causing mental confusion, severe headache and fits,
- Gut infections causing severe diarrhoea lasting many weeks,
- Cancers, particularly a skin cancer called Kaposi's sarcoma (not common),
- Penicillium marneffei, cryptococ.

About half of the people diagnosed with AIDS die within two years of diagnosis without access to medication.

of virus in the blood. A combination of these drugs needs to be taken for life, and they often have side effects. People living with HIV/AIDS who are able to access these drugs can remain well for many years, although the virus remains in the body.

Home-Care Management of AIDS Symptoms

Weight loss: Encourage the sick person to eat, but do not use force, as the sick person may not be able to accept the food and may vomit. Give frequent smaller meals of foods the sick person likes. Let the sick person choose the foods he or she wants to eat from what is available.

Only 150 HIV - positive people countrywide are being treated with crucial antiretroviral medicines, but Myanmar has targeted treatment for 2,000 people by the end of this year and 12,000 by late 2005.

Source: *Min Thwe, who headed the National AIDS Control Programme in Myanmar, at the XV AIDS conference in Bangkok. July 2004.*

Treatment for HIV Infection

At present, there is no cure for AIDS. However, there are treatments for the relief of symptoms, treatments for opportunistic infections, and an increasing range of antiretroviral drugs that attack HIV itself.

Good nursing care can do much to relieve the symptoms of HIV such as related fever, sweating, itching, diarrhoea, headache, and cough. Treatment for opportunistic infections such as tuberculosis, diarrhoea, and Pneumocystis carinii pneumonia can extend and improve the life of people living with HIV and their families. A person with HIV can take isoniazid to prevent tuberculosis and co-trimoxazole to prevent other bacterial infections. These are called prophylactic medicines. Antiretroviral drugs reduce the level

Ask help from health worker if you notice rapid weight loss or if the sick person consistently refuses to eat any food, or is not able to swallow.

Fever: Keep the client in comfortable condition without extra clothes or blankets. Provide cool sponging if possible or just wipe the skin with wet cloths and letting the water evaporate. Fresh air is not harmful and helps to lower the fever. Keep the patient well-hydrated (drinking plenty of fluids and water). Give Paracetamol orally. If the patient cannot swallow, it is possible to give some Paracetamol by rectum or injection.

Diarrhoea: Give frequent drinks in small amounts: water, rice soup, other soups and pudding. Encourage the sick person to drink



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a o m u f y g p? t p m; u l l m; E l l b r # p m; & e f w l u w e f t m;
a y: y q O r f o b r; y d v # f p t E s f t e d w O l u l u l a y s n h o m
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x m; a o m a & w p z e t l u j z i l v p a e l y g p y l u l l u l l a q; y q
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p o n i v l l v n f x d & m u f y g p n? j z p E l l v l l v e m. t e d
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the above fluids as much as possible. Avoid very sweet drinks and alcohol. Make oral rehydration solution (ORS) and give as a drink frequently. Encourage eating food as much as possible. Clean rectal area with toilet paper or soft tissue paper after passing stool. Wash the rectal area when necessary, with soap and water. Apply Vaseline around the rectal area if the patient feels pain.

Seek help from health worker for vomiting with fever, blood in the stool, diarrhoea lasting more than five days, broken skin around the rectal area and patient becoming weaker and weaker.

Coughs and Breathing Difficulties: For simple coughs, local-soothing remedies such as honey and lemon can help. Make a lemon juice-lemonade sweetened with honey. Use local remedies e.g. steam with menthol or eucalyptus leaves.

Help the sick person into a position that eases breathing; sitting is best. Leaning slightly forward and resting arms on a table may help. Use extra pillows for back support. Open windows to allow fresh air in. Give patient water frequently. Gently tap the patient on the back and chest to loosen sputum and make it easier to cough.

Seek help from health worker if the patient has difficulty breathing, pain in the chest, a cough lasting more than 2 weeks or bloody sputum. The health worker will check for Tuberculosis.

Itching skin rash: Itching skin is very common. It can be due to infection. Cool the skin or fan it. Avoid heat and hot water on the skin. Avoid scratching, which causes more itching and sometimes infection. Cut finger-nails short and keep them clean to avoid infection. Apply aqueous (water based) cream, or Vaseline on the itching part of the body after a bath before drying. Put one tablespoon of vegetable oil in 5 litres of water when washing

the sick person. Rub the itchy skin with a cucumber or a wet tea bag.

Seek help from health worker if itching continues or for painful blisters or extensive skin infections.

Thrush (painful mouth ulcers) or pain on swallowing: Avoid extremely hot, cold or spicy foods. Remove bits of food stuck in the mouth with cotton wool, gauze or soft cloth soaked in salt water. Rinse the mouth with dilute salt water (a finger pinch of salt in a glass of water) after eating and at bedtime, or with a half teaspoonful of baking powder (sodium bicarbonate) in a mug of water (500 ml) if there are white patches in the mouth (thrush/candida). Use a soft toothbrush or stick to remove debris. Mix 2 tablets of aspirin in water and rinse the mouth up to four times a day. Give soft food, such as cold milk, porridge, potatoes or honey depending on what the sick person feels is helpful.

Seek help from a health worker if there is no response to home treatment, persistent sores, smelling mouth, white patches or difficulty on swallowing.

Nausea and Vomiting: Seek locally available foods that the patient likes (tastes may change with illness) and that cause less nausea. Offer frequent small foods such as roasted potatoes, boiled rice or pudding. Offer the drinks the sick person likes, such as water, juice or tea. Take drinks slowly and more frequently. There are some effective and safe local remedies like licking ash from the wood. If possible, avoid strong odour and cooking close to the patient.

Seek help from health worker for vomiting lasting more than one day, dry tongue, passing little urine or abdominal pain.

Dry Mouth: Give frequent sips of drinks. Moisten mouth regularly with water. Let the sick



person suck on fruits such as pineapple, orange or passion fruit.

Seek help from health worker if dry mouth persists.

Bedsore or pressure sores: Change position often. For small sores, clean gently with salty water and allow drying. For bedsores that are not deep, leave the wound open to the air. For pain, give pain-killers such as Paracetamol or Aspirin regularly. For deep or large sores, clean gently every day with salt water, fill the bedsore with pure honey and cover with a clean light dressing to encourage healing. For bloody or smelling sores put on enough crushed Metronidazole tablets to cover the area.

Seek help from health worker for any discolored skin or bedsores getting worse.

Treatment of hiccups: The patient should drink cold water quickly and eat two-heaped teaspoon of sugar. Rub with a clean cloth inside soft part of the top of the mouth. Breathe into a paper bag, stopping when you feel uncomfortable. Hold breath, stop it after feeling uncomfortable. Pull knees to the chest and lean forward (compress the chest).

Worries and fears: Take time to listen to the sick person. Discuss their problems in confidence. Providing soft music or massaging may help the sick person to relax. Pray together if requested.

Seek help from health worker, if the sick person is abnormally sad, not able to sleep and

in a state of loss of interest or threaten to kill themselves.

Trouble sleeping: Listen to the sick person's fear, which may be keeping them awake. Reduce noise where possible. Do not give the sick person strong tea or coffee late in the evening. Give treatment for pain if present. Give a comforting drink at night.

Confusion: Signs of confusions are forgetfulness, lack of concentration, trouble speaking or thinking, frequent changing mood and unacceptable behaviours such as going naked and using bad language.

Keep the patient in a familiar environment. Keep things in the same place, which is easy to reach and see. Remove dangerous objects. Speak in simple sentences, one person a time. Keep other noise down (such as TV, radio). Make sure a trusted caregiver is present to look after the sick person. Provide comfort for the patient. Avoid confrontation (arguing). Do not say or do things that could upset the patient since he/ she might still be able to understand. Use gentle reminders of place and time.

Seek help from a trained health worker if this is a new confusion or the sick person becomes violent, or for any condition not improving and causing distress.

Sources:

- *Caregiver Booklet*, WHO
- *Protecting the Future*, IRC
- WHO, "*Sexually Transmitted Infection*." www.who.int.

AIDS ranks third in priority among the 39 listed diseases in the 1996 Myanmar National Health Plan; malaria is first followed by tuberculosis. Drug abuse is listed as priority number seven. The NAP does not have a policy specifically focusing on drug use and HIV. However, an objective is to provide those engaging in risk behaviours appropriate information to increase awareness of HIV/AIDS and to promote risk reduction.



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Treatments for people with HIV/ AIDS

Nicolas Durier, MSF France



This article explains about the treatment of people with AIDS using available drugs and so also antiretroviral drugs.

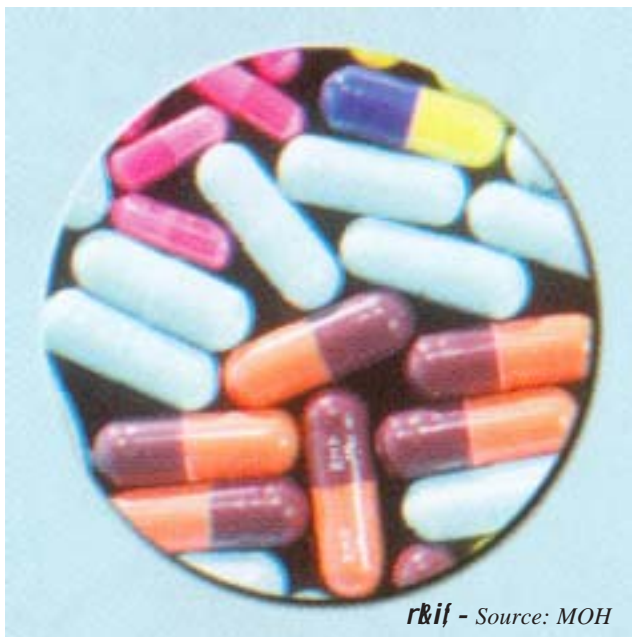
As already explained in other sections, when it has entered the body during risk exposure, the Human Immunodeficiency Virus mainly targets and destroys slowly some of the white blood cells that coordinate the response of the immune system to different other germs. These specific white blood cells are called **CD4 cells**.

Thus, 2 main types of treatment are usually needed by HIV-infected persons: a) the treatment of opportunistic infections that may occur because of the CD4 cells decrease, and b) and the treatment against HIV itself that causes this CD4 cells decrease.

Treatment of opportunistic infections

The treatment of opportunistic infections can be either preventive or curative. It is preventive

when the opportunistic infections have not yet occurred but that the risk is big because the CD4 cells have already significantly decreased. It is curative when the opportunistic infection has already developed. An example of possible opportunistic infection is the *Pneumocystis Carinii* Pneumonia (PCP). *Pneumocystis Carinii* is present in the environment. When present in the human body, it poses no problem at all when CD4 cells are above 200/ml. When CD4 decrease below 200 because of HIV, the risk to develop PCP is high. Hence, when someone has CD4 below 200 but has not developed the PCP, he/she requires a long-term preventive antibiotic treatment (Bactrim low dose). When the PCP has developed (CD4 are below 200), its treatment is based on the same antibiotic but at much higher doses and for a shorter period. After its cure, preventive treatment of PCP recurrence is also necessary. The same situation applies to some other possible opportunistic diseases. A fungal infection by *Cryptococcus Neoformans* can commonly cause very severe meningitis when CD4 decrease below 100. Its prevention is possible by some antifungal drugs (fluconazole) when CD4 are known to be that low. Its treatment by some other antifungal drugs at high dose is necessary when the meningitis has already developed. Despite this, one main problem in the prevention or cure of opportunistic infections is that they usually tend to occur one after another



r&i - Source: MOH



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r&f - Source: MOH



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since the immune system is progressively weaker and weaker because of HIV, and that some of them are not well controlled by the existing drugs. Therefore, in the absence of effective treatment against HIV itself, preventive and curative treatment of opportunistic infections cannot prevent from death to finally occur in HIV-infected persons.

Antiretroviral treatment

The most important treatment in HIV-infected persons is the treatment against HIV itself. Progressively since 1986, different drugs having some effects against the multiplication of the HIV have been discovered. They are called antiretroviral drugs. These existing antiretroviral drugs block some of the steps of

multiplication of the HIV. They don't destroy it. As a consequence, new HIV virus cannot be formed, and newly produced CD4 cells are not infected and not destroyed by HIV. In fact, despite the fact that antiretroviral drugs appeared as early as 1986, it is only since 1996 that very effective antiretroviral therapy has been identified: it is called triple antiretroviral therapy and consists in the association of 3 different antiretroviral molecules acting at different places in the cycle of multiplication of HIV. When given to HIV-infected patients, triple antiretroviral therapy can usually cause a complete stop in the multiplication of the virus. The virus becomes undetectable in the blood stream and remains only "frozen" in some of the

white cells of the body (in the lymph nodes for example). As a result of these very important anti-HIV effect, triple antiretroviral therapy can indirectly cause CD4 levels not only to remain stable but in fact to increase pretty dramatically as new ones are produced and remain free from HIV. When CD4 cells increase again and reach again safe levels as a result of triple antiretroviral therapy, opportunistic infections usually cannot develop.





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1? y&#p&#i&#r&#_

• **vu&#t "u &#k&#&#f&#y&#p&#q; 3 r&#r&#n (u) t i&#e&#f&#t m&#w&#t i&#f&#NRTI (Nucleoside Reverse Transcriptase Inhibitors) (c) t i&#e&#f&#t i&#e&#f&#t m&#w&#t i&#f&#NNRTI (Non-Nucleoside Reverse Transcriptase Inhibitors) (*) y&#t&# i&#f&#PI (Protease Inhibitors) w&#j&#z&#p&#b&#n?**

• **(u) t i&#e&#f&#t m&#w&#t i&#f&#NRTI w&#f&#a&#r&#m&#v&#l&#u&#t; 5 c&#k&#b&#n?**

- AZT (Zidovudine)

- D4T (Stavudine)

- 3TC (Lamivudine)

- DDI (Didanosine)

- ABC (Abacavir)

• **(c) t i&#e&#f&#t i&#e&#f&#t m&#w&#t i&#f&#NNRTI w&#f&#a&#r&#m&#v&#l&#u&#t; 3 c&#k&#b&#n?**

- Nevirapine, Efavirenz, Delavirdine

• **(*) y&#t&# i&#f&#PI w&#f&#a&#r&#m&#v&#l&#u&#t; 6 c&#k&#b&#n?**

- Indinavir, Ritonavir, Saquinavir, Nelfinavir, Amprenavir, Lopinavir

3 r&#r&#w&#f&#&#v&#&#&#f&#y&#p&#u&#k&#t w&#f&#r&#h

2NRTI + 1NNRTI (OR) 0yrm? AZT + 3TC + Nevirapine

2NRTI + 1 PI 0yrm? D4T + 3TC + Nelfinavir

2? t&#m&#o&#m&#c&#u&#f

• **t&#v&#t&#f&#t i&#A&#&#f&#y&#p&#q i&#y&#r&#; j&#z&#p&#a&#y: r&#u&#l&#v&#m; q&#E&#i&#b&#n?**

• **p&#d&# q&#l&#v&#E&#t&#t&#t&# m; p&#p&#u&#l&#y&#e&#l&#v&#n&#a&#u&#m i&#f&#r&#e&#f&#a&#p&#o&#n i&#(t&#e&#n i&#q&#l&#t p&#o&#v&#y&# i&#f&#w&#p&#t&#t&#)?**

• **t&#c&#f&#t a&#; , l&#u&#l&#p&#u&#a&#m* j&#z&#p&#r&#u&#l&#v&#s&#t&# t&#v&#t&#f&#t i&#A&#o&#E&#e&#f&#u&#l&#n&#f&#a&#p&#o&#n?**

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• **t&#v&#t&#f&#t i&#A&#u&#m i&#f&#t a&#j&#c t&#a&#e&#q&#l&#o&#n&#f&#t q&#i&#a&#m&#u&#a&#e&#o&#E&#h&#m* g&#u&#l&#r&#f&#a&#e&#o&#r&#m; u&#l&#n&#f&#o&#m r&#e&#b&#o&#l&#y&#e&#l&#v&#n&#f&#h&#q&#m i&#f&#a&#y; E&#i&#b&#n?**

3? t&#q&#i&#r&#a&#j&#o&#n&#u&#f&#r&#m;

• **v&#l&#D&#a&#y&#s&#u&#l&#i&#f&#a&#t&#m i&#f&#t&#v&#t&#f&#t i&#A&#u&#l&#u&#E&#i?**

• **a&#e&#o&#v&#i&#f&#w&#p&#b&#u&#l&#v&#a&#q; a&#o&#m&#u&#b&#l&#e&#&#r&#n?**

• **a&#q; &#y&#i&#v&#f&#i&#f&#t&#v&#t&#f&#t i&#A&#y&#r&#; v&#m&#y&#l&# p&#d&# q&#l&#v&#r&#m; u&#l&#n&#f&#w&#l&#u&#t&#l&#u&#a&#p&#o&#n?**

• **a&#q; o&#p&#f&#y&#u&#l&#u&#l&#v&#f&#l&#v&#n&#f&#a&#q; c&#E&#i&#&#n&#&#f&#y&#l&#m&#o&#n?**

• **x&#h&#u&#m i&#f r&#f&#u&#k&#l&# t&#m&#e&#b&#i&#b&#n&#f&#w&#p&#b&#u&#l&#v&#h&#t&#j&#r&#i&#q&#l&#t&#j&#z&#p&#a&#y? u&#m&#v&#f&#i&#(E&#f&#f&#r&#m; p&#h) r&#n&#f&#o&#n&#h&#q; t&#w&#l&#u&#b&#l&#o&#n&#u&#l&#w&#n&#l&# t&#m&#e&#b&#i&#f&#u&#y&#a&#q; a&#j&#y&#m i&#f&#o&#l&#e&#l&#v&#l&#t&#y&#r&#n?**

• **y&#h&#f&#a&#b; x&#u&#q&#l&#u&#t&#b&#n?**

• **a&#e&#m&#u&#q&#u&#l&#u&#p&#r&#m; j&#y&#k&#y&#b&#e&#a&#i&#t&# u&#e&#f&#t&# u&#r&#m; o&#n&#l&#y&#v&#t&#f&#e&#l&#p&#r&#f&#o&#y&#r&#f&#r&#m; v&#i&#b&#n?**

• **a&#o&#c&#m&#p&#h&#u&#b&#a&#o&#m&#l&#v&#n&#f&# t&#v&#t&#f&#t i&#A&#u&#l&# k&#l&#v&#f&#e&#a&#o; l&#t&#j&#c&#m; o&#r&#m; u&#l&#p&#u&#E&#i&#b&#n?**

4? t&#i&# f&#r&#m;

• **3 r&#r&#w&#f&#&#v&#&#&#f&#y&#p&#q; u&#l&#t&#v&#t&#f&#t i&#A&#p&#w&#i&#D&#i&#c&#i&#o&#l&#p&#e&#r&#v&#l&#t&#y&#g**

• **3 r&#r&#w&#f&#&#v&#&#&#f&#y&#p&#q; u&#l&#t&#m&#u&#f&#t&# a&#j&#c t&#a&#e&#r&#m; w&#f&#a&#y; y&#g**

(u) **t&#c&#f&#t a&#; , l&#u&#l&#p&#u&#a&#m* g&#r&#m; &#&#l&#f&#o&#l&#p [l&#v&#f**

(c) **p&#d&# q&#l&#v&#t&#E&#W&#m, &#a&#o&#m&#t&#q&#i&#k&#e&#n&#f&#o&#h; v&#f&#i(200 - 350 q&#l&#v)**



Essential principles of existing triple antiretroviral therapy

1) Composition:

• 3 main classes of antiretroviral drugs exist: a) the nucleosides inhibitors of the HIV reverse transcriptase also called NRTI, b) the non-nucleosides inhibitors of the HIV reverse transcriptase or NNRTI and c) the inhibitors of the HIV protease or PI. (The reverse transcriptase and the protease are 2 essential keys used by HIV to multiply).

- 5 molecules are currently available in the class of NRTI (AZT, D4T, 3TC, DDI, Abacavir),
- 3 molecules in the class of NNRTI (Nevirapine, Efavirenz, Delavirdine) and
- 6 molecules in PI (Indinavir, Ritonavir, Saquinavir, Nelfinavir, Amprenavir and Lopinavir).

The triple antiretroviral treatment usually given consists on 2 NRTI + 1 NNRTI or 2 NRTI + 1 PI. Example: AZT + 3TC + Nevirapine or D4T + 3TC + Nelfinavir.

2) Advantage:

- They can completely block the HIV multiplication
- They permit to restore (at least partly) the CD4 cells and immune system
- They dramatically decrease the risk of opportunistic infections and reduce the HIV-associated mortality
- They changed HIV infection from a death sentence to a chronic disease
- Even patients with very late HIV disease and advanced condition can go back to a normal life.

3) Inconvenient:

- They are not a cure against HIV
- They have to be taken every day, and for life long
- If stopped, HIV starts to multiply again and to infect again CD4 cells
- If patients miss doses, risk of resistance increase
- Thus, the efficacy of a triple antiretroviral regimen is not maximum for life long and after some time (usually some years), depending mainly on the patient adherence to the doses recommended, efficacy has decreased enough to require a change of antiretroviral regimen.
- They cause regularly side effects
- They remain expensive
- They usually require follow up of quite complex and expensive laboratory tests
- They require to be given by well-trained health personnel
- When effectively treated, patients remain infected with HIV and can still transmit it to others.

4) Indication:

- Triple antiretroviral therapy is NOT necessary as soon as someone is infected with HIV.
- They are indicated when
 - a) patients have already some opportunistic infections, or
 - b) CD4 counts have gone down to a risky level (below 200-350 cells).



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Counselling for HIV/AIDS

Health Messenger Team



This article provides health workers with some guidelines to give good counselling on sensitive topics related to HIV/AIDS. It provides health staff with useful information about effective communication aiming at detecting and preventing risky sexual behaviours.

Sexuality and sexual options

Sexual behaviour change of a client is an important component of HIV counselling. Unfortunately, many counsellors find it difficult to get over being embarrassed dealing with the sexual issue; at other times, they are judgmental and label a sexual behaviour as not normal. Counsellors will need the essential four C's- Compassion, Care, Communication and Counselling- to achieve success.

Whatever may be the beliefs or personal views, counsellors must be non-judgmental in viewing the client as a person requiring

Skills required for good counselling

It is necessary for counsellors to obtain an understanding, or history of the behaviour, which may have exposed the client to HIV infections or AIDS. This means that the counsellor must be able to gather information about very private- and sometimes illegal or socially condemned-behaviour. Effective discussion of sensitive topics will depend in large part upon the ability of the counsellor to:

- gear his/her communication to the emotional and intellectual level of the client;
- make the client feel safe, secure and accepted by establishing a supportive relationship; and
- demonstrate his/her own ease in talking about topics usually avoided in ordinary social life or in medical consultations.



compassion, care and help to practice safer sex rather than concentrating on changing the sexual orientation of the person.

client. With some clients, counselling can be a process, which develops gradually and may need to be eased into slowly. Early on, a

Creating an atmosphere of trust

Whatever approach a counsellor uses, it will require skill, tact and sensitivity towards the



rapport will need to be established, together with an overall atmosphere that helps the client to develop a feeling of safety and trust, without which the counselling process will not be completely successful. The counsellor's style must therefore be reassuring, confident and direct, but considerate of the client's feelings and fears and acknowledging the client's difficulty.

Interview method to detect risky behaviours

The following specific guidelines on talking about sensitive topics will be useful to counsellors:

1) Ask direct questions so as to be clear about what is worrying the client, and what else he/she wants and expects from the counsellor.

Example: "What do you want from me (this clinic, hospital, etc.) right now? What made you decide to come here now?"

2) Establish the reasons for the client's concern or belief that he/she is infected or at risk of infection.

Example: "You tell me that you are afraid you have AIDS. Tell me what you know about the ways in which people become infected. In which of these ways are you most at risk?"

3) Anticipate a certain degree of embarrassment at discussing sex; point out that you realize that people do not usually discuss it in such depth.

Example: "We do not usually talk very openly about sex in our country. But now, since you believe you may have been at risk of infection, you and I must determine the degree of risk. To do that, I have to ask some very specific questions. Most people feel a bit embarrassed by these questions, and you may too. For example, I need to know how many

sexual partners you have had over the past six months."

4) Explain clearly why you must enquire into sexual practices and drug injecting- that it is in order to determine precisely what the client needs to do to prevent becoming infected or passing the infection on to others.

Example: "HIV is transmitted in a number of quite specific ways. You know that sharing needles is dangerous for you and for others. What can you do to keep yourself free of infection, or to protect other people?"

5) Explain why you are asking questions about all forms of transmission.

Example: "Sometimes people are offended when I ask about practices that seem strange or even repulsive because they are not common in this area. But, people travel, and sometimes experiment, so we must make sure that all the possible risks are covered."

In such interviewing, the counsellor should use the formal expression first (e.g. vaginal intercourse). If it is not understood, the slang expression should be used and the client asked which one is preferred. The client must not feel that the counsellor is making any moral judgement on any sexual behaviour or other risk behaviour.

The counsellor should check frequently to make sure that the client understands what is being said- for instance, by asking the client to repeat in his/her own words what the counsellor has been saying.

Three main messages to be remembered by the client at the end of the counselling session

The counsellor should also ensure by asking the questions given below that everyone being counselled for the prevention of HIV infection



receives and understands the following 3 essential messages:

- There is no cure for HIV infection. Prevention is the only defence at the present time

Questions: “How do you think that HIV infection is spread? If you want to stay free of infection, what changes will you have to make? What will you tell others (spouse, partner) about why you are changing your sexual behaviour?”

- HIV can be transmitted through vaginal and anal sex; sharing needles; and contaminated blood.

Questions: What do you think people find most difficult when they give up (whatever the risk behaviour is)? What do you think might be hardest for you? When you say you do some risky things, what do you mean?

- HIV transmission can be prevented only through abstinence, or sex without exposure to blood, semen or vaginal/cervical fluids. To lessen the risk of sexual transmission, men should **use a condom** each time and from start to finish. Women should ensure that their partner uses one. The more sexual partners, the greater the risk of exposure. Drug injectors should not share with anyone else syringes or other drug-related instruments that pierce the skin.

Questions: “Do you think it is possible for you and your spouse/partner to abstain from sex? Have you tried condoms? When you and your spouse/partner talk about condoms, how comfortable is each one of you? What do you



r&f - Source: UNICEF

know about the best way to use condoms?”

The client should be given time and information with which to discuss appropriate means of infection control and avoidance. This information must be communicated in a language and terms that the client understands. The counsellor will need to try different versions and to vary it for individual cases.

Clients may be given a pamphlet or leaflet containing information on HIV transmission, prevention and condom use. If they cannot read, the counsellor should go over the details, using questions to double-check that the information is being understood.

Sources:

1. *An orientation to HIV/AIDS Counselling- A Guide for Trainers*, WHO, New Dehli, 1993.

2. *The AIDS handbook, A Guide to the Understanding of AIDS and HIV*, J. Hubley, Macmillan, 1995.

Win Maw is 20 years old. She is a sex worker. She used to be amphetamines addicted but she managed to quit drugs. She is now affected with mental disorders and she is six-month pregnant. She would like to abort but it is already too late. I told her how to prevent pregnancy and sexually transmitted diseases by using condoms during each sexual intercourse. I examined her pregnancy and gave her some vitamins and HIV education materials. On 20 July, 2004, I went to see her again and found out that she had given birth and someone had already adopted her child. She was continuing her job as a sex worker, but used condoms with all her clients. (*story reported by a social worker from NHEC*).



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Misconceptions about HIV/AIDS

Health Messenger Team in collaboration with Maw Maw Zaw



This article reports on common misconceptions about HIV/AIDS among Myanmar migrant workers in Thailand. This survey was conducted in Bangkok in 2002, on a sample of 367 Myanmar migrant workers, using a quota sampling method.

In countries affected by HIV/AIDS on a large scale, lack of knowledge and misconceptions about the causes of the virus are found to be common. Misconceptions and a lack of knowledge prevail especially among communities having lower educational attainment and restricted access to public information sources and health services. Myanmar migrant workers in Thailand tend to have all these characteristics, which are compounded by limitations in Thai language and their illegal migration status in the country.

However, we all have our own fears, prejudices and beliefs about sexuality, risk, illness and death. These arise from our past experiences, present situation and culture. We

need to understand how these feelings influence how we think about AIDS and how these misconceptions lead us to adopt risky behaviours.

Socially acceptable norms

Many traditions and cultures have their brand of masculine prowess and some of them could actually be harmful “misconceptions” leading to risk behaviour for HIV transmission. Getting first sexual experience with a “professional” woman before marriage has long been a common practice in Thailand and some other countries in the region. Most of these “experienced women” are sex workers



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r&f - Source: Care Raks Thai

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Assessment of knowledge, attitudes and risk behaviors regarding HIV/AIDS among Myanmar migrant workers in Bangkok, Thailand. Thesis of Master of Public Health, Maw Maw Zaw, 2002



nowadays and widely known in the particular community of Burmese migrant workers. In general, very few migrants approve of extra-marital sex. However, the survey shows that a large majority of male migrants agree that single men can have sex with SW.

Perception of condom use

A high proportion of interviewees consider the use of condoms as disrespectful or not being faithful to their partner which is a common problem in many cultures, and even in spite of an extensive HIV/AIDS campaign this attitude has not changed much. In fact, this is one of the main reasons why a large number of women are becoming infected by their male partners who contract the disease through “unsafe” commercial or casual partner sex. Poor knowledge and lower acceptance of condoms, as well as their restricted availability is often cited among the main reasons for low condom use.

Perception of HIV/AIDS transmission

69% of interviewees believe or are not sure that HIV/AIDS is a punishment from God. Only 31% disagree and say that people get HIV/AIDS because of their risk behaviours. This irrational attitude towards HIV is also reflected in about 48% of the migrants believing or being undecided that drinking alcohol before and after sex prevents HIV infection. This is a hazardous attitude to have, and could be a source of high-risk behaviours (see article-page 49, on Alcohol Abuse and HIV). Other beliefs, such as the possibility of being infected through kissing, the absence of risk when using condoms “from time to time”, and immunity to the virus if young, heterosexual and healthy, are also reported to be common.

Perception of People Living With AIDS

In this study the majority of migrants (65%) are either unwilling to work or live with PLWA or are unclear about it. Similarly, about half of them are in favour of or neutral to the proposition of forcing the PLWA to live far away from the community. Obviously, the dominant attitude among the migrants is stigmatization and rejection of PLWA.

Attitudes toward PLWA are a critical issue in many countries. In many places, PLWA and their families are very isolated. Stigmatization of PLWA might delay their seeking support from adequate health services and consequently worsen their condition.

Conclusion

The attitudes of the migrants towards HIV/AIDS are quite mixed. Only a little over half of the migrants believe that AIDS is a big problem. About 71% of the migrants have a “neutral” or non-committal attitude towards HIV/AIDS, which could be a source of confusion and misleading judgements. This confusion and misunderstanding make the migrants more vulnerable to risk behaviours and should be addressed in information campaigns. Therefore, health and social workers have a major role to play in providing migrant communities with accurate information about HIV/AIDS and promoting behavioural change for healthier lifestyles.

Source:

Assessment of knowledge, attitudes and risk behaviors regarding HIV/AIDS among Myanmar migrant workers in Bangkok, Thailand. Thesis of Master of Public Health, Maw Maw Zaw, 2002.

Alcohol Abuse and HIV/AIDS

Pam Rogers, CARE Project



Alcohol abuse can lead to risky sexual behaviors that can put people in danger of contracting HIV/AIDS. Moreover, consumption of alcohol by people with HIV/AIDS can worsen their condition. Therefore, prevention of addictions is an important component of HIV/AIDS prevention.

People with alcohol use disorders are more likely than the general population to contract HIV (human immunodeficiency virus). Similarly, people with HIV are more likely to abuse alcohol at some time during their lives. Alcohol abuse is associated with high-risk sexual behaviors and intravenous drug use; both major modes of HIV transmission. Concerns about HIV have increased as recent trends suggest a resurgence of the epidemic among men who have sex with men, as well as dramatic increases in the proportion of cases transmitted heterosexually. In persons already infected, the combination of heavy drinking and HIV has

been associated with increased medical and psychiatric complications, delays in seeking treatment, difficulties with HIV medication compliance, and poorer HIV treatment outcomes. Decreasing alcohol consumption in people who have HIV or who are at risk for becoming infected reduces the spread of HIV and the diseases associated with it.

People who abuse alcohol are more likely



Saw Htoo became very unhappy in his life because he lost everything he owned and had to run to Thailand. Here he stayed on the border with his wife Naw Wah and son Saw Say. They were always worried about security. To help himself feel better, Saw Htoo started to drink more alcohol than he was used to. Everyday he would come home drunk. His wife Naw Wah was very sad and angry that her husband had left her for his friend the alcohol bottle. Feeling frustrated she let him know that she was not happy with him.



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risk sexual behaviors, including multiple sex partners, unprotected intercourse, sex with high-risk partners (e.g., intravenous drug users, prostitutes), and the exchange of sex for money or drugs. There may be many reasons for this association. For example, alcohol can

One day Saw Htoo met a man who offered to make him happy. He took him to a secret place where he offered him some free heroin. Saw Htoo was not sure but because he was drunk already, he decided to try it. This heroin felt very good indeed and Saw Htoo never wanted to stop using it. He could not afford his own needles so he borrowed needles from the people he met in the secret place.

act directly on the brain to reduce inhibitions and diminish risk perception. However, expectations about alcohol's effects may exert a more powerful influence on alcohol-involved sexual behavior. Studies consistently demonstrate that people who strongly believe that alcohol enhances sexual arousal and performance are more likely to practice risky sex after drinking.

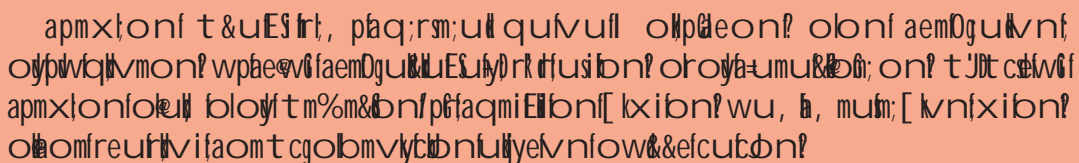
Some people report deliberately using alcohol during sexual encounters to provide an excuse for socially unacceptable behavior or to reduce their conscious awareness of risk.

to engage in behaviors that place them at risk of contracting HIV. For example, rates of intravenous drug use are high among alcoholics in treatment, and increasing levels of alcohol ingestion are associated with greater intravenous drug-related risk behaviors, including needle sharing.

A history of heavy alcohol use has been correlated with a lifetime tendency toward high-

Alcohol increases susceptibility to some infections that can occur as complications of AIDS. Infections associated with both alcohol and AIDS include tuberculosis; pneumonia caused by the bacterium *Streptococcus pneumoniae*; and the viral disease hepatitis C, a leading cause of death among people with HIV. Alcohol may also increase the severity of AIDS-related brain damage, which is

Saw Htoo's wife was even more unhappy with him and would not let him come near her because he was always drunk or high from the drug. One night Saw Htoo was taken to a brothel. Here he spent an hour with a prostitute. He was very drunk and could hardly remember anything the next day.



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Saw Htoo continued to drink and use drugs. He became very angry at Naw Wah and one day beat her and raped her. She was very frightened. At the time, Saw Htoo thought he was very strong and a real man but in the morning he had trouble remembering what he had done.

characterized in its severest form by profound dementia and a high death rate.

Studies show that decreasing alcohol use among HIV patients not only reduces the medical and psychiatric consequences

Sometime later Saw Htoo started to feel very unwell and lost a lot of weight. When he drank now his memory became worse and he became very confused and angry. He went to the doctor who took a blood test and told him he had AIDS and Hepatitis C. Soon Saw Htoo's liver gave up and he died. Later his wife also died as she had caught the HIV virus from Saw Htoo. His son now had no parents.

associated with alcohol consumption but also decreases other drug use and HIV transmission. Thus, alcohol and other drug abuse treatment can be considered primary HIV prevention as well. For example, Avins and colleagues found a 58 percent reduction in injection drug use, with similar decreases in high-risk sexual behaviors, among heterosexual patients

one year after treatment. Participants who remained abstinent showed substantially greater improvement in both outcomes compared with those who continued to drink.



Saw Htoo's son Saw Say who was 20 years old had followed in his father's footsteps and had become a young alcoholic. When his father and mother died he decided to stop drinking and got treatment for his addiction. He then dedicated himself to helping other young people to seek help for their drinking problems and to learn about how to avoid HIV/AIDS. He visited HIV patients and helped them to cut down their drinking and to get addiction treatment. Saw Say is alive today.



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IDUs and HIV: A Case study

Greg Manning



Shiv was sitting under a tree in the park. He was watching the new man in the park. The man was in pain. His pain was getting stronger and stronger. Shiv knew what the man's problem was. He needed some heroin, but had not been able to buy any.

Shiv had felt the same pain 3 different times in his life. He remembered when someone had helped him when he was in pain. That help was so important to him. But he also felt scared. He did not want to feel that pain again.

But today, Shiv was OK. Other people's rubbish was his treasure. He had found some old wires. He sold them to the scrap dealer. He had 20 Rupees (less than US\$ 0.50) in his

hand. Now he could buy the things he needed from the chemist to stop his withdrawals for the rest of the day.

Shiv came over to the new guy. He found out that the man had 30 rupees with him. This was not enough to buy heroin, but he was becoming desperate for it. Shiv told him that he had some medicines with him that would ease the man's pain. He also said that the man had enough money for it. The man had never heard of such medicine before and begged for Shiv's help.

Shiv mixed the contents of three small bottles (containing buprenorphine, an opiate, and an antihistamine and a sedative) together in another





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bottle he was carrying. Starting with himself, he showed how to inject the “cocktail”. Then he sucked the needle and wiped it dry with his shirt. He helped his new friend to do the same. Very soon, the man relaxed and the pain in his body was relieved. This was the first time he’d injected any drugs. Where he comes from, heroin fumes are inhaled.

He was very interested in this miracle medicine. It would definitely help him through

the next few days. He could stretch out the few rupees he had while he was staying with his in-laws. He was in Delhi for only four of days to work out something with his wife’s family.

He found out where to get more of this medicine and how to use it. He also asked how long before he would need to use it again. He gave Shiv some money for the service and medicines and went on his way.

This simple event can start an HIV epidemic in an area, which is not yet affected by HIV.

The man carries with him information that could create a new population of injecting drug users in his area. He did not know the risks associated with the use of this ‘medicine’, which saved him from the pain of his heroin withdrawal. He will tell his heroin using friends about his experience.

HIV can spread very quickly in groups of injecting drug users. Some places have reported that over half of their injecting drug users become infected with HIV within one year of identifying the first HIV positive injecting drug user.



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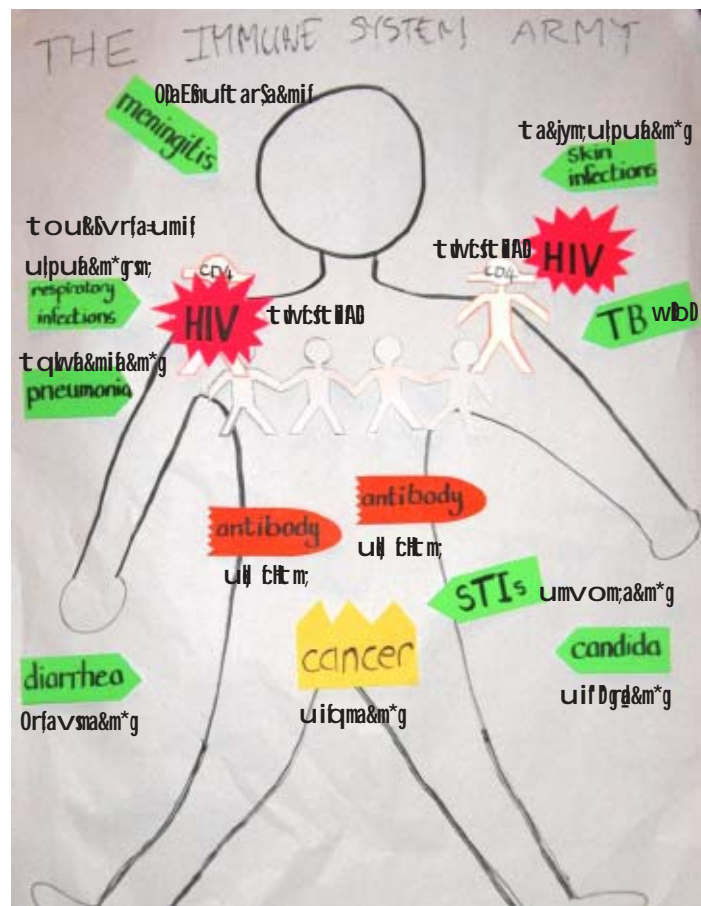
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Social Impact and Underlying Causes of HIV/AIDS Epidemics

Julia Matthews, Women's Commission for Refugee Women and Children



This article will help health workers to identify the underlying conditions of the HIV epidemic.

Conflict situations and HIV/AIDS risk

Conflict-affected settings are associated with conditions in which HIV/AIDS and other sexually transmitted infections (STIs) may thrive. These settings often coincide with limited access to means of prevention, treatment and care. STIs, including HIV, if not addressed, may spread rapidly among conflict-affected populations for many reasons. The disturbance of community and family life among displaced populations may disrupt social norms governing sexual behaviour. In the absence of socio-cultural constraints, adolescents may begin sexual relations at an earlier age, take sexual risks and face exploitation. Women and children may be coerced into having sex to obtain their survival needs. During civil strife and fight, displaced persons, especially women and girls, are at increased risk of sexual violence, including rape. Proximity to armed forces, a population that has been associated with high rates of HIV, facilitates the spread of HIV in conflict situations. Finally, in displaced settings populations from low prevalence areas may mix with populations from high prevalence areas, increasing the overall HIV rate in the region.

HIV/AIDS Tree

The symbol of the HIV/AIDS tree helps to visualize the ways in which HIV spreads. The roots of the tree – or the three routes in which HIV is transmitted – are through sex, blood

and from mother to child. These roots are nurtured by soil – or social vulnerability factors – which represents all of the influences on a person: his or her knowledge, education, beliefs, attitudes, access to resources and health services and whether he or she is impacted by war. Depending on whether a community is educated about how to prevent HIV, provides access to HIV prevention and care services or is impacted by poverty will influence how HIV spreads in their community. Prejudice, discrimination and stigma – beliefs and actions that keep people silent or isolated – represent the water that helps the HIV/AIDS tree to grow.

The result of the spread of HIV – the tree's branches – shows how HIV has a wide-ranging effect on the individual, family and society. For example, in addition to a person showing the physical signs and symptoms of HIV, such as sores or weight loss, individuals also experience an emotional impact, which may include anger, fear and sadness. Families are also greatly impacted by HIV. For example, family income may decrease with the loss of someone working, girls may be kept out of school to care for sick family members and in some societies women may lose their house or landrights when their husband dies. On a larger scale, societies may lose valuable contributing members leading to a reduction in the country's productivity. Indeed, HIV/AIDS usually attacks the young and economically productive group of the population. The death of the young people affects the productivity and therefore



Therefore, prevention efforts at the lower part of the tree should target the socio-economic vulnerability factors. Humanitarian workers can raise the awareness of individuals about their risk of HIV, support people who may not have the power in their relationships or the resources to control their circumstances, and establish or improve services to the community in which they work. Health workers should not consider PLWA as a burden to society. Indeed, PLWA can also be important stakeholders in the fight against HIV/AIDS epidemics by taking part in advocacy activities for change and awareness-raising in their communities.

Given the clear need to address HIV/AIDS in conflict settings and the opportunities which humanitarian interventions may bring, the Women's Commission on behalf of the RHRC Consortium developed a manual, *HIV/AIDS Prevention and Control: A Short Course for Humanitarian Workers* aimed at health programme management and clinical staff working in conflict-affected settings. Dr. Wendy Venter developed the training manual and the theme of the HIV/AIDS tree used throughout the course. A training was held for humanitarian staff working on the Thai-Burma border in Bangkok in May 2004. The Women's Commission (www.womenscommission.org) is currently working to secure funding to translate the curriculum into Burmese, Karen and Thai which will facilitate further dissemination of the course on the Thai-Burma border. The Women's Commission plans to make follow up visits to support the work of local organizations hosting training courses. To order copies of the manual, contact info@rhrc.org.



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Women Empowerment and HIV/ AIDS

Dr Padma, AMI Myanmar



Empowerment of women towards protecting themselves against STD/HIV/AIDS and other reproductive health problems is a major step in the fight against the epidemics.

This article presents a program set up by AMI in Dala Township, Burma.

The special vulnerability of women over STD/HIV/AIDS along with many other health problems has been well documented. With the steady increase of number of women infected by HIV in the world, the threat is no less to the so called weaker sex group than to what it was in the beginning. Around half of all people living with HIV in the world are female. In Africa women are 30% more prone to be infected with HIV than men.

Young women and girls of age 15-24 form 64% of the HIV infected population among the young people.

In Myanmar, HIV was detected among Intravenous drug users (IVDU) and now the trend has changed to more prevalence among general population through sexual transmission.

Increased prevalence of the disease among particular groups of population which are commonly addressed as 'high risk group' has shown more impact on their innocent partners also. Hence, it is more logical on awareness creation and knowledge rising through health education to risk group as well as their partners which would support HIV prevention.

Exploring people's awareness on their sexuality

Contextualized research, relying on qualitative methods such as in-depth interviews and focus group discussion, explore people's awareness of their sexuality. It recognizes sex and sexuality involved couples and larger groups, in different settings framed by one's age, socioeconomic status and residence.

Contextualized research can itself be educational, creating space for people to deconstruct their sexuality and to map out risks and responsibilities. It is this participatory nature of research that will be vital in future interventions for HIV and STDs.



r&if - Source: KEWG



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2003 cEðf			
puflvibmv	286	6 (2.1%)	292
atmulvibmv	590	34 (5.8%)	624
Eðibmv	484	31 (6 %)	515
'Zibmv	797	52 (6.1 %)	849
2004 cEðf			
ZEVO&v	926	93 (9.1 %)	1019
azaz:O&v	864	113 (11.5 %)	977
rwlv	1276	159 (11.8 %)	1435
{y&v	1012	170 (14.3 %)	1182
arv	947	312 (24.8 %)	1259
Z&lv	1060	291 (21.5 %)	1351



AMI HIV/AIDS program in Dala

AMI has been working in a small, difficult to reach township known as Dala, in Yangon division of Myanmar ever since it started its mission here. In the health sector, preventive activities towards STD/HIV transmission by health education and care & support of the affected persons have been the major activities at Health promotion Center of AMI in Dala. At the STD clinic the number of Health care seekers mainly with STD symptoms has been steadily increasing. Around 1000 STD consultations are being carried out daily. During September 2003 to June 2004 more than 5000 STD positive patients were identified and were provided treatment and follow up. With the increased prevalence of STD, the HIV prevalence is expected to be higher than the national prevalence rate.

It was observed during the beginning of the clinical activities that the male participation among the care seekers was only around 10%. It was also noted that a great majority of the women attending the clinic, had received serious STDs like Syphilis and Gonorrhoea

from their husbands. With the poor percentage of male participation, repeated STD infection among their spouses was another major problem the staff had to face.

To increase the number of male attendance in the clinic, a male doctor was appointed and the clinic hours was extended to late evening in the aim of helping the working group of men. But all these efforts did not improve the situation until a program to empower the women was thought about and was started. STD positive women were explained about their disease, the importance of spouse treatment to reduce the repeat infection, abstinence or 100% condom usage during treatment, follow up and rechecking, the association between STD and HIV etc. Since then the number of male participation started to show slight increase yet very far from reaching 50%.

A similar women empowerment program has been planned to be carried out in the community to reduce the STD prevalence especially among the women and during its first phase a base line survey was carried out using in depth interview among 300 married women in their reproductive age. The husband of all

Table showing the attendance of care seekers along with % of male participation

	No. of women attending STD clinic	No. of men attending STD clinic (%)	Total no of STD care seekers
Year 2003			
September	286	6 (2.1%)	292
October	590	34 (5.8%)	624
November	484	31 (6%)	515
December	797	52 (6.1%)	849
Year 2004			
January	926	93 (9.1%)	1019
February	864	113 (11.5%)	977
March	1276	159 (11.8%)	1435
April	1012	170 (14.3%)	1182
May	947	312 (24.8%)	1259
June	1060	291 (21.5%)	1351





the participants belonged to 'high risk group' (trishaw drivers, boatmen, fishermen, taxi drivers or port labourers). The goal of the survey was to empower women towards protecting themselves against STD/HIV infection and other reproductive health problems.

Result of the base line survey

Majority of the women included in the survey were in the age range of 21 – 30 years, married for less than 5 years living in nuclear family with less than two or no children.

Most women participants described their relationship with their husbands as just tolerable, bad or terrible. Happy good relationship was found among 15 % only. The frequency of sexual relationship among them (>50%) was around 1-2 times in a week.

Regarding condom use, majority (42%) said that condom was never available in their house; some (30%) said it was available only when someone distributed freely and the rest mentioned that it was available at their home sometime in the past.

Majority (60%) of the respondents complained of general weakness but managed to do the daily routine work, some (30%) mentioned that they enjoyed good health but according to few (10%) their poor health did not permit them to do their daily routine work even.

Decision making power at home was found to be poor among majority (56%) of the respondents.

Knowledge on STD/HIV was found to be less satisfactory among most women (75%) with some (16%) of them having no knowledge at all on the subject. Knowledge on HIV transmission was found to be poor among most women (89%) mentioning none or less than two modes of transmission. Knowledge on preventive measures towards HIV infection also was found to be very low among them.

Around 10% of the respondents were able

to mention the sign and symptoms of STD/HIV, transmission modes and preventive measures satisfactorily.

Nearly one third of the respondents (31%) reported having repeated STD infection. Multiple sex partners was found in a small percentage (1.3%) but according to some of them (11.3%) their spouses had multiple sex partners. Among the spouses majority of them (82%) had tobacco chewing and drinking habit.

Most women (48.75%) received very little money (<10\$) from their husband to spend in a month but a good number of them (43%) said that they have ability to earn. More than two third of the women mentioned that they did not receive support from other family members when needed.

Adjusting programs to situation

The survey provided in-depth information on the status of women in Dala. A report from the counselor and the medical staff working at the center also supported the information received in the survey. According to them in sexual relationship, women from Dala match their gender group from everywhere by having very little say towards condom use or monogamy. Violence against women and poverty has driven many young women to take up sex workers job. Sexually active adolescent girls do not have life skill to deal with sexual negotiations particularly around safer sex. Poor health care systems result in many women to accepting STD symptoms to live with.

The survey also helped the health educators to modify their education module and to apply the results in future women empowerment programs. This survey could be the initial step towards behaviour change among the vulnerable women of Dala and their other family members. Similar program could be applied in other townships where AMI is planning to extend its activities.



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Empowering Community Change – HIV/AIDS Prevention

Mary Yetter, OXFAM UK



This article provides health and social workers with some guidelines to design plans for community involvement in HIV/AIDS prevention.

In my experience with community based programmes in various countries in Africa, Sri Lanka, Pakistan, and in Thailand, I have found that there are many differences in terms of culture, attitudes, and beliefs. But one thing in common is that wherever communities' work together they can reduce the impact of the problems that exist. This includes reducing the risk of infection and mitigating the impact of HIV and AIDS.

Community responses to HIV/AIDS have not received attention as a method of prevention in light of increased access to volunteer counselling and testing and ARVs.

Even with these interventions there is still a great need for community-based interventions. Community-based interventions designed by and for communities increase people's capacities to take responsibilities for themselves and their community. Some of the key factors that appear to be universal barriers to HIV/AIDS prevention are stigma and access to accurate information. Working through and with our communities who know the social and cultural issues around HIV/AIDS can help all stakeholders to implement more effective HIV/AIDS prevention programs.





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Getting started

Who? – who is organizing the intervention, who needs to be involved, and who will benefit from the intervention?

What? – what is the problem being addressed, what is the perceived and true extent of the problem?

When? – what is the time frame of the intervention?

How? – what type of methodology will be used?

Where? – What is scope and target area of the activities?

Who

The most difficult aspect of community based HIV/AIDS prevention is who should be involved. It is vital to include representatives from all sectors of the population to get an accurate representation of the problem.

- Local leaders (traditional and non traditional), Elders (male and female), Men, Women, Youth, Disabled, Chronically ill, Teachers, Market vendors, Minority groups, Traditional Healers, and Religious leaders

It is important that the participation of all sectors is discussed by holding public community meetings. In addition, it is important to establish links with organisations that can assist with information and services.

What (problem analysis)

The problem needs to be confirmed through discussions with representatives from the community. Information needs to be systematically collected from their group. This means they have held focus groups, mapping activities, and interviews with selected individuals.

When

When will the community act and how long

will the programme run? Is it going to be a quick awareness programme, behavioural change, or longer term programme linking with Volunteer Counselling and testing and treatment? This information can be established based on the problem analysis.

How

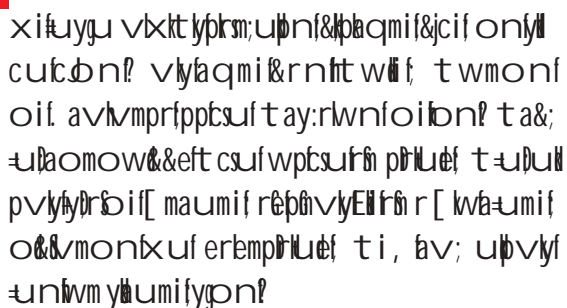
Some of the key activities that mobilize a community are discussions, information dissemination, drama, role-plays, musical activities and community parades. Capacity building can include seminars, workshops, training, and mentoring.

For example, **stories and drama** developed with the target audience can place facts about HIV into the context of people's lives in a way that involves them personally. These stories can help people to understand problems more clearly and to try out options for change. This is a participatory approach to using media, rather than an approach that just puts out messages. It enables people to discover privately in their own heads, without feeling threatened or accused, that they may need to make changes and how they might do this.

Workers have developed **stories, role-plays and skits** with their groups to stimulate discussion and clarify problems. They invite people to role-play a problem situation and ask the group how they would solve it. This can empower people to take action.

Where

What will be the scope of the programme? If you are in a camp setting is the target the entire camp? Will you be targeting particular groups? Mobilizing communities is more difficult if they do not feel the project will directly benefit them. It is important to remember that it is better to start small than to start big and realize that you cannot do a proper job.



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Examples of community-based prevention activities

Family planning workers have a major role to play in raising awareness among their community about HIV/AIDS and consequently overcome barriers to change. They can organize in small groups and decide to:

- train counsellors;
- organize condom distribution;
- develop local media such as drama;
- start trading co-operative so that people do not need to work as prostitutes.

Community workers can help people to explore how STDs, HIV and AIDS may affect their lives and their options for change. This may well enable people who are free to choose to adopt safer sex. But often people do not have the power to change their behaviour or they have more pressing needs. Groups at high risk of HIV infection may not even hear about these infections, and if they do, they may be unable to use the information. AIDS becomes just one more anxiety in a life of crisis and risk

So what can community workers do to help people who cannot enjoy safer sex because they are poor and powerless? Women can increase women's income and reduce the

need for women to offer sexual services. Groups of women can practice telling their men what they want sexually and support each other. Men can be helped to face up the consequences of risky sexual behaviour, and male peer pressure can prompt and support change. Community workers can help people to feel a realistic concern about all STDs, including HIV, and enable them to take effective action to prevent transmission.

Be positive about safer sex. Women particularly can relax and enjoy sex more if it is less risky, and people may expand their options, making sex more exciting, creative and pleasurable.

Conclusion

Each prevention activity held at community level should be very clear with the information transmitted, in order to avoid any misunderstanding that would annihilate the achievement of the goal defined at the beginning of the programme.



Community participation



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Community Care for People with HIV/AIDS World Vision HIV/AIDS Programme in Ranong

Dr Win Maung, World Vision Ranong



Communities should be more and more involved in the fight against HIV/AIDS. This article presents World Vision activities in the field of HIV/AIDS in Ranong. It is a good example of implication of communities in supporting people with HIV/AIDS.



In Ranong, care for people living with AIDS started in 1992, under a World Vision managed community-based programme. Two years ago, care activities started in a clinic funded by the Japanese Embassy. When I arrived in Ranong, there were around 10 people living with AIDS. Presently, we are taking care of 40 people living with AIDS. This increase in number may be due to the implementation of Voluntary Confidential Counselling and Testing programme. It may also be due to an increased reliability on our clinic, better effectiveness of the services we provide and better knowledge of people concerning HIV/AIDS, thanks to health education activities we developed in the area.

New needs, New Strategy

Taking care of 40 patients is a difficult task with limited staff in the clinic. Therefore we developed home-care services for the patients

who can stay in their family. Volunteers trained by World Vision in the field of Reproductive health, HIV and STDs, Family Planning, Counselling and nursing provide this service in their communities. Indeed, the spread of HIV/AIDS epidemics all throughout the world obliged Health

Care providers to modify the way patients living with HIV/AIDS are taken in charge, by developing self-help through community participation.

Proximity and Confidentiality

Volunteers trained by World Vision in Ranong are given a certain number of patients to take care of. They are provided with drugs, food and Health Education material. Once in the patient's house, they are able to care the patient, give him/her medicines and give advice for the family to be able to take in charge his/her basic needs. But their task is not limited to these activities. Volunteers check both physical and mental status of the patients. They have a major role to play in comforting them and giving them hope in an atmosphere respectful of confidentiality. When returning from their field visits, volunteers give report to the clinic. Critical cases are referred to the clinic for intensive care.



Personalized follow-up

Because they are the one who are the most able to understand and listen to the patients, some volunteers having HIV/AIDS themselves have been recruited. One of our volunteers, Ma Pyone, lost her husband who was infected by AIDS. She now supports people living with AIDS as she gave care to her husband before he died.

Volunteers provide different services according to the cases they encounter in the field. People suspected of having HIV because of risky sexual behaviours are referred to the clinic for Voluntary Counselling and Testing. HIV positive patients and patients having developed the disease are classified into three categories:

Category A

Volunteers are assigned to carry out home visit at least once a month to all new HIV positive clients without opportunistic infection and provide them with oral Vitamins (Centrum) and Aspirin (Aspent M) for one month.

Category B

Volunteers under the supervision of medical staff of the clinic are supposed to pay home visit at least once a week to clients with

opportunistic infection and provide them with prescribed drugs.

Category C

Volunteers under the supervision of medical staff from the clinic provide home visit at least 3 times per week to clients with severe symptoms (severe Tuberculosis, severe herpes and severe diarrhoea). They provide drugs for opportunistic infection, Vitamins, Aspirin, Thymo-modulin (Votro cap) and ARV (if necessary, ARV are available at the hospital only).

Currently in Ranong, patients belonging to Category C are very few (only one case on our project). Before this project started, mortality rate per month was very high. Now the mortality rate is declining due to ability to treat opportunistic infections, provision of anti-tubercular drugs, Aspirin, Thymo-modulin and sometimes ARV (given by the hospital).

Conclusion

Voluntary Counselling and Testing is an easy way to control the spread of HIV. It is also the best way to detect the virus early and to arrange community-based care services for infected people. Today, many people living with AIDS can enjoy healthy lifestyle if the infection is detected early and if community is involved in the provision of care-services.

Stories of sex workers along the Thai-Burmese Border

Mae Mo is a sex worker. She is 40 years old. Soon after the death of her husband, she came to Thailand with her fifteen-year old daughter. She had no choice but to earn money as a sex worker. She had no identity card. So she had no way to do other jobs. She is five months pregnant but in spite of her condition she has to accept clients because she has no other source of income. She did not know anything about condom before I met her and explained the importance of its systematic use. *(story reported by a social worker from NHEC)*



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Thai Youth Action Programs

Owen Elias, Thai Youth Action Programmes



There are plenty of ways HIV/AIDS can be addressed according to the various kinds of beneficiaries HIV/AIDS prevention programs target. Thai Youth Action programs proposes a participatory approach to talk with young people about sensitive issues linked to HIV/AIDS.

“Penis change condom”, Yammy yelled and several of the participants dashed to find a new group. “Condom change penis”, she cried and they scattered again, laughing as they ran, grabbing new partners.

At first they had been a little shy, not being used to discussing sexual issues so openly, but as the workshop progressed the young participants were increasingly at ease. The TYAP approach of presenting HIV/AIDS education through participatory games and activities is designed to create a friendly, relaxed environment in which young people can explore issues, which are normally considered taboo.

A participatory approach

TYAP (Thai Youth Action Programs) has been providing peer-led HIV/AIDS education to young people in the north of Thailand since 1995. The



organisation’s work with refugee youth began in 1999, when the Karen HIV/AIDS Education



Working Group (KEWG), a community-based organisation working in the refugee camps along the Thai-Burmese border, grew concerned about the lack of awareness about HIV/AIDS and reproductive health among young refugees. A visit from KEWG staff to observe TYAP youth education programs led to an invitation for TYAP to help provide HIV/AIDS and sexual health education in the camps.

Following a series of successful training sessions The Intercultural Youth Training of Trainers program was set up in 2003 to teach the staff and volunteers of KEWG, the Shan Women's Action Network and Chiang Mai Safe House to plan and implement their own reproductive health programs. The training focuses on HIV/AIDS and reproductive health, and on leadership, facilitation and communication skills.

Changing attitudes

Sarinya Shingthongwan, or Yammy, the program coordinator and chief trainer is enthusiastic about her experiences at the Mae La camp. "The participants in the camp are very keen to learn. They are helpful and ask lots of great questions. They have a better attitude than youth in Chiang Mai and engage in less risky behavior". She reports that most participants already have a reasonable level of basic understanding about HIV/AIDS and reproductive health, having already received some education in this field from KEWG. She feels that she is filling in the gaps, giving the participants the opportunity to explore issues, which most teachers are too shy to address.

The principal difficulty Yammy feels she faces in running the training is language. Some of the

participants speak Thai but others speak only Burmese or Karen. Working with translators can be slow and awkward and some words or concepts don't translate well. "We can not find a good word for 'masturbation' in Karen", Yammy jokingly complained.

An introduction game

In order to put participants in the right frame of mind for discussing what are traditionally difficult issues, TYAP begins its workshops with a variety of games to relax the group and build trust. Yammy suggests the "Rabbit change house" or "Penis change condom" game to make participants feel more comfortable with using explicit language and to review knowledge of AIDS prevention. This activity makes a good energizer and prepares participants for discussions of sexual issues.

The game can be played with any number of participants and runs for about 20 minutes. The participants get into groups of three, with one or two people left without a group. In each group, two of the participants hold hands to form a circle and the third stands in the middle. The two holding hands represent the 'house' and the one in the middle the 'rabbit'. The facilitator then calls one of three things; either "Rabbit change house", in which case all the 'rabbits' run to find a new 'house', or "House change rabbit", in which case all the 'houses' rush to grab a new 'rabbit', or finally "Rabbit-House-Boom", in which case all the participants break up and regroup. The aim is to play the game as fast as possible because those who were left without a group at the beginning will try to become either 'rabbits' or 'houses' and will leave someone else without a group.



Once the participants are familiar with the game you can change the language to ‘penis’ instead of ‘rabbit’ and ‘condom’ instead of ‘house’. “Penis change condom”, “Condom change penis”, “Penis-condom-boom”.

This is sure to make your participants feel more relaxed after a few rounds but it is important to ask them how they felt about the game and what it was about afterwards. For example, how did they feel when they weren’t inside the ‘condom’? Did they feel less safe?

A game to make discussion start

Another activity with some similar themes is ‘Air/Water/Land’ or ‘Transmit/Prevent/Symptom’. This game can be used as a warm up for a discussion and explores how much participants already know about HIV/AIDS. Beginning with ‘Air/Water/Land’, the participants all stand in a circle with the facilitator in the middle and chant “Air, water, land”. The facilitator will suddenly pick a participant and point, calling “Air”, “Water” or “Land”. The participant then has to name a creature from that place. Eg. “Water” – “Frog” or “Air” - “Bird”.

After you have played this for a while you can begin to use “Transmit, prevent, symptom” instead of “Air, water, land”. Now the participants will not be naming animals but means of transmitting or preventing HIV/AIDS and its symptoms. Again it is important to reflect on the activity as a group when it is over.

Discussions in small groups

Not all of the activities TYAP uses are light hearted games and many serious discussions take place during the training sessions. For

example means of transmission are reviewed by ranking body fluids in terms of risk. Sperm, vaginal fluid, breast milk, blood and saliva are all discussed in small groups in terms of Quality (kind of activity) Quantity (amount of fluid transmitted) and Route (of transmission). Any misconceptions that the participants have about HIV transmission can be cleared up in feedback.

Good communication skills for talking AIDS with youth

Yammy has six points of general advice for anyone running activities with young people on HIV/AIDS and reproductive health:

1. Create a friendly, open, relaxed atmosphere
2. Listen to the opinions and experiences of the participants with an open mind
3. Do not judge the participants’ behavior or opinions. Do not talk about ‘right’ and ‘wrong’
4. You must respect the participants’ privacy and not disclose what they have shared with you
5. Make sure all the participants are fully involved in the activities
6. Make sure you review what has been learned (particularly at the beginning of the day)

Finally, Yammy adds: “Sex is not so hard to talk about once you begin”.

The Intercultural Youth Training of Trainers Program is supported by Astrea.

TYAP can be contacted at tyap@loxinfo.co.th, or our website viewed at www.tyap.org

An Interview with Honeymoon from KEWG

Health Messenger Magazine Team



This article is an interview with Honeymoon, a project staff from Karen Education Working Group, an organization doing HIV/AIDS education campaigns in the camps along the Thai-Burmese Border.



Under the supervision of KRC (Karen Refugee Committee), KEWG organizes training for Karens working with various organizations in the camps. Education campaign started since 1996. In Maela, education on HIV is provided to the youth and PMCT (Prevention of Mother to Child Transmission) activities are implemented in collaboration with SMRU (*Shoklo* Malaria Research Unit) clinic. VCT (Voluntary Counselling and Testing) activities are also made in collaboration with MSF (Medecins Sans Frontieres). Delivery of home care is provided once a month in Maela Camp. Education for female groups is carried out in all the camps.

1. Karen Education Working Group is doing HIV/AIDS education activities in the camps. Can you give us some examples of activities you propose to your beneficiaries?

The repatriation process is a possibility, so people living in the camps need to be informed

before going back to their country.

Basic education on HIV/AIDS is given through video-play. The knowledge of each group is assessed, before and after video show. HIV education and condom promotion is provided to the youth. Every time we do condom promotion, people who want to get condoms have to come to collect them in the resource center or at the clinic. Putting condoms in the shops would not be socially acceptable therefore we made them available through other channels.

2. What are the major difficulties you encounter when on the field? What are the major taboos you have to face? And how do you come over these difficulties?

Speaking about sex is a big taboo. There is no other organizations speaking about sex in the camps. It is very difficult to introduce sex education in schools. But it is possible to give sex education at community level. Community leaders are fine with us. Every time we have a problem in the community, we can refer to community leaders and we arrange a meeting in order to take decision. Community leaders do not want us to distribute the condoms on the public place, but condoms can be found in resources centers and in the clinics. So this is how we work. Community leaders want to make sure that the condoms are given to the right persons, at the right time and at the right place.

There is also a lack of confidentiality in the



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p h j y l a p & e f t m; a y; w, f v l s v f, l u w, ?



r&i f - Source: KEWG

u e f h t o h r s h i v i & e r n b n f t a u m i f y c u f r s m; u l t o h
j y l y g v? t o h y k v # f t r s d o m; t w l u E s h t r s d o r d
t w l u f t a u m i f y c u f v l p f h a w n f o l y g v m;?

' l u Q o n p c e f w f a e a o m o r s m; o n b l w, O h a u s
r t & t u m t u g h y; x m; v l t h p f & E l b l k h u n f
u w, ? t m; v h a t h p j z p E l l w, f v l u e r w l u
a j y m w, l q i f & t s f o m r a & o b l t f & s f a w m i j z p E l f
w, h y g t j l v y n m a y; o w i f p u m; a w l u Q o n f
p c e f r s m; w f l u s, f y e p h a & m u b o h; z l t a &; u l w, ? i g
w l o n f t d v t s t h a d i p u l u y h a m * g z p h e w l k l f
E l l f s j f e r m E l l f v l u m; r f a e & w m j z p l w, ? ' l u Q o n f
r s m; t a e e l t E l f i b l e j y e f h u l w i f y i q i x m; & e f
v l t y a y o n? o l w l u b l w l u m u g & e e n f r s m;
(t o y n m) a y; x m; y l z p e f t a &; u l w, ? , c i f t w l v f
u a w m l t r s d o m; r s m; t a e j z i h u l D e l v m; e n f r s m;
E s f t d v t s t h a d a t t l f l t u p l y n m a y; q u p y l w, f
v l o y r x i t h u b l? , c l a w m l t r s d o m; r s m; t a e e l
u e f E s f t d v t s t h a d a t t l f l t u p f t a u m i f a j y m
a e u y d u l e f x i l v m u a w m h, c k l t a j y m i f t v l o n f
u & i f y n m a &; v l y a q m i f t z a v l y a q m i f a u m i f y d?

o i & t a w e t j u l f s n o n b i c e f p m r s m; & & y g o v?

t o u f t & g j u b o r s m; . v e f r t r o n f l u Q o n p c e f
r s m; r f i t v e f t a &; y g w, ? v l i, f r s m; t a e j z i h v r
a &; O e h a q m i f r s m; v u l v s f r a o m f n f o l w l v o v l v f
v y l y f o l h u b l? t j g u l l y m i f y p & e l v x k l r f o Z m &
w l o r s m; j z p l w l t o u j u d w l v a w l y n m a y; z l v l v, ?

' l t d v t s t h a d a t t l f l t u p l u p P u l l u f e r m a &;
& a x m i l v p t c l v n f r s d f u y l v m w m E p f t a w m l u m c l y d
j z p l w, ? o& omf v n f ' l u Q o n p c e f r s m; r f o p v t & w h
b 0 a e x l l h a; j z p l v m a t m i f t r l t u s i h a w a j y m i f w n j r i f
a w o l v # f a w m h v r a &; & a x m i l u l v n f x b o f v l y f
a q m i & a y r n?



camps. Confidentiality is something that does not belong to the Karen culture. For instance, some people come to the hospital for VCT because some other people in the camp accuse them of having AIDS. So confidentiality in health issues is something that Karen people have to learn.

3. What are the major risky behaviours you noticed in the camps?

Because of the culture, the beliefs and the religious boundaries, people's behaviour in the camps is different from other communities. Compared to people in urban areas, the people in the camps are a bit more conservative and stricter on sexual issues. That's why the number of people infected with HIV in the camps is very low. But throughout my experience, I noticed that there is a lot of unprotected sex. When people from the camps go outside to work, the lifestyle there is different, and they might put themselves at risk. Some people are going out of the camps, and have another life when they are out of the community's social control.

4. Can you tell us about the use of condom among Karen refugees?

Most of the time, condoms are perceived as birth control means. Promoting condom use is however generally perceived as encouraging young people to have sex more or earlier.

5. What are the arguments you use to make condom promotion? Do you use the same arguments with men and women?

The people in the camps believe that they cannot have AIDS, because they are protected by their culture. But we say that everybody can

have AIDS, from the poor to the rich, even the housewife. This kind of message should be spread widely in the camps. We are in the middle of two countries that are infected with the HIV epidemics. Refugees need to be prepared to go back to their home country and therefore, they should be given means (that is the knowledge) to protect themselves. In the past, men did not really feel very much concerned by contraceptives and HIV/AIDS education. Now men start talking about condoms and HIV/AIDS. I think KEWG campaign might have played a role in this change.

6. What are the lessons you've learned from your experience?

The influence of the elderly is so important in the camps that even if young people can easily access social services, they are not free to use them. To change that, we have to educate the people who have the power within the community, that is the elderly.

The issue of HIV/AIDS has been for a long



time exclusively approached from the health angle. But the social angle is to be taken into account if we want to see some behavioral changes for safer lifestyles in the camps.



tuftst | AbulpuElaomenfvrsm;



HIV is not transmitted from hugging and kissing on the cheeks.



r&lf - Source: Care

HIV is not transmitted from tears and sweats.



r&lf - Source: Care

HIV is not transmitted from toilets and urinals.



r&lf - Source: Care

HIV is not transmitted from sharing clothes, towels and telephones.

w&p>me&sr;r&vq&i&E&f&t&i&qu&y&la&um&f&sr;u&U&j&ci&/&O&y&r&m&/&j&ci&E&h&ur&f&y&u&u&U&j&ci&/&w&h&=u&mi&h
t&v&e&f&t&I&A&u&l&p&u&l&y&g&av&h&m&o&k&ow&e&j&y&k&s&u&r&sr;t&&t&v&e&f&t&I&A&u&om&o&r&sr;.r&b&m;p&D&i&r&sr;
w&h&on&b&m&re&aw&ex&i&/&t&p&m;t&p&m&x&lon&g&e&f&u&e&r&sr;/r&u&E&so&l&v&y&D&g&sr;/&t&y&&mc&i&r&sr;/&a&u&l&u&e&r&sr;/
w, &v&h&sr;E&f&t&f&om&sr;t&w&h&E&f&sr;a&u&mi&t&v&e&f&t&I&A&u&l&p&u&l&y&g&av&h&m&o&k&ow&e&j&y&k&s&u&r&sr;
r&i&f - <http://www.niaid.nih.gov/>.

t v t s t I A D K B L w w w x i w f t v t s t I A B w a d o m v n i / t q l g w h w g z i k d w e i f r s v q i h t v t s
t I A U l p u b o m t a x m u f t x m ; r a w @ y g " g v t e e p r f o y f r s r ; t & w h w f . o b m 0 * P % b w W l s r ; t &
t v t s t I A U l p u r _ u l l e f o w x m ; o n ? o h o w e y k v t c u r s r ; t & / e r j i c i f a u m i h v h w f r s v q i h
t v t s t I A U l p u b n f t a x m u f t x m ; r a w @ y g j y i f x e p h e r j i c i f o b [k w y g p y z i h d i q u f
q b n f t c g s r ; w h i w h w f t a j r m u f t r s r ; z v \$ f & d o m v n i t v t s t I A D U l p u r _ t E W & m , f
j r i l r m ; a u m i f r n b r # o d u a o ; y g a c i / r u & n i q d E s h r p i w l e s w q i h t v t s t I A U l p u b n h
t a x m u f t x m ; r s r ; u l l o y U S f r s r a w e p i f r & d o ; y g
r k i f - <http://www.niaid.nih.gov/>.

Non-transmission routes of HIV



r&lf - Source: Care

vubqElwqujci/vuiv&rfa&hujiESkdw@llw& f
jci/wb=umilt dvfst llAGHrulpuyg

HIV is not transmitted from shaking hands, holding hands and touching.



a&t wwlujci/ a&t wwlujci/wb=umilt dvfst llAGH
rulpuyg

HIV is not transmitted from swimming pools and vil-
lage ponds



r&lf - Source: Care

jci/lujciESkurljllujci/wb=umilt dvfst llAGHrulpuyg

HIV is not transmitted from a mosquito bite and bed bug bite.



r&lf - Source: Care

w&p>meft;rsvqilt dvfst llAGHrulpuyg

HIV is not transmitted from animals.

Studies of families of HIV-infected people have clearly shown that HIV is not spread through casual contact such as the sharing of food utensils, towels and bedding, swimming pools, telephones, or toilet seats. HIV is not spread by animals and insect-bite such as mosquitoes or bedbugs.

Source: <http://www.niaid.nih.gov/>.

Although researchers have found HIV in the saliva of infected people, there is no evidence that the virus is spread by contact with saliva.

Laboratory studies reveal that saliva has natural properties that limit the power of HIV to infect. Research studies of people infected with HIV have found no evidence that the virus is spread to others through saliva by kissing. No one knows, however, whether so-called “**deep**” kissing, involving the exchange of large amounts of saliva, or oral intercourse increase the risk of infection. Scientists also have found no evidence that HIV is spread through sweat, tears, urine, or faeces.

Source: <http://www.niaid.nih.gov/>.

Note:

Distance Learning Health Magazine

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