HEALTH MESSENGER

living with HIV/AIDS

September 2005

Issue 29
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 readers' misunderstanding of the text.
Dear Readers,

This is the third Health Messenger issue dedicated to HIV/AIDS. AIDS has a great impact on both emergency and long-term development. Since the first AIDS diagnosis in 1981, almost 38 million people are living with HIV, and over 20 millions have died. This rapid spread of HIV and related illnesses and deaths are impeding the progress in improving health and reducing poverty worldwide.

As today no definitive treatment for cure is available, we are attempting to achieve prevention of infections and the quality of care for people living with HIV. Expansion of voluntary confidential counselling and testing can ensure widespread knowledge of HIV status and then HIV treatment and prevention. Reduction of HIV-related stigma is a top priority to promote accessibility of prevention and treatment programmes. Also, antiretroviral medicines have been developed. However, access to antiretroviral treatment and care for other HIV-related illness remains low.

This issue thus complements the two previous ones, promoting rights of people living with HIV/AIDS through prevention, non discrimination and access to comprehensive care and appropriate treatment.

Enjoy your reading,

Dr. Yin and Dr. Khin
Medical Editors
နောင်ရဲ့ စိတ်ကျန်ကလေးများအတွက် အကြောင်းအရာအား ရေးသားပါသည်။ သို့သော် စိတ်ကျန်ကလေးများအတွက် အကြောင်းအရာအား ရေးသားပါသည်။

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AIDS was first recognized in the United States in the summer of 1981. The HIV virus was identified as the causative agent of AIDS in 1983.

A virus is a very small organism that can get inside the human body and multiply, getting inside the cells and using them as a factory where it is reproduced. This process makes the person sick. HIV is so small that sixteen thousand HIV viruses can fit on the head of a pin.

**Body's immune system**

The body has its own defense system: the immune system, composed of different types of white blood cells and special blood proteins. The immune system can be regarded as an army of cells trained to fight off any foreign organism invading the body. Among these white blood cells, the CD-4 ones - also known as T helper cells - are the army commanders. They control the proper functioning of the immune system. When a foreign organism enters the body, the CD-4 cells give command for the immune system to attack the invader. It may take a while for the immune system to build up an effective response. During that period, the person may have some symptoms and signs of illness.

**HIV and the immune system**

When getting into the human body, the HIV virus attacks the immune system. There are many viruses that can cause illnesses in humans, but HIV differs from these in that it is the only virus that specifically attacks the CD-4 cells. HIV virus gets inside the CD-4 cells, where it then multiplies. Up to 10 million viruses are produced daily, gradually destroying the CD4 cells. Without the commanders, the defense force is no more able to defend its territory properly.

The immune system usually produces specific antibodies to combat specific invaders. In the case of HIV infection, the body produces HIV antibodies to fight against the HIV virus; however, they cannot overcome it. These antibodies are what we commonly measure in HIV tests.
(၃) ကိုယ်စားလှယ်မှုနှင့် ပတ်သက်သော ရွေးချယ်မှုများ

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![Graph showing CD4 count, HIV RNA, and clinical stages](image-url)
Infection with HIV
At that moment, the virus gets into the body.

Window period
The time span from the entry of the HIV virus into the body to the time where HIV antibodies are detectable is called the "window period". Antibodies to HIV usually appear within 6 to 12 weeks of primary infection (rare exceptions are represented by individuals having defects in the ability to produce HIV-specific antibodies).

At that time, the virus multiplies quickly and still there will be no symptoms. This period is very infectious as the level of viruses in the blood - and other body fluids - is very high. However, the HIV test result is here negative because the person does not have yet the antibodies measured by the test.

Sero-conversion
This stage marks the end of the window period and usually lasts a week or two. The body starts to create antibodies against the HIV virus. From now onwards, the HIV test will be positive. During this period, the person may have a flu-like illness with fever, headache, sore throat, tiredness, swollen glands, joint pains and a rash. This often passes unnoticed (25% of people do not even experience illness at that moment). After recovery, the person is completely well again.

Asymptomatic period
Most people remain healthy for about 3-8 years, but actually the number of years will vary from one person to another. It can be from less than a year to 15 years or more. About 5-10% of people start to have health problems after 1 to 2 years. Another 5-10% has no symptoms for up to 15 years. This depends on the socio-economic circumstances of the person. Good food, healthy life-style and access to drugs can prolong life. Even if the person is apparently healthy and does not have any symptoms of illness, the viruses continue to actively multiply and weaken the immune system, gradually. In addition, although s/he may look very healthy, s/he is able to transmit the virus to others.

HIV/AIDS related illness
Over time, the HIV virus gradually weakens the immune system. As a result, HIV-infected persons become vulnerable to infections that do not usually affect other people. It can happen that these infections get into the body of healthy persons: in that case, the healthy immune systems destroy the infection easily and the persons do not get sick. But for people whose immune system is weak, it's quite different. The infections have the...
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opportunity to multiply themselves inside those people's body, making them sick. These infections are called "opportunistic infections", as they use the opportunity provided by a weak immune system to enter the body and make the person sick. During this phase, the signs and symptoms are mild at first but gradually more frequent, more severe and prolonged. This period lasts from months to 4-5 years.

**AIDS**
Later on, the person's immune system has been so weakened that s/he is very vulnerable to infections and cancers. The amount of viruses in his/her blood becomes very high, and the person is dangerously infectious to others. HIV test can be negative at this point, because the immune system is so weak that it is unable to produce antibodies anymore. At this stage, we can say that the person has AIDS. Unless treatment is available, the duration is usually less than 2 years. In developing countries, most people die within one year. In places where ARVs are used, the person can live for many years.

AIDS generally occur when CD-4 counts are less than 200 per $\mu L$. The World Health Organisation has listed a few signs, helping in provisional diagnosis of AIDS for public health purposes. The presence of two major signs with one minor sign (with presence of HIV antibodies) can be an indication of AIDS, provided that there is no other cause of immune depletion. The major and minor signs are listed below:

**Major Signs**
- Weight loss of more than 10% body weight
- Chronic diarrhea for more than 1 month
- Fever for more than one month

**Minor signs**
- Persistent cough for more than one month
- Generalized itching skin rash
- Recurring herpes zoster
- Oropharyngeal candidiasis (thrush of mouth and throat)
- Herpes simplex
- Generalized enlarged lymph nodes.

Source
HIV/AID prevention and control: A short course for humanitarian workers (RHRC Consortium)
Clinical Stage I
Asymptomatic or persistent generalized lymphadenopathy (PGL) and/or normal activity

Clinical Stage 2
Unintentional weight loss < 10% body weight
Minor mucocutaneous manifestations, Herpes zoster within previous 5 years
Recurrent upper respiratory tract infections and/or symptomatic plus normal activity

Clinical Stage 3
Unintentional weight loss > 10% body weight
Unexplained chronic diarrhea > 1 month
Unexplained prolonged fever > 1 month (constant or intermittent)
Oral thrush
Oral hairy leukoplakia
Severe bacterial infections (i.e pneumonia, empyema, meningitis, pyomyositis)
Pulmonary tuberculosis within the previous year
Vulvovaginal candidiasis and/or bed-ridden < 50% of normal daytime in the past month

Clinical Stage 4
HIV wasting syndrome (weight loss > 50% of body weight or BMI < 1 8.5 plus either a chronic fever or chronic diarrhoea > 1 month in the absence of concurrent illness
Pneumocystis carinii pneumonia
Toxoplasmosis of the brain
Cryptosporidiosis or Isosporiasis with diarrhea > 1 month
Cryptococcosis, extrapulmonary cryptococcosis disease of an organ rather than liver, spleen or lymph node (ex: retinitis)
Cytomegalovirus disease of an organ other than liver, spleen or lymph node
Herpes simplex virus infection, mucocutaneous ( > 1 mth) or visceral
Progressive multifocal leuкоencephalopathy
Any disseminated endemic mycosis (e.g., histoplasmosis)
Candidiasis of the oesophagus, trachea, bronchi, or lung
Atypical mycobacteriosis, disseminated or lungs
Non-typhoid Salmonella septicemia
Extrapulmonary tuberculosis
Lymphoma, Kaposi's sarcoma,
HIV encephalopathy and/or bed-ridden > 50% of the day during the last month
ကိုယ်တိုင်ပညာရေးအတွက် အလျောက် ကြေညာမည်ကို အဆိုပါနှင့် အပေါ် ပြည်သူရေးများ အနီးအနား၌ ဆက်စပ်ထားသော အချက်အလက်များကို ထိန်းဆောင်ပါ။

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HIV/AIDS has become a major issue in every part of the world. To understand the UNHCR's policy upon HIV/AIDS, Health Messenger team interviewed Ms. Ann Burton, Regional HIV/AIDS Technical Officer, UNHCR (Bangkok).

Health Messenger: "Hello Ann, first of all could you please introduce yourself, as well as UNHCR policy on HIV?"

Ms Ann Burton: "HIV/AIDS is now a policy priority for UNHCR and they have been scaling up HIV/AIDS activities globally. This is a new position aimed at preventing and responding to HIV/AIDS in refugees, returnees and other persons of concern to UNHCR in the Asia region. We are looking at HIV/AIDS in a number of areas: national policy in relation to HIV/AIDS and refugees, protection in relation to HIV/AIDS, prevention and care, treatment and support. The protection focus is particularly important to UNHCR as this is its core mandate."

Health Messenger: "Could you define "protection"?"

Ms Ann Burton: "Protection means that refugees’ rights in relation to HIV/AIDS are recognized and respected. For example, that there is no denial of asylum on the basis of HIV status, or that HIV-positive refugees are not deported or denied the right to return to their country of origin. In addition, refugees are often heavily stigmatized and, when refugees are HIV-positive, they can be doubly stigmatized. In some settings refugees are wrongly accused of bringing HIV infection into the country. This is one of the myths that UNHCR is trying to counteract. In fact, in most refugee situations, the prevalence of
အလိုအပေါ် ပြောချက်များနှင့် စီးပွားရေး ဝင်ရောက်သော ကျန်းမာရေး အလုပ်အကိုင်များကို ဆောင်ရွက်ရန် ရည်ရွယ်ပေးပါသည်။

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HIV/AIDS is lower than in the host community, which is the case here in Thailand. Another point is about resettlement. Some countries require HIV testing prior to resettlement; UNHCR wants to make sure that it is done in accordance with international guidelines and standards. For example, HIV testing must be provided with full pre and post-test counseling, confidentiality must be maintained, and refugees who test HIV positive must be referred for appropriate services."

Health Messenger: "In addition to protection, which are UNHCR other areas of intervention?"
Ms Ann Burton: "UNHCR also looks at prevention, care, treatment and support, monitoring and evaluation of HIV/AIDS activities. UNHCR's stance is that HIV/AIDS interventions should be of similar level and quality to those available to the host community. This includes access to antiretrovirals."

Health Messenger: "Do you have any precise information about HIV/AIDS on the border?"
Ms Ann Burton: "As I have already said, prevalence of HIV in the camps is very low, and is lower than in most of the surrounding areas in Thailand and in Burma. HIV positive persons are concentrated among the high-risk groups; this is mainly men who leave the camps and who are usually away for prolonged periods of time. Even though the prevalence is low, this does not mean we can be complacent. To date awareness-raising has been aimed at the general community but now we need to target those who are at greatest risk of infection."

Health Messenger: "So in terms of programming, how does UNHCR work?"
Ms Ann Burton: "We do not directly implement, we have implementing partners or operational partners. Implementing partners are agencies that we would fund to undertake particular activities usually to strengthen their own programs; and operational partners are agencies we
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are working in collaboration with, without actually having any funding relationship. We have some funds available to support HIV/AIDS activities in the Asia region. When I visit the different camps, I speak with the agencies working in those camps to identify how they can best spend these additional funds.

Health Messenger: "What about your collaboration with the other UN agencies?"
Ms Ann Burton: "UNHCR is a co-sponsor of UNAIDS. We are represented on the UN theme group on HIV/AIDS. Refugees are often a forgotten group and we advocate to ensure that refugee issues are adequately represented on the national HIV/AIDS agenda. For example, Thailand is currently revising its national strategic plan for HIV/AIDS; refugees are not mentioned in the current strategic plan and we are trying to ensure that they are recognized as a specific vulnerable group in the revised plan. A lot of this advocacy is done through the UN HIV/AIDS theme groups. There are bi-monthly UN Border Health Meetings convened by WHO. These are an opportunity to link with initiatives of other UN agencies that may be relevant to the refugee camps. For example, UNICEF’s Child Protection work in the camps is directly related to HIV/AIDS by reducing vulnerability amongst young people."

Health Messenger: "How long will this UNHCR program last?"
Ms Ann Burton: "This is a multiyear programme."

Health Messenger: "More globally, could you explain UNHCR's position regarded to mandatory testing?"
Ms Ann Burton: "We are strictly opposed to mandatory testing for HIV. A person has the right to either choose to undergo HIV testing or to choose to not test. Mandatory testing violates

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Refugees are often a forgotten group and we advocate to ensure that refugee issues are adequately represented on the national HIV/AIDS agenda.
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this right. Also mandatory testing does not lead to behavior change and is not a recommended public health intervention. UNHCR supports voluntary counseling and testing for HIV as both a preventive measure and also linking positive persons to care, treatment and support.

Health Messenger: "What else about human rights?"

Ms Ann Burton: "In terms of HIV/AIDS, we want to ensure that the rights of refugees affected by HIV/AIDS will not be denied. This includes denial of asylum and the right to return on the basis of HIV status. We also want to ensure that refugees have access to an appropriate range of HIV/AIDS services."

Health Messenger: "More globally, violation of human rights and HIV infection are directly linked. Could you explain in what way?"

Ms Ann Burton: "The link is very strong. Lack of recognition of human rights not only causes unnecessary personal suffering and loss of dignity for people living with HIV/AIDS but it also contributes directly to increased transmission of HIV since it hinders the response. For example, when human rights are not respected, people are less likely to seek counselling, testing, treatment and support because it means facing discrimination, lack of confidentiality or other negative consequences. Furthermore, people who are denied basic rights may be forced into situations which place them at greater risk of HIV."

Health Messenger: "And what about the migrants? Does UNHCR work with this population?"

Ms Ann Burton: "UNHCR's primary mandate is refugees. We would only work with the migrant population if requested by the government although we are aware that they represent one of the most vulnerable populations. In some areas we will include migrants in our advocacy efforts e.g. greater access to anti-retroviral therapy for both refugees and migrants, but it is mainly WHO (World Health Organization) and IOM (International Organization of Migration) who are working with this group."
It has been almost ten years since the first highly active anti retroviral medications to control HIV infection became available for people with HIV in developed countries.

At that time most activists thought it was foolish to advocate for all people with HIV on earth to have an equal right to treatment. They thought that the medicines were too expensive and the treatment regimens were too complex for poor people. At the Vancouver international AIDS conference in 1996 I remember seeing graffiti spraypainted on the sidewalk: "HIV + poverty = death".

In some ways times have changed. When the United Nations first developed guidelines on HIV and human rights in the late nineties, there was little mention of treatment of HIV. But the guidelines had to be amended just four years after they were published. As the new millennium dawned, care for HIV became a human right.

In 2001 the United Nations convened a Special Session of the General Assembly and a unanimous Declaration of Commitment was made. All member states of the UN called upon themselves to provide "the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality controlled anti retroviral therapy". The Declaration of Commitment of the UN General Assembly Special Session on HIV/AIDS stands as the first milestone in the right to care.

Then in a surprising and bold move,
မိတ်ဆွေးနှောင်း မိမိသည် အားကြီးသောအချက်များကို မြင်ရန် နွေးရစ်သော စဉ်းစားချက်များ စစ်မှုများ အားလုံးကို ရေးသိမ်းပါမည်။ မိတ်ဆွေးနှောင်းအပေါ် စီးပွားရေး ပြုလုပ်သူများကို မြင်ရန် နွေးရစ်သော စဉ်းစားချက်များ စစ်မှုများ အားလုံးကို ရေးသိမ်းပါမည်။

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the new Director-General of WHO in 2003 made a target of 'Three by Five' or three million people on antiretroviral therapy by the end of 2005. That is half of all people on earth who need the medications. The time of accounting is coming up. WHO has admitted that the target will not be met. Many people are disappointed to see that it will become 'One by Five' or only one million people on treatment by the end of this year. But then just last month a summit meeting of the G8 group of rich countries was held. The political leaders of these eight countries made a commitment to provide the resources for antiretroviral therapy for all people in the world who need it by the year 2010. So it is now established that care is a right, targets are set, and the financial resources are ready. What next? Advocacy to make the promises a reality.

What other arguments are there for increased access to care?

The most important argument for increased access to care for people living with HIV is that it is a human right. That should be enough for decision makers to consider it. But they often have competing demands on their resources and need convincing to make changes in their plans. The first argument that can be made is that helping people with HIV live longer and better lives leads to economic benefits to the person with HIV, his or her family, and the community. People with HIV are often young and economically productive. Whether they are women or men, they often provide for and care for their children. The Burmese community inside or outside of Burma simply cannot afford to lose them without everyone losing economically.

Another argument for more and better care for people living with HIV is that it will decrease stigma and discrimination for people living with HIV. As HIV infection becomes a chronic treatable disease instead of a death sentence, fear of the disease will decrease and discrimination may become a thing of the past.

One argument that cannot be made is that better care will automatically
ပေးထားသော စာမျက်နှာကို ဝက်ထက်များအားဖော်ပြပါ။
prevent new infections. There is at present no evidence that better care or anti retroviral therapy prevents more people from being infected with HIV. People with HIV have more virus in their blood so transmit HIV more easily shortly after they have been infected. At this time they usually don't know they have HIV so they are not treated. Treatment is usually started only when they have begun to get sick. So advocates cannot promise decision makers that ‘good treatment is good prevention’.

Many of the elements of a care package are already readily available, affordable and effective. They both prolong life and make life better. They include:
- Voluntary counselling and testing for HIV as the entry point for access to all health care services and self management
- Prevention and treatment of tuberculosis (TB) in people living with HIV
- Treatment of other opportunistic infections
- Prevention of other opportunistic infections (e.g. cotrimoxazole, fluconazole, etc.)
- Home-based care and community based care approaches
- Tackling HIV related stigma, especially in health care settings, which often keeps people away from health services
- Substitution therapy (e.g. methadone) for recovering injection drug users
- Traditional healing and treatment approaches
- Promoting food security and micronutrient provision
- And, of course, Anti Retroviral Therapy (ART)

Who can advocate?
Employers, funders, academic institutions, civil society groups, networks of people with HIV, health workers, media representatives, government bodies, advocacy groups, pharmaceutical companies and faith-based organisations should be giving more urgent attention to relatively simple approaches to keeping people with HIV alive.

One individual can advocate well. And one organisation can have powerful advocacy skills. But there is power in numbers. Ten health workers who approach one
CARE for people with HIV
to increase care will have a greater impact than one health worker. Christian and Buddhist organisations who plan together to make a joint presentation to an international NGO will have a better result than any one of the two organisations presenting alone. And a coalition of health worker associations and groups of people living with HIV will have a greater impact than either one of these groups alone. Advocates do not need to be professional advocates. Some of the best advocates in the world are simply people with HIV who know their rights and capture the interest of the correct people to hear them.

Who do we approach to advocate?

But before we go out to advocate, we need to identify our targets. Who should we speak with? Many HIV/AIDS activities in Burma and on the border are already being funded by the British, American, Canadian, Australian, Japanese, and European governments. Next time a representative of one of these countries visits your work, ask for a few minutes of their time. International NGOs that work with you have also made commitments to provide care for people with HIV. Approach them accompanied by people living with HIV and ask to talk with them about care activities. It is also worth approaching United Nations representatives to ask them for copies of their organisational commitments on treatment and care for HIV. Armed with copies of the new UN human rights and HIV guidelines and the Declaration of Commitment, it is time for many of us to actively approach decision makers to meet their commitments and targets. Just asking for antiretroviral therapy is not enough. We need to ask for three things:

1. Ensuring widespread access to the above comprehensive care and treatment options: for example, helping people to discover their HIV status, to delay their progression to AIDS, and to prevent and treat HIV-associated conditions;
2. Improving health literacy among people living with HIV: particularly in relation to ‘early’ HIV-associated conditions, their prevention, management and drug treatment;
3. Identifying and minimising the factors that accelerate the development of AIDS-related conditions.

Advocacy for prevention

In reinforcing advocacy for increased access to care and improved care for people living with HIV, we should not forget prevention. Resources for care
လူမှုကြောင်းသိပ္ပံစနစ်ကို အဖွဲ့စည်းရာတွင် ပြည်သူများ အဖွဲ့စည်းသော ပြည်သူများက ပြည်သူများကို သော့ချက်ချင်သော အဖွဲ့စည်းများကို သော့ချက်ချင်သော ကိုယ်စားလှယ်များကို ကျောက်စားပါ။

HIV/AIDS Action Centre
22-22/1, Soi 1, Ratchphakinai Rd,
Chiang Mai
(near Chiang Pauk Gate)
or email: infor@aidswatch.org
http://www.aidswatch.org

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should not come at the expense of resources for prevention: they should be additional resources.

**Advocacy materials**

The AIDS-Care-Watch Campaign of Health and Development Networks in Chiang Mai can help as they have a wealth of materials to support advocacy. They can be approached in person at:

*the HIV/AIDS Action Centre*

22-22/1 Soi 1,

*Ratchaphakhinai Rd, Chiang Mai* (near Chiang Peuak Gate)

or by email:

<info@aidscarewatch.org>

In Burma you can contact:

Dr Sid Naing

Social Mobilization Adviser of UNAIDS

Yangon International Hotel,

330 Ahlone Road, Yangon.

<sid.naing.unaids@undp.org>

**A final word**

When doing advocacy for AIDS care it is best if we must remember the words of U Thant, "It is no longer our resources which limit our decisions. It is our decisions which limit our resources."

Estimated percentage of people on antiretroviral therapy among those in need, situation as of June 2005
စိုးရိမ်အသင်းကို ဖုန်းရွေးချယ်ပြီး ပြသချင်ချင်သော အမှုများအား ဖော်ပြပါသည်။

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Services offering Voluntary Counselling and Testing (VCT) for HIV are spreading along the border, in clinics and in refugee camps.

Many health workers now speak about "VCT" and sometimes, in different places and settings, I hear health workers saying: "That patient was referred to VCT" or "We will do VCT on all the patients coming to our clinic", or "We have to VCT that man, because his wife has AIDS".

Did we forget what the V means and why it is there?

Sometimes, instead of a voluntary counselling followed by a voluntary testing, we might be doing a non-voluntary ("compulsory") counselling followed by a voluntary testing, or a non-voluntary ("compulsory") counselling followed by a non-voluntary ("compulsory") testing.

In a study in South Africa, several human rights violations were documented in three areas: privacy and disclosure; informed consent and HIV testing; access to health care services.

We take this occasion to reflect on what VCT means, what the service should be and offer, what are the requisites to start an effective VCT service, which problems can arise in the community if a VCT service does not work well, and what we should look at to assess whether the service offered is truly voluntary.

Voluntary Counselling and Testing means that this particular Counselling and this particular Testing is "Voluntary". This means that both Counselling and Testing must be chosen freely by the person.

It is very important how we use our words. For example, a phrase like: "I would like to send you to VCT, is it ok?" should not be used, because it pushes the patient to say yes and may be that person is not ready yet to have counselling. A phrase like this is much better: "There is a service offering counselling to help you clarify your fears. You can think about it and, if you wish, I can refer you to it".
the other way round (Voluntary Counselling) and it is the person that, after counselling, asks to be tested or declines to be tested (Voluntary Testing).

The person has to feel completely free to do it or not to do it. Whatever the health worker thinks, s/he has to follow the wish of the person involved.

**Why is it important that counselling and testing are voluntary?**

Because the knowledge of being seropositive may have serious consequences for the life of a person and not always the health worker can see all the negative sides of doing the testing. It is therefore the person and not the health worker who has to take responsibility to decide whether the benefits of knowing her status outweigh the risks of being tested.

**Why would patients voluntarily choose not to be tested?**

As long as there is this fear, we can understand why a person might prefer not to be tested.

In many VCT settings, persons who test positive are not offered treatment with anti-retrovirals, but some kind of "support". This support (financial, psychological, medical) although very useful to help them, will not prevent them in the long-term to get worse.
များနေရာများအတွက် စိတ်ဝင်စားမှုများအား လေ့လာပြီးမှာ အချိန်များနှင့် လူသိမ်းရေးမှုများနှင့် အစိတ်အပိုင်းများကို လေ့လာပေးပါ။

ပြီးနောက် အချိန်များနှင့် လူသိမ်းရေးမှုများကိုလည်း လေ့လာပေးပါ။

စိတ်ဝင်စားမှုများအားလိုအပ်သော အချိန်များနှင့် လူသိမ်းရေးမှုများကို လေ့လာပေးပါ။

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and die. If people were explained this and understood this clearly, it would not be surprising that they might decide to refuse the test, because the benefits of the support are small in comparison with the risks of being abandoned by the community.

If we want that more patients will come and agree, on a true voluntary basis, to counselling and testing, we have to be able to ensure that the benefits outweigh the risks: confidentiality needs to be absolutely guaranteed and treatment with anti-retrovirals should be offered.

If a service is offering treatment to people who test positive, the person might decide to run all the above risks to keep his/her health.

But if confidentiality is not happening and treatment is not offered, than the benefits for the individual are very limited.

If we are aware that in our service confidentiality is a problem and anti-retroviral treatment is not offered, but still patients agree to be tested, we have to critically question whether our service is truly "voluntary".

**Counselling**

Counselling is a confidential dialogue between a person and a counsellor held in a private environment. The aim is to help the person to take personal decisions related to HIV/AIDS. Only with the consent of the person, counselling can be extended to spouses, sex partners and others.

It is agreed that, after the first counselling (often called Pre-Counselling, meaning before the testing), if the patient wishes to be tested, there will be another counselling, where the health worker will tell the person the result of the test (often called Post-Counselling, meaning after the test).

Both pre and post counselling can involve more than one session, as many as the person needs to be able to take a decision and to cope with the result.

Usually we speak about informed consent to testing, meaning that the person, to be able to take a decision about testing, has to understand what testing involves: which benefits there are if she decides to accept the testing and which risks she will have to face. The job of the health worker/
စက်သီးသီးပညာရေးသားများစွာ ကိုယ်စားပြုသော စိတ်ပျန်မှု အကြံပေးချက်များကို သိရှိလိုက်ပါ။ မိုးသော သင်္ချောင်းများအပေါ် ပြောပြချက်များကို ကြည့်ရှုလိုက်ပါ။

စစ်မှု
စစ်မှုစွဲဌာန် ဘာသာရပ် သိကြပါစို့။ စစ်မှုသားကြီး အကျိုးအကြောင်း စစ်သဘင်းအရေအတွက် အခြားသော စစ်မှုစွဲဌာန် သိကြပါစို့။

စစ်စက်သီးသီး
စစ်စက်သီးသီးကို အသုံးအနှုတ်များ ကြည့်ရှုပါ။ စစ်သီးသီးလေး အကြောင်း စစ်စက်သီးသီးကို ကြည့်ရှုပါ။

ယုတ်က များစွာ
ယုတ်က များစွာ ပြောပြချက်များကို ကြည့်ရှုပါ။
counsellor is to explain risks and benefits clearly, without influencing the decision of the person. Some medics think that, because of their medical knowledge, ‘they know best’ and they should make the patient follow their advice. But counselling is not advising the person to follow what we think right: it is explaining, answering, educating and helping the person taking a decision in her best interest. Very often, despite our knowledge, we do not know best, because who knows really the life of another human being and what is good or not good for her to do?

Confidentiality

Confidentiality is a key component in a VCT programme. Both counselling and testing should be confidential. Confidentiality means that the person asking for counselling has to be sure that nobody will know that he has gone for counselling (confidential counselling) and, if he decides to be tested, he has to be sure that nobody will know that he has been tested and that the result of the testing will be known only by the health worker counselling him and, if needed, by the health worker looking after his medical care (confidential testing). In many studies and surveys, confidentiality about counselling and testing was seen as a key issue by the people. Many persons might decide not to go for counselling and testing because they are afraid that counselling and testing is going to be an effective tool for social support and intervention. The testing provided must be of good technical quality (highest specificity and accuracy). The result of the test must be kept confidential and health care workers who are not directly involved in the care of the patient should NOT be told or allowed to see the result. The patients need to feel that the decision is completely in their hands.

Testing

If testing is carried out without a true voluntary informed consent by the patient, this has been proved to be counter-productive in the control of HIV epidemic. The very people who are at risk will hide in fear of being stigmatised and it will be difficult to find ways to help them. We should ask ourselves:
- will the result of the test be used for the benefit of the person?
- is there a policy and means to support the person following the test result?
- is there a policy to support the person even if she refuses testing?
Only if we can answer yes to all three

The job of the health worker/counsellor is to explain risks and benefits clearly, without influencing the decision of the person.
testing are not going to be kept secret. If the person feels that he cannot refuse the counselling and cannot refuse the testing, he might decide not to go to ask the result of the testing. Especially in a small or closed community (as for example the refugee camps, or the Karen community with all its extended networks of inter-related individuals) many people have expressed concern that confidentiality is not possible to be kept. In the refugee camps medics often know the patients or are distant relatives or know a medic who is a relative. It has been seen in many settings that confidentiality is often broken (breached) by friends, relatives or acquaintances. It often happens that a health worker speaks to his wife or friends, and then everybody in the community knows the result of the test. People interviewed expressed concern about having the result of the test written in their notes and that the notes were handled by many different health workers. Also using a "code word" instead of writing "HIV" was considered not good enough, because soon everybody knew what that code meant and confidentiality was therefore not kept. Another concern of the people interviewed was to be seen by others when going for counselling or testing, if the service was offered in a separate room. They thought that very quickly the community knew what that room was for (counselling for HIV) and that confidentiality was then impossible to keep. Many people chose to go to another town for VCT, but this is not always possible.

If there is no confidentiality, a VCT service is not going to work as a tool of support for the person, but it can instead become a way of spreading discrimination and can add hardship to people already living in difficult conditions.

**Individual versus Community**

Some health workers feel strongly that they have to protect the community, forgetting that their first responsibility is towards the patient. Much discussion is still going on internationally about individual versus
community responsibility and rights. But everybody agrees that, so long as discrimination and stigmatization persist, confidentiality is crucial to protect the individual person who comes asking for help. In a study in Kenya they found out that violence against women because of a positive test was common: is it right to disclose the test to the husband without consent of the wife? How many broken marriages we will be responsible for? Is this really the way to encourage people to change sexual habits? Most people now agree that, if people were well counselled, they would agree to disclose their status to their partner if they knew that there is no risk of violence. VCT services need to give to the individual true **guarantee of confidentiality and non discrimination**.

### Antenatal care services and HIV screening

In many antenatal clinics, HIV testing is offered after counselling. Very often the counselling is not voluntary in this setting, but comes as part of a "package" of the first antenatal visit. Because other investigations are often requested (malaria test, CBC, VDRL, hepatitis B), there is some doubt whether counselling about HIV can be really understood when many other things are discussed.

If anti-retroviral are not going to be offered to the mother, to know the HIV status may be of limited benefit. Even if anti-retroviral prophylaxis is given to prevent transmission to the baby, if the mother truly understands that those tablets are not going to help her and that her baby is going to become an orphan, she still has the right to refuse to be tested, or maybe she should not have been offered testing in the first place.

**Testing could subject the woman to risk of violence and loss of the support of the husband.**

To advise a positive woman to bottle feeding instead than breast feeding is considered not a good advise in poor countries, because of the cost of the milk powder (with risk of underfeeding the baby) and lack of access to clean water (with risk of diarrhoea and other illnesses).

**The same services should be offered to women accepting and those refusing the testing.** It is not ethical, for example, to refuse to deliver a woman if the HIV status is not known and she declines the test. Medical and surgical staff should take the same precautions for all patients, regardless of their status.

### Evaluation

VCT should be regularly evaluated, to
see if it is offering what it says.

Effective tools for evaluation are:
- independent surveys in the community with people who have used the service and with people of their community;
- independent questionnaires and talks with the counsellors and other medics;
- to check the percentage of people who have been offered the service and have declined;
- to check how many people counselled have been tested;
- to check how many people tested came back to know the result of the test.

To offer effective VCT programme, the essential requisites therefore are:
1. confidentiality and non-discrimination have to be guaranteed;
2. freedom of the individual has to be ensured for both counselling and testing:
   - the person should ask for counselling, not the health worker pushing for it;
   - full, true and balanced information should be presented during counselling;
   - testing should be done only as desired by the person and only after informed consent;
   - individual rights and decisions have to be respected whatever the health worker thinks is right or wrong;
3. VCT should be an entry point to provision of comprehensive HIV/AIDS prevention and care services, including referral for care and management of opportunistic infection, continuing psychological support, assistance with risk of stigma and access to anti-retroviral therapy;
4. since the start there must be a plan to regularly evaluate the service to check whether it satisfies the people or acts against their interests.

Moreover, other requisites are highly desirable, such as:
1. the service should be easily accessible at hours which are suitable for the people, not the health workers;
2. most of the people counselled have been tested;
3. many of the people tested do not ask for the result of the test;
4. people interviewed in the community express fear about confidentiality;
5. violence against women in the community is common because of a positive HIV test;
6. stigmatisation is found to be common;
7. every person attending a clinic has been counselled.
ပြုလုပ်သည်တစ်ဦးကို သီးသန်း။ သီးသန်းများစွာ သီးသန်းကို သီးသန်း။ သီးသန်းအရေအတွက် သီးသန်းအတွေး သီးသန်းကို သီးသန်း။ သီးသန်း။ သီးသန်းကို သီးသန်း။ သီးသန်းကို သီးသန်း။ သီးသန်း။ သီးသန်းကို သီးသန်း။

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2. VCT should be integrated into other services, as STDs, antenatal, family planning clinics, OPD and IPD consultations, etc. It should not be a special set up easily recognisable by everybody;
3. counsellors should have appropriate training but, if possible, should be part of the service (already working in the OPD or IPD or antenatal clinic, etc.);
4. management should support staff, retain skilled staff and prevent burnout;
5. education about HIV/AIDS in schools, factories, blood donation units, out patient waiting rooms, IPD should be strongly promoted as a method to decrease stigmatisation.

If our services do not follow these requisites, maybe it is time for a thorough evaluation: are they truly voluntary? Do they respect the right of the individual? What are the benefits and the risks for the people coming to our services? Are we offering a service to the people or are we harming people?

Any health programme that does not maintain the dignity of a patient and deprives him of his basic right to employment or access to medical care or social support is harmful on a long-term basis.

Resources:
Abdool Karim Q, Abdool Karim SS, Coovadia HM, Susser M., "Informed consent for HIV testing in a South African hospital: is it truly informed and truly voluntary?", Lancet. 1995 Apr
Lo B., Wolf L.E., "Ethical Dimensions of HIV/AIDS" InSite Knowledge Base Chapter, August 2001
Temmerman M, Ndinya-Achola J, Ambani J, Piot R, "The right not to know HIV-test results."
Walters L, "Ethical issues in the prevention and treatment of HIV infection and AIDS". Science. 1988 Feb

Health Messenger

NB:
"In many camps, everybody knows what the VCT room is for, but it's important to know that most people who have been there for testing are negative, so we should not think that everybody going there is positive."


အိမ်အရိုးများအတွင်း ဗုဒ္ဓဟူးဆိုင်ရာ စီးပွားအချက်များကို လက်ခံထားပါသည်။

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NRTIs (Nucleoside reverse transcriptase inhibitors)

reverse transcriptase အခြေများ (၁) အခြေအနေကြီး အိမ်အရိုးများ တိုးတက်စေရန်

NNRTIs (non-nucleoside reverse transcriptase inhibitors)
This section will review the current treatments available in Thailand for adults infected with HIV

**Background**

HIV infection involves the death of cells, called CD4, necessary for the functioning of the immune system. In late stage of the disease, the CD4 count has fallen to below 200 cells/mm³ and/or complications of HIV infection have arisen, including opportunistic infections, different types of tumors, muscle wasting, and neurological complications (Refer to Diagram on Page 4). Some patients progress more quickly to the late stage of the disease, and then death, while others progress more slowly. Still, on average, it takes 10 to 11 years in the U.S. and about 7 in Thailand for patients who do not receive ART to get to that stage. The amount of virus in the blood (or viral load) best predicts how quickly a patient will progress: the higher the viral load, the more quickly a patient is likely to progress to AIDS and death.

There are five main goals to take into consideration when starting a treatment for HIV infection:
- Preventing complications due to HIV infection, such as opportunistic infections.
PIs (Protease inhibitors)

reverse transcriptase
- Avoiding both short term and long term adverse drug reactions associated with ART
- Avoiding HIV resistance
- Preserving HIV treatment options for the future
- Preventing HIV transmission

These goals must be carefully weighed in the decision to start or change the treatment for HIV infection.

Medications to treat HIV infection that are currently available in Thailand fall into three main categories, based on which step of HIV multiplication they intervene. (Table 1)

The first anti-retroviral agent used against HIV is an agent called AZT (also called zidovudine or ZDV). It is one of several drugs called nucleoside reverse transcriptase inhibitors (NRTIs), which block an enzyme called reverse transcriptase, needed by the virus to multiply in the infected cell (step 2).

However, when used alone, the virus quickly develops resistance and treatment is no longer effective. The two other categories are the non-nucleoside reverse transcriptase inhibitors (NNRTIs), which intervene at the same step as NRTIs but on a different part of the enzyme, and protease inhibitors (PIs), which block the assembly of virus proteins inside the cell into mature viruses (step 3).

Combined with AZT and other NRTIs, these agents block the multiplication of HIV: the amount of virus in the blood decreases and the CD4 count stops falling and increases, protecting the patient against opportunistic infections. By blocking several steps in the multiplication of the virus, the risk of resistant virus is also greatly reduced.

These drugs have a huge impact on the prognosis of HIV infection, with dramatic decreases in mortality, rates of development of AIDS in patients

Table 1: Anti retroviral Treatment Categories

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<thead>
<tr>
<th>Treatment Class</th>
<th>Drug Name(s)</th>
<th>Approximate Cost per month, baht</th>
<th>Usual Adult Dose</th>
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<tr>
<td>Nucleoside Reverse Transcriptase Inhibitors (NRTIs)</td>
<td>Zidovudine (AZT or ZDV)</td>
<td>1,200</td>
<td>300 mg bid or 200 mg tid</td>
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<td></td>
<td>Stavudine (d4T)</td>
<td>30 mg dose: 300 40 mg dose: 360</td>
<td>&lt;60 kg: 30 mg bid &gt;60 kg: 40 mg bid</td>
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<td></td>
<td>Didanosine (ddI), tablets</td>
<td>400 mg qd: 6,000 250 mg qd: 3,750</td>
<td>&gt;60 kg: 400 mg qd or 200 mg bid &lt;60 kg: 250 mg qd or 1.25 mg bid</td>
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Combining with AZT and other NRTIs, these agents block the multiplication of HIV.
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<tr>
<td>Treatment Class</td>
<td>Drug Name(s)</td>
<td>Approximate Cost per month, baht</td>
<td>Usual Adult Dose</td>
<td></td>
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<tr>
<td>NRTIs</td>
<td>Zalcitabine (ddC)</td>
<td></td>
<td>0.75 mg tid</td>
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<tr>
<td></td>
<td>Lamivudine (3TC)</td>
<td>720</td>
<td>150 mg bid or 300 mg qd</td>
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<td></td>
<td>Abacavir (ABC)</td>
<td></td>
<td>300 mg bid or 600 mg qd</td>
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<td></td>
<td>Emtricitabine (FTC)</td>
<td></td>
<td>200 mg qd</td>
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<tr>
<td></td>
<td>Tenofovir (TDF)</td>
<td></td>
<td>300 mg qd</td>
<td></td>
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<tr>
<td>Protease Inhibitors (PIs)</td>
<td>Indinavir (IDV)</td>
<td>9,000</td>
<td>800 mg q8h</td>
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<td></td>
<td>Ritonavir (RTV)</td>
<td>31,500</td>
<td>300 mg q12h</td>
<td></td>
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<tr>
<td></td>
<td>Nelfinavir(NFV)</td>
<td></td>
<td>1250 mg bid or 750 mg tid</td>
<td></td>
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<td></td>
<td>Saquinavir (SQV)</td>
<td>Fortovase: 21,600</td>
<td>1200 mg tid</td>
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<td></td>
<td>Amprenavir (APV), caps</td>
<td></td>
<td>&gt;50 kg: 1200 mg bid</td>
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<tr>
<td></td>
<td>Fosamprenavir (FPV)</td>
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<td>1400 mg bid</td>
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<td></td>
<td>Lopinavir (LPV, mixed with RTV as LPV/r)</td>
<td>400 mg LPV + 100 mg RTV bid</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Atazanavir (ATV)</td>
<td></td>
<td>400 mg qd</td>
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<tr>
<td>Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)</td>
<td>Nevirapine (NVP)</td>
<td>1,260</td>
<td>200 mg qd for 14 days, then 200 mg bid</td>
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<tr>
<td></td>
<td>Efavirenz (EFV)</td>
<td>3,150</td>
<td>600 mg qhs</td>
<td></td>
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<tr>
<td></td>
<td>Delavirdine (DLV)</td>
<td></td>
<td>400 mg tid</td>
<td></td>
</tr>
<tr>
<td>Pills containing combined drugs</td>
<td>Comvir or Zilavir (AZT + 3TC)</td>
<td>1,680</td>
<td>1 tablet bid</td>
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<tr>
<td></td>
<td>GPOvir (d4T, 3TC, NVP)</td>
<td>d4T dose: 30 mg: 1,320, 40 mg: 1,500</td>
<td>1 tablet bid</td>
<td></td>
</tr>
</tbody>
</table>

Prices per Chiang Mai University Hospital pharmacy, 2005. Prices elsewhere may differ. Many drugs also are less expensive when used in combination. Finally these prices also do not include other costs such as blood tests and checkups, which are needed.

infected with HIV, and hospitalizations as a result of complications of HIV infection. Because they work so well, these treatment combinations are often called potent combination ART, or Highly Active Anti Retroviral Therapy (HAART). When HAART first emerged, there was hope that HIV could be cured or that patients could take
မိရိုး အစိတ်အပိုင်းခွင့်ပြုချက်ခြင်း

မိရိုးအစိတ်အပိုင်းခွင့်ပြုခြင်း အသစ်ကို ဖော်ပြရန် သဘောတူညီချက်များအား ပြောပြပါ။ သို့သော် ပြောပြန်ရန် မလိုအပ်ဖွယ်ပြုချက်ခြင်း သို့မဟုတ် ပြောပြန်ရန် မလိုအပ်ဖွယ်ပြုခြင်း မရှိကြပါ။

မိရိုးအစိတ်အပိုင်းခွင့်ပြုခြင်း အသစ်ကို ဖော်ပြရန် သဘောတူညီချက်များအား ပြောပြပါ။ သို့သော် ပြောပြန်ရန် မလိုအပ်ဖွယ်ပြုချက်ခြင်း သို့မဟုတ် ပြောပြန်ရန် မလိုအပ်ဖွယ်ပြုခြင်း မရှိကြပါ။
Treatment of HIV demands strict adherence, meaning that the patient takes the prescribed dose of the prescribed medication at the prescribed schedule, following prescribed dietary instructions. Even missing a few doses a month greatly increases the risk of resistance of the virus to ART and treatment failure. This can be especially a problem where the cost of these treatments are too high and/or where there are other issues that make it difficult to ensure a continuous source of medications or other supplies and services.

Who should start treatment?
Not all patients with HIV infection need ART. The decision to start it or not should balance out the risks with the benefits of treatment. Although treatment can improve the patient's immune function and his or her health and quality of life, it is associated with the risk of side-effects and the development of resistance, in addition to, increased cost. Thus, they should not be started unless the patient needs it. In addition, the patient must also understand these risks and benefits, especially the importance of adherence, and be willing to start what are some of the most complicated and difficult medicines to take. Close counseling, support, and patient education are important steps that must happen before starting HAART indefinitely, like other chronic medical conditions such as hypertension or diabetes. These have not proven to be the case. There is no cure for HIV. Current medications only control the multiplication of the virus. Stopping medications quickly results in re-emergence of the virus in the blood. Furthermore, many patients cannot take the same HAART combinations indefinitely: serious side effects, both short and long term, are common, resulting in patients eventually having to change or stop their treatment. Many of these medications also have interactions with other drugs the patient may be taking, such as for tuberculosis. Lastly, the virus continues to develop resistance in many patients, resulting in the drug's failure to control HIV. Unlike chronic medical conditions such as hypertension, treatment of HIV...
အောက်ပါ စာပိုဒ်တွင် အစိုးရအဝေး နေသူများ မိုးစေရန် ဖန်တီးစေသည်။ ဗိုလ်ချုပ်မှာ အပြည်ပြည်သူ အစိုးရ အားနုပိုင်ရှင် (၂၀၁၃) အတွက် အသုံးပြုသော ကာကွယ်ရေးလုပ်ငန်း (လေးသော အသုံးပြုသော ကာကွယ်ရေးလုပ်ငန်း) တွင် အခြေခံသော သောက်ရှိသည်။ အကြောင်းအရာ ပြောပြသော အခါမှ မိုးလျှင် မိုးစေရန် ဖန်တီးကာ မိုးစရာ မိုးစေရန် ဖန်တီးကာ မိုးစရာ

မိုးဦးစီးသောလူများသည်

ဖျင်သွားပါက ပြင်သစ်များသည်

စိုးရိမ်မှုကို အထိမ်းအမှတ်ပြုသော ချိုးဖျင်သွားပါက ပြင်သစ်များ၊ နေသောက်ဦးစီးသည်

မိုးဦးစီးသောလူများသည်

ဖျင်သွားပါက ပြင်သစ်များသည်
treatment. **ART cannot be started if the patient is not ready to do so.**

The decision to start should then take into account three main factors: the CD4 count, the viral load, and clinical symptoms.

When CD4 count is available, the WHO recommends that all patients with a CD4 count less than 200 cells/mm³ should start the treatment, as their death risk is really high without any treatment. For those with a CD4 count in the middle range (200-350 cells/mm³), the benefits of treatment should be carefully weighed against the risks. For patients with WHO Stage III (moderate) disease AND a CD4 count <350 cells/mm³, treatment should be offered as they have clinical evidence of immune deficiency. For patients with a CD4 count above 200 cells/mm³ BUT with no or mild symptoms (stage I or II disease), the WHO recommends a monitoring with no start of ART yet.

If the CD4 count is not available, all patients with stage III or IV should be offered treatment. For patients with clinical symptoms (Stage II disease), the total lymphocyte count (TLC) can be used. Those patient with stage II disease AND a TLC < 1200 cells/mm³ should also be offered treatment. However, TLC is not reliable for the clinical stage I. Thus, treatment is not recommended.

Measuring viral load testing is expensive and complicated and thus is not considered necessary before starting ART.

The WHO also recommends ART to be started for all persons whose HIV infection has been confirmed AND having advanced HIV disease. These include all patients with clinical AIDS (WHO Stage IV or Severe Disease), regardless of CD4 count, as these patients are at high risk of further clinical deterioration and death without ART.

### What treatments should be started?

Suppressing HIV usually requires using 3-4 drugs in combination that have been shown to work well in clinical trials (HAART). Except for prevention of maternal to child transmission in pregnant women, 1 or 2 drugs should never be used in the treatment of HIV infection as resistance can quickly arise. Currently, the recommended


| စီစီစွဲများ တွေငါးမျိုး စီစွဲများ တွေ ကြည့်ရှုဖို့ ကြည့်ရက် | စီစွဲများ တွေငါးမျိုး 
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starting combinations are two nucleoside reverse transcriptase inhibitors (NRTIs) AND either a non-nucleoside reverse transcriptase inhibitor (NNRTI) OR a protease inhibitor (PI), preferably a ritonavir-boosted PI or nelfinavir. In some cases, three NRTIs can be used, which makes it easier to take. However, studies have shown that this is less effective.

In some cases, several medications are combined together into one pill, which makes taking it easier. An example of this is GPOvir, containing two NRTIs (stavudine or d4T and lamivudine or 3TC) and an NNRTI (nevirapine), made by the Thai Government Pharmaceutical Organization. Because it has all the recommended drug classes, this can be taken by itself, once in the morning, and once at night. Another commonly seen combination pill is Combivir (also called Comvir or Zilavir), containing zidovudine (AZT) and lamivudine (3TC). Unlike GPOvir, because this only has two NRTIs, a third drug, either a PI or NNRTI, must also be taken with it. In the case of many PIs, such as lopinavir, indinavir, and saquinavir, another PI, ritonavir, is mixed into the pill (ritonavir-boosted PIs). This is to help increase the blood levels of the other PI and make it more effective; these are considered as one medication, NOT a combination. Preferred, possible initial combinations are stated in the table below.

Which combination is chosen depends on provider and patient preference, taking into account such issues as the

| Table 2: Preferred Initial Regimens: Choose one from Column A and one from Column B. |
|-----------------------------------------------|---------------------------------|
| Column A: 2 NRTIs                             | Column B: PI or NNRTI           |
| Zidovudine (AZT) + Lamivudine (3TC)           | Efavirenz (EFV)                 |
| Stavudine (d4T) + Lamivudine (3TC)            | Nevirapine (NVP)                |
| Zidovudine (AZT) + Didanosine (ddl)           | Indinavir + Ritonavir (RTV/IDV) |
| Didanosine (ddl) + Lamivudine (3TC)           | Lopinavir + Ritonavir (LPV/r)   |
|                                                | Saquinavir + Ritonavir (RTV/SQV) |
|                                                | Nelfinavir (NFV)               |
မြှင့်တင်သည့် စာတွဲများ

စာချက်များသည် ပြည်တွင်း စာရေးလုပ်ငန်းများကို ဖော်ပြသည်။ ဗိသုကာစာရေးလုပ်ငန်းများကို အခြေခံများကို ဖော်ပြသည်။ စာရေးလုပ်ငန်းများကို တင်ပြသည်။

မြန်မာလိုက်စာပိုဒ်များ

စာရေးလုပ်ငန်းများကို အခြေခံများကို ဖော်ပြသည်။ စာရေးလုပ်ငန်းများကို တင်ပြသည်။

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number of pills, possible side-effects, drug interactions, other conditions or illnesses of the patient, and dietary restrictions. In many countries, cost is also an important issue, which prevents many patients from starting combinations containing PIs.

A complete medical history and clinical assessment must be performed before starting ART. Particularly important are current medications, illnesses (such as tuberculosis), and conditions (such as pregnancy), which can affect the choice of treatment for HIV. Before starting treatment, patients should also be educated about each agent, in particular side-effects. No combination is the best for every patients: treatment should be individualized as well as possible. Treatment success occurs through the building of trusting and long-term relationships between the provider and the patients. Particularly early in the process of starting ART, intensive counseling and patient education are really important, as well as frequent follow-up visits to check the side-effects and encourage adherence.

At the minimum, laboratory tests should be performed including hemoglobin (or hematocrit) if the patient is starting on a zidovudine (AZT), whose common side-effect is anemia. Other helpful tests include a white blood count with differential, CD4 count, AST (SGOT) and ALT (SGPT) levels, BUN and creatinine, glucose, and bilirubin levels. For women, a pregnancy test should be performed, and all women started on efavirenz should receive contraception (efavirenz should not be used during pregnancy, especially during first trimester due to risk of birth defects).

The patient should return within two weeks following initiation of ART for monitoring, based on patient report and physical examination. The medication combination used and the symptoms that arise can guide further laboratory tests that are done in the follow-up visit.

**When should treatments be changed?**

Treatments may need to be changed if there is treatment failure, significant
side-effects, or intolerance. There are several types of treatment failure that can occur after a patient has been started on HAART, all of which can require changing the medications used. Virologic failure is the failure of treatment to reduce viral multiplication in the blood to below detectable amounts and is diagnosed by checking a patient’s viral load. This may occur because the virus has become resistant to the drug or because the drug is failing to reach the virus (poor absorption of the drug, drug interactions, and poor adherence). Because viral load tests are expensive and frequently unavailable, we often rely on monitoring for immunologic and clinical failure, which can occur because of virologic failure.

In immune reconstitution syndrome, the signs and symptoms of an opportunistic infection occur because of inflammation by against a subclinical infection, which happens because the immune system is recovering.

Side-effects are common with ART, varying in severity or its implications. Some, such as nausea and vomiting are frequently seen, which can limit adherence. Some side effects of medications can be life threatening. These include Stevens Johnson Syndrome with NNRTIs, nevirapine associated hepatic necrosis, pancreatitis from didanosine (ddl), and lactic acidosis from nucleosides (NRTIs). The last complication is rare but has a high mortality rate, and is seen mostly with d4T and ddl, especially if they are used together. Thus, this combination of drugs is no longer recommended by the WHO.

Symptoms often are non specific, including fatigue, loss of appetite, nausea and vomiting, abdominal pain, and shortness of breath. If this is suspected, the ART should be stopped immediately and, if possible, the diagnosis should be confirmed with a serum lactate level.

It is important to distinguish between treatment failures and side-effects since the way to deal with these two problems are different. For treatment...
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<th>d4T/3TC/NVP</th>
<th>d4T</th>
<th>AZT</th>
</tr>
</thead>
<tbody>
<tr>
<td>d4T</td>
<td>d4T &amp; ABC &amp; TDF</td>
<td></td>
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<tr>
<td>NVP</td>
<td>NVP &amp; EFV</td>
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<tr>
<td>AZT</td>
<td>AZT &amp; d4T</td>
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<td>NVP</td>
<td>NVP &amp; EFV</td>
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<td>NVP</td>
<td>NVP &amp; PI</td>
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<tr>
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<td>d4T &amp; AZT</td>
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<td>d4T &amp; ABC &amp; TDF</td>
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<td>EFV</td>
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<td>AZT/3TC/EFV</td>
<td>AZT &amp; d4T</td>
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<td>EFV</td>
<td>EFV &amp; NVP</td>
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<tr>
<td>Regimen</td>
<td>Toxicity</td>
<td>Drug Substitution</td>
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<td>--------------</td>
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<tr>
<td>d4T/3TC/NVP</td>
<td>d4T-related neuropathy or pancreatitis</td>
<td>Change d4T for AZT</td>
</tr>
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<td></td>
<td>d4T-related lipoatrophy</td>
<td>Change d4T for ABC or TDF (if not available, consider AZT or ddl)</td>
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<tr>
<td></td>
<td>NVP-associated severe hepatotoxicity</td>
<td>Change NVP for EFV (Except pregnancy in 1st trimester)</td>
</tr>
<tr>
<td></td>
<td>NVP-associated severe rash (non-life-threatening)</td>
<td>Change NVP for EFV (Except pregnancy in 1st trimester)</td>
</tr>
<tr>
<td></td>
<td>NVP-associated life-threatening rash (Stevens-Johnson Syndrome)</td>
<td>Change NVP for a PI</td>
</tr>
<tr>
<td>AZT/3TC/NVP</td>
<td>AZT-associated persistent GI intolerance or severe hematologic toxicity</td>
<td>Change AZT for d4T</td>
</tr>
<tr>
<td></td>
<td>NVP-associated severe hepatotoxicity</td>
<td>Change NVP for EFV (Except pregnancy in 1st trimester)</td>
</tr>
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<td></td>
<td>NVP-associated severe rash (non-life-threatening)</td>
<td>Change NVP for EFV (Except pregnancy in 1st trimester)</td>
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<td></td>
<td>NVP-associated life-threatening rash (Stevens-Johnson Syndrome)</td>
<td>Change NVP for a PI</td>
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<tr>
<td>D4T/3TC/EFV</td>
<td>d4T-related neuropathy or pancreatitis</td>
<td>Change d4T for AZT</td>
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<td></td>
<td>d4T-related lipoatrophy</td>
<td>Change d4T for ABC/TDF (if not available, consider AZT or ddl)</td>
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<td>EFV-associated persistent CNS toxicity</td>
<td>Change EFV for NVP</td>
</tr>
<tr>
<td>AZT/3TC/EFV</td>
<td>AZT-associated persistent GI intolerance or severe hematologic toxicity</td>
<td>Change AZT for d4T</td>
</tr>
<tr>
<td></td>
<td>EFV-associated persistent CNS toxicity</td>
<td>Change EFV for NVP</td>
</tr>
</tbody>
</table>

Table 3: Major Toxicities of Common First-line agents and recommended drug substitutions (from WHO)

failure, the entire regimen may need to be changed. For toxicity or side effects particularly those that limit adherence or are life threatening, changing the offending drug for one in the same class is often the answer. Sometimes all the drugs have to be stopped, with ART restarted only when the substitute drug becomes available. For example, for a patient who cannot tolerate zidovudine (AZT), stavudine (d4T) is often substituted. Another common substitution is using the NNRTI nevirapine (NVP) for another NNRTI, efavirenz (EFV), because of central nervous system symptoms or
စီးပွားရေးနှင့် အတူအတူ သမိုင်းသစ်အများကို ဖော်ပြရန် ပြုလုပ်သည်။ 

- ကျောင်းသားများ၏ အတိုကောက်အားဖော်ပေးနေသည်။ 
- သွားလို့မှာ ပြန်လာခြင်း။ 
- ထို့ပြင် သီရိပါဝင်သူများ၏ အပွဲများကို ပြသည်။ 
- ထို့ပြင် ကျောင်းသားများ၏ အခြေခံမှုများကို ပြသည်။ 
- ထို့ပြင် သီရိပါဝင်သူများ၏ အခြေခံမှုများကို ပြသည်။ 

- ကျောင်းသားများ၏ အပြားလောက်သော အခြေအနေများနှင့် ပတ်သက်သော အခြေအနေများကို ပြသည်။ 
- ကျောင်းသားများ၏ အပြားလောက်သော အခြေအနေများနှင့် ပတ်သက်သော အခြေအနေများကို ပြသည်။ 
- ကျောင်းသားများ၏ အပြားလောက်သော အခြေအနေများနှင့် ပတ်သက်သော အခြေအနေများကို ပြသည်။ 

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- ကျောင်းသားများ၏ အပြားလောက်သော အခြေအနေများနှင့် ပတ်သက်သော အခြေအနေများကို ပြသည်။ 
- ကျောင်းသားများ၏ အပြားလောက်သော အခြေအနေများနှင့် ပတ်သက်သော အခြေအနေများကို ပြသည်။
ART does not prevent transmission of HIV; condoms should be used every time the patient has sex.

After ART has been started, the patient should be closely monitor for side effects, adherence, and response to therapy. At follow-up, all patients should have clinical evaluations of signs and symptoms, with additional laboratory testing done depending on these findings. For example, patients on nevirapine (NVP) who have signs and symptoms of hepatic toxicity should have their AST and ALT checked, and patients on AZT who may have anemia should have a hemoglobin level checked. Efficacy can be monitored through checking a CD4 count every 6-12 months, if possible, and monitoring for clinical failure.

Although ART has changed the way we care for HIV, like many other medical conditions, it requires a partnership for success. ART is only one part of the care of patients: don't forget, you are not treating the virus, you are treating the patient. The complete care of the patient with HIV is beyond the scope of this chapter. However, it is, at minimum, important to:
- review drugs at every visit, noting dosage, how and when the patient is taking them, and toxicities or side effects.
- have ongoing patient education and give the opportunity for the patient to ask questions. In particular, it is important to stress that taking ART is an ongoing commitment: we only have limited amounts of drugs, if they are incorrectly taken can cause resistance, which means fewer choices and less effective treatments left for the patient. The patient should also not share his or her medications with others.

- review HIV risks and transmission: emphasize that ART does not prevent transmission of HIV; condoms should be used every time the patient has sex and, if the patient uses drugs, he or she should not share needles or drug equipment. These are important even if the partner is also HIV-infected as viruses resistant to ART may spread this way, in addition to other diseases such as STIs and hepatitis.
- monitoring and treatment of other conditions, including reproductive health issues (such as gynecologic problems and family planning), substance abuse, and nutrition.
- Last but not least, treat and prevent opportunistic infections. Don't forget that most people with HIV don't die of HIV, they die because of opportunistic infections. In particular, cotrimoxazole should be started in all patients with WHO stage II, III, or IV disease.

Note: For more details about HIV infection, including symptom management and treatment of opportunistic infections, please refer to issue number 25 of Health Messenger, which is devoted to the broad topic of HIV infection.
င်ဗျင်သာဖြစ်သော အိုးပိုင်ဆိုင်မှုများ

မှန်သောသောကြောင့် အစဉ်အမှတ်အသားများကို သေချင်းချင်သော အစိတ်အပိုင်းများကို အသုံးပြုသည်။

အစဉ်အမှတ်အသားများကို သေချင်းချင်းသည်ကို သေချင်းချင်သော အစိတ်အပိုင်းများကို အသုံးပြုသည်။

ခံစားဆောင်ရွက်ခြင်းများကို သေချင်းချင်သည်ကို သေချင်းချင်သော အစိတ်အပိုင်းများကို အသုံးပြုသည်။
Nutrient requirements for people with HIV/AIDS

Adapted from World Health Organization Report of a Technical Consultation, 2003
(Andrea M. Menefee, TBBC)

Good nutrition is very important for optimal health and survival for everyone, regardless of HIV status. Good nutrition can be best achieved through eating a balanced and healthy diet.

For people with HIV/AIDS, good nutrition is especially important, since people with HIV/AIDS may have weight loss. Weight loss and wasting in people with HIV/AIDS is mainly due to the higher energy needs (kilocalories = energy from all foods) that come from infection and from frequent diarrhea and other infections. This article provides the latest information and recommendations from the World Health Organization for nutrition in people with HIV/AIDS.

Adults

Energy

Energy needs is required to increase by 10% in asymptomatic HIV infection to maintain body weight in asymptomatic HIV-infected adults. This can be gained by eating some extra rice and curry at breakfast and dinner, and eat lunch.

In case of symptomatic HIV and AIDS, it should be increased by 20% to 30% in order to maintain adult body weight during infection. One must eat a lot of extra rice and curry during breakfast and dinner. Eat a big lunch and eat some snacks between meals. It may not be possible for a person to eat that much during infection or illness. Therefore, people with symptomatic HIV should eat as much as possible when they are recovering from infection.

In the camps, supplementary feeding is provided to all people with chronic infections, including people with HIV. The supplementary feeding provides about 30% extra kilocalories. Families of people with HIV should encourage them to eat supplementary food every day.

Protein

Protein should follow normal requirements for healthy people. Protein can be found in variety of food: meat, dairy products, eggs, and lentils are rich source of protein. It is recommended to eat plenty of rice, beans, oil, etc. plus vegetables, meats, egg, etc. AsiaMIX provides plenty of good protein.
နောက်ဆုံးဖြစ်စေရန် ကျွန်ုပ်တို့ အခြေခံရန် အားလုံးကို ဖော်ပြရန် လိုအပ်ပါသည်။ ၎င်းတို့ကို အပြင်ထားသော အရေးအမြင်များ အချိန်ထားသော အရေးအပေါ်များ အလေးအကိုင်များ အရွယ်အစားများ လိုအပ်ပါသည်။ ၎င်းတို့ကို လက်ရှိစာရင်း လိုအပ်ပါသည်။

မြောက်ဘက်တွင် မိုးမှားစွာ မှန်ကန်သော အချက်အလက်များ အသုံးပြုပါသည်။

အခြားသော အရေးအမြင်များကို အလေးအကိုင်များ လိုအပ်ပါသည်။

ထိုသော အချက်အလက်များ အသုံးပြုပါသည်။

အခြားသော အရေးအမြင်များကို အလေးအကိုင်များ လိုအပ်ပါသည်။

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ထိုသော အချက်အလက်များ အသုံးပြုပါသည်။

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အခြားသော အရေးအမြင်များကို အလေးအကိုင်များ လိုအပ်ပါသည်။

ထိုသော အချက်အလက်များ အသုံးပြုပါသည်။
Fat
Fat should follow normal requirements for healthy people. Plenty of rice, beans, oil, etc. plus vegetables, meats, egg, etc. should be taken. Be sure to use oil in all meals.

Micronutrients
HIV-infected adults should eat a diet that ensures they get at least the same amount of micronutrients as healthy adults. Micronutrients should follow normal requirements for healthy people. To obtain sufficient levels of micronutrients, one should eat plenty of rice, beans, oil, etc. plus vegetables, meats, egg, etc. AsiaMIX provides many important vitamins and minerals.

Children

Energy
Asymptomatic HIV infected children are required to increase energy by 10% to maintain growth. They must eat some extra rice and curry at breakfast and dinner, always eat lunch, and have at least 2 snacks between meals.
When the disease progresses to symptomatic HIV and AIDS, the energy needs is required to increase by 50% to 100% over normal requirements so that those children who have weight loss will be increased again. They should be fed with a lot of extra rice and curry during breakfast and dinner and eat a big lunch. Have a big snack mid morning, mid afternoon, and before bed.
Normal guidelines should be followed to treat malnourished children.

Protein
Protein should follow normal requirements for healthy children. Normal requirements can be obtained by eating plenty of rice, beans, oil, etc. plus vegetables, meats, egg, etc. AsiaMIX provides plenty of good protein.

Fat
Fat should follow normal requirements for healthy children. The children should eat plenty of rice, beans, oil, etc. plus vegetables, meats, egg, etc. AsiaMIX provides many important vitamins and minerals.
Micronutrients
Vitamin A supplementation has been shown to reduce all-cause mortality and diarrhoea morbidity in vitamin A deficient children, including HIV infected children.
- supplement children 6 to 59-month-old who are born to HIV-infected mothers every 4-6 months (100,000 IU for infants 6 to 12 months and 200,000 IU for children > 12 years)
- supplement HIV-infected children 6-59-month-old children every 4-6 months (100,000 IU for infants to 12 months and 200,000 IU for children > 12 months).

-Pregnant and lactating women-

Energy
Similar recommendations for energy for adults are applied to pregnant and lactating women.

Protein
Protein should follow normal requirements for healthy pregnant and lactating women. It can be acquired in similar ways by eating supplementary feeding foods, plus plenty of rice, beans, oil, etc. plus vegetables, meats, egg, etc. Use oil from supplementary feeding to make AsiaMIX.

Fat
Fat also should follow normal requirements for healthy pregnant and lactating women. To meet the requirements, one has to eat supplementary feeding foods, plus plenty of rice, beans, oil, etc. plus vegetables, meats, egg, etc. Use oil from supplementary feeding to make AsiaMIX.

Micronutrients
Iron-folate supplementation
Iron-folate supplementation is a standard part of antenatal care for preventing anaemia and improving fetal iron stores during pregnancy and lactation.

Vitamin A
Vitamin A intake should follow normal requirements for healthy pregnant and lactating women (Daily vitamin A intake by HIV infected women during
pregnancy and lactation should not exceed the RDA).

* supplement lactating women once as soon as possible after delivery, but no later than six weeks after delivery (200 000 IU).

**Multiple micronutrient supplements**
During pregnancy, daily multivitamin supplementation with B-complex vitamins, and vitamins C and E, improved birth outcomes in infants born to HIV-infected women, and increased maternal weight gain during pregnancy, haemoglobin concentration and CD4 cell counts. Daily use of multivitamin supplements during lactation reduced postnatal HIV transmission and mortality in infants born to nutritionally vulnerable women and to women with immune deficiency. The supplements also reduced the risk of diarrhoea and improved infants' immune status.

Detail information on nutrition can be found in Health Messenger Magazine issue 26.

**Terms Used**

Diet: All the foods we normally eat (eg rice + beans + AsiaMIX + oils + vegetables + salt + fishpaste, etc).

Energy: The amount of energy - kilocalories - that comes from foods we eat - it includes carbohydrates, protein, and fat. On average, we need at least 2,100 kcal per day. Carbohydrates rich foods include rice, noodles, bread, potato, corns and flour mixed food.

Protein: Provides energy, and helps develop muscle, helps children grow, and repairs the body after illness or injury. Main protein foods are: chicken, pork, beef, fish, crab, also eggs and milk, and plant protein like beans, nuts, red beans and soyabeans.

Fat: The part of foods that provides energy and helps us use vitamins like vitamin A and E. Nutrients rich in fat are: oil, meat and refined sugar.

Micronutrients: Vitamins and minerals are necessary for survival, growth, optimal body function. Micronutrients do not provide any energy, but help immune system function, protect us from disease, and help build and maintain the many components of our bodies, including blood skin, teeth, bones, etc. Vitamins and mineral are commonly found in dark green and orange vegetables like pumpkins, tomatoes and fruits like papaya, mango, oranges, etc.

Symptomatic: Infection with signs/symptoms - eg diarrhea, pneumonia, oral fungus, etc.
Asymptomatic: Infection without any signs/symptoms - a person may not know they are infected because they look and feel healthy.
ရောဂါစောင်မှာ သူ့ကွဲပြားနေပါသော ပုံဖော်တစ်ပြင် အများအားဖြင့်
အကြောင်းကြောင့် တောင်းဆိုခြင်းကို ပြောပြီး ကြည့်ရှုနိုင်ပါသည်။

အသိအမှတ်

ပေးပိုလျော်စွာ အသိအမှတ် ချောင်းရေးသား လိုအပ်သည်။

ချိန်အလိုက် တာဝန်များကို ရရှိနိုင်ရန် 

အများအားဖြင့် လူမှုကို ချောင်းရေးသား လိုအပ်သည်။

စျေးနောက်ပိုင်း

ပေးပိုလျော်စွာ စျေးနောက်ပိုင်း ကြည့်ရှုနိုင်ခြင်းကို ပြောပြီး ကြည့်ရှုနိုင်ပါသည်။

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Tuberculosis (TB) is a frequent and treatable cause of morbidity and mortality in HIV-infected patients.

Most cases are caused by reactivation of dormant TB infection secondary to decreased cell mediated immunity. Mycobacterium tuberculosis is transmitted by respiratory droplets spread by coughing, sneezing, or talking. The infectious droplets may remain airborne for up to 48 hours.

Clinical presentation
In patients with earlier stages of HIV disease (CD4 cell counts of 300 cells/mm$^3$ or above), the presentation tends to be similar to those without immunodeficiency. A productive cough of several weeks duration, haemoptysis, fever, and weight loss are common. Chest x-ray reveals focal infiltrates and cavities involving the upper lobes.

In patients with more pronounced immunodeficiency (CD4 counts of less than 200 cells/mm$^3$) the features of tuberculosis tend to be atypical, with greater frequency of extra pulmonary involvement and diffuse pulmonary disease without cavitations.

Patients with advanced HIV disease more often have miliary TB and involvement of the lymphatic system, central nervous system, soft tissue, bone marrow, liver, and other viscera.

Fever is common, but cough may not be present. There may be a prior history of tuberculosis. Chest X-ray may demonstrate involvement of any lobe of the lungs, and the clinical presentation may be indistinguishable from a community acquired pneumonia. Cervical, hilar, paratracheal or mediastinal adenopathy are highly suggestive of tuberculosis.

Diagnosis
Sputum acid-fast bacilli (AFB) smears are positive in half of patients. Chest x-rays may not show classic upper lobe infiltrates. Diffuse, interstitial, or lower-lobe infiltrates, often with prominent hilar and paratracheal enlargement, are common findings.

If TB is strongly suspected, empiric therapy should be initiated.

Once the diagnosis of TB is made or appears likely, contact investigation should be initiated (for confirmed cases) and exposure of additional persons should be prevented.

Treatment
The recommended initial treatment regimen for patients with HIV infection and new TB consists of 2
months of daily isoniazid (H), rifampin (R), pyrazinamide (Z), and ethambutol (E), followed by 4 to 7 months daily or twice-weekly HR. In non new TB, add streptomycin (S) injectable in the first 2 months.

Rifampicin induces the activity of cytochrome P-450 in the liver, an enzyme that lowers the concentration of HIV protease inhibitors (PI) and non-nucleoside reverse transcriptase inhibitors (NNRTI) to subtherapeutic levels. Low plasma levels of ART are associated with incomplete viral suppression and the emergence of the drug resistance. Therefore, concomitant administration of rifampicin with these drugs is not recommended.

Initiation of HIV treatment: do not initiate treatment of both TB and HIV simultaneously due to overlapping drug toxicities, drug interactions, adherence requirements, and possible paradoxical reactions (immune reconstitution). If antiretroviral therapy (ART) was previously started, then continue if important benefit and adherence has been shown [nevirapine (NVP) needs to be replaced by efavirenz (EFV) though] or stop if bad clinical condition, concern for drug adherence, and in PI concomitant treatment. If ART was not previously started, avoid initiating treatment of both and always treat TB first with ART introduced after 8 weeks.

\[ CD4 < 200 \text{ cells/mm}^3 \]: Start ART before the end of the TB treatment with EFV-based ART, ideally after the patient has been stabilized on TB treatment.

\[ CD4 > 200 \text{ cells/mm}^3 \]: Defer ART.

Monitoring Therapy: regular follow up for sputum smears until they become negative which monitors response of pulmonary tuberculosis therapy. Sputum smears typically become negative after the first month. Monthly clinical assessments is done with special warn of symptoms of hepatitis (nausea, vomiting, dark urine, fever, malaise) and cutaneous hypersensitivity. LFTs, CBC, Creatinine or BUN, visual acuity (E), uric acid (Z).

Screening and prevention

Tuberculin skin testing. All HIV infected persons who do not have active TB should be screened for TB by tuberculin skin testing. When a reactions = 5mm or there is evidence of contact with active pulmonary TB, prophylaxis should be initiated with H 300mg/day po + pyridoxine 10 mg/day x 9 months.

References
ပလူးစိုးရိုက်ကူးစွေ့မှုပြုပြီးသော စာမျက်နှာဒလ်ဖန်တီးမှုအား ပြုလုပ်ပါ။

စာမျက်နှာကို ပြောင်းပြန်သွင်းနိုင်သည်။

HEALTH MESSENGER: 76
Responding to bad news: including HIV/AIDS result

Adapted from World Health Organization, Handbook on AIDS Home Care, 1996

Trying to understand people living with HIV/AIDS is really important. The feelings they may experience are described in this article.

As we all know, there is no curative therapy for HIV infected people. Treating and preventing the opportunistic infections and using anti retroviral drugs, we can manage the physical well being of the PLWHA. More difficult to handle is the psychological consequences encountered in them.

Before VCT, one may be anxious with the possible outcomes. When the HIV positive status is known, the responses can be variable. Even when one is already expected to be HIV positive because of his/her risky behaviour, s/he may react with different stages of emotional changes.

People who find out that they have HIV infection or AIDS, or learn that someone important to them has HIV or AIDS, may experience many different feelings such as anger, fear, and sadness. Each of the following feelings or reactions is part of a normal response to a situation of great stress. A person might move from one response to the next in a progression leading finally to acceptance of their situation or, more commonly, their feelings will keep changing. One day they may feel rejected and lonely; and the next day, hopeful and energetic. One day depressed, another day angry.

Let us look at each of these reactions, and observe how people with HIV/AIDS differ in their emotional responses.

1. SHOCK

When people experience shock or loss, they have feelings or emotions called "loss reactions". These feelings usually occur when new and serious problems like HIV and AIDS are confronted. Most people are frightened of HIV/AIDS. No matter how much someone is prepared, it is a shock to learn that one has HIV infection or AIDS. People might feel confused, not knowing what to do. At this time, it is good to be with someone they trust.

No matter how much someone is prepared, it is a shock to learn that one has HIV infection or AIDS.
2. DENIAL
Sometimes, people may deny having the disease at all. Feelings of denial can cause family communication to break down. Denial, unfortunately, is a very common reaction, which delays positive action. Any positive reaction can start after getting over this reaction.

At first, a person might not be able to accept that s/he really has HIV/AIDS. They might think 'the doctor must be wrong or it can't be true' (no willingness to accept is due to the fear of AIDS and everything the illness implies). Denial may come from the fear of being rejected by loved ones. If you are trying to help a person in similar situation, don't be angry or impatient with him as he will not be able to face facts. Try to remember that, as a care provider, you can help the person try to explore what HIV or AIDS means. This is the best way to help overcome denial.

3. ANGER AND BLAME
A person might become very angry when he learn that he has HIV or AIDS. This is a common feeling. He will generally blame himself or the person who might have infected him with HIV. Some may even blame God.

Anger is normal but it may not be helpful since it focuses on blaming others (being angry with them) or oneself (feeling guilty), rather than taking positive actions. Talking to someone whom he confides in can help a person to overcome his/her feelings of anger and to accept the situation.

If you are trying to help someone with HIV or AIDS, anger is a difficult reaction to cope with, especially when it is directed at you. It is important for you to try to understand and not take the anger personally, even if it is difficult to receive anger without responding.

4. BARGAINING
A person with AIDS might try to bargain, thinking, 'God will cure me if I stop having sex or the ancestors will make me better if I slaughter a goat or I will be good and it will go away'. People with HIV or AIDS need to be helped to accept the reality.

5. FEAR
People with HIV or AIDS fear many things. For example,
- Pain, Death
- Losing their job and dignity
- Losing their marriage, friends and family, rejection, leaving their children
- Other people knowing that they are...
infected
- Being regarded as a bad person
- The future of their family
The fear is going to fade out when they talk to someone who understand. People living with HIV/AIDS might also find that they are worried about things that they do not need to fear. For example, they may find that when other people learn they have HIV, great love and kindness were shown rather than feared rejection.

6. LONELINESS
A person with AIDS might often feel lonely. This feeling may come and go for a long time and depends on the support given by family and friends. Anyone who has AIDS must be helped to remember that s/he is not alone. There are many other people living with HIV/AIDS.

Families and communities must understand that people with HIV and AIDS need companionship. Infected people can gather and provide companionship and support for each other.

7. SELF CONSCIOUSNESS
People with HIV or AIDS might think everyone is looking at them or talking about them. This makes them want to hide. Sometimes, people with AIDS may feel unworthy of friendship.

You can help them not to hide or feel discouraged by encouraging them to stay active and voluntarily participate in the community activities. This can increase the society's acceptance showing that people with HIV or AIDS can be of some value in society, just like everyone else. Help them to understand that as long as they take preventive measures, they will not spread the infection to their loved ones.

Help them to think well of themselves and to be confident. They are as important as everyone else. Self esteem is as important as curative therapy.

8. DEPRESSION
If someone finds out that s/he has HIV or AIDS, s/he may feel that there is no good reason for living. The person may feel useless, and want to stay at home, not eating, and not talking to anyone.

Depression can make people weak in mind and body. It is important to try and help them overcome it and not to give up in life and death matters. Encourage them to continue with their normal routine as well as to put on nice clothes, visit friends, keep busy with things that matter, do something that helps others, and to think about their children and friends who still need them.
များစွာ ကြည့် ရှုပ်ထားပါတယ်။ အခြေခံ သို့မဟုတ် သေချာစွာ ပိုစွာ ပြောပြထားပါတယ်။

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9. ACCEPTANCE
After some time, most people will usually begin to accept their situation. This helps them to feel better. Such persons will feel more peaceful, and will begin to think about the best ways to live:
- What can I do to make the best of the rest of my life?
- What food should I eat to help me stay healthy?
- What plans should I make so that my children are provided for in the future?
- Let me bless for every single day. Let me appreciate my family and friends and show them how much I care for and about them.

10. HOPE
You can help people with HIV or AIDS to have hope about many things:
- Hope that they will live for a long time.
- Hope that each sickness will be treated as it comes.
- Hope that they are loved and accepted for who they are.
- Hope that scientists will find a cure.
- Hope based on belief in a life after death.
It is important to have hope even if facing desperate situations. Hope lifts spirits and gives strength. Hope can help each person to fight HIV and AIDS, to live positively and to live longer.
Remember, even if a person has hope today, it is possible to feel angry or depressed tomorrow. This is normal. Even emotions of people without HIV or AIDS go up and down normally everyday. The important thing is to try to instill the feelings of hope again and again. People who have AIDS or people who are in contact with someone with AIDS are often afraid that the negative feeling described above will become very strong. These feelings cannot, and should not, be avoided. They are normal reactions to a crisis. Family, friends, neighbors, health care workers (anyone who cares) can help another person cope with these feelings by listening patiently and non-judgementally. Then let him/her express his/her feelings openly and provide relevant information about medical and social services and help him/her to live a life positively in the community.
ဗုဒ္ဓဓာတ်များစွာ စာဖတ်မြင်ကြည်မှု

ဗုဒ္ဓဓာတ်များစွာ စာဖတ်မြင်ကြည်မှု သည် အိမ်မြေကြီး အစီအစီ လုပ်ငန်းများစွာ ဆောင်ရွက်နိုင်ရန် အနေဖြင့် ဖော်ပြထားသည်။ အချက်အလက်များစွာ စာဖတ်မြေကြည်မှုများ အိမ်မြေကြီး လုပ်ငန်းများစွာ ဆောင်ရွက်နိုင်ရန် အနေဖြင့် ဖော်ပြထားသည်။

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Stigmatization and discrimination

Adapted from HIV/AIDS prevention and control, A short course for humanitarian workers (RHRC)

Stigma is prejudice and discrimination against a set of people who are regarded by others as being flawed, incapable, morally degenerate, or undesirable, and who are treated in a negative way. Prejudice is an attitude, while discrimination is overt behaviour.


Why is HIV/AIDS stigmatized?

HIV infection and AIDS are associated with taboo subjects: sex, drugs, disease and death. In the early stages of the epidemic, the disease was associated with sex workers, men who have sex with men (MSMs), and injecting drug users. In most situations, these groups are already stigmatized and marginalized. Some people think that extramarital sex and selling/buying sex are sinful and socially unacceptable. People living with HIV/AIDS (PLWHA) are perceived as being linked to these behaviours. This explains the prejudice against them.

Some people do not have sufficient knowledge about HIV infection. They know that the disease is incurable and fatal. In addition, their ignorance and misconception about transmission can result in irrational fears.

Prejudice and discrimination are emotional matters, not based on facts.

People do not admit that an incurable disease acquired through "immoral" behaviour is spreading through their community, they tend to keep it silent. When someone within the family is HIV positive, they are afraid it will damage their reputation.

Possible stigma

Self stigmatization

When people learn of their HIV status, they may feel very bad: self-hatred, depressed and playing the role of a sick person. They also may think that they are being judged by others. Consequently, they isolate themselves, which has a negative impact on their mental well-being.

Stigma from health care workers

In some situation, health care and social workers behave unethically: apathy in providing services, judgmental attitudes, breach of confidentiality, compulsory disclosure of HIV status can occur. For example, in Thailand, 40% of a group of
PLWHA interviewed said that their HIV status had been revealed to someone else without their consent. Representation and communication Careless language and unclear terminology used by the media, social leaders and the society in general may result in a misrepresentation of PLWHA as people dying rather than living positively. Social and work environments Stigma can result in job loss, house eviction or being denied for a loan. The children of PLWHA may be ostracized at school and in the community. When this happens to refugees, the problem is worse. They may be blamed for bringing HIV into their host country, and for being an additional burden on the host country's resources.

Understanding the consequences of stigma
People associated with the risk of HIV infection are sometimes from the groups that are already marginalized, such as sex workers, or MSM. This results in perpetuation of stigma. As people do not want to be stigmatized, they may be afraid to take preventive measures, such as insisting on condom use. By doing so, they are afraid their partners might assume that they are not faithful to their partners or they are infected with HIV or STIs. Stigma can create a false sense of security among the general population. People do not perceive themselves to be at risk. Stigma also make people afraid to go for testing and to seek care, and reluctant to talk openly about HIV/AIDS. When HIV is not talked about, it is easier for people to deny its existence. All these factors drive the problem underground, making myths and misconceptions to be spread more easily enhancing the problem of HIV/AIDS.

Fighting stigma
It is not easy to remove stigma. However, three broad strategies can help:
- Communication
- Measures to protect PLWHA against discrimination
- Care of PLWHA

Communication
Addressing misconception
Provision of accurate information from
An example of what stigma can do

"There is a strong potential for stigmatization of the HIV victims in the camps. Wherever we have gone to sensitize, some refugees tell us to show them who is infected in the camp so that they can avoid contamination"

(UNHCR staff member, UNHCR news report to UNHCR website, December 3, 2003)

respected sources will promote public awareness. When public figures support PLWHA, stigma can be reduced significantly. For instance, religious leaders have a large influence in many cultures. Involving them could be helpful, because when leaders start talking about HIV, it is easier for their followers to do the same.

Encouraging people to talk more about HIV/AIDS create opportunities for them to address fears and misconception. Providing safe places to talk and receive necessary counseling is essential.

**Disclosure by PLWHA**

Most people have the impression that they could not get HIV. Here are some examples of disclosure to fight against this:

- Ex-President Kenneth Kaunda of Zambia disclosed that his son had died of AIDS, showing that anyone can be affected.
- UNHCR had arranged for a number of PLWHA to visit a refugee camp: Dr. Dieudonne TS Yiweza, UNHCR's Regional HIV/AIDS coordinator for Central Africa, explained his decision to organize the session: "we thought that by having infected persons from outside visit the camp, skeptical refugees could realize that AIDS does exist, while at the same time, we protect infected refugees from stigmatization" (From UNHCR news report on UNHCR website: For AIDS day, Dec. 3, 2003).
- A young activist from South Africa, from UWC student group, shows that PLWHA are the same as everyone else: helping people identifying them will give HIV/AIDS human face.

**Advocacy**

"Advocacy is a method and a process of influencing decision makers and public perception about an issue of concern, and mobilizing community
action to achieve social change, including legislative and policy reform, to address the concern.” Group of people actively fight for the rights of PLWHA. For example, in South Africa, a group called the Treatment Action Campaign (TAC) played a major role in pressuring the government to provide ARVs, using human rights protections in the constitution.

**Personal commitment of politicians and other community leaders**
When the campaign is led by respected politicians and community leaders, the effects are very promising.

**Measures to protect PLWHA against discrimination**
It is important to promote non-discrimination practice among health and social workers, and to train them accordingly. Health staff in particular need to be trained about the importance of confidentiality and consent to testing and treatment. In addition, PLWHA should know more about their rights and be supported to take action against discrimination. In such a way, we can reduce stigma.

**Care of PLWHA**
Treating opportunistic infections and providing ARTs turn HIV/AIDS into a manageable chronic illness rather than a death sentence. PMTCT programmes can prevent vertical transmission. There are significant challenges to provide ARVs in resource poor setting. However it can be done. In Haiti, a community-based ARV program started in 1998 has been very successful: Community health workers visit patients in their villages on a daily basis, to provide support and ensure that ARVs are being taken. This project has resulted in decreased mortality among PLWHA as well as decreased stigma because it took into account not only the medical/behavioural aspect of HIV/AIDS but also the socio-economical impact.

One of the most important aspects of care for PLWHA is involvement of PLWHA themselves. Indeed, they have been very effective in raising awareness, advocating for their rights, organizing services, and providing care and support for PLWHA.

By taking into account the above mentioned measure, we hope stigma and discrimination around HIV/AIDS will be reduced, and the well-being of PLWHAs promoted.
Home-based care means the provision of necessary health services for people living with HIV/AIDS.

In some situations, people living with HIV/AIDS are unfortunately neglected by friends and relatives. Home visitors are thus very important. This is the extension of health services from hospital level to the community level, which is normally mainly carried out by family support, community involvement and cooperation of health care personnel.

I am a counselor and also a home visitor supervisor. It happened to be a sunny day. My first visit as a home visitor was to a PLWHA's place. No one was looking after him. He was laying weakly on an old mat in a little hut inside the compound of a Thai boss. As soon as he saw me, he got up from bed and greeted me.

He felt sorry, as I had to pass through a muddy lane to reach him. I comforted him with a big smile before checking whether he had fever or not. He could not eat well because of oral thrushes. I then helped him to cleanse his oral cavity. I also gave some treatments for his boils and advised him to keep them dry and clean. Then I observed the sanitation status of his utensils and checked whether he had enough drinking water. Afterwards, I spent about 45 minutes with him, for psychological support and counseling, and to assess his needs. He told me that my visit made him feel comfortable and secure, that he would like me to come and meet him regularly.

My next destination was the house of a HIV infected mother. She had delivered a baby recently, who was now on a formula milk feeding. She was also staying in a Thai boss' compound, quite far away from the main road, with her husband and two children. Her husband did not have a regular job: he was unfortunately denied from employment. I tried to console her and to give her advice on...
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her social problems. I encouraged the family to contact Non Governmental Organizations (NGOs) providing for social and financial assistance. I also suggested the mother to take good care of herself and her family, especially of her baby who had frequent diarrheas. Then I gave her a few packets of oral rehydration salt (ORS) and showed her how to correctly prepare oral rehydration solutions. I also trained them on hygienic food preparations and hand washing techniques. The whole family listened to me with full attention.

Actually, I visit the patients - living alone or within their family - once or twice a week. For each visit, I spend about 3-4 hours, giving both psychological (counseling) and physical (home-based care) support. Each peer counselors are scheduled to visit each PLWHA twice a month to provide counseling and assess their needs. They inform me whenever important and unusual matters arise. The two cases I've just spoken about benefit from a favorable environment for counseling and home care. However, in certain situation, small space sharing, over-crowdedness with non family members and/or curious neighbors hinders an efficient home based care.

On my way back to the Mae Tao clinic, I always think over our conversation and their specific needs.

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Interview with Home visitor

This is a brief interview with a home visitor for the readers to have some idea on how people are caring for people living with HIV/AIDS.

Health Messenger: When did you start this job?

Home Visitor: I've been working at the Mae Tao clinic long before VCT started. Before 2003, there was no VCT activity at the Mae Tao clinic yet. In April 2003, the clinic started HIV/AIDS prevention activities in collaboration with Family Health International (FHI) organization. In November 2003, a VCT section was introduced at the Mae Tao clinic, being able to provide Voluntary Counseling and Testing for those who wanted. I was working as a counselor as well as a home visitor. I was visiting the houses of HIV positive pregnant women, or women who had already delivered their babies. There I was providing health education and counseling.
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Health Messenger: Could you please briefly explain about your duties?

Home Visitor: When clients come for blood testing, provide both pre-test counseling as well as post-test counseling. We also try to link the patient with appropriate organizations, which provide social, medical or financial support for PLWHA. We provide prophylaxis treatment for opportunistic infections and definitive treatment if available. AZT has already been provided to HIV positive pregnant women. We also advise them to undergo caesarean section. At the Mae Tao clinic, milk powder is given for the baby up to one and a half year old. I visit 4 to 8 houses per month. Besides, 6 peer counselors who provide home-based care to 30-40 houses per month.

Health Messenger: Do you like your job, and why?

Home Visitor: Yes, I do like my job. I'm working for my community, who really need help. I'm also interested in providing health care. This is a perfect job for me.

Health Messenger: Do you have any difficulty? If yes, which ones?

Home visitor: The beneficiaries are usually illegal migrants and I cannot speak Thai, I cannot communicate with the Thai police on behalf of them. Another difficulty is to find the families as they often change houses. In addition, it's difficult to establish a follow up, as they live in quite distant and remote areas. Sometimes, we also encounter the problem of milk powder shortage.

Health Messenger: What is your suggestion to improve your program me?

Home visitor: I would like to mention that the people I meet want to be part of the community. They'd like to work as well. I'd like to request not to discriminate those who are living with HIV. Please have some sympathy as well as empathy. The employers should keep employing them. Above all, it would be nice if ART could be implemented for them.
Testimonial of people living with HIV/AIDS

This is a testimonial of a person living with HIV and taking cotrimoxazole prophylaxis.

My name is Ko Lay. I am from Tavoy, a town located in the southern part of Myanmar. As the economic level of my country was not very good, I decided to cross the border ten years ago and started working at a fishing ship. At first, I worked at Ranong, then I moved to work at Mahachai. I took a lot of drugs. I used intravenous drugs as well. Once I was arrested as an illegal migrant worker, which made me stop taking heroin.

I had heard of ways of transmission of HIV. I knew that by sharing a needle, I could get HIV. But unfortunately I could not stop using it.

When I got TB, I was tested for HIV and learned that my test result was positive. I had to start taking anti-TB medicines. Before taking them, I was almost bedridden. I could not eat, and had fever with loss of weight about half of my size. Finally, after completion of my TB treatment, I was feeling much better, weight was gaining back.

Now, I'm having skin infections. I do not dare to go out. Others might look at me with curiosity. I have no cure for my skin infection. I do not want to go back home. I do not want to disgrace my family. I feel very lonely, as I always have to stay by myself. I sometimes read books. I'm so glad that a home visitor from the Mae-Tao clinic comes sometimes and visits me. He helps me with numerous things. Once I got thrush in my mouth, I could not eat at all. He showed me how to clean my mouth, and also gave me some prophylactic medications such as co-trimoxazole, and others. After taking them, the thrushes disappeared: I could eat well again. I am still taking cotrimoxazole.

World Vision Thailand is supporting me 350 bahts per week. Thanks to this support, I can survive. At night time, I cannot sleep. I'm thinking of my future. I'm scared that my condition gets worse. What I heard from some home visitors was that ART could make you live longer. I wish I had a chance to get ART. In that case, my health would be better and I could work again.
Patients should be informed about the treatment options in detail, including the positive and negative impacts of each. The patient should be fully informed about the potential side effects and complications. The doctor should also provide information about the cost of the treatment and any insurance coverage. It is important that the patient is able to make an informed decision about their treatment.

In conclusion, it is crucial for patients to be well-informed about their treatment options. This will ensure that they are able to make the best possible decision for their health. It is also important for doctors to be transparent about the treatment options and any associated costs. This will help to build trust between the doctor and patient, and ensure that the patient is able to make an informed decision about their treatment.
This is a testimonial of a person living with HIV/AIDS and treated with HAART in Maela refugee camp.

I live in Maela camp but I've also been working outside the camp. There, I haven't always followed our Karen traditions. My wife went to the pregnant woman consultation and she agreed to make a test for HIV. Her screening test was positive and she said it to me as soon as she came back to the house. She asked me to accompany her to talk to the counselor. We went there together, and after talking with the counselor we agreed to make a test. The news was very sad because we were both HIV positive. I had infected my wife through sex. There was a chance that she could pass it to our baby. Before my wife asked me to go for testing, I was getting more tired and weak. I also had some skin diseases that didn't go away with the treatment provided at OPD. Finally the counselor arranged an appointment with the doctor for us and we both got CD4 tests and then treatment. They gave us both triple therapy called GPO-vir. Now we have a daughter who is growing well. She is bottle-fed and we hope that she will not be infected. They will test our daughter when she will be 18 months old. After taking the medicine for 4 months I have been strong enough to go back to work and my skin diseases had cured. It is great to be living normally again and to be able to support my wife and baby. The counselor has been very helpful to us especially when we lost our appetite which occurred when taking the medicine. We followed the advice to take the medicine exactly on time, to eat good food, get exercise and rest. Now the doctor gave us one month drugs which make me easy to schedule for my work.
The Karen HIV/AIDS Education Working Group (KEWG) was formed in 1996 to deal with the issue of Karen HIV/AIDS awareness among the displaced Karen in Thailand.

Whilst there was a lot of media activity and condom promotion to reduce the HIV epidemic in Thailand in the late 1980s and early 1990s, no one talked openly about HIV in the camps. Using scarce resources, the KEWG has successfully trained teachers, students, community leaders, adult males, pregnant women, youth religious groups and health workers in refugee camps. The KEWG has also become the leading counseling and support group for people and their families in the camps, who are concerned about HIV/AIDS or who are confirmed to have the disease.

A survey conducted by Shoklo Malaria Research Unit (SMRU) midwives in Shoklo, Bono, Mae Salit and Poe Pah Tah camps in 1994 demonstrated that only 30% of pregnant women had ever heard of HIV/AIDS and only <1.5% of the pregnant women knew that condoms could prevent HIV. Since then, the KEWG has been busy conducting knowledge and awareness campaigns with the community and section leaders, religious leaders, medical staff, teachers, women and youth groups within the camps. Although PMCT is about pregnant women the community response to HIV is important to the program success. When community and religious leaders are informed and knowledgeable about HIV they can make a great deal of difference to the humane treatment of people living with HIV and take positive, non-discriminatory action against the spread of HIV.

Implementing the PMCT program

The KEWG has based its PMCT program on the principles of voluntarism, confidentiality and informed consent. To do this it was necessary to 1) prepare the women and 2) prepare the health care workers - especially the counselors. The program started with preparing...
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Preparing the women

PMCT would be not successful unless the pregnant women thought that they needed it. For program managers it is also useful to know the level of knowledge of the women so you can see on which areas the educators and counselors need to concentrate their efforts. KEWG conducts knowledge surveys (the same one) on a regular basis to assess the level of knowledge of women and as one of the ways to look at the impact of their program. Within the Karen community the main problem identified has been wrong beliefs about how you can get HIV such as sitting on the place where someone with HIV sat. The baseline knowledge survey was conducted and low literacy rate among pregnant women, directed KEWG to create 12 interactive talks based on pictures for PMCT.

After 3 months of education, women who attended all 12 talks voted privately in favour of offering Voluntary Counseling and Testing (VCT) which commenced in May 2002. Now, more than 3,500 women have had group counseling for PMCT and more than 80% of women have opted to have a HIV screening test.

Preparing the health care workers

Home visitors

The KEWG home visitors play a MAJOR role in providing social and psychological care for the HIV positive patients in the camp. Home visitors check whether the patients take their medicine on time, take the correct dose, store them in a safe place and seek help and advise when appropriate. Home visitors provide a supportive, non-discriminatory, contact person but some patients have also asked not to have home visits.
Counselors
Besides the home visitors, four PMCT counselors have been trained. The larger the group of counselors and testers, the greater is the chance for breach of confidentiality, which is why the counselors have been trained in taking blood, counseling the woman, coding blood samples and explaining the results of negative and positive tests back to the mother. Logbooks are kept independently of the health NGOs and locked up, and register logbooks do not include women’s names or initials, etc. Checklists are used by the counselors to make sure they have covered all the necessary items and given opportunity for the woman to speak and ask questions. Regular evaluations of their counseling skills are part of the ongoing work of PMCT in Maela - this needs to be done by someone who speaks the language that the counseling is taking part in.

The Laboratory technician
KEWG has also created a lab result log book in order to avoid the breach of confidentiality from the laboratory in a PMCT program - it includes only the code and the result.

Midwives
The midwives have had workshops on HepB, HIV and STD, confidentiality and counseling. Universal precautions (hand washing, glove, mask and gown) are always emphasized at workshops. The midwives and the counselors are in frequent contact with each other, as well as with the doctor. The midwives are responsible for the routine antenatal care of the pregnant woman explaining how a pregnant woman can pass HIV to the baby.

(Photo)
woman and they consult the doctor when medical conditions arise. The midwives encourage all women to deliver in the unit and to come early in labour. They also start the process of teaching women how to prepare clean bottles.

**The steps of PMCT when a new pregnant woman enrolls in the antenatal care program**

**Step 1. Pre-test Counseling**

Group Counseling is performed in a private room as an informal group discussion using the pictures (total of 15) from the PMCT group counseling guide. If the point of the picture is missed then the counselor explains the main points. Afterwards, each woman goes for one on one counseling in another private room, if she likes. In the one to one counseling, the counselor establishes what the pregnant woman understands about HIV before any testing is done. If the pregnant woman scores negatively on any of the four knowledge questions, further counseling is conducted with an emphasis on the parts that she does not understand. KEWG decided it could be harmful to test a woman when she cannot understand what it is about. If it takes more than one counseling to help her understand then that is OK.

**Step 2. Post test counseling**

If the counselor gets any positive results, they first discuss directly with the senior HIV midwife to check the gestation of the pregnancy in the antenatal record. Women in late pregnancy (> 28 weeks gestation) need to be called back discreetly so confirmation testing can be implemented as soon as possible, if that is what the woman decides. Since ANC attendance in Maela is high, most women can just be seen routinely the following week or when they pass by.

Depending upon the test result, the counselor uses the specific checklist: a negative test and positive test. If the woman is in the window period or high risk group she may need retesting.
later in pregnancy. The counselor needs to remind the woman of this and tell her when she should come back if she wants retesting.

Step 3. Confirmation of a positive screening test
Depending on the test result the counselor uses the specific checklist. More than one post test counseling may be required.

Step 4. CD4 and ARV counseling
In the case of a positive confirmation test the woman needs to see the doctor for a general check-up and counseling from a KEWG member about ARV and CD4. If she understands and wants to take ARV then a CD4 test is done. Once the CD4 count is known the treatment is arranged by the Aide Medicale International doctor.

Step 5. Treatment with ARV in pregnancy
When pregnant women are infected with HIV with advanced clinical (AIDS associated/defining illness) or immunological disease (Low CD4 count) they need anti-retroviral treatment and the risks of ARV side-effects are outweighed by the benefits of receiving treatment. However in women who do not yet need ARV for their own health the use of ARV can decrease the risk of HIV to the baby dramatically. What treatment should we use?

Treatment of HIV with ARV in pregnancy:
Worldwide there are different opinions on what treatment should be given to pregnant and lactating women, but it is also dependent on what drugs are available and their cost, how the antenatal care structure can adapt to cope with giving ARV and on the availability of ARV for non-pregnant patients. The data on fetal toxicity of ARV drugs is only collected slowly and there are also problems using drugs that may then make the virus resistant - so that if ARVs becomes available they are no longer useful in that patient.

It is impossible to talk about all the advantages and disadvantages and clinical case scenarios in the space provided but set out below are 3 different treatment possibilities: these regimens have all been used at Maela camp and are available on different parts of the border.

1. **Triple Therapy** i.e. 3 drug combination (current policy for Maela camp residents)

   A. Pregnant women with CD4 counts below 200 cell/ml and or stage 4 HIV disease

   ARV should be given as soon as possible, preferably after the 1st trimester of gestation, D4T/3TC/NVP (GPO-vir). Routine antenatal follow-up and routine adult ARV follow-up is
done at 2 weeks and then monthly intervals. Routine ANC is continued. So far women who have conceived on GPO-vir have continued the same regimen. The infant is treated with AZT for at least one week.

B. Pregnant women with CD4 counts > 200 cell/ml

ARV is given as close to 28 weeks as possible using D4T/3TC/EFV. Routine antenatal follow-up should be continued. However, ARV therapy is stopped after delivery. Regular follow-up and CD4 count is checked every 6 months. When women will become eligible for ARV, they should be started on D4T/3TC/NVP (GPO-Vir). The infant is treated with AZT for at least one week.

2. Double therapy i.e. 2 drug combination. There are different possibilities of two drug combinations:

   A. AZT (from 28 weeks or as close as possible) + NEV (600 mg) in labour. Infants get one week of AZT and single dose NEV.
   B. Zidovudine (AZT) + Lamivudine (3TC) started at 36 weeks and continued for one week after delivery. Infants also get one week of AZT + 3TC.

3. Monotherapy i.e. one drug

   A. AZT

   Before delivery: 300mg of zidovudine bid from 28 weeks, check haemoglobin or haematocrit at baseline and regularly (e.g. 2 weeks, then monthly). In labour: 300mg every 3 hours (recommended as IV but in Maela we use oral), start when having early labour pains. The infant gets AZT for one week.

Some general points:

ALL INFANTS:
- No breast-feeding and particularly no mixed feeding (breast and bottle) because he has high HIV transmission rates. Milk powder needs to be started in ANC. The mother needs to be trained in preparing bottles correctly to avoid bottle fed diarrhea. KEWG has guidelines for this.
- Should follow the routine vaccination schedule (British HIV Guidelines).
- Co-trimoxazole as PCP prophylaxis should be prescribed for infants born to mothers at high risk of transmission, i.e. not the infants born to mothers who received adequate ARV during pregnancy.

ALL MOTHERS:
It is required to have adequate drug levels during pregnancy, not a single dose should be missed because of delivery.
at least one week.

B. Nevirapine (when there is no time for AZT and no chance the person may receive triple in the future).

If the woman didn’t receive AZT in ANC or for less than 2 weeks and is in labour, nevirapine 200 mg single dose is used when the woman starts labour (before delivery).

The infant gets NEV 2 mg/kg single dose and if possible AZT for at least one week.

For NEV we dissolve the tablet for the baby in 1 0 cc of boiled and cooled water - double check your dilution.

Step 6. What to do at delivery

Midwives deliver women with HIV in the camp applying UNIVERSAL PRECAUTIONS unless there is an obstetric indication for Caesarean section. It is not known what additional benefit there is of Caesarean section to the woman/infant when the mother is on triple therapy. Everytime a HIV positive patient is transferred this is a risk of breach of confidentiality and health workers need to keep this in mind to minimize this risk.

Suggestions for successful PMCT

- Once you have a positive screening test you need to find out the gestation of the pregnancy - if it is late pregnancy you need to move fast to be able to provide any timely, effective prevention.

- When AZT is used, it is better if the woman keeps extra doses with her. You need to start explaining at 28 weeks to the woman that she needs more drugs in labour and keep on repeating the information. When labour pains start, she could take the first dose and start making her way to the clinic. Triple therapy is much easier because we do not have to worry about this.

- At the beginning of the PMCT in Maela camp, 50% of the infants in the program died from bottle diarrhea. Everyone on the PMCT team needs to know how to prepare a correct strength, clean bottle of powder milk. When possible, home visitors have to check the conditions for bottle preparation and storage in the home.

- Be flexible - if somebody needs to go
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and see her mother for 1 month then be prepared to give her the medicine for one month. Emphasize the importance of taking the medication one time, everyday of the pregnancy to provide the best chance for the child to be negative.

- Encourage couple counseling for involvement of the partner. In addition, this could detect positive partners and children and provide further treatment opportunities.
- Confirmation should be made for every positive test result - we have had false positive results with the rapid screening tests available for blood donors.

If you have any questions and about PMCT package, please contact Niramoon, KEWG office.
Phone: 055 545 021
Fax: 055 545 020

PMCT package

1. Knowledge survey - measure the effectiveness of your PMCT education
2. Guidelines for group counseling of pregnant women
3. PMCT checklist - pretest counseling
4. Does the woman understand what you have told her - 4 quick questions before offering testing
5. Checklist for negative result
6. Checklist for positive screening test
7. Checklist for positive confirmation test
8. Checklist for CD4 and ARV counseling
9. Evaluation of HIV counselors
မူရင်း (စိုးလှည်း) အိမ်ခန်းအတွက် စီးပွားရေးနှင့် ပြန်လည်ကျော်ကြားခြင်း

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Some people's negative perceptions on condom use are mentioned in this article and how to overcome these perceptions are discussed.

Condoms are the most effective way of preventing sexually transmitted infections including HIV. Promotion of consistent condom use is widely accepted and practiced as the primary method of preventing HIV infection. In spite of the clear advantages of condoms, there are challenges in using them.

**Condoms reduce sensation**

Condoms make some couples frustrated and they lose their sexual excitement as the condom reduces sexual pleasure produced by the sense of friction. This can interfere with spontaneity and sexual pleasure. (Possible solution: Men and women can imagine that they are having sex without a barrier or take more time and attention in foreplay to get sexual satisfaction. Reduction of sensation by condoms is a positive feature for some young men who reach orgasm too quickly).

**Condoms prolong sex**

Some men feel pressure about having to maintain an erection to keep the condom on. Some people have prolonged sex which can be due to thinking of other things during sex or due to life related stress or frequent sex with not enough rest in between. (Possible solution: To overcome pressure, learn to enjoy using condoms by using them during sex play before intercourse, shift your thoughts away from other issues to concentrate on sexual pleasure; take adequate rest between episodes of sexual intercourse; take a good rest when feeling stress over other life issues).
ပြောပြပါတယ်။ အချက်အလက်များကို သိရှိလိုပါက ကြည့်ပါ။

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Alcohol and condom use
Alcohol intoxication can reduce sound decision making on condom use. It can also lead to men not getting or maintaining an erection to use condoms. (Possible solution: do not get drunk before sex or have sex before heavy drinking).

Condoms break and hurt
Condom breakage can be due to incorrect use of a condom or putting two condoms on instead of one. (Possible solution: Follow the instructions on the package to use condoms correctly and use them often to develop a consistent method that works for you. Only use one condom at a time).

Pain can be due to an absence of natural lubricating fluid in the vagina after prolonged sex. (Possible solution: Use a water-based lubricant or increase natural lubrication by touching, fondling or kissing).

Condoms are barriers in a trusting relationship
People feel fear to use condoms as it keeps mistrust in the relationship or challenging the morality of their partner. (Possible solution: Consider and discuss using condoms as one valid way of showing love, care and concern for your partner. Use life-skills such as assertiveness and negotiation for condom use).

Appearance determines condom use
Some people choose their sexual partner by external appearance. Good looking people are thought to be trustworthy so no condom is used. (Possible solution: Looks are deceiving. Healthy looking people can have HIV. This message needs to be emphasised in information campaigns).

Perceived vulnerability makes sense of condoms
When people perceive that they are not vulnerable to HIV they have false sense of security and condoms are neglected. (Possible solution: We have to make realistic risk assessments. Educators need to use case histories in order help us gauge our risk).

Religion hinders condom use
Some people with religious faith
ယူနာစောင်ခြင်းမှာ အနောက်တိုင်း အကြီးအကျယ် ပျော်ရွှင်းထွန်းပြီး စိုက်ပျိုးပါ။

ဒီဖျင်တွေကို နေ့စွဲပြုလုပ်ပေးထားပါတယ်။ ဒီပေါက်ချက်မှုကို အစိုးဗီနှင့် ကျွန်တော်တို့ ရင်းမြစ်သော စိုက်ပျိုးရာ ထိပ်ပိုက်ပွဲများ၏ အုပ်ချုပ်ရာ ပြောင်းလဲမှုများ ထိန်းသိမ်းပါ။

ပြန်လည်ကာကွယ်ရှိလျှင် ဓာတ်ပျင်းသော ကျွန်တော်တို့ ရင်းမြစ်သော စိုက်ပျိုးရာ ထိပ်ပိုက်ပွဲများ၏ အုပ်ချုပ်ရာ ပြောင်းလဲမှုများ ထိန်းသိမ်းပါ။

pweisenfeld@femalehealthfoundation.org.
believe that condom use is prohibited by their God as it is concerned with birth spacing and contraception. No religion absolutely prohibits condom use. When condoms are the better of two evils or when condoms save lives, they are accepted by religious leaders and can be accepted by even the most religious people. (Possible solution: We must involve religious leaders and religious people to support condom use in health education campaigns on

Sometimes it is impossible to use a male condom:
Sometimes men simply refuse to use a condom and women have no choice but to have sex with them.
The female condom (fc) is another alternative for safer sex. It has been proven effective against pregnancy, sexually transmitted infections, and HIV infection. Research has shown that female condoms do not replace male condoms but lead to more protected acts of sex.

Female condoms are a newly-introduced female-initiated choice for safer sex so they don’t have the stigma that male condoms do. They are simple to use after a woman has practiced using them and can be used with both water based and oil based lubricants. Some people find that they increase sexual pleasure and so they can be used as an erotic tool. A man doesn’t need erection for a woman to use a female condom and they can be used when man cannot use or refuses to use a male condom. This increases a woman’s power in sexual negotiation. There are barriers to using female condoms as well. Health care providers have their own preconceived biases about condoms and may pass their preconceptions on to potential users. Female condoms take practice to use correctly just like male condoms. And public sector subsidies are needed at present until enough female condoms are used for the cost to decrease.

Female condoms are available in Rangoon at present under the trade name Feel. They may be introduced in Thailand/Burma border areas in the near future. More information about female condoms can be obtained by email to pweisenfeld@femalehealthfoundation.org

The female condom (fc) is another alternative for safer sex.
People with HIV disease who are not yet taking antiretroviral therapy can take advantage of cotrimoxazole prophylaxis. Cotrimoxazole can prevent Pneumocystis pneumonia and several other common bacterial infections. It can also prevent toxoplasmosis.

Cotrimoxazole prophylaxis is promoted by WHO and UNAIDS for the prevention of several secondary bacterial and parasitic infections in eligible adults and children living with HIV and AIDS. Current recommendations in WHO’s Integrated Management of Adolescent and Adult Illness programme are one double strength (960 mg) tablet daily for all people with AIDS and for people with symptomatic Stage 2 and 3 HIV disease. People with HIV and TB are especially helped by cotrimoxazole preventive therapy.
Glossary

HIV - Human Immunodeficiency Virus
AIDS - Acquired Immuno Deficiency Syndrome
RHRC - Reproductive Health Response in Conflict
UNHCR - United Nations High Commissioner for Refugees
UNICEF - United Nations Children’s Fund
UNAIDS - The Jointed United Nations Programme on HIV/AIDS
WHO - World Health Organization
FHI - Family Health International
IOM - International Organization of Migration
SMRU - Shoklo Malaria Research Unit
KEWG - Karen Education Working Group
VCT - Voluntary Counseling and Testing
PMCT - Prevention of Mother to Child Transmission
PLWHA - People Living With HIV/AIDS
ART - Anti Retroviral Therapy
NRTIs - Nucleoside Reverse Transcriptase Inhibitors
NNRTIs - Non Nucleoside Reverse Transcriptase Inhibitors
PI - Protease Inhibitors
AZT/ZDV - Zidovudine
d4T - Stavudine
ddi - Didanosine
ddc - Zalcitabine
3TC - Lamivudine
ABC - Abacavir
FTC - Emtricitabine
TDF - Tenofovir

RTV - Ritonavir
NFV - Nelfinavir
SQV - Saquinavir
IDV - Indinavir
FPV - Fosamprenavir
LPV/r - Lopinavir (LPV, mixed with RTV as LPV/r)
APV - Amprenavir, caps
NVP - Nevirapine
EFV - Efavirenz
DLV - Delavirdine
ATV - Atazanavir
Comvir or Zilavir - AZT+3TC
GPOvir - d4T, 3TC, NVP
HAART - Highly Active Anti Retroviral Therapy
ALT (SGPT) - Alanine amino transferase
AST (SGOT) - Aspartate amino transferase
BUN - Blood Urea Nitrogen
Health Messenger is a quarterly distance learning magazine directed at health and social workers and their communities. Health Messenger aims to communicate health information and knowledge to those living in areas where resources are limited. Everyone is aware that teaching is more effective if the whole community is involved in the learning process. Medics, nurses, laboratory technicians, home visitors, school teachers should join together in this effort.

This special issue on HIV/AIDS has been supported by UNHCR.