AIDS is a disease which kills. It is caused by a virus called HIV (human immunodeficiency virus). This virus is spread from one person to another, mostly through sex.

Women, as well as men, need to know the facts about safer ways of having sex (see right). But information about HIV/AIDS is often aimed more at men than women; in many places printed leaflets and posters do not reach women in rural areas, or those who have less access to formal education. In addition, it is usually men, not women, who are the decision makers in sexual relationships.

The worldwide epidemic of HIV means that women need to develop the language and the confidence to negotiate safer sex with their partners. This issue contains practical suggestions for persuading men to have safer sex (see pages 2 and 3).

Traditionally, women are also society’s carers. Those who care for people with AIDS, either in the home or hospital, should read the guidelines on page 6 since these can be adapted to most health care settings. Infection control is of particular concern to traditional birth attendants, who are regularly exposed to large amounts of blood and body fluids.

We hope this issue of AIDS action will provoke discussion, and demonstrate how women are successfully organising in the fight against AIDS. A fight in which women need support from each other, from their communities, and from men.

A few facts

What is AIDS?
The letters A·I·D·S stand for Acquired (something you get) Immune Deficiency (lack of defence against disease) Syndrome (symptoms of more than one disease). The virus that causes AIDS (HIV) attacks the body’s immune system (defence against disease), leaving the body unprotected against serious illness. You can be infected with HIV for eight or more years before symptoms of illness develop. During this time, people can pass the virus on to others without knowing it.

What is safer sex?
Unsafe sex is sexual contact through which infected semen, vaginal fluids and/or infected blood (including menstrual blood), enter another person’s body. Although the virus can pass through mucous membranes (for example, inside the vagina or penis) it does not appear to pass through healthy, unbroken skin. So it is safer to only allow sexual fluids to come into contact with unbroken skin on the body. During sexual penetration (where the penis enters the anus or vagina) it is safer to use condoms, which prevent the virus in sexual fluids passing from one person to another.

Is AIDS a ‘woman’s disease’?
In some countries, sexually transmitted diseases (STDs), including AIDS, are called ‘woman’s disease’. This reflects an inaccurate belief that women give men these diseases. Men and women give each other STDs and HIV/AIDS. In fact, some studies suggest the risk of HIV transmission through sexual intercourse from a man to a woman is slightly higher than from a woman to a man. But in both cases, this risk should not be taken.

In this issue . . .
- Talking safer sex practical suggestions
- Safer sex cabarets
- Women in Zimbabwe
- WHO Report HIV, pregnancy and childbirth
Talking safer sex

Around the world, women are coming together at workshops in an attempt to find both the language and the confidence to persuade men to have safer sex. These workshops include role-play, discussion and counselling activities. Gill Gordon, from the International Planned Parenthood Federation, brings together some practical suggestions developed in Thailand, West Africa, the UK and elsewhere.

How to start

- Talk about safer sex before you are physically close, when your head can rule your feelings.

- Practice what you want to say before you actually say it, eg. practice saying what you want to do sexually, what you think is safe (see AIDS action issue four), saying ‘no’ if necessary. You could rehearse conversations with a trusted friend, and get yourself used to saying the words.

- Say something simple and clear, such as ‘Is a condom OK with you?’ or ‘Let’s use this (show condom) for protection’. Be yourself. Teach your partner by example. Be honest about sex, love and happiness. You are more likely to get honest responses and your sex life could improve as a result.

- Talk about a radio programme, or play, that you have heard or seen about safer sex and about what your friends think about the danger of AIDS.

- Be assertive. It’s your life and health you are discussing. Say what you want very clearly so there is no misunderstanding. For example: ‘I always use condoms’ or ‘I’d only have sex with someone who cared enough to use protection.’ Keep repeating what you want. Don’t get confused into arguing about why you shouldn’t want safer sex. If necessary, walk away.

- Maybe you don’t have to say anything. Before seeing your partner, practise putting condoms on a banana until you don’t feel embarrassed.

- Don’t drink or use drugs when you have sex: if you do, you will have less control over your actions.

Solving problems

Pleasure and condoms Men often complain that condoms spoil their pleasure, particularly those men who have never, or very rarely, used them! Men can also worry that they may lose their erection when putting on a condom. But women can help to make condoms seem erotic by putting them on in a sexy, stroking way during love-making. Women in Bangkok at a safer sex workshop had a competition to see who could come up with the most creative ways of persuading men to use condoms. Here’s some of the things they said in reply to a reluctant man:

**Man:** Condoms really spoil things. It’s like having a shower with your raincoat on.

**Woman:** I think they are really hot and sexy. If we use them we don’t have to worry. I really like them, please let’s do it. I’ll put some lubrication at the tip, you won’t know you’ve got it on!

**OR**

**If you don’t like these, next time we’ll try another kind.**

**OR**

**Wait till you try these new condoms. They feel like silk, and they are so thin, you can hardly tell they are on.**

**M:** I’ll lose my erection

**W:** No, you won’t—I’ll help you put it on and that’ll help you keep it!

**OR**

**W:** Let me put it on with my mouth (some women do this so well, that the man is not even aware of it).
Talking safer sex

Keeping up the romance Many people think that women should be swept off their feet with passion, and that ‘romantic sex’ should be spontaneous. But romantic sex is really about being close — whatever you do.

M: By the time I put that on, I'll be out of the mood.

W: Don't worry, I'll help you stay in the mood. We feel strongly enough to!

M: It kills romance.

W: It doesn't have to be that way.

M: Condoms are unnatural, a fake, a turn-off

W: Please let's try to work this out. An infection is not that great either. Let's try a condom.

Avoiding insult People sometimes feel insulted when the subject of sexually transmitted disease (STD) comes up. Unfortunately, most people wrongly believe that 'nice' people don't get STDs or HIV infection. Anyone can get an STD, including HIV infection. Make it clear that you are not just protecting yourself — talk about his health concerns as well as yours.

W: I don't have any diseases, I haven't had sex for a long time.

M: I know. I don't have any diseases either, but I still want us to use a condom since either of us could have an infection and not know about it.

M: What an insult! You think I'm the sort of person who gets AIDS?

W: I didn’t say that. Anyone can get an infection. I want to use a condom to protect us both.

M: I love you. Would I give you an infection?

W: Not deliberately. But most people don't know they are infected. That's why this is best for both of us.

Condoms are not the only answer... Couples in all cultures have found ways of enjoying sex without putting the penis inside the vagina, and risking pregnancy or loss of virginity. Some of these ways, such as stroking the clitoris or penis, or ejaculating outside the vagina (on unbroken skin), are safe. Other ways, such as penetrating the anus with the penis, are not safe.

M: I won't have sex if you want me to use a condom.

W: OK. Let's try something other than intercourse.

M: What kind of things?

W: We could play with each other, all over... or massage each other, or fantasise.

M: That's not real sex.

W: Sex can be more exciting this way — you can always learn something new...

Sex outside the relationship

A hidden message behind condoms for protection against infection is that one or other partner has had sex outside the relationship. This brings up painful feelings such as jealousy or lack of control. You can have HIV infection for eight or more years, without knowing it. This makes it easier for women to request condom use because of concern about past relationships. Some women get over the problem by saying they want to use condoms for contraception: 'The pill doesn't suit me. I'd prefer condoms.'

M: I won’t have sex if you want me to use a condom.

W: OK. Let’s try something other than intercourse.

M: What kind of things?

W: We could play with each other, all over... or massage each other, or fantasise.

M: That’s not real sex.

W: Sex can be more exciting this way — you can always learn something new.

Gill Gordon, AIDS Unit, International Planned Parenthood Federation, Regents College, Inner Circle, Regents Park, London NW1, UK.
Every year, thousands of sexual tourists visit Thailand, attracted to the many local people who survive by selling sexual favours to customers of the ‘Go-Go Bars’ and sex shows. Mark Timm, writing from the capital city of Bangkok, describes how a bar workers’ association is producing safer sex shows for the ‘Go-Go Girls’ and their customers.

In the streets of Patpong, Bangkok, bright lights flash the names of the Go-Go Bars, appealing to the sexual tourists with names like Pussy Galore or Baby a-Go-Go. In most of the bars women in bikinis are dancing to painfully loud music in front of an audience of men. But tonight, in Rafifi Bar, the Go-Go dancers now have the chance to be part of the audience. The Honeybee Cabaret is a sex show with a difference. Produced by the Patpong bar workers’ association, Empower, the performers act out a series of comedy skits (short plays) all of which carry one message: practice safer sex. Up on the stage, a Go-Go bar customer pleads with a parade of women to have sex with him. One after another they refuse because he won’t use a condom — until the audience laugh at his frustrated sexual appetite. A stern-faced Thai border guard then sets up his ‘Check Point’ on stage. He has the same message for all those who want to pass, including a rock star, a business executive and a teacher: ‘No condom. No entry.’

The humour that is a part of every Honeybee show is intended to help the women and their customers overcome shyness in discussing and practicing safer sex. Empower’s Director, Chantawipa Apisuk, explains; ‘People laugh when somebody is rolling a condom onto a banana — but it gets the message across.’ Responses vary. Some customers clap and laugh at the skits — others try to ignore them. Some bar owners are hostile to Empower’s efforts but others welcome them. ‘These owners feel our education programme does not hurt their business — instead it builds awareness among the workers that will make their business last.’

Empower has staged nearly twenty similar shows throughout Patpong during the past four years. These safer sex cabarets are just one part of the organisation’s anti-AIDS campaign. Empower also runs a drop-in centre, five minutes walk from Patpong, which provides information on AIDS and other sexually transmitted diseases (STDs) through videos, counselling and pamphlets and talks. Women with AIDS or HIV infection are referred for treatment and counselling to local doctors who are willing to guarantee confidentiality.

By the end of 1989, the number of people reported as infected with HIV in the country had risen rapidly to 13,600. Unofficial government projections suggest that there are currently around 30,000 infected people and that this figure will rise to over one million by 1994. Source: British Medical Journal, February 1990.
Identifying our strengths

Colleen Lowe Morna talks to women in Zimbabwe

Summary: The ways women are finding to fight AIDS. The social problems they face. Important role of traditional healers.

A few months ago, a group of Zimbabwean women formed the Women’s AIDS Support Network which held its first meeting in November 1989 (see page seven). ‘Women feel powerless, but really they are not,’ says Sunanda Ray, a doctor and one of the Network organisers. ‘It is a question of identifying our strengths. If women can’t get support from their families, they can get support from traditional organisations and women’s groups.’ These include the Women’s Action Group (WAG), a non-government organisation concerned with women’s rights; the AIDS Support Network and the National Traditional Healers’ Association (Zinatha).

The AIDS Support Network aims to help women gain the confidence to fight AIDS, in a society where women have little control over the sexual behaviour of men.

Sexual loyalty

Under the former white settler government, black women were regarded as minors all their lives: first by their fathers, then by their husbands, and finally by their sons, especially if the husband died. A combination of landlessness and tax laws drove most men from the rural areas to towns in search of work. Husbands and wives were separated for long periods. The husband’s family often tried to ensure that wives remained sexually loyal to their husbands, but many of the husbands found new sexual partners in the towns. This remains true today, as Dr Marvellous Mhloyi, a sociologist from the University of Zimbabwe, explains: ‘Men still expect to marry virgins, but never dream of being virgins themselves. After marriage, it is considered OK for men to have sex outside the marriage.’

Zimbabwe has a high rate of sexually transmitted diseases (STDs), and now a rapidly growing AIDS epidemic. Some 1,148 AIDS cases have now been officially reported, and it has been estimated that about five per cent of adults (men and women) may be infected with HIV in some urban areas.

A large number of women live with the fear that they might get AIDS from unfaithful husbands. The Samaritans of Zimbabwe, a phone-in service for distressed people, say that of all the AIDS related calls they get, the biggest number is from women worried about their husband’s sexual behaviour.

Sexual attitudes and stigma

In trying to protect themselves from HIV, wives often face hostility from their husbands. ‘Women who insist on their husbands using condoms [to protect against disease] get one of three responses,’ says a Women’s Action Group spokesperson. ‘They are either told that they should have children [condoms prevent this], or get accused of sleeping around, or get a slap for accusing the man of sleeping around.’ Problems facing women do not stop here. Several men who have developed AIDS, have accused their wives of bewitching them out of jealousy, and sent them back to their homes. As one Harare doctor explains, even when husbands are told how they could pass the virus on to another woman, ‘it is so hard to tell whether the advice is acted upon.’

Mothers who are infected with HIV must also confront the pain of (often unknowingly) passing the virus on to their unborn children. A quarter of the reported AIDS cases in Zimbabwe are children under four years old. Today, AIDS is the biggest child killer in Harare’s main hospitals.

Traditional healers

Zinatha has held six AIDS education discussion groups for N’anga (traditional healers). N’anga have an important role in providing advice on AIDS and spiritual support, because they already have a powerful influence on the population and could persuade people to change their behaviour. Zinatha’s President and sociologist, Dr Gordon Chavunduka, says: ‘Around half of Zinatha’s members are women, and they are especially gifted at counselling.’ N’anga help to dispel the myth that AIDS results from witchcraft, by asking: ‘If witches knew how to create AIDS, what took them so long to do it?’

Thabitha Murambwa is a traditional healer and midwife. In her consulting room in a high-density suburb, she proudly displays several cartons of condoms. ‘Men are more receptive to me when I tell them to use condoms than they would be at the clinic.’ When her own sons take condoms from the box and give them to friends, she turns a blind eye. ‘I tell the young people to take care of themselves. Because now there is AIDS.’
General guidelines on cross-infection control in the dental surgery

As with all health workers, dentists and others dealing with oral inspections and treatment in HIV infected patients are potentially at risk of becoming infected with the virus during procedures where they may come into contact with the patient's blood and body fluids. Effective cleaning, sterilisation and personal hygiene are of the utmost importance when dealing with all patients.

Even where there is a lack of resources, effective cross-infection control can be carried out, if careful thought is given to methods of instrument sterilisation and storage, to the scheduling of patients and careful cleaning of work surfaces. Effective infection control is possible in most situations even if only simple materials like soap and water and household bleach are used. However, many oral health personnel are not yet adequately trained to carry out appropriate infection control procedures. Where this is the case, in-service training programmes in cross-infection control should be planned and implemented.

Personal hygiene

- Wash hands after patient contact. Use a mild soap where possible. In procedures where blood spillages occur, operator and assistant should wear rubber gloves.

- Wear protective eye glasses and a face mask if possible during rotary cutting procedures to protect from spray and droplets.

- Wear short-sleeved operating clothing, change regularly and when soiled, and do not wear outside the clinical area. Avoid contact with open cuts on the patient's skin.

Cleaning and sterilising instruments

All instruments for invasive procedures (including needles and syringes) should be sterilised if at all possible, or at least given high-level disinfection. Since skin on the hands can be easily pierced by sharp instruments, strong rubber gloves should be worn. Instruments and equipment containing water (for example, handpieces and water syringes) should be flushed through with sterile water immediately before and after use.

Dry heat: Closed oven at 170°C for at least two hours

Steam: Closed pressurised vessel at 121°C 1 bar (15 pounds per square inch) pressure for 20 minutes

High-level disinfection

Clean, dry instruments may be disinfected, but not sterilised, as indicated below:

Boiling: Immersion in boiling water for 20 minutes. This is sufficient to inactivate (destroy) HIV, Hepatitis B virus and bacteria, but not spores present in large numbers.

Chemical: Chemical disinfection must not be used for needles and syringes. Chemical disinfection for other skin-cutting and invasive instruments should be used only as a last resort, if neither sterilisation nor disinfection by boiling is possible.

Chemical

| Immersion time |  
|----------------|-----------------|
| 2% glutaral (glutaraldehyde), aqueous | 30 minutes at room temperature for high-level disinfection. 10 hours at room temperature for sterilisation |
| 6% hydrogen peroxide | 30 minutes at room temperature for high-level disinfection |

After immersion, all equipment should be thoroughly rinsed with sterile water, and then handled with sterile gloves and forceps and dried with sterile towels to prevent recontamination.

In New York City, USA, AIDS is the major killer of women aged between 25 and 39 years. In this city alone an estimated 50,000 women are infected with HIV. Marie Saint Cyr, health promoter and counsellor at the Women and AIDS Resource Network, talks to one of them.

Connie (not her real name) is a 26-year-old woman of Korean and American Indian descent. She has HIV infection and is receiving AZT — an anti-viral drug treatment.

When did you first realise AIDS could affect your life?
It was in 1983 that I first heard about AIDS. At that time, my boyfriend was a drug user. We had been together since I was 14. I knew then that I could get HIV through drug use (sharing needles). But it wasn’t until I developed symptoms of the disease a year ago that I became concerned. Today, when I think about it, AIDS. At that time, my boyfriend was a drug user. We had been together since I was 14. I knew then that I could get HIV through drug use (sharing needles). But it wasn’t until I developed symptoms of the disease a year ago that I became concerned.

Your first concern was, who can I tell?
What am I going to do with my life now? Where do I go for help?

How did you resolve these questions?
I realised I could not do it alone. I came to the Women and AIDS Resource Network where I got information about services available to me and the counselling and support I receive has helped me get on my feet.

You do not have children. Would you like to have them?
Yes, if I could, even though I was told that it is not good for me. I have problems with my period now. I used to have periods regularly but now the virus seems to have stopped my menstruation.

Where is your previous boyfriend now?
He died. He was shot by a police-woman some years ago. After his death, I had difficulty handling the situation and coping with life. I started using some drugs. Heroin and cocaine, mostly sniffing and then shooting (injecting) it. I used drugs off and on for three years. I have been coming off drugs for the last year.

How has AIDS affected your family?
Three out of seven of us children have HIV infection or AIDS. My mother is really suffering the worst from this epidemic, even though she is not sick — she is our care giver. Two of us who are sick are home with her. She is always making sure we eat right, get our medication, get rested. My brother is on a tremendous effort to get over his previous drug habit.

So even when you knew about the disease you did not connect it with personal risk?
That’s right.

Did you stop having sex with your boyfriend, or start using a condom?
No.

When did you have a test for HIV?
In June 1989 — at the insistence of my doctor. I had begun to have an idea that I was getting sick with AIDS.

What was the most difficult thing for you when you found out you were positive?
My first concern was, who can I tell? What am I going to do with my life now? Where do I go for help?

How would you say to other women now?
It is urgent that they have safer sex. AIDS is real and it can destroy your whole family. For those who may have an idea that they have been exposed to the virus — sharing needles, for example — the sooner the better they should get tested and get medications.

The most likely ways in which Connie could have caught HIV infection were by having unprotected sex with her boyfriend (who may have been infected with HIV) or by sharing needles with an HIV infected drug user.

For further information on the support services offered by the Women and AIDS Resource Network, write to Marie Saint Cyr Delpe, Executive Director, WARN, P.O.B. 020525, Brooklyn, N.Y. 11202.


The Women and AIDS Support Network in Zimbabwe was started in June 1989, and grew out of the first conference of the Society for Women and AIDS in Africa (SWAA) held in Harare earlier in 1989 (see AIDS action issue 8). Zimbabwean women felt the need for their own national organisation within this region-wide group. The Network as yet has no formal structures, but the organisers hope to make AIDS a concern for all organisations working with women in the country, and to develop clear ideas for future direction.

Women and AIDS Support Network, PO Box 3378, Harare, Zimbabwe.
Readers’ letters

AIDS and skin problems

At a recent workshop on AIDS which I attended, it was submitted that a rash is one sign of the disease. How substantial is this, and what is the nature of the rash? How resistant is the AIDS virus? Can it be effectively killed or made static by chemotherapy?

George Hondo, City Health Department, P O Box 278, Gweru, Zimbabwe.

Dr Sam Kalibala replies:

In Africa, what is referred to as the ‘AIDS rash’ is the itchy maculopapular generalised skin rash. It is an important sign of HIV infection.

Currently there is no drug that can eradicate HIV from the body, once infected. Chemotherapy is being developed to make the virus ‘static’ (inactive and less likely to cause damage) and there is good progress in this direction. [See AIDS action/WHO Report issue eight].

Transmission of HIV

It has been said that AIDS is widely spread by homosexuals. Is this true? Other people say it is spread by:

• sexual intercourse between a man and a woman;
• transfusion of contaminated blood;
• unsterilised needles and syringes;
• infected pregnant women who can pass it on to their babies.

Are any or all of these true?

D. Samuel, Harare, Zimbabwe.

Dr Anthony Pinching replies:

HIV, the virus that causes AIDS, is mainly sexually transmitted. Like other sexually transmitted diseases (STDs), AIDS is most readily spread among people who have unprotected intercourse with many sexual partners. Like syphilis and gonorrhoea, it can be transmitted either by heterosexual or homosexual intercourse, vaginal or anal. In some parts of the world, homosexuals have tended to have many sexual partners and so be at increased risk of STDs, including HIV. In other regions, heterosexuals commonly have many partners, so STDs and HIV can spread rapidly among them. HIV may also be spread by infected blood, for example, via contaminated needles and syringes, and from mother to baby in the womb. The risk of an HIV infected man or woman infecting their regular sexual partner by putting the penis inside the vagina, without using a condom, is between 30 and 60 per cent. [On mothers and babies, see WHO Report inside].

Resources

The following organisations can provide information on women and AIDS:

• Positively Women, 333 Gray’s Inn Road, London WC1X 8PX, UK. Provides support services for women with HIV and AIDS in the UK, and can respond to overseas enquiries.
• Society for Women and AIDS in Africa (SWAA), UTH, Dept of Pathology and Microbiology, P O Box 50110, Lusaka, Zambia. Established in 1989 by a group of African professional women, to carry out research and education. Men and women are welcome to join, or to write for information on regional activities and organisations.
• Women and AIDS Resource Network (WARN), P O Box 020525, Brooklyn, NY 11202, USA. The information service is dedicated to the needs of women and children, and can respond to enquiries worldwide.
• Women’s Health and Reproductive Rights Information Centre (WHRRIC), 52 Featherstone Street, London EC1Y 8RT, UK.

Health education material

Flannelgraph: visualising AIDS

Flannelgraphs are used to illustrate an idea, a sequence of events or a story, using printed pictures on pieces of flannel (a soft material) which stick to any rough surface or board. Teaching Aids at Low Cost (TALC) have produced a flannelgraph for health education in family planning, sexually transmitted diseases and AIDS. It consists of several sheets of printed flannel (the pictures need to be cut out) that can be used to build up a story about how a baby is conceived, or how HIV is transmitted. A detailed teaching manual is included. It is easy to transport and needs no special equipment. Suitable for semi-literate communities.

Available from: TALC, P O Box 49, St Albans, Herts AL1 4AX, UK. Price: £21.30.
What new approaches have been developed in AIDS health promotion? What methods are effective in encouraging behaviour change? Reit Berkvens, Editor of the newsletter Health Promotion Exchange, summarises the highlights of the 1989 international AIDS health education conference, held in Cameroon and attended by over 500 participants.

Reaching the hard to reach
Bill Smith, from the Academy for Educational Development (AED) in the USA, stressed that knowledge alone was not enough to change behaviour. He illustrated this through the fictional story of ‘Maria’, a sex worker. If Maria did not really believe herself to be at risk, or that AIDS is a serious illness, or that condom use is effective, she will not change her behaviour. David Zucker, also from AED, compared Maria with another sex worker, ‘Sylvia’, based on research in an urban area in Asia. Although each woman lives in similar circumstances; they are equally aware of AIDS; both believe themselves to be at risk; both know that AIDS is one of the ‘most serious’ risks facing sex workers today; and both are positive in their attitudes towards the solution (condom use), there is one big difference: Sylvia uses condoms and Maria does not. Why? The answer lies in the psychological differences between the women, not in basic knowledge and attitudes. In this case, effective health education must involve more than just giving information, for example role-play and actively practising skills needed to negotiate safer sex.

Meurig Horton, consultant to the Health Promotion Unit at the WHO Global Programme on AIDS (GPA), presenting the results of research in seven cities among men who have sex with men, concluded that the major predictive indicators in initiating behaviour change are self-efficacy (the belief that one is in control of one’s life and can make positive changes), perceived risk, self-esteem and attitudes towards condom use. Consistent behavioural change was related to a supportive environment, such as peer acceptance of sexuality and peer support networks.

Counselling
Peer counselling has now become an important strategy to support behaviour change, according to Dace Stone, from AED. Counsellors who are trained to provide information, assist in decision making and promote behaviour change can counsel their peers at any time or place: in and out of school, at home, in the street, by telephone, in a hospital waiting room. In the Philippines, HIV antibody positive sex workers are being trained to provide pre- and post-test counselling to other sex workers who visit clinics. In the USA, drug users who have broken their addiction, are trained to counsel other drug users on the streets.

Counselling through the provision of home based care is another important development. One of the best known examples of community counselling through home care is that organised by Chikankata Hospital, Zambia (AIDS action issue 8).

Reaching young people
Most countries have now developed schools AIDS education programmes and materials. The WHO/UNESCO project in the Pacific, which provides training to teacher-trainers, is an example of an effective, region-wide programme. The guide for teacher-trainers and teachers, can be adapted for local use.

In Jamaica, parents are now involved in education about AIDS and sexually transmitted diseases (STDs) for their children. Previous experience of peer counselling for youngsters on sexual education and drug abuse highlighted the problem of constantly replacing and training new young counsellors. Dr Clark from UNESCO, Jamaica, explained that counsellors often dropped out while preparing for examinations, or when they found a job, or started higher education. Constant training of new counsellors had become a very expensive strategy. Now parents are involved, many being reached by integrating AIDS/STD issues in adult literacy programmes—a method which had successfully worked in drug abuse prevention and control programmes.

The problem of talking openly about sexuality in schools is addressed through a video used in a Ministry of Education project in Burundi. Thomas Munyuzangabo explained how the video—in which a teacher responds to a girl’s question about Continued p4 WHO Report
Transmission of HIV infection from mother to child

Transmission of HIV (the virus that causes AIDS) from an infected mother to her foetus (unborn child) or infant is thought to occur in 20-40 per cent of cases. Data collected so far suggests that women who have symptoms of HIV-related disease/AIDS are more likely to transmit the virus to their child (before, or during, birth) than women who have asymptomatic infection (that is, they have the virus but do not show signs of illness). Asymptomatic infection can last eight or more years. It is also possible that women at the stage just after being infected (for example, during the first few days or weeks), are more infectious than at the later stage of asymptomatic infection. This means that if a woman is pregnant, or breastfeeding, at the time of infection with HIV (for example, through a blood transfusion), there may be a higher chance of HIV transmission to her foetus or infant.

Transmission before birth (prepartum)
HIV transmission, via the placenta, can occur even in the first three months of pregnancy. In studies, HIV has been found in foetuses aborted within the first three months. There is evidence that women who have AIDS have a higher than average rate of spontaneous abortion.

Transmission during birth (intrapartum)
Transmission of HIV from an infected mother to her infant can occur during birth, probably because the infant is exposed to a large amount of HIV infected maternal blood and secretions during delivery. Nevertheless, studies comparing the rate of perinatal HIV transmission appear to show no difference in transmission according to the mode of delivery, that is, whether the infant is delivered vaginally or by caesarean section.

Transmission after birth (postnatal)
Handling and cuddling of her baby by a mother with HIV infection does not transmit HIV to the baby. The risk of transmission via breastmilk is apparently very low. Risk of infection via breastmilk is probably greatest if the mother is infected after birth, and sero-converts (becomes HIV antibody positive) while breastfeeding.

The immunological, nutritional, psychosocial and child spacing benefits of breastfeeding are well recognised. Breastmilk is also important in preventing infections which could accelerate the progression of HIV-related disease in already infected infants. In situations where the mother is considered to be HIV-infected, and recognising the difficulties in assessing the infection status of the newborn, the known benefits of breastfeeding should be compared to the theoretical, but apparently small risk to the infant of becoming infected through breastfeeding. In many circumstances, and particularly where the safe use of alternatives is not possible, breastfeeding by the mother should continue, irrespective of her HIV infection status.

Other routes of transmission to infants and children include:
- Infected blood transfusions. In areas where blood is not screened for HIV, blood transfusions have been shown to be an important route of HIV transmission to children.
- Improperly sterilised needles and syringes have been associated with transmission of HIV infection to children. See Guidelines on Sterilisation and Disinfection Methods Effective against HIV (WHO AIDS Series No. 2, 2nd Ed., 1989).

Other potential risk factors for HIV transmission to children include:
- Sexual abuse of infants/children by an infected adult.
- Ritual scarification or other traditional practices which involve cutting the skin with equipment not properly sterilised between each use.

A child cannot get HIV infection from ordinary physical contact, such as playing and hugging, with an HIV-infected mother or other family member. HIV is not transmitted by insects, such as bedbugs or mosquitoes; or from sharing or using things in the same house, including using the same lavatory or pit latrine.

Paediatric HIV infection/AIDS

Testing for HIV infection
Testing for HIV antibodies in the blood of an infant under 12-18 months of age does not provide a definitive diagnosis of HIV infection/AIDS in the infant. This is because the mother's HIV antibodies (if she is infected) may remain in the baby's blood for up to 18 months. The antibody test, therefore, will as likely reveal antibodies from the mother as from the child.

If the child is under 18 months old, HIV infection cannot be proven in the majority of cases in the absence of a diagnosis of AIDS. After 18 months, the presence of antibodies to HIV in an infant indicates the presence of HIV infection. An unknown percentage of infants of HIV seropositive mothers die of unconfirmed HIV infection before reaching 18 months of age.

A few children who are HIV seropositive at birth (due to the presence of their mother's antibodies) subsequently test negative for HIV antibodies but have clinical symptoms which indicate HIV disease/AIDS and are found to be HIV-infected. This means that children who are HIV antibody positive at birth should have long-term follow up even if they test antibody negative after 18 months; there is a very small chance that they could still be HIV infected and develop AIDS.

Definitions and clinical manifestations
The Centers for Disease Control case definition for AIDS was established mainly for reporting purposes in developed countries and is less useful in developing countries where laboratory facilities are limited.
The proposed WHO clinical case definition of AIDS in infants and children (see Weekly Epidemiological Record, 1986, Volume 61, pp.69-76) lists a number of clinical symptoms. However, in developing countries, the clinical manifestations of HIV-related disease and AIDS are frequently difficult to distinguish from the clinical manifestations of other severe and common illnesses of childhood. The most common opportunistic infections in HIV-infected children are pneumocystis carinii pneumonia (PCP) and candida oesophagitis, although bacterial infections are also a common finding. PCP tends to occur in the young infant. Lymphoid interstitial pneumonia (LIP) usually occurs at two to three years of age. Neurological manifestations may appear early.

HIV and pregnancy

What every mother-to-be should know

All women who are pregnant, or who wish to have children in the future, should be informed about HIV infection/AIDS. They should be told how the virus is, and is not, transmitted, and encouraged to consider whether they think they could be infected, or at risk of infection. Pregnant women should be told the following facts:

- if the mother is infected, there is a chance (between 20 and 40 per cent) that her unborn baby may be infected
- the risk of transmission is probably highest if the mother becomes infected with HIV during pregnancy, or is already showing signs of AIDS
- an infected infant may die within the first few years of life.

Testing pregnant women

Where mothers are to be confidentially tested for HIV, they must all be counselled, so that they fully understand the implications of HIV testing. Testing should be voluntary and confidential.

Some women, and their health workers, may find that there is good reason to suspect HIV infection. Under these circumstances a pregnant woman may also choose to have a test, since this could affect her decision about continuing the pregnancy.

Conclusive studies of the influence of pregnancy on progression of HIV disease in women have not yet been completed. There is at present no firm evidence to suggest that pregnancy adversely affects the health of an HIV-infected woman.

HIV antibody testing of a newborn infant only reliably indicates the HIV infection status of the mother and not the infant. Antibody testing of a newborn infant that is linked to identifying information should only be done where it is clearly indicated for the clinical care of the child. Testing infants raises the problem of possible discrimination against the child and of indirect testing of the mother without her informed consent. Newborns at risk of HIV infection must be provided with adequate monitoring and care.

Collection of data on the prevalence of HIV infection that is as accurate as possible is important for targeting of limited HIV/AIDS prevention and control resources to the areas and people in greatest need. For this purpose, unlinked anonymous screening of pregnant women attending antenatal clinics has been conducted, or is planned, in many countries. In unlinked anonymous screening, samples for HIV testing are obtained from blood specimens collected from an individual for other purposes; all information that could potentially lead to the person being identified is eliminated (“unlinked”) from the sample used for HIV testing. The disadvantage of unlinked anonymous screening is that HIV-positive individuals cannot be identified for counselling and support. The advantage is that unbiased HIV prevalence data can be obtained. Voluntary confidential or anonymous HIV testing for identification, counselling, and support of those found to be HIV-infected is recommended to be made available wherever possible to those persons whose blood is being used for unlinked anonymous screening.

Reproduction and HIV infection

If found to be infected with HIV, both men and women of reproductive age need to decide whether or not to have a child, and how to protect their sexual partner from HIV if he/she is not already infected. Below are some likely situations couples might face.

If a woman is uninfected with HIV, but her sexual partner (male) discovers that he is infected: it is impossible for the woman to become pregnant by her partner’s sperm without running a high risk of becoming infected with HIV. This is because, as yet, there is no way of eliminating the virus from the fertilized egg. However, the woman could receive artificial insemination with non-infected donor sperm, in countries where this is available. The woman should carefully consider whether she could look after the child adequately in the event of her infected sexual partner becoming ill, or dying.

If a woman is infected with HIV, but her current (male) sexual partner is not: the couple could still choose to have a child even knowing that the baby may be infected. However, the woman must be artificially inseminated with the sperm of her partner, since penetrative sexual intercourse (putting the penis inside the vagina) without the protection of a condom could result in HIV infection in the man.

HIV-infected women who become pregnant should be advised about the risks of having an infected child (see What every mother-to-be should know). Termination of pregnancy (abortion) should be offered as an option in countries where this is legal and safe, but the final decision must be made by the pregnant woman. Whatever decision she makes, special emotional support and practical advice should be provided including how to prevent other people becoming infected with the virus. All health care workers, particularly traditional birth attendants and midwives, should be trained to ensure continuing care and support, whilst ensuring privacy and confidentiality for the infected mother and her child.
Developing an AIDS vaccine

Scientists are searching both for a cure for AIDS, and for a vaccine, but do not expect to have a widely available vaccine within the next ten years. However, much research is being done to develop a vaccine. In order to do this, we must learn more about how the body's immune system (defence system against disease) responds to HIV infection. We know that infected people do produce an immune response to HIV by producing antibodies to the virus. Normally, antibodies are made to stick to an invading, harmful organism, enabling the invader to be engulfed and destroyed. However, the immune response to HIV does not seem to be the right amount or type required to effectively control or eliminate the infecting virus.

We also need to know more about the protein 'coat' of the virus (see AIDS action issue eight for an explanation of the virus and how it destroys the immune system). This coat contains the antigens, to which the antibodies stick. The antigens on HIV can be very different. Since protective immunity, such as the production of antibodies, is very specific to a particular type of antigen, not all types of HIV will be inactivated or destroyed by a particular immune response. This problem is being addressed by attempting to identify antigens from different strains (types) of HIV.

Many products are now being evaluated in the laboratory in experiments with animals with the aim of considering them as potential candidate vaccines in clinical trials using human volunteers. These trials are usually conducted in three phases. Phase one studies provide initial information on safety and immunogenicity (ability to start an immune response against HIV) and are usually conducted in a small number of well-studied volunteers. Phase two provides additional information on safety and immunogenicity, as well as initial information on how effective the vaccine is in protecting from infection with HIV. Phase three trials are very complex studies designed to evaluate the efficacy of the vaccine in both protection against infection, and/or the development of disease. Larger numbers of volunteers are used.

However, phase two and three studies raise a number of ethical problems, largely related to the study of how effective the vaccine is in preventing initial infection. If populations are being reached for participation in vaccine trials, they should also be reached for the purposes of health education. They should be strongly encouraged to avoid all possible ways of becoming infected with HIV in the first place. While this will reduce the incidence of HIV infection in the trial population, it may be unrealistic to expect it to be wholly effective so that some measurable rate of new infections will likely continue to occur in the study population, and this should be considered in planning efficacy studies.

It is important to develop a consensus of criteria for international testing of candidate vaccines, relating to the scientific, ethical, social, and legal issues. The World Health Organization is playing an important role in facilitating cooperation among member states and research scientists; to develop safe, effective and affordable vaccines against HIV infection.

Dr Josè Esparza, Biomedical Research Unit, GPA.

Guide to Planning Health Promotion for AIDS Prevention and Control

Fifth publication in the WHO AIDS series, which provides guidelines on planning, implementation, monitoring and evaluating a health promotion programme. Based on experience gained in other public health programmes. Intended for use in all parts of the world. Available in English, French and Spanish. Price: Sw.Fr. 14.00. Please note copies only available from WHO, not from AHRTAG (publishers of AIDS action). This publication replaces WHO Guidelines for health care workers.

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The future

Maria Paelman from the STD Foundation in The Netherlands stressed the need to focus attention on those groups where AIDS is spreading fastest now, such as inner city youth and drug users. Rosemarie Erben, acting chief of the Health Promotion Unit of GPA, summarised the tasks facing health promoters in the next decade:

- Developing personal skills to enable people to change behaviour
- Strengthening community action — mobilising more existing organisations and individuals; decentralising planning, management and funding of activities; establishing intersectoral partnerships; and mediating between conflicting interests in society
- Creating a supportive environment — making resources available, fighting discrimination, and working with the media
- Re-orienting health services to involve health personnel in health promotion, and integrating AIDS health promotion into existing structures
- Building public health policies.

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Any questions about the content of the WHO Report should be sent to WHO/GPA/HPR, 20 Avenue Appia, 1211 Geneva 27, Switzerland.