

HIV NURSING

CARING FOR PEOPLE AFFECTED BY HIV

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Aims and Scope

HIV Nursing has been developed as a forum for those at the forefront of caring for people affected by HIV. The journal is supported by a highly respected Editorial Board drawn from a wide range of nursing specialties. This is further strengthened by an Advisory Panel who will be making regular contributions to the journal.

HIV Nursing is intended to provide a medium for communication on issues relating to HIV care, which will be run by the care professionals for those involved in the day to day matters affecting the lives of patients.

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CARING FOR PEOPLE AFFECTED BY HIV

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HIV in the developing world

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This issue of HIV Nursing offers an international perspective, discussing a range of topics concerning HIV in developing countries. Each year, when the Joint United Nations Programme on HIV/AIDS releases its update on the HIV epidemic (the latest is available online at www.unaids.org), it is easy to see that developing countries face the highest rates of prevalence and incidence, as they have since the very early days of HIV. It has always been a disease that, like tuberculosis, tracks the fault lines of human society. The first article discusses these reasons for the close contiguity of HIV and poverty and some of the factors amplifying HIV risk in developing regions.

In the second article, Sara Page, an experienced international worker based in Harare, Zimbabwe, focuses on specific HIV-related issues in southern Africa, giving important and intriguing insights into elements exacerbating the epidemic there. She suggests that there is hope, provided that sufficient funding and access to treatment and care are facilitated. However, local and regional political, social and economic elements seem to conspire against making real progress and the impact of HIV on the community makes economic recovery even more difficult, creating a cycle of devastation. As the article suggests at the close, a crisis could result if more HIV treatment is not provided.

General statements about the gravity and complexity of the HIV situation must also be considered in the context of the local, personal experience of living with HIV. It is easy to forget that it is individuals who are affected. Although each infected person is only one of many affected millions he or she still experiences the same emotions as us: pain, excitement, anxiety, fear of death, hope and the desire to survive. Bobby Ramakant reports on the experience of people living with HIV on the Indian sub-continent. In the country that recently overtook South Africa as the nation with the highest number of people living with HIV, it is vital for international and national agencies and non-governmental organisations to confront what is rapidly becoming a crisis.

Prevention of HIV in developing countries is – at least according to the superficial and narrow view characterised by tabloid headlines – simply a matter of not having sex. For the majority of people, of course, this is simply not an option, especially for women. The gendered nature of HIV (more women than men are infected) is due in large part to women's vulnerability to infection, and their disempowerment regarding when and how to

have sex. Until safe and effective microbicides become available, the options for women to protect themselves against infection (and unwanted pregnancies) will remain limited. However, Jennifer Westfall, an independent consultant based in Bangkok, Thailand, reports in the third article on an interesting development in Asia: the development and promotion of the female condom in Myanmar (Burma). This approach could be exactly what is required to give women the ability to take control of their sexual protection until microbicides become available.

With all the buzz and busyness around access to antiretroviral therapy in developing regions, it is easy to forget the wealth of other interventions and treatments that are available for the relief of HIV-associated symptoms. Two other articles in this issue address some of these 'alternative' approaches. In the fourth article, Laura Louie writes about the Mae On Project, an initiative that provides acupuncture for people living with HIV in a resource-poor region of northern Thailand. Given alongside more allopathic (conventional) treatments, the project confirms that a combined approach to treatment can benefit the resolution of symptomatic HIV.

There is also a conference report from an event held in Accra, Ghana earlier this year: the Global Summit on Traditional Medicines, Indigenous Knowledge and HIV. Although some might find it difficult to imagine, 'Western' notions of causation, diagnosis, treatment and prognosis are by no means universal. In developing regions of the world, it is the traditional (local) practitioner to whom a person normally turns for the treatment of health problems. The significance of this must not be forgotten: with increasing population mobility across many parts of the world, the increasingly diverse cultural context that results means much more variety in health beliefs. Healthcare workers in developed countries would do well to consider the plethora of alternative views they are likely to face in coming years.

We hope that this issue gives you a lot to think about.

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HIV: transmission, criminalisation and the media

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The increasing tendency for people to be convicted for infecting other people with HIV was illustrated at the end of June when Sarah Jane Porter, a receptionist from South London, was charged with grievous bodily harm through the reckless transmission of HIV. Other people in the UK found guilty of similar crimes include Mohammed Dica in 2004 and Pavlos Georgiou in 1997. Other countries, including the US and Canada, are beginning to consider HIV transmission as a criminal act.

Human rights and AIDS groups consistently voice their concerns over these cases, not least because it is very unclear how the law can be applied fairly in these situations, or indeed – and this is perhaps more important – how a particular level of intent can be assessed and how it should be punished. Did person A intend to infect person B? Was it accidental, reckless (i.e. knowing there is a risk, but taking a chance the virus would not be transmitted), fully intentional (based on a wish to harm another person) or simply a product of extreme denial ('I have not got HIV, so how can I infect anyone else')?

It is the last of these that should cause us most concern. There is a plethora of reports confirming that people living with HIV face stigma, leading to varying levels of discrimination, from avoidance to murder. While the latter is less common, evasion and an unwillingness to interact are prevalent in many contexts, including healthcare and religious settings where one would expect a higher degree of tolerance. A recent report published by Health and Development Networks (HDN), 'Living on the Outside', confirms that HIV stigma is ubiquitous and very damaging [1]. One of the saddest aspects of the Porter case was that a psychiatrist's report undertaken after the conviction confirmed that she was in complete denial about her diagnosis, probably due to her fear of dying or of her being ostracised from society. This manifestation of self-stigma is a common phenomenon in regions of high HIV prevalence, and can be more damaging than the initial effects of the virus itself [2].

One need only look at the incandescent reactions of the tabloid press in the UK over the case to see how a person living with HIV can easily be subjected to vituperative language on the basis of little or no rational reasoning regarding the true nature of the case. It is perhaps useful to see the range of responses in the media:

The Guardian: 'Woman jailed for giving boyfriend HIV' [3]

The BBC: 'Woman jailed for giving lover HIV' [4]

The Daily Telegraph: 'Woman with HIV who deliberately took a string of lovers is jailed' [5]

The Daily Mail: 'Woman jailed for deliberately giving lover HIV' (front page headline: 'Pure Evil') [6]

The Sun: 'Ex tells of HIV nightmare' (front page headline: 'AIDS avenger') [7]

As can be seen, only the first example above is actually true: it simply describes the facts and is the most objective. The rest (including the BBC; even the word 'lover' has added connotations) provide increasingly subjective accounts.

When considering the media, of course, it is important to look at how many people access each outlet. Around 400,000 copies of the Guardian are sold each day. Compare this to the readership of The Sun, which at around 8.5 million is almost equivalent to the population of Sweden.

Newspapers, like all media, notoriously work to their own agenda. We should all be concerned at how the media reports HIV-related issues.

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HIV and developing countries: what are the issues?

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A single phenomenon is key to Jared Diamond's analysis of human civilisation, *Guns, Germs and Steel*: populations inhabiting certain regions almost inevitably face levels of poverty and deprivation not encountered elsewhere [1]. This is despite a strong will to survive and is completely unrelated to levels of ability or education; it is simply a matter of geography. He cites the example of Africa, a cluster of many nations populated by able and innovative people, still mired after many years in grinding poverty. They also seem particularly exposed to the HIV epidemic, and this paper will describe some of the key issues concerning poverty and HIV in developing countries, especially sub-Saharan Africa (SSA), highlighting specific factors that require urgent consideration if the vulnerability of these areas to HIV is to be properly addressed.

How bad is the situation?

Whether Diamond is being unduly pessimistic is a question for debate, but major reports published in the last 18 months confirm that many sub-Saharan countries still face severe social and economic problems, in spite of large amounts of external funding and foreign aid and support. According to Barnett and Whiteside, 'HIV/AIDS epidemics don't just happen; there are social, economic and cultural reasons why such events occur' [2]. In addition to facing difficult and seemingly insurmountable barriers to improving socio-economic status, developing countries also experience disproportionate levels of ill health. It is therefore no coincidence that 'the highest rates of HIV, and the highest rates of increase in HIV infection, are in countries with myriad other problems', including fragile economic systems, weak healthcare infrastructure, limited choices (because of poverty) and dangerous environments (e.g. civil conflicts) [3].

According to the latest World Health Organisation (WHO) statistics, there are indeed correlations between HIV incidence and life expectancy [4]. When statistics generated by the United Nations Development Programme (UNDP) are factored in, we also see that countries with a low human development index (HDI, a measure that accounts for poverty, literacy and education as well as life expectancy) are often countries with high HIV prevalence (Table 1).

So, given that HIV does not occur in isolation, what progress is being made against the social and

Table 1: Human development index (HDI) and HIV prevalence in four African countries [4,6]

Country	HDI*	HIV prevalence (%)	Life expectancy (yrs)
South Africa	120	21.5	47
Botswana	131	37.0	40
Zimbabwe	145	24.6	37
Central African Republic	171	13.5	40

* HDI is a ranking from 1 to 177. One is the highest position.

economic factors that are amplifying the HIV epidemic? One measure is to use the eight Millennium Development Goals (MDGs), which originate from a UN Millennium Declaration signed by 189 nations in 2000. Among these goals are: to eradicate extreme poverty and hunger; to improve maternal health; and to combat HIV/AIDS, malaria and other diseases (e.g. tuberculosis). All the MDGs are health-related, and have a target year of 2015. However, according to the 2005 Millennium Development Goal Report, there is real concern that many developing and transitional regions will not reach their objectives, with SSA lagging well behind in most areas except gender equality, where some improvements have been made, especially in Rwanda [5].

Another useful way of tracking development against poverty is the annual UNDP Human Development Report. The most recent provides evidence of some improvements: more people live in democratic states than ever before; on average, people born in a developing country today can anticipate being wealthier, healthier and better educated than their parents' generation; extreme income poverty is generally falling; and in some regions there have been rapid advances in access to education [6].

However, substantial pockets of poverty remain, such as drought-stricken Niger, where progress is being reversed, and regions where war and uncontrollable disease are diverting already scant resources. The report has a spirit of urgency, recognising that hundreds of millions of people across the globe continue to face high levels of poverty and live in an environment that removes any hope of a healthy and secure life. The report confirms that unless action is taken the poorest countries will continue to get poorer; also, as a result

of economic stagnation, it will take until at least 2012 for SSA to regain 1980 levels of overall income, assuming the current rate of 1.2% per capita is maintained. The situation is urgent and the report pulls no punches about the need for increased funding, using the MDGs as vital benchmarks against which to measure progress towards the alleviation of poverty. The report also highlights the moral imperative to engage with developing countries and find ways to improve the lives of the millions affected.

Specific issues relating to HIV/AIDS

Perhaps the most shocking statistic in the World Health Report is that the WHO anticipates (in its 2030 projection) a continuing rise in the number of deaths caused by HIV – the only major pathology for which this is the case. There can be no doubt that the symbiosis of HIV and poverty is devastating and solutions have to be found at both the macro and micro level. Stillwagon proposes four political solutions at the macro-level, including debt relief, robust legal systems to protect populations and horizontally integrated health services [3]. In addition to these broad interventions, there are three further issues that have a specific impact on HIV care and prevention: shortage of healthcare workers, beliefs about HIV treatment and prevention and gender inequality.

Shortage of healthcare workers

The 2006 World Health Report [7] states that there is a 'a serious shortage of health workers in 57 countries, impairing provision of essential, life-saving interventions such as childhood immunization, safe pregnancy and delivery services for mothers and access to treatment for HIV/AIDS, malaria and tuberculosis.' This is a real problem: in SSA, there are around 750,000 health workers in a region of 682 million people. There are simply not enough healthcare workers to go around and while the global average is 9.3 health workers per 1000 people, in North America it is 41.7 per 1000, and in Africa 2.2; an example of the inverse care law at its most insidious. Africa's estimated shortage of nearly 900,000 health workers means the continent would require a 139% increase in order to address its care needs, and although the Americas have 10% of the disease burden, 37% of global health workers live and work there. Conversely, Africa has 24% of global disease burden but has access to only 3% of health workers. The problem is exacerbated by the 'brain drain', a haemorrhaging of health care workers away from poor African nations southwards (towards wealthier South Africa) and northwards (towards Europe and the United States) [8].

Beliefs about HIV treatment and prevention

What do people believe about HIV and AIDS? Although it is vital to consider health beliefs

generated within cultures (including those of developed countries), obfuscation and confusion can lead to serious problems regarding public understanding of HIV risk and where to seek treatment and support. For example, AIDS denialists have been airing contrary views for years and the result is often confusion and flawed policy-making. A case in point is South Africa, until recently the country with the highest number of people affected by HIV. Since President Thabo Mbeki's public declaration in 2000 of his doubts about the cause of AIDS, official declarations and comments about it have often been highly idiosyncratic. Most recently, the South African Health Minister was vigorously promoting nutritional treatments for symptomatic HIV; this was the result of her support of the controversial nutritionist, Matthias Rath [9]. Here and elsewhere on the continent, alternative views of risk assessment and causation need to be better understood and integrated into local prevention initiatives [10].

Gender inequality

There is also the issue of gender: HIV is now undoubtedly a gendered disease. During a review of progress made by member countries in tackling HIV, UN Secretary General Kofi Annan said: 'The world has been unconscionably slow in meeting one of the most vital aspects of the struggle: measures to fight the spread of Aids among women and girls. These shortcomings are deadly' [11].

This sentiment was echoed by the head of the UN Population Fund, Thoraya Obaid, at the same event: the only way to reverse the feminisation of the pandemic is to 'make sure that women have greater control of their bodies and their lives, as well as of public policies and budgets' [12]. Gender empowerment, providing ways for women to protect themselves and their children, must be paramount or there will be no end to the exposure of women to HIV through enforced sex and their lower status within many societies. 'Gender inequality equals death for the women of Africa', according to the UN Special HIV/AIDS Envoy to Africa, Stephen Lewis, who spoke at the Royal College of Nursing Congress in May 2006.

Conclusion

HIV exists within a complex web of social, economic, political and cultural threads. This paper has discussed a range of issues that surround HIV, especially in SSA: poverty remains a central contributory factor in increasing vulnerability to HIV, but other issues such as the shortage of healthcare workers, gender inequality and ambiguous messages and information about HIV/AIDS all play a large part in jeopardising real progress against the epidemic.

As the discussion above highlights, Africa certainly faces special challenges. Barnett and Whiteside

state that 'Africa's history is one of abnormal normality. It differs from all other regions of the world in the sustained nature of disruption, exploitation and bad government – and the fact that Africans, in contrast to the indigenous people of other world regions, have survived these experiences' [2].

Any solutions will inevitably adopt the same multi-faceted features that characterise contributory factors; what can nurses and nursing organisations do to help? Lobbying at the national and international levels is a beginning; national organisations such as the National HIV Nurses Association (NHVNA), and the American Association of Nurses in AIDS Care (ANAC) are in a powerful position to catch the ears of policy makers, forcing them to address vital issues such as debt relief and healthcare worker migration. The International Council of Nurses (ICN) has recently launched a network for health care workers in the field of HIV care and support: further information can be accessed via the ICN website at: www.icn.ch

We can also share our knowledge and expertise sensitively with needy areas and proceed with an openness to learning from people in the regions worst affected by HIV; they can increase our knowledge about alternative world views and how to care for and support HIV-affected people in resource poor settings. These relatively small contributions could, over time, accumulate into an effective and robust factor in the fight against HIV.

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Zimbabwe: a ray of hope within southern Africa

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Introduction

The southern African region continues to bear the brunt of the HIV/AIDS epidemic. Considered to be the global epicentre, sub-Saharan Africa had 24.5 million adults and children living with HIV at the end of 2005, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimate. Seven of the 10 countries in southern Africa have reported HIV prevalence rates of over 20%. Recent reports indicate that the epidemic might be stabilising in some countries, including Malawi, Namibia and South Africa. However, it is levelling off at very high rates. Other countries such as Botswana, Lesotho and Swaziland continue to report growing epidemics. With the exception of Angola (3.7%), the HIV prevalence rates in southern Africa remain the highest in the world [1].

Zimbabwe, where 1.7 million people are living with HIV, offers a ray of hope for the region. In 2003, UNAIDS reported that Zimbabwe's HIV prevalence had decreased from 33.7% in 2002 to 24.6% in 2003 [2]. The large decrease in prevalence during this period was initially attributed to the change in HIV surveillance approaches. Following the trend to move away from estimates based primarily on antenatal surveillance, Zimbabwe adopted data collection strategies using geographically representative population-based surveys that include results from sexually inactive and non-pregnant women. This change in approach has also led to decreased estimates in Kenya, Burkina Faso and Ghana [3]. At the time, researchers, programme officers and policy makers expressed caution about interpreting the results as indicative of a decreasing trend in HIV prevalence.

However, at the end of 2005, Zimbabwe continued to report a declining trend, with an HIV prevalence rate of 20.1% [1]. The decline has been observed across different age groups (including people from 15–24 years of age), among pregnant women screened while attending antenatal care services and in both rural and urban areas [4]. Having compared data from sentinel surveillance systems, population serosurveys, local studies and service statistics, researchers have expressed increased confidence that there has been a decline in Zimbabwe's HIV prevalence [5]. At a meeting of the UN General Assembly in June 2006, the Secretary General acknowledged Zimbabwe as one of the few countries in the developing world to have reduced its HIV prevalence rate.

The decline in HIV prevalence has been confirmed by several research studies [5–7]. For example, between 1998 and 2000, a research team from Imperial College in London took blood samples from and implemented a questionnaire on sexual behaviour to 9454 people from 12 communities in Manicaland in eastern Zimbabwe. The study was replicated in 2003. The research team found that HIV prevalence had declined from 23% to 20.5%. Among men aged 17–54, infection dropped from 19.5% to 18.2%, whereas among women aged 15–54, the rate dropped from 25.9% to 22.3%. The study found that the proportions of men and women who had casual sexual partners fell from 49% and 22%, respectively. The study also reported a delay in the onset of sexual activity and an increase in condom use [6].

The decline in HIV prevalence is a positive development, yet many stakeholders in Zimbabwe emphasise that prevalence is still unacceptably high. Currently, it is estimated that 3000 people die of HIV-related illnesses every week and most Zimbabweans are unaware of their HIV status. Although Zimbabwe has been acknowledged for achieving a certain level of behaviour change and decrease in HIV prevalence, more efforts will be needed to sustain the declining trend.

Prevention is the key

Given that behaviour-change interventions promoting condom use, the reduction in the number of sexual partners and the delay of sexual debut appear to have contributed to the decline, Zimbabwe's government and the National AIDS Council continue to place a clear focus on scaling up prevention strategies. Speaking at the launch of a programme entitled 'Accelerating HIV prevention in the African region', Dr David Parirenyatwa, the Minister of Health and Child Welfare, said that the programme would see the government taking 'exceptional measures to increase the pace and scale of HIV prevention interventions' [8]. A National Behaviour Change Strategy (2006–2010) is being developed, placing an emphasis on successful prevention strategies, such as condom promotion, reducing the number of multiple partners and promoting faithfulness in sexual relationships. The activities and targets highlighted in the strategy attempt to address the root causes of high-risk behaviour such as gender inequality and stigma.

Balancing prevention with care and treatment

Although education and prevention efforts have successfully reduced the prevalence of HIV in Zimbabwe, it is estimated that 1.7 million people (of the total population of 12 million) are living with HIV. Of these, only 26,000 people are receiving antiretroviral treatment (ART) in Zimbabwe [9]. It is estimated that 300,000 people living in Zimbabwe desperately need ART.

In 2004, Zimbabwe initiated a public programme to provide ART. Under the '3x5' programme of the World Health Organisation (WHO), Zimbabwe's original target was to provide 170,000 people with ART. This has since been revised to 30,000 because of an overall lack of resources. Zimbabwe has received the least amount of HIV/AIDS funding from international sources of all countries in Southern Africa [9].

Recognising the need for resources to address HIV/AIDS, in 2000 the Zimbabwean government established the AIDS Levy Fund, which collects 3% from the income of each individual. Although funds from the levy are reportedly flowing to community level programmes, such as Zimbabwe's extensive Prevention of Mother to Child Transmission Programme and community initiatives, key stakeholders continue to question where the money is actually spent. In particular, some workers living with HIV question why they contribute to the AIDS levy fund, yet continue to struggle to access ART through the public sector.

Zimbabwe is expected to receive a \$10 million grant under the Global Fund Round Five programme. Under the new arrangement, the country expects to provide ART to 70,000 affected people. Despite this initiative, there is an urgent need to scale-up access to care and treatment for people living with HIV/AIDS. Zimbabwe was once considered to have one of the best health infrastructures in Africa for implementation of an HIV/AIDS programme. The country's severe economic crisis has affected its capacity to address HIV/AIDS. Since 2000, funding for health delivery has declined and there has been a haemorrhage of trained health care workers from the country. According to the 2004 Millennium Development Goals report on Zimbabwe, it is estimated that the country requires \$38 million (excluding the costs of ART) to address HIV infection [10]. With many qualified doctors and nurses now leaving Zimbabwe for better economic prospects in developed countries, it will soon be too late to sustain a nationwide HIV/AIDS programme that can save lives in Zimbabwe.

Due to the sheer scale of HIV/AIDS in Zimbabwe, the epidemic continues to have a severe impact on the social, cultural and economic environment. The death of one individual from HIV sets into motion a

spiralling effect on the welfare of households and communities. Life expectancy has dropped from 62 years in 1990 to 53 years today. It is estimated that 761,000 children have lost one or both parents to HIV/AIDS [4]. The UN Development Report estimates that in countries with HIV prevalence rates of over 20%, the annual GDP has steadily decreased by 2% [11]. A study examining the macroeconomic impact of HIV/AIDS on Zimbabwe estimated that 13.92% of the 1993 GDP was lost due to HIV/AIDS [12]. The same study showed that if an individual living with HIV could remain in the asymptomatic stage of HIV (WHO stage 1) longer, less productivity would be lost. If those infected with HIV remain asymptomatic, households and organisations would lose less, as children would not be orphaned at such young ages and valuable skills and knowledge would not be lost. In addition, it has been calculated that even if there were zero incidence of HIV in 2005, Zimbabwe would continue to experience a loss in productivity until the year 2015 [12]. Although prevention efforts are ongoing, the sheer scale of the epidemic requires that greater attention is placed on providing care and treatment people living with HIV so that they will remain as active and healthy as possible. The full social, cultural and economic contribution of the estimated 1.7 million people living with HIV is essential for Zimbabwe's growth and development.

Conclusion

Despite Zimbabwe's recent political and economic challenges, the country offers a ray of hope to the region with respect to HIV. Zimbabwe has demonstrated that education, prevention and behaviour-change strategies can have a significant impact on HIV. However, the remaining high level of HIV infection in Zimbabwe means that AIDS deaths will continue to rise without adequate access to treatment, causing a long, slow crisis for development. Zimbabwe requires a response that will maintain prevention and behaviour-change efforts, while at the same time scaling up access to care and treatment for people living with HIV.

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Staying alive with HIV in India

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Comprehensive treatment, care and support options are not yet a reality for over 5.1 million people living with HIV/AIDS (PLWHA) in India. These figures are contested by government and United Nations agencies but it is becoming clear that antiretroviral therapy (ART) will not be widely accessible to those who need it today to survive for several more years; 2010 is the most optimistic estimate. We have to develop feasible locally available options before many more millions of lives are lost to HIV/AIDS.

Government agencies have been struggling to expand ART roll-out programmes in India. In November 2005, the then Director General of the National AIDS Control Organization (NACO), Dr SY Quraishi, said that there were 39 ART roll-out centres across India and each centre had a capacity that could fulfil the ART needs of 1000 people. Therefore, we had the existing potential to provide ART to 39,000 people. However, only 15,400 PLWHA were benefiting from these services, according to NACO records (www.nacoonline.org). The World Health Organisation estimate at the end of 2005 was that 770,000 people in India needed ART to survive; only 2% of PLWHA who needed ART to survive were receiving it (www.who.int).

It is now time to ask why people who needed ART to survive did not have access to these lifesaving drugs. Dr Quraishi correctly stated that although India has more than 100,000 people who have tested positive for HIV, not all of them need ART. Only those who had clinical manifestation of AIDS-associated illnesses or had CD4 counts <200 cells/ μ l were to be put on ART. But with an estimated 5.1 million people living with HIV, why have only 2% of them been tested? Why is the number of people who die because of HIV/AIDS-associated illnesses rising? And why is the number of people who default and need second-line treatment on the rise?

Naresh Yadav is President of Uttar Pradesh (UP) state's Network of People Living with HIV, a partner organisation of AIDS Care Watch (www.aids-care-watch.org). He says that a high degree of stigma still prevails in India, discouraging PLWHA from benefiting from healthcare services. Perhaps rightly, he asks what the benefit or incentive is of being tested for HIV. The impact of an HIV-positive diagnosis exposes an individual to a broad range of challenges: stigma is strong even in the healthcare setting in UP state and doctors from different clinical domains do not treat PLWHA the same way as HIV-negative patients. Healthcare staff in ART centres are usually sensitive to people living with HIV but there are only two ART centres in the entire state of UP; other departments and allied healthcare services are often insensitive. HIV-positive patients often need a high degree of clinical care at a high discount or free of charge but the general healthcare services in UP state make it difficult for HIV-positive people to access these services.

Amit Dwivedi, Secretary of the Abhinav Bharat Foundation (another partner of the AIDS Care Watch campaign) states that although ART is life-extending for PLWHA, it is important to understand the social dynamics of why PLWHA die without receiving even the basic drugs for tuberculosis (TB), diarrhoea and pneumonia that are available. The stigma associated with HIV has made healthcare service providers insensitive and at times irrational when dealing with HIV-positive patients. Dwivedi says that doctors in primary and secondary healthcare services in India are often averse to treating PLWHA. Gender disparities further aggravate the situation and women are often the last in their families to receive even basic healthcare. Women attend sexually transmitted infection (STI) clinics only in extreme situations with full-blown STIs. Conversely, men access these services whenever primary infection occurs.

A woman living in Hardoi district, who was a sex worker in Poonā, now volunteers for the Asha Trust (another AIDS Care Watch partner) and has not publicly revealed her HIV-positive status. She says that her HIV-positive diagnosis ruined her life. That was the last day of her life of dignity: she was forced to pack her bags in Poonā and return to her native village in Hardoi district. The only way she could get medicine for primary illnesses was by not disclosing her HIV-positive status. She knew by experience that it would become very difficult for her to get any further care or treatment if her status became known to doctors and she would be referred from one department to another. She wept inconsolably when narrating how her own family members in the village identified HIV as a 'witch's illness' and forced her out upon learning she was HIV-positive.

She struggled to survive until she came into contact with Asha volunteers. Now she stays at Asha an Ashram in another village and teaches in an Asha informal education programme. She had never heard of ART but she gained weight and felt better when she got a teaching job at Asha. With her small honorarium she could afford better nutrition and get homeopathic treatment for any illnesses during monthly health camps. The homeopathy doctor comes to this village monthly but is unaware of her HIV status. However, she is able to control most of the infections; she was treated for TB 2 years ago and has been living considerably well with good nutrition, healthcare and a general feeling of wellbeing owing to her job, her association with children and the respect she has in the community. She reflects that basic respect from these children and Asha volunteers has encouraged her to live and look after herself as best she can.

She says that the doctor in the TB clinic in the district hospital discovered her HIV status because he tested her for HIV without telling her. It is important to realise that despite the fact that there is so much talk about voluntary counselling and testing centres for HIV, HIV testing is done without a word of either pre-test or post-test counselling. This woman had been tested twice for HIV without her knowledge or any counselling, once at the STI clinic in Poonā and then at the TB clinic years later. When asked whether the TB doctor's knowledge of her HIV status had affected her TB treatment, she said that she was persuaded to get TB treatment from a government facility in a private clinic for a small sum of money (approximately \$11 for the entire course). Now she has to boil her drinking water because diarrhoea challenges her already weakened immunity.

HIV gradually subdues the immune system of PLWHA, allowing opportunistic infections (OIs) such as candidiasis, meningitis and TB to exploit the body's weakened defences. People living in poorer parts of the world often have no access to clean water and sanitation, have bad nutrition and a

poor health status, and are constantly challenged by a variety of infectious diseases. These factors place them at greater risk of HIV-associated OIs and are believed to shorten significantly the interval between initial HIV infection and the onset of AIDS-related conditions. As a result, HIV/AIDS is often called the quintessential disease of poverty. But AIDS-related conditions can be prevented and treated with established forms of care, support and treatment, including readily available non-ART.

HIV/AIDS care is provided on a daily basis by medical services, families and communities throughout the world. In many of the countries that are hardest hit by the epidemic, the demand for these care services has overwhelmed already fragile health and social systems. This demand has not yet stabilised anywhere in the world and it can only increase as more PLWHA become ill. Without a health system to rely on, PLWHA in many countries similar to India have no option but to assume increasing responsibility for their own health. To do so, people living with HIV need a variety of self-management abilities to monitor and control symptoms and to minimise or entirely avoid complications.

One of the abilities required by PLWHA is health literacy: the ability to obtain, read, understand and act on health information. It largely determines whether a person actively seeks health care when they need it and whether they and their families can make informed treatment decisions. According to the International Alliance of Patients' Organisations and other groups, however, there are many people who do not have sufficient health literacy to engage actively in their own healthcare in this way.

Striving for the ultimate goal of universal access to ART is clearly vital, but as we do so we must protect people's right to health and enable them to survive by all possible means. Three ways that PLWHA can be helped to survive the long wait for ART are:

- ensuring widespread access to non-ART care and treatment to help people discover their HIV status, delay progression to AIDS and prevent and treat HIV-associated conditions;
- improving health literacy among PLWHA, particularly in relation to 'early' HIV-associated conditions, their prevention, management and drug treatment;
- identifying and minimising the factors that accelerate the development of AIDS-related conditions.

Employers, academic institutions, civil society groups, PLWHA networks, health workers, media representatives, government bodies, advocacy groups, pharmaceutical companies and faith-based organisations should give more urgent attention to these simple approaches to keeping people with HIV alive. With life-extending drugs

including ART beyond the reach of hundreds of thousands of people in India, it is imperative to find simpler ways to keep people alive until expanded ART services can reach them. Many are readily available, affordable and effective. They include:

- voluntary counselling and testing for HIV as the entry point for access to all healthcare services and self-management;
- prevention and treatment of TB in PLWHA;
- drugs to treat/prevent other OIs (e.g. cotrimoxazole and fluconazole);
- home- and community-based care approaches;
- tackling HIV-related stigma, especially in healthcare settings, which often keeps people away from health services;
- pharmacotherapy (e.g. methadone) for recovering injection drug users;
- traditional healing and treatment approaches;
- promotion of food security and micronutrient provision.

Until healthcare systems become strong enough to provide ART to all those who need treatment, we need to do all we can to prevent needless deaths and raise awareness about vital life-saving components of comprehensive care and support for PLWHA. Locally available options include directly observed treatment, short-course (DOTS), cotrimoxazole, substitution therapies, nutritional supplements and campaigns geared to reduce stigma. Let us hope that comprehensive care and support approaches become a reality for every individual in India as soon as possible.

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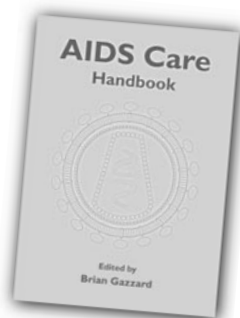
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Female condom programming in Asia: a success story in Myanmar

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Introduction

One of the factors commonly cited as contributing to the increasingly high rates of HIV infection among women in the developing world is the inability to negotiate safe sex and condom use. There has been much discussion of and advocacy for methods of HIV prevention that are under the control of women, most notably concerning microbicides. But in spite of increasing efforts and funding in search of new technologies, the female condom (FC) is currently the only new method of protection that has been approved since the HIV epidemic began. FCs offer a level of protection against pregnancy and sexually transmitted infections (STIs) similar to that provided by male condoms [1,2]. They have been shown to be safe and widely acceptable to men and women in developed and developing countries [3–5]. Research in Thailand has demonstrated that, even in the context of one of the world's most successful condom promotion programmes, the FC achieved an incremental increase in protection that could not be obtained by the male condom alone [6]. Yet FCs remain an under-utilised option, ignored by many HIV and reproductive health initiatives in both public and private spheres.

Background

In the Asia Pacific region there are 8.3 million people living with HIV/AIDS [7]. Relatively low overall HIV prevalence levels hide concentrated epidemics that have existed for many years in certain parts of the region and are poised to explode in others. Concentrated epidemics, where prevalence is high in certain vulnerable groups, require targeted interventions to reduce overall infection rates. This has been demonstrated in Cambodia and Thailand, where interventions focused on high-risk groups, such as sex workers, protected the population as a whole [7].

The prevalence of HIV has risen in the Asia Pacific region among particular groups: injection drug users, men who have sex with men (MSM) and female sex workers (FSWs) and their clients. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), 5–10% of Asian men visit sex workers (male, female and transgender) and the majority of new infections are transmitted in commercial sex transactions [8]. Although male–male sex was overlooked as a risk factor for

many years, there is increasing evidence about the vulnerability of MSM in Asia. A recent study in Bangkok found that 17% of MSM were HIV-positive [9].

Women in the region are also increasingly vulnerable. East Asia has experienced the largest increase in numbers of women living with HIV in the world over the past 2 years, and in south and south-east Asia there are now almost 2 million women with HIV [7]. In addition, over 10 million unsafe abortions are performed in Asia every year and contraceptive prevalence remains low. Cambodia, for example, has one of the highest rates of HIV infection in the region and contraceptive prevalence is only 19% [10]. The need for dual protection could not be clearer.

The FC offers well documented protection against sexually transmitted infections (including HIV) and unplanned pregnancy and is under the control of female or male receptive partners. It is a strong, soft, transparent polyurethane sheath 17 cm long (about 6.5 inches, the same length as a male condom) with a flexible ring at each end (Figure 1). It is inserted into the vagina or anus prior to sexual intercourse. The inner ring aids insertion and secures the device in place during intercourse while the softer outer ring remains outside the canal. The FC has also been promoted for use by men who have sex with men (MSM) with the creation of special packaging and training materials targeted to this group.

However, HIV and reproductive health programmes have largely overlooked the role of FCs, particularly in the Asia Pacific region. Of more than 100 million FCs distributed worldwide since its introduction approximately 10 years ago, fewer than 1 million have been made available in Asia [Patricia Weisenfeld, Female Health Foundation; personal communication, December 2005]. The reasons are varied and include cost, lack of political

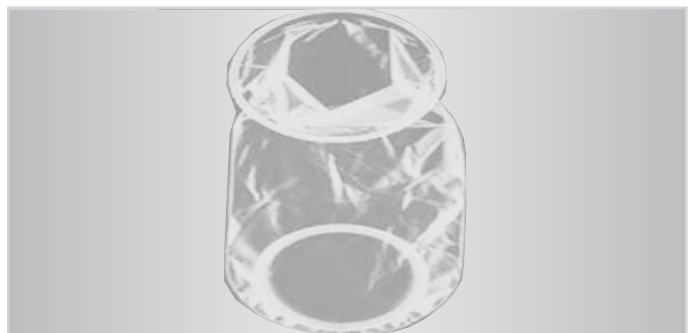


Figure 1: A female condom.

support and commitment, the absence of 'champions' who fight for FCs and questions about introduction and acceptability in the cultural contexts of the region. Recently, initiatives in Asia and the Pacific have started to introduce and integrate FCs into reproductive health programmes, offering new knowledge and experience. Among these, Population Services International (PSI), a social marketing non-governmental organisation (NGO), is one of the largest global distributors of FCs. Successful social marketing for HIV/AIDS prevention involves the systematic application of private sector marketing concepts and tools to motivate lower-income and marginalised groups to adopt and consistently practise behaviours that will reduce their risk of infection. Social marketing serves as a behaviour-change methodology focusing intensively on the end user, and considers several interrelated influencing factors such as individual risk perception, social support and access to affordable products and services.

PSI launched its first FC programme in 1995 and has distributed millions of FCs globally. With support from the UK Department of International Development (DFID), the US Agency for International Development (USAID) and other donors, PSI recently began to introduce FCs in Asia, with a focus on high-risk groups of women and men. PSI programmes in India, China, Myanmar (also known as Burma), Cambodia, Vietnam and Thailand have current or planned initiatives for the social marketing of FCs. However, even within PSI, FCs remain a marginal product, with programming dependent on the presence of champions in individual country offices. Within the region, PSI has been very successful in promoting FCs in innovative and far-reaching programming, providing instructive lessons for implementation elsewhere.

FC programming in Myanmar

Myanmar has one of the highest levels of HIV prevalence in the region; an estimated 31% of FSWs are HIV-positive [11]. PSI launched its Myanmar FC programme in July 2003, targeting female sex workers and eventually MSM. The programme began by recruiting six FSWs to try FC samples and meet with PSI staff weekly to discuss their experiences with the product. This was not intended as an acceptability study but as a means of testing possible brand names and designs for the product, creating appropriate educational materials and helping staff to understand the perceptions of users and the dynamics of use.

Based on the feedback of these FSWs, the FC (named *Feel*) was developed with a brand name and packaging designed to look like a feminine hygiene product and differentiate it from male condoms (Figure 2). One important outcome of the testing was that staff and managers understood the importance of the FC in the lives of FSWs, and as a



Figure 2: The *Feel* female condom.

result became FC champions committed to promoting the condom. Staff were also encouraged to try the FC themselves in order to improve understanding of the product and user experiences.

A key strategy was training a large number of men and women in the target groups and initially restricting sales of the FC to those trained. This approach ensured informed use and created demand for the FC before access to the product was increased. This was done to prevent users from having a negative experience of the product and subsequently rejecting FCs or sharing their experiences with others. Therefore, sales were limited at the outset to FSWs and MSM peer educators (PEs) trained by PSI to promote FC to their peers, and other NGOs working with these same target groups.

Initially, the bulk of sales was to NGOs but direct sales are now higher. About 130 PEs began to sell the FC for a small commission on each sale. During training, PEs are taught to encourage their peers to try the product more than once and to practise insertion before using it with their partners or clients. Single use of the FC is encouraged, but guidelines for cleaning and re-use are explained. FCs are promoted as an alternative when use of male condoms is impractical or impossible. PEs also discuss testing for and treatment of STIs, non-penetrative sex and strategies for negotiating condom use.

PEs meet with individuals, in small groups at PSI's drop-in centre or at venues where high-risk sex takes place. Many PEs sold a few FCs and then lost interest, although several enthusiastic champions of the FC emerged from this group. In 2005, in an effort to increase retention and motivation, the number of PEs was reduced and those remaining were hired as part-time staff (4 hours per day with a small salary in addition to the commission on sales). This seemed to change the nature of their relationship with PSI, with PEs becoming more committed and involved. Sales increased, and at the same time, the price was lowered from US \$0.10 to \$0.05. This was done to ensure that cost was not a barrier, because the average sex worker earns between \$0.50 and \$1 per client.

By May 2006 (within 3 years), outreach staff had conducted training sessions involving more than

110,000 FSW and 80,000 MSM, providing a critical mass of informed consumers. More general access to the product was needed, so 'hot spots' (those areas where target groups meet partners and/or engage in high-risk behaviour) were mapped to target the retail market where FSWs and MSM were likely to buy it. Shops carrying sexual toys and products were chosen as retail outlets capable of reaching the target audience and shop owners were trained. *Feel* is offered at the same price through these venues.

PSI's specialist team initially focused on Yangon and Mandalay. In the rest of the country, generalist outreach staff now also incorporate FCs into their work. They train FSWs and MSM on use of the product, and integrate FC information into HIV/AIDS education sessions with migrant workers, truckers and others. The sales target for 2006 is 145,000, more than double the number sold in 2004.

Recent surveys show that the programme has achieved high levels of coverage in urban areas and suggest that FCs have come to play a significant role in the protection strategies of a large proportion of these two priority populations (Table 1).

Key strategies and lessons learned

One key reason for the success of this programme was the training of large numbers of users, members of staff and other organisations. Staff familiarity with user perceptions and dynamics of use is important for maintaining credibility and commitment to the product. Creating informed demand in the target market minimises negative product experiences and ambitious yet attainable goals helped to increase sales and market reach.

Realistic FC programming starts with an understanding of the needs and issues of the target group, rather than 'pushing' a product; the brand, price and market positioning must be appropriate for the context and audience. FCs should be promoted as one of many options to increase safe sex, including male condoms and non-penetrative sex.

Myanmar is a good example of synergy between several factors: the right niche market; the right

price; enthusiastic and committed champions; adequate staffing and funding resources; ambitious yet realistic goals; and, perhaps most importantly, training.

Conclusion

PSI's operation in Myanmar is a success story in FC programming in the Asia Pacific region. This programme has been able to reach a large but highly targeted audience by dedicating adequate staffing and financial resources to FC programming. The target groups were chosen to reflect the realities of the epidemic in the country: high rates of infection among FSWs and MSM. The focus on the appropriate vulnerable niche groups ensures that FCs are used in high-risk situations and are a necessary intervention for these users.

FCs have been shown to be widely acceptable to users in the developing world. PSI's programme in Myanmar offers valuable insights about focusing efforts in concentrated epidemics and promoting FCs to both men and women. These lessons are applicable to HIV prevention elsewhere in the region and beyond.

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Table 1: Target group surveys

Indicator	FSWs (%)*	MSM (%)†
Ever heard of <i>Feel</i> female condom	93.4	88.4
Ever been shown how to use <i>Feel</i>	67.0	69.9
Know how to use <i>Feel</i> correctly	55.6	58.3
Think <i>Feel</i> is affordable	84.3	69.8
Think <i>Feel</i> is easily accessible	59.2	39.6
Ever used <i>Feel</i>	35.6	32.0
Used <i>Feel</i> in last 30 days	20.3	19.6

* Sample size 754; † Sample size 838.

FSWs were interviewed during January 2006 in Yangon, Mandalay, Lashio and Myitkyina. MSM were interviewed during March 2006 in Yangon and Mandalay.

FSWs, female sex workers; MSM, men having sex with men.

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The Mae On Project: using acupuncture for HIV symptom relief in Northern Thailand

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Introduction

Maintaining a sustainable quality of life (QoL) and addressing physical, emotional, mental and spiritual needs for people living with HIV/AIDS (PLWHA) remains a constant challenge for healthcare providers. This is particularly true of developing regions where access to appropriate treatment and support is often limited. In developed countries, orthodox medicine – sometimes known as the allopathic approach – is the first intervention of choice. This is sometimes followed by a trial of complementary and alternative medicines (CAM) determined by the patient. Allopathic methods and CAM are often used together and are part of an integrated approach to healthcare [1]. Elsewhere, care choice is shaped more by local health beliefs, cost and the willingness of practitioners from allopathic and alternative approaches to work together.

This paper will discuss an innovative project in rural northern Thailand, where allopathic treatments including antiretroviral therapy (ART) exist in tandem with a well-organised and effective programme of acupuncture. Evaluations from the project suggest that an integrated approach to symptom relief provides key benefits for PLWHA in resource-poor regions. These also demonstrate the feasibility of using local healthcare staff and developing such a program with sensitivity.

Background

Complementary and alternative medicine

The use of CAM remains controversial in the context of allopathic medicine. Empirical evidence demonstrating a positive effect is sparse for certain interventions. From a 'Western' medical perspective, it is tempting to group all non-allopathic interventions together but to do so is incorrect. The numerous alternative approaches are underpinned by a vast range of belief systems and can include traditional African medicine, homeopathy, Ayurveda (traditional Indian medicine) and traditional Chinese medicine (TCM), all significantly different modalities whose only common feature is that they are not orthodox. Controversy rages around actual benefits [2] but there can be no doubt that patients do report improvements for certain symptoms. The growing popularity of alternative therapies in developed

countries and increasing respect for non-allopathic paradigms in other regions suggest that it would be foolhardy not to explore the issue further. In the context of HIV care, there are several reviews examining the benefits of CAM [2–5].

Acupuncture

Acupuncture is one of many healing modalities used in TCM. This holistic system of medicine has a long history of preventing and treating disease and enhancing the immune system. It is based on the flow of *Qi* or life energy along the pathways of the body called meridians. When imbalances or blockages of this energy occur, pain and illness result. Acupuncture consists of inserting and manipulating hair-thin needles in selected points on the body to remove blockages and re-establish the normal flow of *Qi* through the meridians. In this way, it returns harmony to the body, restoring function, relieving pain and thereby treating underlying illnesses. Of all the alternative approaches to treatment, acupuncture is often cited as the intervention with the most obvious (and proven) benefit. This was a prime motivator for the development of the Mae On Project.

Acupuncture is a potentially useful treatment for improving the symptoms of chronic HIV infection and the side effects of ART among PLWHA. There is evidence that it reduces the severity of symptoms such as peripheral neuropathy [6] and general malaise [7], and that it also improves sleep quality [8]. Although there are often cultural barriers to using CAM [9], evidence for its benefits is compelling in the context of certain illnesses, for general palliative care and specifically in the care and support of people living with HIV [10].

Thailand

Although classed by many as a developing country, Thailand is more realistically 'middle income'. Its gross domestic product per capita (GDP) was \$7600 in 2003, much more than Laos (\$1759) or Uganda (\$1457) but much lower than the UK (\$27,147) or Norway, the highest ranked country (\$37,650) [11]. The population of Thailand is approximately 65 million. HIV infection cases numbered 540,000 or 1.5% of the adult population at the end of 2005, with 112,000 people reporting advanced (symptomatic) HIV disease [12]. About 45% of those with advanced disease have access to ART.

The Mae On Project

The Mae On district is located in northern Thailand, close to the city of Chiang Mai. Mae On Hospital is a rural community facility serving a population of approximately 20,000.

The Mae On Project began in April 2004 and had three main objectives: to develop a program to train medical staff in acupuncture as adjunctive treatment for PLWHA at Mae On Hospital; to develop a free clinic at Mae On Hospital to provide acupuncture for PLWHA; and to undertake an evaluative study using quantitative and qualitative data to assess the efficacy of the intervention on QoL, the symptoms of chronic HIV infection and the side effects of ART.

Setting up the clinic

The acupuncture clinic was established with the cooperation and support of Mae On Hospital. Two Thai nurses volunteered for training in acupuncture; both had obtained their Bachelor of Science degrees in nursing and were keen to develop their skills in a completely new direction. The nurses received 110 hours of didactic training in acupuncture over a 4.5-month period, and 6 months of supervised clinical training in a weekly acupuncture clinic for PLWHA. Training was provided by three TCM practitioners and the nurses were able to perform acupuncture on the opening day of the clinic. During the first 3 months of clinical training, they quickly learned how to conduct a basic TCM interview, make a diagnosis and design a treatment plan.

Once the clinic opened, 32 PLWHA at various stages of HIV-infection regularly attended weekly acupuncture treatments in a group out-patient setting. Standard TCM tongue and pulse assessments were recorded for each participant on every acupuncture visit. The acupuncture points used were based on the principles of TCM as well as each participant's individual clinical presentation. Each treatment was personalised over the course of the study to accommodate the individual's changing symptoms and health concerns.

Treatment consisted of ear and body acupuncture as well as indirect moxibustion, electro-acupuncture and tui na massage, three complementary therapies often used as adjuncts to acupuncture to enhance efficacy (see Glossary). Disposable and sterile acupuncture needles were used on all subjects.

Evaluation

How effective was the acupuncture? Given the controversy surrounding all interventions of this type, it was vital to undertake some form of evaluation. A non-randomised, single-arm study was carried out over a 6-month period, for which 27 HIV-positive participants with stable medication use and no significant morbidities were enrolled. Participants were invited to take part through local

HIV/AIDS health-care providers in the Mae On and neighbouring Sangkhampaeng and Doi Saket districts. Of the participants, 68% had a diagnosis of AIDS and 19% were asymptomatic. The mean age of participants was 35.9 years; 74% were women, and 78% were on ART. The mean period since HIV infection was 6.1 years and the mean period since AIDS diagnosis was 1.4 years.

All participants gave informed consent (in the Thai language) and clearly understood access to the treatment was not determined by their willingness to participate in the study. Data were collected using repeated pre- and post-acupuncture questionnaires that included the QoL scale and the Memorial Symptom Assessment Scale (MSAS) [13]. The pre-acupuncture questionnaires were administered three times before initiation of treatment (at enrolment, and at 3 and 6 months thereafter). The post-acupuncture questionnaires were administered during acupuncture treatment at 2, 4 and 6 months.

These quantitative tools were supplemented with qualitative, semi-structured exit interviews conducted with participants to evaluate the efficacy of acupuncture on physical symptoms and QoL. These took between 40 and 60 minutes and were tape-recorded. A native English speaker, United Nations-certified in translation and interpretation of the Thai language, conducted the interviews in Thai. These were comprised of closed and open-ended questions and informal conversation.

Results from the evaluation were intriguing: no significant changes in QoL were apparent from the questionnaire scores, but 17 participants already treated with ART reported a significant decrease in pain ($P=0.01$) after acupuncture treatment. Comments from the interviews confirmed that 96% of participants reported improvement in symptoms such as pain, peripheral neuropathy, dizziness and frequency of upper respiratory infections; 89% stated improvement in sense of wellness and emotional wellbeing; and 48% reported an increased ability to work more, thereby decreasing financial worries.

Here are some examples of patients' comments:

'Prior to having acupuncture I was aware of the symptoms and this would cause me some stress. But now that these symptoms have eased, almost gone, I don't think about this anymore and consequently feel emotionally and spiritually better. And I can also look to the future with greater hope because I don't have to worry about these symptoms anymore.'

'Since doing acupuncture I really firmly believe my life has improved. My physical symptoms are all gone ... [I have] more concentration ... I feel that my health is better than those who don't have HIV. I feel it's a combination of antiretrovirals and acupuncture.'

'Acupuncture increases my hopes and aspirations and gives me encouragement, strengthens me. I have something to lean on. If I don't come here, I feel like I've left something out of my life.'

Discussion

Overall, the findings of the evaluation suggest that acupuncture may be beneficial to people living with HIV in this rural region, improving physical symptoms and QoL. Apparent differences found between the quantitative and qualitative data may be due to several factors. In reviewing the questionnaires at the end of the study, it was recognised that they were culturally inappropriate, written beyond the educational level of participants or potentially misunderstood. In addition, other non-controlled factors could have affected the MSAS and QoL scales. These factors include nutritional status, social factors, economic livelihood and psychological wellbeing.

By contrast, interview data may be a better tool for capturing the results of acupuncture in this population. Data showed a cascade effect of acupuncture on QoL. For example, many participants commented on how acupuncture decreased their physical symptoms, which allowed them to work more. This in turn enabled them to earn more money, thus reducing finance-related stress and leading to greater opportunities to participate in community and social life.

Conclusion

The Mae On Project demonstrates the feasibility of establishing and maintaining a hospital-based acupuncture clinic for PLWHA in a rural area. The project drew on local nursing expertise, and confirmed that acupuncture was acceptable to this population, with many participants requesting that similar clinics be started in other districts to accommodate those PLWHA who were unable to travel to the Mae On Hospital. The director of Mae On Hospital and the head nurse of the HIV/AIDS program expressed great satisfaction with the acupuncture program, requesting training for more nurses. The acupuncture clinic continues to run on a weekly basis at the Mae On Hospital and has a waiting list for new patients.

Acupuncture has important benefits for this resource-poor area. It is well tolerated and safe, with no adverse complications reported. Acupuncture has no side effects if used correctly, and treatments can be planned around the availability of hospital staff, and the patient's work/life schedule. It is cost-effective and has no interactions with allopathic medications, including ART. The average cost of a weekly acupuncture treatment for one participant was approximately \$1.45, translating to about \$6 per month per patient. Many clients commented that they experienced improved appetite, better sleep, less stress and more energy, even though they were not treated directly for these conditions. This suggests that the Mae On project has proven to

be a vital resource in the care and support of PLWHA in this region.

Glossary

Electro-acupuncture involves the application of low voltage electricity to inserted acupuncture needles to improve the function of the affected neuromuscular system.

Moxibustion is the use of burning herbs (*Artemisia vulgaris*) to prevent and treat disease by warming acupuncture points. Moxibustion has the ability to help decrease the main digestion-related deficiencies of spleen and stomach caused by HIV. It is also used to dispel dampness and cold, and to stimulate the flow of Qi so that the organ systems are nourished and work in harmony.

Tui Na Massage is an ancient Chinese massage technique that is used to promote the flow of Qi and blood in the body.

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Global Summit on Traditional Medicine, Indigenous Knowledge and HIV/AIDS

Ian Hodgson

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14–18 March 2006

Accra, Ghana

This important conference was held in the Ghana Institute of Management and Public Administration in Accra, Ghana. The tone for the week was set by Dr Richard Fru (Garden of Eden Institute of National Medicine, Cameroon) during the opening presentation: traditional healers (THs) dispensing traditional medicines (TMs) are used by 80% of Africans. Although allopathic medicine (AM) has achieved almost global hegemony, local, community-driven and culturally relevant interventions are the primary source of treatment for millions of people. The 'ancient' or indigenous knowledge that informs traditional medicine was frequently contrasted here in Ghana with the relatively recent, more 'youthful' allopathic interventions.

The purpose of this summit, opened by the enthusiastic Health Minister of Ghana, the Hon Courage Quarshigah, was to remedy the imbalance between allopathic and traditional medicine, and promote a paradigm of care allowing the two approaches to co-exist. Presenters at the summit hailed from Africa and beyond: delegates were present from Zambia, Tanzania, Ghana, Cameroon, Belgium, Malawi, Canada, Hong Kong, the United States and the United Kingdom. In spite of this geographical variety, the majority of delegates had a unifying desire to emphasise alternative approaches to the care and treatment of people living with HIV/AIDS. These approaches are rooted in local knowledge and draw on a long cultural heritage predating modern interventions by centuries. Many of the speakers focused on herbal and plant-based interventions; non-African interventions included traditional Chinese medicine (TCM) and the use of acupuncture for HIV/AIDS symptom relief in northern Thailand, which was presented by Dr Laura Louie (the Mae On Project). This shows that 'ancient' treatments still have a role to play in the management of modern disease.

Traditional Medicine and its benefits

What are the benefits of TM? Primarily, it uses a holistic approach, allowing for the physical, mental, emotional and spiritual aspects of an individual.

Some presenters described methods used by empirical science to evaluate the application of TM in HIV treatments: Dr Luc Pieters of the University of Antwerp in Belgium, described the development of research studies to evaluate the effectiveness of herbal remedies and the specific modes of action of particular herbs. Dr Mary Richardson of the National Foundation for Alternative Medicine, Washington DC, USA, highlighted the continuing need to regulate traditional medicines so as to maximise safety and efficacy, especially with regard to contamination.

These and similar papers revealed a difficult facet in the evaluation of TMs: product consistency. If one herb being used for a treatment is to be evaluated, for example, when in the lifecycle of the plant is the medication to be extracted, and from where? These and similar questions pose serious challenges for TM, but one common feature reiterated throughout the week here in Ghana is the relative affordability, low toxicity, and ease of manufacture of TMs. Their effectiveness against the 'monster' of HIV/AIDS is also a feature that many at the summit felt to be significant. It is the strong cultural relevance of TMs, derived from knowledge within the local community, that is perhaps their most potent characteristic. They are literally owned by the populace.

However, the issue of the regulation of practitioners remains important, a fact highlighted by Dr Dabra VI (Prometra, Ghana) during his description of a local project in which THs were provided with additional information about HIV in a bid to ensure that their practice was safe. A similar project in Mali also suggested that, in the right circumstances, THs were willing to engage with education programmes designed to ensure that TM was practised safely in a way that would not diminish its uniqueness or relevance, but would ensure risk of HIV transmission was minimised (e.g. during circumcision rituals). Dr Rokia Sanago of the University of Mali described a study in which 249 THs took part. Following culturally sensitive education, 97% altered their practice to minimise HIV transmission. Other examples [for instance, ensuring the THs are aware of interactions between antiretroviral therapy (ART) and TMs] suggest that it is possible to integrate traditional and modern knowledge in meaningful and beneficial ways, as has been often demonstrated in the context of 'Western' naturopathic medicine.

What is indigenous knowledge?

TM is founded upon indigenous knowledge (IK) and is local and immediate. People seeking treatment are already part of the 'world' of the TH, whose approach is also shaped by the cultural history of the region. However, defining IK is difficult, as it remains a nebulous concept not well-understood even by its 'custodians', according to Dr Luis Sambo, Director of the WHO regional office in the Democratic Republic of Congo. As a result, it is imperative that there is a legal framework to protect the intellectual property rights of THs. Dr Esther Kibuka-Sebitosi of the University of South Africa discussed the meaning of indigenous knowledge, and the ways that the knowledge held by THs can be protected from unscrupulous or excessively acquisitive organisations and companies.

She suggested, based on a survey carried out in the region, that THs are afraid of exploitation and wary that they will not get fair recompense for the passing of knowledge to 'outside' organisations. She raised an interesting additional point that resonated with others during the conference: the very nature of traditional healing and indigenous knowledge is that it is, by definition, local and rooted in the immediate culture. From a legal and ethical perspective, therefore, trying to define what actually needs protecting is difficult. Also, the names of plants and interventions will vary between regions and taxonomies will inevitably be different.

A clash of cultures?

Throughout the event, the unifying factor underpinning all activities was a firm belief in community and the power derived from approaches to illness and treatment that are rooted within the local social and cultural system. A fear of losing this ancient knowledge was reiterated many times – Health Minister Quarshigah suggested people had unfortunately 'decided to disconnect [themselves] from indigenous knowledge', partly because scientists have 'no use' for it at all. He declared his ardent support for TM, perhaps a sign that there will be additional prominence given to policies that protect and encourage traditional medicine, at least in Ghana.

The essential contrast between AM and TM was well illustrated by a practising allopathic doctor, Wisconsin-based Dr Richard Nagler. He was incisive in his critique of the inflexibilities in 'Western' medicine and its 'different goals and different approaches to the use of knowledge'. Nagler's argument is clearly central to the whole question of validity and acceptability of TM, and close to the view of anthropologist Arthur Kleinman, who argued in the 1980s that all approaches to illness are essentially relative, and equally valid; it is simply a matter of point of view. Nagler concluded with a call for all governments and organisations to

have as their goal the 'support and respect' of TM. Dr Richard Atleo, Hereditary Chief of the Ahousaht tribe in British Columbia, Canada, also confirmed the contrasts between knowledge generated by traditional science (through research) and by traditional medicine (through outcome). To many ears, this might sound like heresy, and indeed, orthodox Western-driven research paradigms may not be the best approach when evaluating the efficacy of TM.

What is important is the need for a model of treatment and care drawing on the best of both paradigms: the scientific approach of Western medicine (valuable for many medical emergencies) and TM rooted in IK and often best suited to chronic conditions that are unresponsive to Western interventions. As this conference confirmed, although this might seem a perfectly rational way of dealing with contrasting paradigms, the allopathic, 'scientific' approach often usurps the traditional, with the result that interventions offered to patients are founded entirely upon an alien paradigm.

On the final day of the conference, Dr Godfrey Swai, a public health specialist based in Dar es Salaam, Tanzania proposed a self-sustaining integrated medical clinic featuring AM, traditional African medicine, acupuncture, nutrition and health maintenance programs as an example of a useful model for development. He described how the rise and fall of colonialism and slavery over the centuries was inversely related to the dominance of traditional medicines in African cultures. He believes that now is the time for truly holistic interventions in the relief of HIV/AIDS symptoms, especially as the provision of ART and associated treatments often falls short of expectations.

The summit here in Ghana was driven by a desire to encourage mutual trust and respect between TM and AM. Dr Rodwell Vongo, President of the Traditional Health Practitioners Association of Zambia provided perhaps the most revealing question: 'Do Western doctors believe in demons or ghosts? Do traditional healers believe in psychosocial issues?' Words not normally heard at events dealing with treatments were also heard during the conference: 'dreams', 'visions', 'myths', and 'stories'. Although Vongo was clearly encouraging the development of TM in mainstream treatments, he also went on to comment on the lack of progress on both sides in expanding their understanding of other approaches and paradigms. He was also clearly aware of the stigmatisation of THs, and proposed that allopathic and traditional healers should 'join forces'.

As HIV/AIDS continues to ravage many parts of the developing world, and the roll out of ART lags far behind the targets set by international agencies, traditional medicine offers an accessible alternative, especially when allied with allopathic

treatments that are already well established, such as treatments for tuberculosis.

TM is not dependent on external and often culturally novel treatments that are too expensive or simply unavailable for many people. They provide (in this case) a resolutely African solution for an African problem, and result in an overall package of care with an impact far beyond that of individual components when grafted on to other forms of treatment. Following the conference, the declaration included these words, summing up the spirit of the event and challenging governments and agencies to act:

'... We urge state parties, governments and multilateral organisations to respect the customary laws and practices that define access and

availability of indigenous cultural knowledge, and to ensure adequate and mutually acceptable exchanges.'

The full declaration can be found at: www.africa-first.com/gsaidstmik2006/declaration.htm

NB: This article has also been posted on the Health and Development Networks (HDN) Af-AIDS eForum. To view archives, please go here: <http://eforums.healthdev.org/read/?forum=af-aids>

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NHIVNA update

■ *Annual NHIVNA Conferences.* Many thanks to those of you who helped make our 8th Annual Conference in Leeds our biggest and best ever. Over 200 delegates attended the 2-day conference, which had a mixture of plenary and concurrent sessions. We have read your evaluations and taken all your comments on board. This year NHIVNA awarded nearly £2000 as prizes for the best examples of research and practice development to those who submitted abstracts to the conference.

■ Work is well underway on next year's conference, which will be held 28–29 June 2007 in London. You should get the dates in your diary and request funding to attend the only HIV conference in the UK aimed specifically at nurses. If you are currently working on an original nursing research project, have developed new practices to improve patient care or education for staff or patients, why not consider submitting an abstract for next year's conference?

■ *Generic HIV Nursing competencies.* These are now ready for the first round of consultation, which coincides with the launch of the new-look website so please go to www.nhivna.org and download the competencies. Your feedback is very important, as we want them to represent nurses around the country. This stage of consultation is until September; the specialist competencies are still in development and we hope to also have them on the website by September.

■ *NHIVNA HIV Nursing Award.* The aim of this award is to recognise a nurse working within the field of HIV, who through his or her practice has made a significant or unique contribution to the care and management of people living with HIV. The nominated nurse will have displayed innovation and excellence through their efforts to improve patient care, service delivery or multi-disciplinary working, e.g. setting up nurse-led

services, workforce planning to improve service delivery, establishing standards of care or developing new ways of working within their team. You can nominate a colleague by completing an application form which can be found on the new NHIVNA website (www.nhivna.org). The winner will receive a fully sponsored place to attend an international conference of their choice. The deadline is March 2007 and the winner will be announced at the 9th NHIVNA annual conference in June 2007.

■ *NHIVNA Executive Committee.* Sue Russell, NHIVNA Treasurer, has stepped down. I would like to thank Sue for 6 years of commitment to NHIVNA. Brenda Mann is the new Treasurer. Also, Roy Brazington has taken on the role of Honorary Secretary. I will be stepping down as Chair of NHIVNA in 2007, having been involved with NHIVNA since its inception 10 years ago. It has been so rewarding to be part of something so exciting and I am very proud of all our achievements. I am pleased to say that Sheila Morris is now Chair Elect and we'll be working together for the next 12 months until Sheila takes over as Chair. We will also be announcing new committee members over the next couple of months.

■ *Website.* The new website is finally here and the first thing you will notice is that the web address is new, so please put www.nhivna.org into your bookmarks in your web browser. If by chance you visit the old website it will redirect you to the new site. On the site you'll find membership forms, HIV Nursing competencies and application forms for the NHIVNA/BI grants and scholarships. In the future we will have a resource section and a members-only area where we can post copies of guidelines and policies for members to share.

Nicky Perry, Chair, NHIVNA, Brighton

CALL FOR PAPERS

We would like to invite authors to contact us with Papers on the following topics for publication in Issue 7.1 (February 2007).

- Peer-reviewed articles on nurse-led practice.
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Antiretroviral Resistance in Clinical Practice

Edited by Anna Maria Geretti

Antiretroviral Resistance in Clinical Practice is a novel publication that has been developed to serve as a handbook for physicians dealing with the problems of antiretroviral resistance in their practice.

Antiretroviral Resistance in Clinical Practice covers an extensive range of topics (see below) written by eminent and internationally renowned authors led by the Editor Dr Anna Maria Geretti. Dr Geretti is a Consultant Medical Virologist and Honorary Senior Lecturer based at the Royal Free Hospital in London, and has a special interest in antiretroviral therapy and resistance.

The book examines the mechanisms of resistance to reverse transcriptase, protease and entry inhibitors with contributions from Charles Boucher, Noortje van Maarseveen, Nicola Mackie, Anne-Geneviève Marcelin, Eva Poveda and Vincent Soriano. With chapters by Martin Däumer and Tobias Sing, Alessandro Cozzi-Lepri, Karin Metzner, Carlo-Federico Perno and Ada Bertoli, Caroline Sabin and Martin Schutten, readers will be able to gain a valuable insight into the complex topic of resistance and obtain an update on the various methods used to measure, predict and interpret resistance.

Françoise Brun-Vézinet and Diane Descamps review the overall benefits of resistance testing, whereas Andrea De Luca examines the impact of resistance on viral fitness.

Marta Boffito investigates the pharmacokinetic implications of resistance, and Ricardo Camacho discusses the implications of HIV-1 subtypes on resistance testing, while Clare Booth gives an overview of transmitted resistance.

Finally, there is a chapter dedicated to a series of case studies compiled by experienced clinicians and each accompanied by an expert commentary.

Antiretroviral Resistance in Clinical Practice will prove to be a valuable handbook to all those who want to understand the increasingly complex problem of antiretroviral drug resistance in HIV medicine.

Topics covered in *Antiretroviral Resistance in Clinical Practice*:

- Mechanisms of resistance
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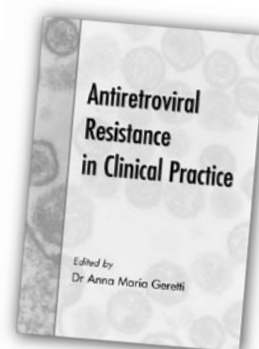
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