

AIDS action

ASIA-PACIFIC
EDITION

ISSUE 24
JULY-SEPTEMBER
1994

Keys to counselling

Counselling aims to enable a person to cope better with stress, find realistic ways to solve problems and make informed decisions. A counsellor's role is to listen and ask questions, and to provide relevant information, practical suggestions and emotional support. Counselling is not about giving advice or telling people what they should do.

The rapid spread of HIV means that demand for counselling services is increasing. Counselling is an essential part of voluntary and confidential HIV anti-body testing programmes. It also plays a very valuable role in HIV prevention and care on its own, without testing. Issues such as reducing the risk of infection, family planning, relationships, sexuality and sexual problems, are all important areas for discussion. And, as described on pages 6 and 7, counselling is a vital part of caring for people who are dying, and supporting their carers.

Voluntary and confidential HIV testing, with counselling, can help someone who wants to find out if they are infected, although it does not necessarily lead to safer sex—behaviour change depends on many other factors too. Testing can be very risky for people who are vulnerable to discrimination or if confidentiality cannot be guaranteed.

Anyone who is considering an HIV test for whatever reason should always have pre-test counselling, to help them assess if they have been at risk, learn about the test and its implications, decide whether or not to be tested and think about how they can prevent infection. Counselling should mean that a person's consent or refusal to be tested is an informed choice—made freely without pressure, and based on their feelings about the disadvantages and advantages of knowing their HIV status.

Counselling after an HIV test is equally important, whether or not someone is infected with HIV, or if they do not want to know the results. One post-test counselling session is



ANTONIO GERENA

Practising new skills: counsellors need training and support

often not enough. A person may need ongoing support and to be able to return for more sessions if he or she wishes.

HIV affects everyone

The impact of HIV goes far beyond HIV-positive individuals. It has great implications for their sexual partners and family members—including future children. Articles on pages 4 and 5 show how coping with HIV can be easier if people choose to share counselling sessions with those close to them.

People with HIV have an important role in providing support to others, as their experience of living with the virus can help them to understand people's feelings and reactions. They should not be seen as just 'clients' or passive recipients of care, but should have the same opportunities as others to train as counsellors or educators. Many counselling services are now setting up self-help or discussions groups run by and for people who are HIV-positive.

AIDS Action would like to hear from readers about problems they are experiencing in counselling, and ways in which they are trying to solve these.

IN THIS ISSUE

- **Counselling and HIV**, Page 2
- **Dealing with difficulties**, Page 4
- **Caring for people who are dying at home**, Page 6
- **Basic Facts about HIV & AIDS**, Page 9

Published by

AHRTAG
Appropriate Health Resources
& Technologies Action Group

HAIN
Health Action Information
Network PH6 0994E1

What leads to good counselling?

AIDS Action describes the personal qualities, skills, and support needed by counsellors

HIV counselling means working with people who are, or could be, confronted by an incurable, infectious and often stigmatised disease. This can be a challenging and often emotionally draining task.

Personal qualities such as respect for the rights and dignity of other people, and a degree of emotional stability are very important. Counsellors need to be non-judgemental and able to keep confidentiality, to listen, and to express ideas clearly.

Institutional support is valuable. Counsellors need to have time and privacy in which to counsel, and contact with people who will use the service, through referrals for example. Although some medical staff may not have the time to counsel patients, it is important for them to support increased access to counselling. Some practical support, such as condoms, soap, bleach, plastic sheets, home care visits and travel expenses can also be provided to people who are counselled.

Training in counselling skills is an essential step towards becoming a good counsellor, although it is possible to be one

without having advanced training in counselling, psychology or family therapy, for example. Training in counselling skills is very useful for anyone who provides care and support—from doctors and nurses to volunteers working on AIDS telephone helplines. In most communities there are also certain individuals who are respected and looked to for advice and emotional support, and they also may be interested in learning counselling skills.

Counselling skills enable a person to:

- explain the facts clearly and simply, and provide appropriate information—for example, facts about the HIV test, HIV/STDs prevention and family planning methods
- talk about sexuality and sex in a non-judgemental and open way that encourages someone to talk freely about what they do, including stigmatised acts such as anal sex or sex before marriage
- listen and give them time to talk
- ask questions that do not encourage a particular response but prompt someone to say more about what they feel, giving them the opportunity to think about their own life and relationships with others
- empathise, which means understanding how someone else feels about their situation,

- without imposing personal values and thoughts
- give psychological support, enabling someone to identify and explore their reactions, feelings and emotions
- help someone to make realistic decisions and to find ways to adjust to change, by drawing upon their own resources (and those around them in the form of people and services)
- establish trust and keep confidentiality.

What does training involve?

A training course in basic counselling skills should involve at most 20 people, who participate in several workshops spread over a few months. People often concentrate best during workshops of a few days. It is best to set realistic objectives, and include ways to evaluate the course through discussion, supervision and questionnaires.

Training sessions should enable participants to practise the skills needed for good counselling, including exercises to help them explore their own values, fears, and prejudices. Training should be practical and participatory, using a mixture of group exercises, demonstrations, role-plays, short talks, and visual aids such as videos.

For example, one objective of the course would be improving participants' knowledge of AIDS. This could be achieved with a group exercise followed by a discussion. Participants could then do role-plays in groups of three or four. One person plays the role of the client asking questions, and a second person acts as the counsellor. The other member(s) watch and give positive and negative comments at the end of the role-play.

During and after training, regular supervision and the opportunity to work together with an experience counsellor are essential to help the trainees practise their new skills, and to deal with their emotional reactions to counselling. A follow-up workshop should be held a few months after the course, where trainees role-play difficult situations they have experienced. In the long term, regular meetings with colleagues, supervision and further training are important.

Dr Robert Bo (City University, London, UK) and **Karia Meursing** (Metabeleland AIDS Council and Mpilo, Zimbabwe).

*Poor counselling
—with no privacy
or confidentiality,
and giving advice
without listening
—does not
help anyone!*



Adapted from PETRA ROHR-ROJENDAL

Support for safer behaviour

Can counselling help people to reduce their risk of HIV/STDs? **AIDS Action** reports on an initiative in India.

A young man who had tested HIV-positive two years before was very distressed because his parents were putting great pressure on him to get married. He came for counselling, and decided to invite his parents to join a session with him. He was able to tell them about being HIV-positive, that he needed their care and support, and that he felt that not marrying was the most responsible way to behave. After talking through the issues, his parents were more willing to accept his decision.'

This man is just one of the many people who have visited our AIDS counselling centre in Pune, India. Counselling is a very important way to provide support to people who are HIV-positive. However, there are very few counselling services in India. We know that some people committed suicide once they found out they were HIV-positive, and often they had no access to counselling or other help.

Our centre provides pre- and post-test counselling and follow-up sessions, and runs groups for people who are HIV-positive. Men make up the majority of clients, although we are trying to make our services available to women too. For the sake of privacy, the centre does not advertise its services, but relies on word-of-mouth, and referrals from doctors, STD clinics and other health care institutions.

In the past, blood banks were referring donors whose blood had tested HIV-positive, but who had received no counselling. Confirmatory testing had not been carried out on these samples, and we found that up to 30 per cent were in fact HIV-negative. We feel that this is an opportunity to counsel people who may be HIV-positive about prevention and offer them an HIV test if they want it.

In cooperation with the blood banks, we now contact all the donors whose blood has tested HIV-positive. We give them pre-test counselling, and carry out a confirmatory test if they agree to this. If people decide that they do not want to know their status, we respect their wishes.

While we do encourage people to tell their partners about their HIV status, we do not put pressure on them. Breaking confidentiality can

increase people's distress. For example, it does not help a woman to be told that her husband is HIV-positive without his consent. She may be unable to insist on safe sex or support herself if she leaves home.

We feel that counselling, without HIV testing, can help some people to make changes in their behaviour, and thus protect themselves and others from HIV/STDs. As well as running the centre's services, we also counsel patients — who are mostly male — at the local government STD clinic.

All patients are asked to have a one-on-one session after their diagnosis. After telling them why we are there, and reassuring them of privacy and confidentiality, we ask them about their sexual practices and condom use. We then discuss prevention and ways to reduce risk, and show them how to use condoms. They are invited to come back if necessary, and to bring their friends too.

'A migrant labourer was diagnosed as having syphilis. He had just gotten married, but was living away from his wife and having unprotected sex with other partners. After counselling about HIV and STDs, he became more aware of the risk to his wife and future children. He agreed to try condoms but

was concerned about his need to have sex. Various options were discussed, and he decided to arrange for his wife to stay in the city with him. He has kept in touch with the counsellor, and has had no more STDs.'

Discussing sex is not easy in our culture. We always start with discussing neutral topics, such as work or children, before talking about sexual behaviour. During one-on-one sessions we find that men are willing to talk about sex, and the problems they have in changing their lifestyles or sexual practices.

We try to discuss all the reasons why they have unprotected sex or multiple partners. For example, they may be unable to suggest anal or oral sex to their wives, or do not feel they have satisfying sex, or live away from home. After this discussion, addressing the issues becomes easier, and we can talk about practical solutions.

We feel that counselling in STD clinics is an effective way to reach men, and, indirectly, their wives and other sex partners (mostly sex workers) who may have less power to protect themselves.

Dr. Sanjay Pujari, AIDS Counselling Centre, Health Plus, 1730 Sadashiv Peth, Pune 411030, India.



AIDS CELL, INDIA (Reprint)

An HIV-positive person has been referred for counselling, but does not know that their blood has been tested. HIV testing without counselling and consent is an abuse of a person's rights. However, in some workplaces, hospitals and clinics, people are tested in this way. Those who test HIV-positive are often referred for counselling. Some people may suspect or know they have been tested, while others may not be aware of the situation.

Possible approaches

- It is very important for senior staff to try to stop the practice of testing without proper counselling.
- If the person does not know they are HIV-positive, it may be possible to start the process again. First, the counsellor can give proper pre-test counselling. If they decide not to have a test, or not to be told the results, then their wishes should be respected.
- If someone already knows or suspects that he or she has been tested, counsellors should avoid using only one session to tell the client that he or she is HIV-positive. Instead, the counsellor could begin by explaining the test and its implications, and why the person's blood has been tested. The discussion could then cover whether the person wants to know the results, giving one enough time in which to mentally prepare to learn that the suspicion is correct.

A person is anxious about telling a sexual partner that he or she is HIV-positive

Deciding whether or not to tell a partner is very difficult. Many HIV-positive people—particularly women—fear being rejected, abandoned or losing their children. They are also afraid of being blamed for what has happened, or that their partners will tell others.

Not telling a partner poses practical and ethical problems. The couple will not be able to fully discuss whether to have children, or how to cope with possible illness and death. Unprotected sex may result in the partner becoming infected. Keeping silent makes adopting safer sex more difficult—a partner may not see the need to use condoms for penetrative sex. Alternatively, the partner may already be infected, and may want counselling.

Dealing with difficult issues

There are many challenges in HIV counselling—AIDS Action suggests some approaches which can also be used during training for role-plays or discussion.



ANTONIO GERENA

Possible approaches

- If someone is in a stable sexual relationship, the counsellor should try to introduce the idea of 'shared confidentiality' right from the beginning. People who come for pre-test counselling alone can be invited to come back with their partners, so that the decision about testing can be made together.
- If a person feels unable to disclose the news, and if resources are available, the counsellor can suggest that he or she have counselling and testing again, this time with the partner. The person encourages the partner to accompany him or her, behaving as though there had not been the first test.
- A person may not be ready to tell anyone very soon after the test, if he or she is still healthy. The counsellor can offer more counselling, sessions, and suggest the person meets others who are HIV-positive.
- If someone does not see the need to protect others from infection, the counsellor should emphasise that the partner may not yet be infected, and that safer sex will prevent transmission. Using a condom also helps to keep the person themselves healthy by reducing the risk of STDs (which can be more severe in people who are HIV-infected) and re-infection with HIV.

A person is reluctant to tell close family members or carers that he or she is HIV-positive.

There are no ethical reasons why someone should tell friends or family members, because there is no risk of infection through casual contact. But deciding not to tell anyone can result in loneliness and depression, and make it difficult to get help and support.

Possible approaches

- Some people over-estimate the likelihood of rejection, and counselling can help them to assess the situation more realistically.
- The counsellor can encourage persons to think of others they could trust, such as members of a self-help group for HIV-positive people or a doctor.
- The counsellor can suggest that the person ask close family members or friends to share a session, if this helps to disclose the news.

A person may have HIV infection, but after counselling does not want to be tested or to know his or her status.

It is important to remember that HIV testing is not the aim of counselling.

Possible approaches

The counsellor should always accept the person's decision, and never put pressure on someone to have the test. The discussion could focus on the ways in which a person can live life without knowing whether he or she is infected with HIV. Safer sex is advised whether or not someone is infected with HIV.

A person doesn't seem to understand what being HIV-positive means, or denies the test result.**Possible approaches**

It may be difficult for someone who is unfamiliar with Western theories of illness to understand what HIV infection is. Counsellors need to find out the best way to explain the issues in a particular culture.

- If someone has severe physical or mental health problems, or is very upset, counselling about AIDS may not be possible. The caregivers themselves may benefit from support, and opportunities to discuss the issues. The family should not be told that the person has HIV, without the person's permission. However, if the person is very confused or ill and nearing death, the counsellor may consider telling key family members.
- Denial is often linked to feelings of extreme anxiety and helplessness, and fears that life is finished. Over time and with continued counselling this may change. The counsellor can help the client to view HIV infection as something that can be managed, and develop a positive attitude about life with HIV.
- Denial makes it possible for the client to explore what he or she feels. The counsellor can try to discuss being HIV-positive as an imaginary situation: "Let's pretend it's true, and look at what it would mean for your life."

Karla Meursing was a counsellor at the Matabeleland AIDS Council and Mpilo Hospital, Zimbabwe. Thanks also to Thandi Nhlengethwa (TASC, Swaziland) and Kgomotso More (counselling coordinator, NACP, Botswana) for sharing their experiences.

Public and professional attitudes in Thailand

(Excerpted from the book *Candles of Hope: The AIDS Programme of the Thai Red Cross Society* by Werasit Sittitrai and Glen Williams)

As in many other countries, the AIDS epidemic in Thailand has provoked enormous fear and confusion within the general public. Many people still believe that the virus can be passed on through social contact, by mosquitoes, or via shared eating and drinking utensils. These misconceptions have often led to irrational fear of HIV-positive people and discrimination against them in employment, education and housing. A typical case was Chao Sebusum, a factory worker who was infected with HIV through a blood transfusion, and whose HIV-positive status was revealed through the mass media. Later he appealed to the public through the national newspaper *Thai Rath*: "My whole family is in great difficulty because I have AIDS. We've all lost our jobs. My eldest son was chief mechanic at the Pioneer company, but he was forced out of his job. Two children worked in a battery factory, but when the factory management learned that I was their father, they were pressured into quitting their jobs. The youngest, who is eight, should be going to school but I don't have the mental strength to take him there. We have to find new places to live all the time. When the house owners find out who we are, they make us leave. Please let people know that I'm the only one in our family with AIDS. Please take pity on me ...".



Members of the Wednesday Friends' Club perform a play calling everyone in Thailand to show care and compassion for one another—including people with HIV.

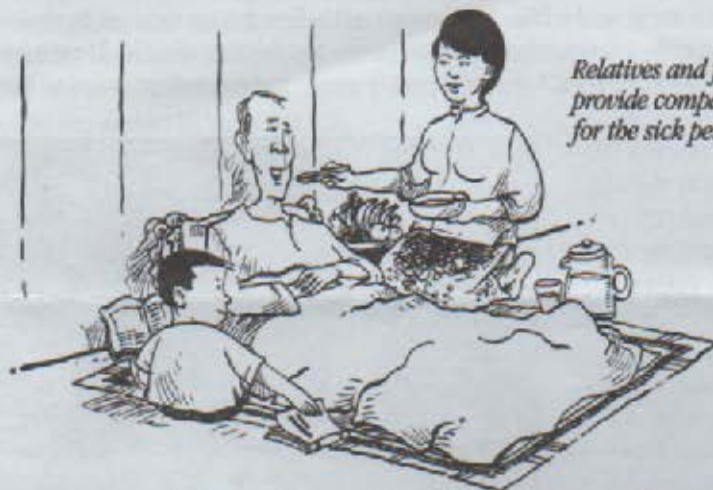
Since AIDS in Thailand is widely viewed as a cause for shame and disgrace, people with HIV or AIDS live in a perpetual state of fear, not so much of dying, but of being rejected by society if their HIV status becomes known to others. In order to avoid rejection and discrimination, HIV-infected people in Thailand generally try to conceal their HIV status from their neighbours, friends and work colleagues for as long as possible. The very few people who have announced their HIV-positive status to the mass media have invariably suffered discrimination as a result.

Public confusion about HIV and AIDS is often reflected in the language used to describe people infected with HIV: "Many people and also the mass media call us 'people with AIDS,'" says Mee, and HIV-positive man who works as a volunteer for an AIDS support group in Bangkok. "But we don't like that because it suggests that we are really ill, which most of us are not. We are people with HIV, not people with AIDS, and we can live normal lives for a long time."

The responses of many doctors and nurses in Thailand towards the AIDS epidemic have often been marked by fear and confusion. Although attitudes of health professionals are generally improving, many doctors still refuse to operate on a patient diagnosed HIV-positive, and many nurses are afraid to touch HIV-infected babies and mothers. It is still common for hospitals to test pregnant women for HIV and to exert pressure on HIV-positive women to undergo an abortion, or to be sterilized after giving birth. At least one hospital in Bangkok refuses to accept HIV-positive women for delivery. Most hospitals stamp the records of HIV-positive patients with the warning BIOHAZARD, which means that they go to the end of the queue when waiting for an X-ray or other service. This is not only humiliating and time consuming for the patients concerned, but medically unnecessary.

Care for the dying

AIDS Action highlights key issues for health workers who are supporting someone who is very sick and dying at home.



Relatives and friends can provide companionship for the sick person.

TONY HIRRO

Many people with AIDS are being cared for at home because hospitals with very limited resources cannot cope with growing numbers of patients. People often prefer to be in a familiar environment with those they are close to.

At some point in a person's illness, little can be done to extend life. The decision to stop trying to prolong life must be made by the person (if they are conscious), with their carers and health workers. After this, terminal or palliative care is given. This is care that helps the dying person to be as comfortable as possible, and to prepare emotionally and spiritually for death. Even where resources are limited, good palliative care can be given.

Practical issues

Choosing a suitable place Choose a convenient room in consultation with all those involved. The person's bedroom may not always be suitable, as it may be too small or shared with others. The room needs to have good light and ventilation and be quiet and comfortable, but also enable the person to remain involved in family life.

Health services support The local health centre should be briefed about the person's condition, so that staff can provide advice and appropriate drugs.

Community and family support

Reducing the pressures on the carers—usually the women in the family—is important. Relatives and friends can help in household or other work, and provide companionship for the sick person. The health worker should discuss how to mobilise support with the family and the local community leaders, perhaps by involving neighbours or members of community or religious associations.

Patient care

The health worker can give advice to enable the sick person to be as comfortable as possible.

Severe pain in the form of headaches, and in the chest, hands or feet, is very common. Sores and ulcers in the mouth or around the genitals and anus can also be very painful.

Painkillers should be taken before the pain becomes very bad, and regularly while it lasts. Mild painkillers such as aspirin may have no effect. Instead, the worker can prescribe morphine or pethidine if available, without worrying about possible addiction. Alternatively diazepam can be given to sedate the person. However, the sick person and his or her carer should be aware that sedation may cause the condition to worsen.

Other methods to relieve pain include putting a cool, clean, moist cloth over the painful site,

pouring clean water over it, or massaging it gently with oil or vaseline. Carers should respond to the person's request to lie or sit in a particular position or for changes in their environment. Deep and regular breathing may help them to relax.

Diarrhoea can be a major problem, sometimes persisting for several months, with stools that may be watery, mucoid or foul smelling with pus. The person may be very depressed, sometimes refusing to eat or drink for fear of making the diarrhoea worse. Encourage them to eat frequent, small and nutritious meals.

Dehydration can be prevented by giving plenty of fluids, such as water, unsweetened fruit juices, soup, rice water or weak tea. If the patient is vomiting, fluids in small amounts must be taken more frequently. Foods and fluids containing too much sugar can make the diarrhoea worse. The health worker can also consider prescribing adsorbents for a short time such as kaolin or pectin, or anti-motility drugs such as loperamide, which may succeed in stopping persistent diarrhoea (although they do not cure the infection).

Oral rehydration therapy should be given if there are any signs of dehydration, such as having a dry tongue or feeling thirsty. Oral rehydration salts (ORS) solution made from a packet, or home-made sugar and salt solution are the best methods. Sometimes intravenous rehydration can be carried out at home, if a trained health worker is able to monitor the procedure very closely.

The sick person should be kept as clean, dry and comfortable as possible, with frequent changes of bed sheets. Plastic covering can be used to protect the mattress or blankets, and a bed pan provided if necessary. Smells can be dispersed with good ventilation, air freshener sprays (if available) or by burning herbs used locally.

Mental confusion (dementia) affects many people with HIV-related illness. They may become unaware of what is happening around them, be forgetful, unable to think clearly, or move clumsily. Their awareness of being confused may come and go, and this can be very upsetting.

Persons who are confused need constant attention and reassurance, and sometimes others may be needed to restrain them from hurting themselves. Dangerous objects should be removed from within their reach, and medication needs to be supervised.

Severe dementia can cause very restless or aggressive behaviour, and a sedative may help. However, carers need to be aware that this is likely to make the person drowsy and worsen his or her overall condition.

Looking after a confused person is exhausting and distressing. Carers need to be encouraged to have enough rest, and to take turns in nursing and being with the person. Health workers should explain to the family that the person's behaviour is not intentional but caused by the effect of the virus on the brain. Some drugs can also cause confusion. The medication list should be reviewed, and it may be appropriate to stop all drugs.

Severe skin abscesses or ulcers can become infected. This infection—sepsis—can affect the rest of the body, making the person feverish, with low blood pressure and a fast pulse rate. They may be in great pain and discomfort.

Ulcers need to be cleaned regularly with antiseptic (if available) or salty water (one teaspoonful in a cup of water). The health worker should lance any unburst abscesses, and drain and dress the wounds. This helps greatly in relieving pain and fever. Attempts should be made to disperse the bad smell associated with severe sepsis.

Fever can be lowered by removing unnecessary coverings, and the skin cooled by fanning and using moist cloths. To prevent skin problems, the skin should be kept clean and dry. If the sick person is bedridden, the legs and arms should be moved gently several times a day, and the body turned every few hours to prevent bed sores from developing.

Emotional stress

Someone who is dying may suffer from great psychological stress. Appropriate emotional and spiritual help should be offered. Counsel-

ling can help someone understand and explore their reactions to death and dying, and accept the fact that death is near. It also enables a person to make decisions about issues such as how children will be cared for, making a will, informing other relatives, and arranging for burial. It is important for family members to give the person opportunities to talk about his or her feelings, enabling the person to cope better with anxiety, fear, loneliness and guilt feelings that often worsen as someone becomes weaker.

Fear of death is a normal reaction. Carers should not give false reassurances, but can help the person to talk about his or her fears. Spiritual support should be provided if the person wishes. Fear can make people angry about their situation, and aggressive towards people they are close to. It may be helpful to explain to the sick person what can happen physically as someone dies (for example, he or she may have difficulty in breathing or move in and out of consciousness).

Loneliness is very depressing for sick people. Friends and relatives often stop coming to see them, or, when they do visit, they act like strangers. People should be encouraged to visit, but need to be given opportunities to discuss their feelings about being with someone who is dying.

Feelings of guilt and regret are very common, in part because of the stigma often associated with AIDS. People may feel responsible for exposing their partner to infection, or guilty because they feel they have brought shame to their families or friends. Failure to settle debts, fulfill ambitions or responsibilities to children, can cause feelings of guilt, sorrow and regret. A person may want forgiveness or to discuss ways of resolving problems one feels responsible for.

Caring for the carers

Looking after a partner, friend or family member who is dying is stressful and upsetting. It also adds enormously to the burden of household work—particularly for women. Counselling can help people to cope with the strain, and to solve problems, such as identifying someone else to look after the children or cook.

If the issue has not already been discussed, it is important to encourage the sick person to discuss the implications of his or her HIV status with a partner (or other close and trusted relatives). Alternatively, if the person is very ill or near death, the health worker should try to talk with close family members.

Family members need to be encouraged to talk about their feelings with each other, as well as the sick person. It also helps to talk with friends who may be having, or have had similar experiences. Community and health workers themselves also need support and counselling.

When death is near

The family often needs more emotional support than the person themselves, because he or she finds it difficult to accept what is happening. If the sick person is very weak or unconscious, a decision should be made with the relatives to stop trying to rehydrate or give food. The health worker should explain that the end has come, and attempts to try and revive the person should not be made.

When death comes, the health worker should calmly and quietly organise the preparation of the body for burial, making sure that there is no skin contact with blood or other body fluids. They should also make sure that, for example, the death certificate is signed, and that arrangements for the funeral have been made.

Unless invited to stay, the health worker should then leave the family to contact other relatives and to mourn the dead person according to their cultural traditions. Family members should be offered counselling to help them cope with grief and other feelings, as well as support for practical problems.

Dr. Elly Katabira, Dept. of Medicine, Makerere University Medical School, PO Box 7072, Kampala, Uganda.

WHO's new AIDS Home Care Handbook covers nursing care, medical treatments and other practical issues. Single copies are available free from WHO/GPA, 1211 Geneva 27, Switzerland.

Attention all readers!

Every year hundreds of newsletters are returned because readers have changed their addresses and have not informed us.

To check that current addresses are up to date, we have sent questionnaires to people who receive over 19 copies of the newsletter, or who have been on our mailing list for more than three years.

If you have received either a yellow card or a letter asking you to complete a distribution survey, please send replies and completed cards to **HAIN** as soon as possible. These questionnaires also give you the opportunity to tell us about your occupation, workplace, and how you use AIDS Action.

If other readers have not been in touch with us recently, please write in and tell us about yourselves and your work, beginning your letter with the heading: Mailing list information appeal. Thank you.



HIV/AIDS Hotlines

There are a growing number of hotlines in major Asian cities, providing anonymous information and counselling about HIV/AIDS.

The numbers in parenthesis refer to the country and city code.

HONG KONG (852) 780-2211

Hours: 24 hours for recorded messages and fax-on-demand services.

Counsellors available from Mondays to Fridays, 8 AM to 8 PM.

Languages: English and Cantonese

Sponsoring Organization: Hong Kong Department of Health

INDIA

Bombay (91- 22) 371-9020

Hours: 11:00 to 6:00 P.M. Monday to Saturday

Languages: English, Marati

Sponsoring Organization: (PFI) Population Services International

MALAYSIA

Kuala Lumpur (60-3) 981-2863 and 981-2864

Hours: Mondays to Fridays, 7:30 to 9:30 PM

Languages: English, Malay, Cantonese

Sponsoring Organization: Pink Triangle

PHILIPPINES

Metro Manila (63-2) 500551

500921 597450

Hours: 10 AM to 12 midnight, daily

Women's AIDS Hotline 504507 / 504427

Hours: 10 AM to 8 PM, Monday to Friday

Languages: English, Filipino (Tagalog)

Sponsoring Organization:

Remedios AIDS Foundation

SINGAPORE (65) 252-1324 / 247-1611

taped information service

Hours: 8 AM to 5 PM Monday to Friday

8 AM - 12 noon Saturdays

Languages: English, Mandarin, & Malay

Sponsoring Organization:

Action for AIDS (AFA)

THAILAND

Bangkok (66-2) 276-2950 / 277-8811

Chiangmai (66-53) 274-15 / 274-151

Hat Yai (66-74) 230-165

Hours: 8 AM to 10 PM, Mondays to Fridays

9 AM to 6 PM, Saturdays and Sundays

Language: Thai

Sponsoring Organization:

Hotline Center Foundation

RESOURCES

Statement from the consultation on testing and counselling for HIV infection, 1992

Guidelines for the clinical management of HIV infection in children, 1993.

Single copies of the above two resources are free from WHO/GPA, 1211 Geneva 27, Switzerland.

Practical issues in HIV testing is a new publication providing information about

when, how and why testing for HIV antibodies is ethical and helpful, and including details about new technologies. *Available free from AHRTAG to readers in developing countries and £2.50 elsewhere.*

Updated slidesets and handbooks useful for training medical staff in managing STDs, and HIV infection in children and in adults (in Asia-Pacific) are available from TALC. Write to PO Box 49, St. Albans, Herts, AL1 4AX, UK for a 1994 Catalogue.

AIDS action

Asia-Pacific edition

Note from the Editor:

Welcome to the first issue of the Asia-Pacific edition of AIDS Action. Like the international edition, we hope to provide timely and practical information four times a year about HIV/AIDS. Our readers are primarily health and social workers, but we also intend to reach policy and opinion makers, as well as the general public.

This is a regional edition of the international newsletter, but the scope is not much narrower, since our coverage is almost halfway around the world, from Iran to Western Samoa, containing over two thirds of the global population. At last count, there were 53 nations in this part of the world. This is an important period for many nations in the Asia-Pacific, with some undergoing economic and social changes unprecedented in their modern histories. These changes are bound to influence the conditions which can affect the spread of HIV/AIDS. Increasing numbers of migrant workers, the expansion of urban centers, and the rapid growth of tourism are only some of the trends in the Asia-Pacific which can affect the spread of the disease.

The rise in HIV infections in some countries in Asia is "explosive", according to the World Health Organization. With an estimated 2 million infections in the region today, the number is expected to hit 10 million by the turn of the century. One private research group asserts that the disease could cause economic losses of up to \$52 billion, or about 2% of the region's combined GDP, by the year 2000.

The team publishing this edition is based in Manila, Philippines, but will be maintaining a network of contacts throughout the Asia-Pacific which will provide information, articles, and ideas. Staff members will also be visiting countries in the region to get first-hand information.

We encourage readers to write, call, e-mail, fax, visit, and otherwise keep in touch. This is your newsletter!

HOWIE G SEVERINO, Editor

Basic Facts about HIV and AIDS

1. A person can have HIV but not AIDS.

HIV is Human Immunodeficiency Virus. There are two types of HIV — HIV-1 and HIV-2 — both of which cause Acquired Immune Deficiency Syndrome (AIDS). Most HIV infections in Asia involve HIV-1.

After a person is infected with HIV, he or she can remain without signs or symptoms for 3 to 12 years. Eventually, HIV destroys a person's immune system, which makes that person vulnerable to many opportunistic infections such as pneumonias, tuberculosis, and diarrheal diseases. When this happens, the person is said to have developed AIDS.

A person with HIV can pass on the virus to other people even without having developed AIDS. But you cannot tell if a person has HIV by simply looking at him. Even in a person who has developed AIDS, the signs and symptoms are not specific: rapid loss of weight; enlarged lymph nodes; coughing; diarrhea.

2. HIV is not transmitted through casual contact.

HIV does not live long outside the body. It cannot be transmitted through the sharing of clothes or eating utensils. Neither can it be acquired through toilet seats or swimming pools. HIV is not transmitted through sneezing or coughing. A person with HIV will not pass on the virus through hugging or kissing. In other words, a person with HIV does not need

to be isolated. Persons with HIV can continue to lead productive lives.

3. HIV is mainly transmitted through sexual intercourse; sharing of contaminated needles and syringes by drug injectors; receiving infected blood through transfusions, and through an infected woman to her fetus or baby in the womb, during childbirth, and during breast-feeding.

HIV is found in many body fluids but the concentrations in fluids like saliva are too low to cause infection. Infection levels of HIV are found in the blood, semen, and vaginal and cervical secretions, and breastmilk. Understanding that, we can see why the main routes of HIV transmission are (a) unprotected sexual intercourse; (b) sharing of contaminated needles, mainly during injecting drug use; (c) receiving infected blood through transfusions, and (d) through an infected woman to her fetus or baby in the womb, during childbirth, and during breast-feeding.

4. Unprotected sexual intercourse is the most common route of HIV transmission.

Unprotected sexual intercourse accounts for about 85 percent of the world's HIV infections. HIV is usually transmitted from a man to a woman and from a man to another man, and to a lesser extent, from a woman to a

man. "Promiscuity" (having many sexual partners) is not, in itself, a cause of HIV infection. It is unprotected sex — sex that allows an exchange of infected semen, vaginal and cervical secretions, or blood — that allows HIV transmission.

The risks for HIV are increased if a person has other sexually transmitted diseases such as syphilis, chancre or herpes, because these illnesses leave wounds in the genitals which make it easier for HIV to enter the body. A person with untreated STD is also more likely to pass the virus to someone else during sexual intercourse.

5. There are no "high-risk groups", only "high-risk behaviours".

The term "high-risk group" is inaccurate because it prejudices people. Sex workers (prostitutes), for example, are often blamed for spreading HIV. Yet, it is sex workers who are put at risk for HIV because they cannot protect themselves from other people's high-risk behaviours.

Another reason why it is difficult to talk about high-risk groups is that quite often, there is an overlap of high-risk behaviours. For example,

an injecting drug user may get infected through unprotected sex and can, in turn, spread the infection to others through sex, as well as the sharing of syringes and needles. To try to target "injecting drug users" as a separate population may therefore be impractical because the practice may be found in many different groups.

6. Vulnerability to HIV is affected both by biomedical and psychosocial factors.

While the term "high-risk group" is seen as inaccurate, there is recognition that some populations may be more vulnerable to HIV because of biomedical and psychosocial factors.

For example, women are more vulnerable to HIV because of sex-specific anatomical and physiological characteristics, i.e., women's reproductive tracts are more prone to injury during sex than the male genitals. The risks are even higher with young women.

Besides biomedical factors, there are important social and cultural reasons for people being put at risk. Many sex workers are forced into their professions, together with the risks of HIV, because of poverty. Handcapped by their gender and their class, sex workers may not be able to negotiate for safer sex with their clients.

In Asia, constant population movements — both voluntary and forced — put people into situations of risk as they become defenseless in their new environments. Contract workers are examples.

Any group that faces discrimination from society — an ethnic minority group for example — also become vulnerable because it becomes more difficult to reach them with information and education.

7. HIV antibody testing is not an effective HIV prevention method.

The most widely used tests to detect HIV infection are those that check for HIV antibodies in the blood. These antibodies are produced by the body in reaction to the infection, but the antibodies do not appear immediately after infection. The delay — called the window effect — is usually six to eight weeks, but with some people, it may take three to six months for the body to produce antibodies. Mainly because of this window effect, HIV antibody tests are unreliable as prevention methods. A negative test does not necessarily mean that the person does not have HIV.

HIV antibody testing is useful only to help estimate the prevalence of infection in a country; but even here, the method is not always that reliable because of the tendency to concentrate the tests on so-called high-risk groups such as sex workers.

HIV antibody testing should always be accompanied by pre- and post-test counselling so the person understands what is involved, and what the test results mean.

Rather than depending on tests, we should all be responsible enough to evaluate our own risks, and to take measures such as safer sex to protect ourselves and others from HIV.

8. HIV can be prevented, mainly through information and education.

There are several effective measures to prevent HIV (see sidebar). To implement these measures, massive public information and education campaigns are needed.



BMC/HAIN

Education is the key to prevention

9. There is no known cure or vaccine for HIV infection or AIDS.

Media reports about drugs for HIV and AIDS can be confusing. Some of these drugs — such as **zidovudine (AZT)**, **ddI** and **ddC** — are used only to slow down HIV.

Many Asian and Pacific traditional medical therapies, ranging from medicinal plants to acupuncture, are now being tried for HIV infection and AIDS but none have been proven to stop the course of HIV infection.

Neither have scientists been successful in developing a vaccine against HIV. It is unlikely that a cure or a vaccine will be found in the near future.

10. HIV is a major problem in Asia.

As of early 1994, 187 countries throughout the world have reported over 850,000 AIDS cases to the World Health Organization (WHO). But since reporting is always incomplete, WHO estimates there may be over 3 million people

who have developed AIDS since the start of the epidemic. About 15 million people are estimated to have HIV, about 2 million in Asia alone.

By the year 2000, the global cumulative figure may rise to about 40 million infections. By then, Asia may have the most number of infections — about 10 million.

Because HIV is mainly transmitted through sexual intercourse, most infections are found in people aged between 15 and 40, also the most economically productive years. The impact on families, communities and nations can be



HIV antibody testing is not an effective HIV prevention method.

tremendous. In Asia, HIV poses a real threat to the economic development of many countries.

ML Tan is a medical anthropologist and Executive Director of Health Action Information Network (HAIN). He also teaches at the University of the Philippines.

Preventing HIV/AIDS

Some of the measures below can be taken by the individual but it is also clear that governments and non-government organizations need to create an environment that promotes HIV risk reduction.

Preventing Sexual Transmission of HIV/AIDS

- Abstinence is the only foolproof way to prevent sexual transmission of HIV/AIDS. It is a method that can be promoted among young adults since postponing sex has many advantages besides prevention of HIV.

- Mutually faithful sexual relationships are effective if neither partner has yet been exposed to HIV. It takes two to be monogamous: if one partner is faithful and the other is not, the risk for HIV infection is still present.

- Safer sex practices are those that reduce the risk of exposure to infected blood, semen, or vaginal and cervical secretions. These include a wide range of non-penetrative sexual practices (e.g. kissing; hugging; massage). If there is penetrative sex (vaginal; anal, and oral), consistent and correct use of condoms greatly reduces the risks for HIV.

Preventing Non-Sexual Transmission of HIV

- If you need a blood transfusion, be sure that the donated blood has been screened for HIV (as well as other blood-borne diseases

such as hepatitis B, syphilis, malaria).

- Women who are infected with HIV, or whose husbands are infected with HIV, may want to use contraception to prevent transmission to the fetus. However, it is still a woman's right to decide if she wants to have a pregnancy or not. The chances of the fetus being infected is about 20 to 30 percent.

- A mother with HIV will have to weigh the costs and benefits of breast-feeding. In many countries, the benefits of breast-feeding — increased resistance to many diseases and better nutrition — may outweigh the costs and risks of bottlefeeding.

- Injecting drug users should not share syringes and needles. Hospitals and health care centers should always provide sterile syringes and needles. Injections should be used only when necessary.

Yokohama hosts 10th International Conference on AIDS and STDs

Perhaps appropriately, we are launching this Asia-Pacific edition of AIDS Action in Yokohama, Japan, site of the 10th International Conference on AIDS and STDs. This is the first time such a conference is being held in Asia.

The conference is sponsored by the Japanese Foundation for AIDS Prevention. Significantly, the two co-sponsors are the Global Network of People Living with HIV/AIDS (GNP+) and the International Council of AIDS Service Organisations (ICASO). The two co-sponsors have helped to speak out for the needs of

people living with HIV/AIDS, and the large NGO sector working with HIV/AIDS. The participation of the two co-sponsors was especially important for facilitating the participation of groups that were, technically, barred from entry into Japan because of existing laws. These included sex workers, injecting drug users, and people living with HIV/AIDS.

In the next issue of AIDS Action Asia-Pacific, we will feature a full report about this important conference.

Asian Business Responds to AIDS

About 80 people attended a workshop, "Asian Business Responds to AIDS" held in April. The Hong Kong meeting was organized by insurer Aetna Life and Casualty Company's Asia-Pacific arm and the World Health Organization (WHO).

Michael Merson, head of the WHO Global Programme on AIDS, noted that just three years ago, an estimated 500,000 Asians were believed to have been infected. Today, the estimate is that 2 million may have been infected, a figure that could quintuple by the year 2000, to over 10 million.

Merson described the rise as "explosive" in several Asian countries and warned against thinking of "high risk groups". He noted that the high mobility of populations in Asia is itself a factor for HIV's spread.

Merson said that AIDS would divert national resources from infrastructure investment to health care for persons with AIDS. Consumer markets would shrink through loss of personal income and as an increasing amount is spent on hospital bills and drugs. Work productivity would be affected as workers stay home because of illness or to take care of ill relatives.

Merson said that the contribution of the private sector is crucial: "I am not talking about business donations — I am talking about corporate leadership."

He emphasized that comprehensive prevention programs would be most cost-effective and that business leaders need to establish an AIDS-in-the-workplace program based on non-discrimination, care and support. This would include provision of condoms and services for sexually transmitted diseases. Merson called on business leaders to "ignore demands for pre-employment HIV screening" since this was not an effective way to slow the epidemic.

Responses from business corporations in the region have generally still been weak although in Thailand and Japan, business coalitions have already been formed to fight the spread of AIDS.

The Hong Kong and Shanghai Banking Corporation has abandoned its previous policy of requiring prospective employees to take the HIV test. The bank's external relations manager said the tests proved to be expensive and inaccurate.

AIDS Action is published quarterly in seven regional editions in English, French, Portuguese and Spanish. It has a worldwide circulation of 179,000. The International edition of AIDS Action is produced and distributed by AHRTAG in London. The Asia-Pacific edition is produced by Health Action Information Network (HAIN).

• AIDS Action Asia-Pacific edition staff
Editor Howie G Severino
Production staff Antonio Gerena, Luzviminda Modelo, Jojo Videna
Art and layout Cesar C Natividad
Project coordinator M. Tan

• International edition
Executive editor Nel Druce
Managing editor Kathy Attawell
Design and production Ingrid Emsden
Editorial advisory group
Calle Almedal Dr Tud Parwati Merati
Nina Castillo Dr Claudia Garcia Moreno
Professor E M Esslen Dr Chandra Moul
Dr Sam Kalibala Professor Anthony Pinching
Ashok Row Kavi Dr Peter Poore
Dr Ute Kupper Barbara Wallace
Professor Keith McAdam Dr Michael Wolff

Publishing partners

ABIA (Brazil)
Colectivo Sol (Mexico)
ENDA (Senegal)
HAIN (The Philippines)
Consultants based at University Eduardo Mondlane (Mozambique)

The Asia-Pacific edition of AIDS Action is supported by The Ford Foundation, CAFOOD, Christian Aid and Redd Barna (Norway).

SUBSCRIPTION DETAILS

If you would like to be put on the mailing list to receive AIDS Action, please write to:

HAIN
No. 9 Cabanatuan Street, Philam Homes
Quezon City 1104, Philippines
Tel: (632) 978805 / 986760
Fax: (632) 721-8290
E-mail: aidsaction@phil.gn.apc.org

Subscription charges
Free: Readers in developing countries
US \$20: Individuals elsewhere
US \$40: Institutions elsewhere

REPRODUCING ARTICLES

AHRTAG and HAIN encourage the reproduction of articles in this newsletter for non-profit-making and educational uses. Please clearly credit AIDS Action/AHRTAG/HAIN as the source and, if possible, send us a copy of the reprinted articles.

AHRTAG (Appropriate Health Resources & Technologies Action Group) is a UK-based international development agency which supports the goal of health for all by promoting primary health care.
Registered charity (UK) no. 274260

HAIN (Health Action Information Network) is a Philippine NGO involved in research and information on health and development issues.
Registered with the Securities and Exchange Commission 127593

Opinions expressed in this newsletter do not necessarily represent those of HAIN or AHRTAG. The mention of specific companies or of certain manufacturers' products does not imply preference to others of a similar nature. A person's HIV status or sexual orientation should not be assumed based on her or his article or photograph.