Training & Capacity Building Toolkit for Group Leaders

a Positive Women’s Network Training Manual
POSITIVE WOMEN’S NETWORK

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TRAINING AND CAPACITY BUILDING TOOLKIT FOR GROUP LEADERS

a training manual developed for Positive Women’s Network
**TABLE OF CONTENTS**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>About Positive Women’s Network</td>
<td>08</td>
</tr>
<tr>
<td>The Training &amp; Capacity Building Toolkit Manual for Group Leaders</td>
<td>10</td>
</tr>
<tr>
<td>Chapter 1</td>
<td>14</td>
</tr>
<tr>
<td>Awareness of self and others</td>
<td>15</td>
</tr>
<tr>
<td>Chapter 2</td>
<td>20</td>
</tr>
<tr>
<td>Fundamental facts of HIV and AIDS</td>
<td>21</td>
</tr>
<tr>
<td>Chapter 3</td>
<td>58</td>
</tr>
<tr>
<td>Diagnosis of HIV</td>
<td>59</td>
</tr>
<tr>
<td>Chapter 4</td>
<td>64</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>65</td>
</tr>
</tbody>
</table>
The Positive Women’s Network (PWN) is a non-profit organisation committed to creating a world free of HIV and an environment in which women who live with and/or are affected by HIV and AIDS access quality health related services, especially treatment and prevention; and are free from stigma and discrimination.

This commitment translates into the promotion and protection of gender equality and equity, respect for human rights, and mobilisation of resources to enable access to prevention, care and support and treatment.

The organisation aims to restore the dignity and improve the quality of life of women and girls infected and affected by HIV and AIDS. It also advocates for appropriate and effective health care services at national, provincial and local levels.
The PWN enjoys the support of reputable organisations including the African Women’s Development Fund, International Development Fund, PEPFAR, USAID, BroadReach Healthcare, the Global Fund for Women and Department of Health in South Africa.

The PWN operates mainly in impoverished and disadvantaged communities, townships and rural areas. Currently, PWN supports groups operating in the following provinces: Eastern Cape, Gauteng, KwaZulu-Natal, Mpumalanga, and the North West.

The Training and Capacity Building Toolkit for Group Leaders Manual follow on the recommendations of a comprehensive Study Research which was conducted by the PWN as part of a comprehensive response to provide essential packages of care for people living with HIV.
INTRODUCTION
Welcome to the Positive Women’s Network Training and Capacity Building Toolkit for Support Group Leaders (SGL). This training and capacity building TOOLKIT is intended as a resource guide for SGL.

In this TOOLKIT we deal with topics that affect each and every one of us. Our everyday life, our work and our communities. Some topics will be difficult to teach because of the sensitive nature of the issues addressed, it is important that you, the group leader, is equipped with knowledge and skills to deal with most issues which affects your support groups.

We hope that you will work through the topics carefully, and that you find this guide helpful, challenging and encouraging both to you and your support group.

YOUR ROLE AS A GROUP LEADER
We are working in a country, South Africa that has high incidences of HIV and AIDS in the world, Followed by HIV infections, AIDS, TB, rape, teenage pregnancy, violence against women and children. We need life skills that can empower us in our work to provide, inform and teach skills for our support groups and the community we work with.
HOW THIS TOOLKIT IS ORGANISED

For each topic there are 25 – 30 minute lessons, exercises, role-plays and case studies. The training takes up to 2-3 days or it can be structured to fit the groups we work with. The lessons hopefully will build on past knowledge and skills learned. It is an experiential learning that we trust will change attitudes, perspective and values.

The lesson plan builds on self-awareness, self-esteem, assertiveness, problem-solving skills, decision-making and conflict resolution skills. We suggest you follow the lesson plan to suit the needs of your group.

Also, for each lesson, there are specific outcomes and details how the material relates to this course. You will find many opportunities to integrate this material with other learning areas in your work.
WHAT WILL YOU NEED TO RUN THIS TRAINING

You will need some of the following:

- Teaching aids
- Magazines
- Newspapers
- Pictures
- Koki pens, flipcharts, etc.
- Pens and/or pencils
- A private journal or notebook for each participant to write or draw personal things

RIGHTS OF LEARNERS

Some topics may be controversial e.g. the right to termination of pregnancy, equal rights for people living with HIV and AIDS, gender-based issues related to culture, religion and so forth, which are all protected by the Constitution of South Africa in the Bill of Rights and Equality clauses.

Regardless of what your own beliefs system, be it cultural practices or religious values, accurate and factual information should be provided. The issues are controversial for all of us and decisions about them will be influenced by our own attitudes and values. However, receiving information about these issues is a Right.
CONFIDENTIALITY

In the course of these lessons, participants will be thinking about very personal and often highly emotional topics. You need to be careful, but prepared and able to discuss any personal issues the participants may raise.

Do not use participants’ personal experiences unless they volunteer themselves. Ask the group to develop some ground rules themselves about confidentiality.

We hope you enjoy using this training manual and that it helps you to make a real difference in building your learner’s life skills.

Compiled by Abrina Training Academy for Positive Women’s Network, 2015
1. Understanding and accept self as a unique and worthwhile human being.

2. Use skills and display attitudes and values that can improve relationships, family, group and community.

3. Respect your rights and those of others.

4. Demonstrate values and attitudes of (UBUNTU PRINCIPLES).

5. Understanding healthy and balanced lifestyle.
1.1.  **SELF-AWARENESS**

1.1.1.  **SELF-AWARENESS**

Self-awareness is the ability and the capacity for people to perceive themselves, to introspect and recognise oneself as an individual. The ability to have a clear picture (perception) of aspects of their emotions, personality, behaviour, motivations and thought processes.

Self-awareness allows us to understand other people and how they perceive you, your attitudes and your responses to them in the moment.

1.1.2.  **WHY DEVELOP SELF-AWARENESS**

As we develop self-awareness we are able to make changes in the thoughts and interpret what we make in our minds. Changing the interpretations in our minds allows us to change our emotions. Self-awareness is one of the attributes of emotional intelligence and important factor in achieving success.

1.1.3.  **DOES EVERYONE HAVE SELF-AWARENESS**

Most people struggle with Self-awareness of SELF. Who they are, their roots, where they come from, who their parents are if they do not have any or were never told the truth about themselves. Others were brought up with psychological and mental abuse which left them with low self-esteem. Some suffers disorders of inferiority complex.

1.1.4.  **SELF-AWARENESS ALLOWS US**

- Allows us to see our thoughts and emotions and where they are taking us.
- It also allows us to see the control of our emotions, behaviour and personalities so we can make changes
- Until we are aware in the moment of controls to our thoughts, emotions, behaviour and words we will have difficulty in making changes in the direction of our lives.
1.2. **SELF-IMAGE**

Self-image is a mental picture, generally of a kind that is quite resistant to change. Self-image depicts not only details that are available to objective investigation by other (height, weight, colour of eyes, etc.) items that have been learned by self, through personal experiences or internalised judgements of others.

- How you see yourself;
- How others see you;
- How a person perceives how others see them.

All three may not be a true representation of self-schema, which is encoded information about the self. Other people may have poor self image, due to criticism experienced as a child and ends up accepting negative judgements about self.

1.3. **SELF-CONCEPT**

This is different from self-awareness and it refers to the extent to which construction on collection of beliefs about oneself; self-identity, perspective on academic performances, gender roles, sexuality which all answer (Who am I?) past, present and future self. Also about self-knowledge, attitudes and dispositions is defined (e.g. I am fast runner).

1.4. **SELF-ESTEEM**

In sociology and physiology there is an overall sense of self-worth that is:

- Subjective emotional evaluation of self
- Judgement of self
- An attitude toward self (e.g. I am competent, I am worthy concept which is what we think of self). Self-esteem is the positive or negative evaluation of self. Self-esteem means the way we think about ourselves- whether we are unique and worthwhile human beings.

People with high self-esteem will be relaxed in any situation, well-nurtured physically and emotional energetic, positive and optimistic, sociable and assertive, they will also be eager to try new challenges and learn from them. People with low self-esteem will show many of the opposite qualities.
1.5. **SELF-ASSERTIVENESS**

Self-assertiveness describes self as self-confident, self-assertion, bold, clamorous, assured and confident without aggression. Building self, mingled with knowledge and intellect.

1.6. **WHY DO WE TEACH ABOUT SELF?**

We teach about healthy self-awareness, (self-concept, self-image, self-esteem and self-assertiveness) because these are essential foundations for all the other topics in this course. We want you to be confident and motivated to train others, to say “NO” to unwanted peer-pressure, drugs, forced sex, unwanted pregnancy and unprotected sex.

We need to nurture young women to resist destructive male dominance, but also to help young men to become emotionally aware so that they do not resort to violence to express their self-worth.

**EXERCISES ON SELF-AWARENESS**

**Developing Self-Awareness**

Draw a picture of self in a collage, and write about yourself. Make use of magazines.

1. Who is self? (Self-image, self-concept self-esteem and how you can build self.
   (How do you see yourself in the near future?)
2. Are you an assertive person?
3. Discuss about your strengths and weakness, fears and passions, your beliefs and practices.
4. What you want in life, career or talents that best suits you. Your feelings about material or spiritual things.
1.7. SELF-AWARENESS IN RELATIONSHIPS

My Relationships with family, friends, partners, groups and community.

1.8. WHAT IS FAMILY?

South Africa, like many other countries in the world, has different types of families today. Unlike in the past, families were simple, inhabiting large rural areas and had communal living. Today many families live apart, some as nuclear families others as extended but communal families.

1.8.1 REALITIES OF FAMILIES IN SOUTH AFRICA

- A nuclear family (mother, father and children)
- Large communal families urban or rural (parents with extended families)
- Single families (mother or father with children)
- Child-headed household (no parent's only children)
- Households (partners cohabitating with themselves or with their children, but not married)
- Grand-parent/s with children (household without father and/or mother, but maybe uncles or aunts)
- LGBT families with adopted children or of their own
- Husband living away from home, their wives are left with parents or relatives.
- Divorced families
- Teenage mothers living with their children

Families should be the source of good self-esteem, uniqueness and self-worth. There are however different families in our communities. Loving caring families, dominant, stereotype families in our communities.

Every person should be able to examine, value and feel secure in their family no matter what type of family they have.
1. Make a collage and describe your own family and relatives.
2. Describe your relationship with your family and friends.
3. What would be your IDEAL family?
4. How do you value yourself in your community?

1.8.2 IMPORTANCE OF FAMILY & FRIENDS

- Families are the teachers of roles and responsibilities, family ties, internalisation and socialisation, beliefs systems, values, norms, traditional and religious practices.
- Families are responsible for house and home training of UBUNTU PRINCIPLES (families are the first teachers of societies).
- We learn about the value of caring, sharing, cooperating, empathy, honesty, justice, fairness and hospitality.
- How to socialise, norms of social norms and leisure time (attainment of self).
- We learn about friends & friendships, the choice of friends (good or bad friends).
- Peer pressure (loving or bullying) in our families or friends (in all age groups).

GROUP EXERCISE ON FRIENDS

Group Activity

- Discuss in Groups how young people experience different forms of Peer Pressure.
- How do you choose friendships?
- Self-assertiveness is the best skills to deal with friends who enjoy bullying
- Discuss different ways to assert yourself to avoid peer pressure.
LEARNING OUTCOMES

After completing this module, you should be able to:

1. Develop and present on HIV/AIDS
   • Awareness programme which conveys the following information to a target group (a target group may consist of people from widely different backgrounds, interests, concerns and levels of understanding e.g. in and out of school youth; community members; community health workers and nurses)

2. Demonstrate Knowledge on
   • The origins of HIV/AIDS
   • Normal functioning of Immune system
   • The effects of HIV on the Immune system
INTRODUCTION

A few decades ago, a terrible disease, previously unknown to the human race, began to kill in the most alarming and terrifying circumstances. It was as though some primeval beast had surfaced in the collective bloodstream of human race.

Whenever this microscopic beast appeared, it produced panic, fear, guilt, hysteria, accusations, blame, excruciating suffering and always, in the end, death.

Now the beast has a name – HIV/AIDS. HIV is known to be a virus unlike any virus previously encountered by the human race. Its devastating effects, after 30 years on, are still being felt globally, but nowhere more tragically than in the sub-Saharan Africa, where by far the majority of HIV infections and AIDS in the world occur.

Today, HIV/AIDS has become one of the most destructive plagues in the history of the human race. It is a monster which threatens to destroy the human society as we know it, because it has changed all the rules by which we live. Although we, as concerned human beings often seem defenceless against this scourge, we should not despair, because it is not yet too late to take decisive and practical steps to defend ourselves against the ravages of this disease. But, there is no room for complacency. Time is running out. The statistics look more and more frightening.

2.1. ORIGINS OF HIV and AIDS

2.2. HIV and AIDS STATISTICS

Global Statistics 2011

- People Living with HIV and AIDS - 34 million
- Adults Living with HIV and AIDS (mostly) - 50 million
- Children Living with HIV and AIDS – 3.3 million
- People newly infected with HIV – 2.5 million
- Children newly infected with HIV – 333,000
- Aids Deaths – 1.7 million

• South Africa has highest number of new HIV infections worldwide - survey, Mia Malan

• With over 400 000 new HIV infections occurring in 2012, South Africa ranks first in HIV incidence in the world, according to an HSRC survey.

• According to the survey, SA’s increased HIV infection rate is ‘largely due to the combined effects of new infections and a successfully expanded antiretroviral treatment program’. (Reuters).

• The proportion of South Africans infected with HIV has increased from 10.6% in 2008 to 12.2% in 2012, according to the Human Sciences Research Council’s (HSRC) National HIV Prevalence, Incidence and Behaviour Survey. The total number of infected South Africans now stands at 6.4-million; 1.2-million more than in 2000.

• Black African females aged 20 to 34 recorded the highest incidence of HIV among all the analyzed population groups.
According to the survey, the increased infection rate is “largely due to the combined effects of new infections and a successfully expanded antiretroviral treatment [ART] programme” – ART allow people with HIV to live significantly longer, leading to a greater percentage of HIV-infected people remaining in society. ART access almost doubled between 2008 and 2012, with about a third of the country’s HIV-infected population — about two-million out of 6.4-million infected people — accessing ART in 2012.
Provincial Statistics

Ante Natal Clinics Attendees

- KwaZulu-Natal – 37.4%
- Mpumalanga - 36.7%
- Free State – 32.5%
- Gauteng – 28.7%
- North West – 30.2%
- Eastern Cape – 29.3%
- Limpopo – 22.1%
- Northern Cape – 17.0%
- Western Cape – 18.2%
- National Statistics -29.5%

2.3. DEFINITIONS OF HIV and AIDS

- AIDS is the acronym for Acquired Immune Deficiency Syndrome. This disease is acquired because it is not a disease that is inherited. It is caused by a virus (the human immunodeficiency virus or HIV) which enters the body from the outside.

- Immunity: refers to the body’s natural inherent ability to defend itself against infections and diseases.

- Deficiency: refers to the fact that the body’s immune system has been weakened so that it can no longer defend itself against passing infections.

- A Syndrome: is a medical term which refers to a set or collection of specific signs and symptoms that occur together and that are characteristic of a particular pathological condition.

- Although we use the term “disease“ when we talk about AIDS. AIDS, strictly speaking, is not a specific illness. It is really a collection of many different conditions that manifests in the body (or specific parts of the body) because the HIV has so weakened the body’s immune system that it can no longer fight the pathogen/s (or disease causing agent) that invades the body.

- It is therefore more accurate to define AIDS as a syndrome of opportunistic diseases, infections and certain concerns, all of which has the ability to kill the infected person in the final stages of the disease.

2.4. HISTORICAL BACKGROUND TO AIDS

1981 - AIDS IN AMERICA

The first cases of AIDS occurred in America in 1981, a rare form of pneumonia, caused by a micro-organism Pneumocystis Carinii, and Kaposi’s sarcoma (also a rare form of skin cancer). They were all young, homosexual men, with compromised (damaged) immune systems.
Heterosexual people were with suppressed immune system caused diarrhoea and weight loss was identified in central Africa in heterosexual people in 1986–1993. Initially, scientists and doctors were baffled because the causes and the modes of transmission of this new disease (called the “slimming disease” in Africa) could not immediately be identified.

1993
It was only in 1993 that it was discovered that the disease was caused by a virus which at that stage was known as LAV (Lymphadenopathy Associated Virus) and HTLV-III (Human T-cell Lymphotropic Virus Type III). In 1986, the virus causing this condition was renamed HUMAN IMMUNODEFIENCY VIRUS (HIV).

It is Lentivirus (slow), is a genus of the Retroviridae sub-family characterised by a long incubation period. Primate Lentivirus group: Human immunodeficiency virus 1; Human immunodeficiency 2; Simian deficiency virus. Lentivirus can deliver a significant amount of viral RNA into the DNA of the host cell and have the ability among retroviruses of being able to infect non-dividing cells, so they are one of the most efficient methods of gene deliver vector, HIV, SIV and others.

At present there are two viruses associated with AIDS, namely HIV-1 and HIV-2. HIV-1 is associated with infections in Central, East and Southern Africa, North, South America, Europe and the rest of the world. HIV-2 was discovered in 1986 in West Africa (Cape Verde Island, Guinea, Senegal) and it is restricted to West Africa. All current indications are that while HIV-2 is as dangerous a virus as HIV-1, it acts more slowly. This means that it takes longer for the symptoms of the infection to develop in an HIV-2 infected person.

The history of the discovery of HIV is both interesting and controversial. Dr Luc Montagnier of the Louis Pasteur Institute in Paris, France, discovered HIV-1 in 1983. A year later the American Dr Robert Gallo claimed that he had been the first to discover the virus. What followed was a protracted court battle about the “alleged theft” by Gallo of Montagnier’s virus which had been sent to Gallo in good faith for record purposes.

The bi-partisan feelings caused by this court case were so intense that they threatened to undermine the 1987 bilateral talks between the French Prime Minister, Jacques Chirac, and the American President, Ronald Reagan. The issue was eventually resolved by a last-minute compromise which permitted both Montagnier and Gallo to be officially recognised as co-discoverers of the virus.
AIDS Timeline

The first cases of AIDS were reported in 1981, and since then, more than 25 million people worldwide have died from the illness. Currently, more than 33 million people around the world are living with HIV, an estimated 1.1 million in the U.S. How did all of this start?

Circa 1900: From Monkeys to Humans

There are several theories as to how the HIV virus – the virus that causes AIDS – developed in humans. The most widely accepted theory is that humans contracted the virus by hunting certain species of chimpanzees that carried the virus, and then eating them or getting their blood in an open wound.

1981: First Cases Recognized

In 1981, the Centers for Disease Control (CDC) reported on five young, previously healthy homosexual men infected with a rare yeast-like fungus called Pneumocystis Carinii pneumonia (PCP). It is a type of opportunistic infection, seen in patients with compromised immune systems (such as people undergoing chemotherapy, or organ transplant recipients). PCP is the most common opportunistic infection in people with AIDS.

In addition, the same year the Center for Disease Control (CDC) reported a cluster of cases of a rare and aggressive type of skin cancer, Kaposi’s sarcoma (KS) among gay men in New York and California. By the end of the year, 270 cases of severe immune-deficiency among gay men have been reported, and 121 of those died.

1982

In 1982, the CDC called the disease AIDS (acquired immune deficiency syndrome), and defined it as, “a disease at least moderately predictive of a defect in cell-mediated immunity, occurring in a person with no known case for diminished resistance to that disease.” The first American AIDS clinic is founded in San Francisco, and Gay Men’s Health Crisis is founded in New York City.

1983

By 1983, the CDC had established the National AIDS Hotline, with cases of AIDS reported in female partners of males with AIDS. In September, the CDC identified major routes of transmission of HIV, ruling out casual contact, food, water, air, or surfaces. By the end of the year a New York doctor is threatened with eviction for treating AIDS patients, and the first AIDS discrimination lawsuit is filed.
1983
In 1983, Dr. Robert Gallo of the National Institutes of Health (NIH) proposes that a retrovirus is the likely cause of AIDS. In France, Professor Luc Montagnier of the Pasteur Institute reports discovery of a retrovirus called Lymphadenopathy Associated Virus (LAV) that might be the cause of AIDS.

1984
In 1984 Dr. Gallo and Professor Montagnier jointly announce that Gallo’s HTLV-III retrovirus and Montagnier’s Lymphadenopathy Associated Virus (LAV) are likely identical and the cause of AIDS. The Department of Health and Human Services (HHS) announces a blood test to detect HTLV-III has been developed.

1985
1985 brings AIDS into the forefront, as actor Rock Hudson dies of AIDS-related illness, leaving a large sum of money to establish the American Foundation for AIDS Research (AmFAR), chaired by founder Elizabeth Taylor. The case of Ryan White, a teenager who contracted AIDS through a blood transfusion to treat his hemophilia, makes headlines when he is denied entry to his school. He goes on to become a spokesman against discrimination of people with AIDS.

The U.S. Food and Drug Administration (FDA) licenses the first commercial blood test for HIV, called ELISA, in 1985. The HHS and the World Health Organization (WHO) holds the first International AIDS conference in Atlanta, GA, and the U.S. Congress allocates $70 million towards AIDS research.

1986
1986 marks President Ronald Reagan’s first public mention of AIDS, with a vow to Congress to make AIDS a priority. The same year sees the debut of the first panel of the AIDS quilt created by AIDS activist Cleve Jones, and the Surgeon General of the U.S., C. Everett Koop, issues a report urging parents and schools to start open discussions about AIDS and education on condom use.

1987
The FDA approves the Western blot blood test kit, a more specific test for HIV antibodies, in 1987. They also declare HIV prevention as a new indication for male condoms. President Reagan establishes a Presidential Commission on AIDS, and the AIDS Memorial Quilt is displayed for the first time with 1,920 panels at the National Mall in Washington, DC.
1987
In 1987, pianist Liberace dies of AIDS-related illness. The FDA approves the first antiretroviral drug, zidovudine (AZT), and the organization ACT UP is formed and immediately protests the high cost and lack of access to the new drug. The U.S. adds HIV to its immigration exclusion list, and prohibits people with the virus from entering the country.

1988
Elizabeth Glaser, an HIV-positive mother of 2 HIV-positive children, establishes the Pediatric AIDS Foundation in 1988. ACT UP protests the FDA’s drug approval process, leading to a new policy that speeds up drug approvals. The World Health Organization (WHO) declares December 1st to be the first World AIDS Day.

1989
The number of reported AIDS cases reaches 100,000 in 1989. The National Commission on AIDS, established by Congress, meets for the first time in September, and the head of the National Institute of Allergy and Infectious Diseases (NIAID) allows people with HIV, who do not qualify for clinical trials to receive experimental treatments. Photographer Robert Mapplethorpe dies of AIDS-related complications.

1991-1992
In 1991, the Red Ribbon Project creates a symbol of compassion for people with AIDS. The same year, NBA star Magic Johnson announces he is HIV-positive, and Freddie Mercury, lead singer of the rock band Queen, dies of pneumonia resulting from AIDS. By 1992, AIDS is the leading cause of death in U.S. men aged 25 to 44.

1993
Tom Hanks stars as an attorney with AIDS in “Philadelphia,” the first major Hollywood film on AIDS, and the play Angels in America wins both the Tony Award for Best Play and the Pulitzer Prize for Drama.

1994
By 1994, AIDS has become the leading cause of death for all Americans age 25 to 44. The U.S. Public Health Service recommends giving the drug AZT to pregnant women to reduce the risk of transmitting HIV to their baby. MTV’s The Real World features Pedro Zamora, an openly gay man living with HIV. He dies after the season finale at age 22.
1996-1997
For the first time since the beginning of the epidemic, the number of new cases of AIDS diagnosed in the U.S. declines. Highly active antiretroviral therapy (HAART), the AIDS drug “cocktail,” is announced in 1996 and by 1997 it becomes the new standard of HIV treatment.

1998-2000
In 1998, the CDC finds 49% of U.S. AIDS-related deaths are among African Americans, and Congress funds the Minority AIDS Initiative. By 1999, the World Health Organization (WHO) reported that HIV/AIDS was the 4th leading cause of deaths worldwide, estimating 33 million people were living with HIV, and 14 million had died of AIDS. In 2000, the Joint United Nations Programme on HIV/AIDS and the WHO announced a joint initiative to collaborate with major pharmaceutical companies to reduce prices for HIV/AIDS drugs in developing countries.

2001-2002
The first National Black HIV/AIDS Awareness Day is marked on February 7, 2001. In 2002, governments, civil and private organizations come together to establish the Global Fund to Fight AIDS. Young people are being increasingly diagnosed with HIV/AIDS – worldwide 10 million teenagers and young adults aged 15 to 24 are living with HIV.

2003-2005
In 2003, the CDC estimated that 27,000 of the 40,000 new cases of HIV/AIDS in the U.S. were a result of transmission of the virus from persons who did not know they were infected. The U.S. Food and Drug Administration in 2004 approves a rapid HIV diagnostic kit that provides results in 20 minutes. Also in 2004 the President’s Emergency Program for AIDS Relief (PEPFAR), U.S. Government initiative to help save the lives of those suffering from HIV/AIDS around the world, receives $350 million in funding from Congress.

2006-2007
June 5, 2006 marks 25 years since the first AIDS cases were reported and by 2007, the CDC reports over 565,000 deaths from AIDS since the beginning of the epidemic. The projected life expectancy for a person diagnosed with HIV is 24.2 years, with a lifetime cost per person for HIV care of $618,900.
2008
The CDC releases new estimates for HIV infections, which are higher than previously thought (56,300 new infections per year versus 40,000), a reflection of a newer, and more accurate system of recording rates.

In 2008, Luc Montagnier and Francoise Barre-Sinoussi are awarded the Nobel Prize in Medicine for their discovery of the HIV virus. The ban on HIV-positive people entering the U.S. is lifted, and people with HIV/AIDS are permitted to enter the country on a case-by-case basis.

2009
UNAIDS reports that the spread of HIV peaked in 1996 with 3.5 million new infections, and the number of AIDS-related deaths peaked in 2004 at 2.2 million. Since the beginning of the epidemic, 25 million people have died of AIDS-related causes. On the positive side, new HIV infections worldwide dropped by 17%.

2009-2010
The 100th new antiretroviral drug is approved in 2009. In 2010 the HIV travel and immigration ban is finally lifted. That same year, the WHO, UNAIDS, and UNICEF publish a report that shows an estimated 5.25 million people received antiretroviral therapy that year, with an estimated 1.2 million of those starting treatment that year – the biggest recorded annual increase.

Reviewed by John P. Cunha, DO, FACOEP on Monday, August 11, 2014
2.5 Historical Background of AIDS in SA

1982
Similar to the early phases of HIV Epidemics globally, HIV in SA was discovered among gay men (men having sex with other men). In 1982 two white homosexual men were diagnosed with HIV both were flight stewards who visited the USA.

1989
A study reported a HIV prevalence of 12.8% among homosexual men in Johannesburg, half of the men reported having more than 20 different sexual partners in the previous 12 months.

Early concentration of HIV within the gay community led to the belief that the virus was a homosexual disease as a result, the past Apartheid government excused itself from intervening with the wider population, largely questioning their risk of HIV transmission.

The emerging epidemic was moralised by reports of haemophiliacs, who, because they were HIV positive via infected blood transfusion and blood products, in contrast to homosexuals who were considered to have brought the epidemic upon themselves, this group were portrayed as innocent victims.

1991
The number of AIDS cases attributable to heterosexual transmission challenging widespread prejudice that HIV and AIDS was a “gay disease”. Since then, HIV transmission between heterosexual people has become the dominant transmission route in South Africa.

Initial Response to HIV in SA.

1980 -1990
The turbulent political and racial climate that prevailed during this period, attached unfounded political and racial motivations to the belief that AIDS and HIV was a man-made disease. These unfounded political and racial motivations made its way to the National Agenda.
**1990**
The African National Congress (ANC) in exile, alleged that HIV could have been developed in a laboratory, whilst others suggested that it was spread by the then South African police by the use of teargas during the riots or deliberate infection of black sex workers by former ANC collaborators.

Post-Apartheid conservative’s political parties claimed that white South Africans were made vulnerable to HIV transmission through desegregation of public facilities in 1990.

The first steps towards a more rational and coherent response to the AIDS epidemic was at the Maputo statement on HIV and AIDS in Southern Africa was issued following the Fourth International Conference on Health. This brought together ANC representatives and other Apartheid government figures and Health care professionals and non-governmental organisations tackling the disease in other countries.

The document outlined the necessary features for tackling the AIDS epidemic including a focus on prevention and the rights of individuals living with HIV. At the meeting Chris Hani, the General Secretary of South African Communist Party (SACP) and head of the ANC armed Wing said “We cannot allow the AIDS Epidemic to ruin the realisation of our dreams”.

**1990-1992**
Ante-Natal Clinic HIV prevalence increases from 0.7% to 2.2%.

**1992**
The establishment of the National AIDS Coordinating Committee (NACOSA), with action on all fronts including prevention, research, human rights, counselling and welfare with the involvement of a number of government departments, civil society and non-governmental and community-based organisations.

**1994**
The first SA National AIDS Plan was adopted within months of the country’s democratic election and there was optimism that the epidemic on the scale experiences by other countries in the sub-Saharan region could be avoided.
1984
SA has an infection rate below 5% was ready for the epidemic having information about
the different epidemic in the USA, Europe and other African states and Latin America,
with a group of highly literate AIDS specialists in prevention, care and research that could
drive the AIDS Programmes. (Source: Mary Crewe from the University of Pretoria)

1995
The AIDS Director was placed in the Ministry of Health under Mrs Nkosana Dlamini
Zuma. The Sarafina II Scandal awarded by DOH to the playwright Mbongeni Ngema
to produce a sequel to the musical about AIDS directed to young people. The script
was widely panned as confused and irrelevant. The SA government was refused all the
European Commission money to be spent on the budget.

1998
Virodene, an antiretroviral drug based on Antifreeze was being tested on a small scale by
the University of Pretoria. Virodene was found foul to have not have an antiviral effect.

1998
The fight for ARV’s in South Africa began. In Thailand a study was reported to be on trial
using short course Neviripine to prevent mother to child transmission, had cut mother to
child rates in half. Mark Heywood AIDS Legal Project, called for the drug to be on trial in
SA, and said, “Our country cannot afford 50,000 children being born with HIV this year
and an increase on that number next year, and on that number for many years to come.”

The call of Zidovudine (AZT) by the Treatment Action Campaign led by Zackie Achmat
fighting for the rights of people living with HIV and AIDS campaigns against the SA
government and pharmaceutical companies for ART drugs until they become available.
The Western Cape Province, not under the control of ANC provided AZT in 1998.

“Denialism”
Denialism evolves. Former President Thabo Mbeki arguments and policies against
AZT AND Neviripine evolved into a much wider questions on HIV and AIDS known as “denialism”. A school of thought which argued that HIV does not cause AIDS, and
promoting lifestyle choices. Acknowledgement of AIDS as a challenge.
2007 - 2011
Uptake of ARV in South Africa which has now become the biggest HAART program in the world.

2012 – 2016
The National Strategic Plan (2012-2016) build on the ARV programs which are almost self-funded around UNAIDS vision of “zero new HIV infections, zero discrimination, zero AIDS related deaths, zero new HIV infections due to mother to child transmission”

Hope for Tomorrow
Scientists are continuing to work on an HIV vaccine. A study conducted in Thailand in 2009 shows promise that a vaccine may provide some protection from the virus. Clinical trials of the vaccine are expected to begin in South Africa in 2015. Another area of study is microbicides, which are gels, films, or suppositories that can kill viruses and bacteria. Several studies of vaginal microbicides have shown positive results and further clinical trials are underway.

GROUP EXERCISE

Group Activity
- Discuss in Groups the HISTORY OF HIV and AIDS globally and in South Africa.
- When did you first hear about HIV and AIDS.

Source:
LEARNING OUTCOMES

After completing this module, you should be able to:

Demonstrate knowledge and understanding of theories on the origins of HIV/AIDS

1. Identify the myths and misconception of HIV/AIDS
2. HIV and the cycle of human immune system
3. Discuss how a healthy immune system functions
4. Discuss the following:
   • Different routes on HIV Transmission.
   • Signs and symptoms of HIV.
   • How HIV is diagnosed and different stages of AIDS.

2.6.1. THEORIES ON THE ORIGINS OF HIV AND AIDS

There are many farfetched theories about the origins of AIDS. These range from a belief that the virus was developed as an instrument of biological warfare to a view that the virus is brought by aliens from outer space to kill the people on planet Earth.
Figure 4. Model of the structure of life cycle of HIV
Figure 5. Structure of the Human Immune System
External Immune System (The body’s defences)

- Wax: in the ears catches and kills some germs (micro – organism)
- Tears: wash germs and eyes dirt out of the eyes, and can kill germs
- Saliva: in the mouth can kill some germs
- Nose: contains tiny hairs which help to stop germs being breathed in. Mucus in the nose catches and kills some germs before they get to the lungs
- Juices: in the stomach can kill germs
- Blood: contains special white cells to fight off germs that get into the body through wounds
- Skin: stops germs from getting into the body

Figure 6. The immune system fighting the micro-organism
2.6.3. HOW A HEALTHY IMMUNE SYSTEM FUNCTIONS

The best way to understand the immune system is in terms of a microscopic war that takes place inside the body. In terms of this metaphor, we can characterise the immune system as the defence force that defends a country from external threats and invasions. Just as soldiers of an army defend their country from attack and invasion, the components of the immune system defend the human body from external attack.

The body’s immune system comprises of a complex system of blood proteins and white blood cells which work together to repel attacks by invading organisms. The white blood cells (which are formed in the bone marrow) form three different ‘regiments’ namely phagocytes (including macrophages), and two types of lymphocytes namely T cells and B cells.

While each of these ‘regiments’ has its own and defence strategy, they all have the same objective, which is to identify and destroy all invasive substances or organisms which might be harmful to the body. There are four phases in each immune response which the body makes.

Phase I: Recognising the enemy
Phase II: Strengthening the body’s defence
Phase III: Attacking the invader
Phase IV: Halting the attack once the battle has been won

<table>
<thead>
<tr>
<th>FIRST REGIMENTS</th>
<th>SECOND REGIMENTS (T LYMPHOCYTES)</th>
<th>THIRD REGIMENTS (B LYMPHOCYTES)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phagocytes (spies)</td>
<td>CD4 cells</td>
<td>Plasma B cells manufacture the antibodies</td>
</tr>
<tr>
<td>Macrophages (messengers and the dendritic cells)</td>
<td>T helper (General)</td>
<td>Memory B cells (record keepers)</td>
</tr>
<tr>
<td></td>
<td>Killer T cells (killers)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suppressor T cells (peace makers)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Memory T cells (record keepers)</td>
<td></td>
</tr>
</tbody>
</table>

Table 1. ‘Regiments of the White Blood Cell’
Your immune system has many different ways of fighting foreign invaders. When confronted with a virus, your body responds by activating specific processes of the immune system.

1. First your body recognises a foreign antigen or invader, and the dendritic cells or (spies) delivers it to the lymph system, where it is ingested by a macrophage.

2. Then the macrophage processes the virus and displays the antigens/invader for that particular virus on its own exterior. This antigen then signals a helper T-cell.

3. Next the T-cell reads this signal and sounds the alarm for other parts of your immune system to respond.

4. The B-cell responds to this call and comes to read the antigen from the surface of the macrophage.

5. The B-cell then becomes activated and produces millions of antibodies that are specific to the antigen. These antibodies are released into your body to attach to the virus particles.

6. These antibodies are important because the invading virus may outnumber your own immune system cells. The antibodies attach to the antigens and hold on tight.

7. These antibodies then send a signal to other macrophages and other immune cells to come and engulf and destroy the antibody and whatever it has captured.

8. The final stage of your immune system’s response involves the suppressor T-cell. Once the number of invaders has dropped significantly and the infection has been resolved, the suppressor B-cell will signal the other cells of the immune system to rest. This is important as prolonged activation of your immune response could eventually lead to damage to your healthy cells.

9. The Memory cells are then summoned to record the antigen that has attacked the body for future record as immunity.
Figure 7. The Immune System fighting the Micro-organism
THE DIFFERENT TYPES OF WHITE BLOOD CELLS
FIGHTING THE MICRO ORGANISM

Figure 8. White blood cells as defence mechanism
2.7. TRANSMISSION OF HIV

SEXUAL TRANSMISSION OF HIV

INTRODUCTION
HIV is commonly transmitted sexually by penile-vaginal intercourse, anal intercourse and less frequently by oral sex (fellatio). Sexual behaviour that is accompanied by bleeding appears to increase the risk of transmissions substantially.

Other sexual practices may transmit infection, but so few data is available that it is difficult to quantify risk associated with these practices. Many sexual partners increases the risk, but risk varies significantly by geographic region, because the prevalence of infection among the pool of sexual partners strongly affects the probability of encountering an infected partner and therefore the probability of transmission.

HETEROSEXUAL HIV TRANSMISSION
Exposure to risk is through the exchange of semen, vaginal fluids and blood.

• Vaginal and penile sexual intercourse can transmit HIV infection to the male or female partners. The risk is higher to the female partner who is receptive, because of the likelihood of trauma, post-coital vaginal bleeding and access of HIV in the bloodstream.
• Anal intercourse is a high risk factor because of trauma to the rectal mucosa which cause bleeding.
• Oral sexual intercourse poses the same risk to the female partner as receptive oral partner in male homosexual couples.
• Oral vaginal sexual intercourse is increased risk, but the risk is not well documented.
• Increased multiple sexual partners for both heterosexual and homosexual partners.

MALE-TO-MALE HIV TRANSMISSION
Exposure to risk is the exchange of semen and blood which is a very high risk to homosexual partners having penile – anal intercourse.

• Homosexual men or men having sex with other men (MSM), engaging in penile-sexual intercourse through the anus is high risk because of the direct trauma to the anus and rectum. The bowel mucosa cells and the rectum are thinner than in the vagina and HIV targets the macrophages cells in the bowel.
• MSM having insertive penile-anal sexual intercourse are at increased risk because of semen and blood in the anus and rectal mucosa
• Anal sexual intercourse for receptive partner during anal intercourse cause increased viral access to the bloodstream through small tears in the rectal mucosa
• Other sexual practices with other forms e.g. sex toys and fists also increase the risk of HIV infection because

**FEMALE-TO-FEMALE HIV TRANSMISSION**
Female to female sexual intercourse is between two females with either being injection drug user or bisexual (having heterosexual intercourse) where blood and vaginal fluids come into contact.
• Sexual activities are mostly trauma resulting in vaginal bleeding or during menstruation
• Sexual practices include digital, oral contact e.g. on the vagina or anus (fellatio)

There is less evidence that shows HIV transmission from both women having penetrative sexual intercourse with each other constitute high risk to HIV. However, some studies have showed that sharing of toys, others who are Intravenous drug users (IDUs) and female partners having heterosexual partners infect their female partners.

**CONDOM USE AND HIV TRANSMISSION**
The use of condoms during anal intercourse shows reduced sexual transmission of HIV.
• In anal sexual intercourse there is reduced risk but it does not eliminate the risk of HIV transmission in homosexual men using condoms due to condom failure in homosexual men.
• HIV Transmission and Multiple Partners: condom failure appears to be more frequent during anal than vaginal intercourse.
• Male condom efficiency is greatly increased by proper use. The virus is present in pre-ejaculatory fluid so the condom should be put on before sexual contact and air should not be left in tip.
• Female condoms has been approved and is on the market, the female condoms are under the woman’s control that should protect her against HIV.
• Female condom has good efficiency rate, it controls sexually transmitted infections in proper use.
• Issues of gender control in the woman persuading the partner to use the female condom may be a challenge.
**Antiretroviral Therapy and HIV Transmission**
- Studies of men taking ARV’s in the disease stage on ART were less likely to transmit HIV to their female partner than men not ART.
- ART may reduce infections. Currently multidrug regimens of ART which include reverse transcriptase and protease enzymes of HIV can reduce transmission.

**Post Exposure Prophylaxis and HIV Transmission**
Exposure to risk is through the exchange of semen, vaginal fluids and blood.
- This happens with health care workers (doctors, nurses, emergency personnel etc.) who are infected with contaminated blood, body fluids on their skin, in their eyes or skin lacerations.
- Needle stick injuries, scalpels or wound infection or lacerations. Health care workers must follow Universal Precautions to prevent infection.
- Traditional practices regarding scarification, traditional practices such as young men being circumcised in their rituals to become men (Lebollo –Sesotho; Ukusoka-Ndebele) and tattoos.

**Co-factors to Sexual Transmission**
Exposure to risk is the exchange of semen and blood which is a very high risk to homosexual partners having penile – anal intercourse.
- Sexual transmission is driven in part by various infections of the infected partner and in susceptibility of the uninfected host. In addition to condom use, other factors have been identified that can be important factors in changing the probability of transmission.

**Risk Factors Associated with Sexual Transmission**
- Sexually transmitted infections/disease (STI/STD) increase susceptibility to infection by causing genital lesions that facilitate viral entry or by increasing the number of targeted cells for HIV (lymphocyte/monocyte).
- Genital ulcers are often caused by ducreyi (chancroid) infection syphilis and herpes simplex infection, genital ulceration, and chlamydia trichomatis all cause bleeding on the vagina or anus or penis which leads to HIV entry into the bloodstream.
2.7.1. BLOOD-TO-BLOOD HIV TRANSMISSION

- Through blood transfusion in countries where there is no screening facilities
- Through needle stick injuries, tattooing, scarification and exchange of needles and syringes
- Using the same blade during circumcision

2.7.2. VERTICAL HIV TRANSMISSION

VERTICAL TRANSMISSION IN UTERO (WOMB)
- Ascending infection via the vagina
- Exposure to virions in maternal genital secretions
- Exposure to maternal infected blood during the birth process
- Regulated movement of infected maternal cells from maternal cells into the foetal compartments
- Maternal to foetal transfusion of infected cell due to a break in anatomic barriers
- Infection of syncytiotrophoblast by HIV with transmission of the virus to the foetal villous core
VERTICAL TRANSMISSION - LABOUR AND DELIVERY

- During birth
- Birth canal if there is trauma or tears during delivery
- Breastfeeding – breast milk during breastfeeding

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

*All mothers who are pregnant are at risk by definition because they have had unprotected sexual intercourse.

PREDICTORS OF VERTICAL TRANSMISSION

- Maternal viremia (high viral load)
- Maternal illnesses such as (OIs such as TB)
- Chronic illnesses such as diabetes or hypertension
- Sexually transmitted diseases
- Substance or alcohol; abuse e.g. cocain (‘crack babies’)

GOAL OF PREVENTION INTERVENTION

ANTENATAL CARE

- Improve the quality of the mother’s health and prevent mortality
- Identify women who are HIV-positive
- Ensure HIV positive women enter the PMTCT programme
- Prevent mother to child transmission
- Provide AZT from 14 weeks of pregnancy or life-long ART as soon as possible depending on the mother’s indications
LABOUR AND DELIVERY

- Identify HIV positive pregnant women.
- Provide adequate PMTCT coverage.
- Continuity of care and prophylaxis treatment of ART regimens
- Reduce maternal born Nevirapine resistance.
- Initiate neonates born to HIV-positive mothers with ART prophylaxis immediately after birth.

POSTNATAL FOLLOW-UP FOR MOTHER

GOAL OF INTERVENTION

The use of condoms during anal intercourse shows reduced sexual transmission of HIV.

- Provide follow-up post-partum care including a postnatal visit within 3 days.
- Improve the quality of the mother’s health and reduce mortality by including family planning counselling and cervical cancer where applicable.
- Provide post-exposure prophylaxis for infants.
- Reduce postnatal HIV transmission through breastfeeding programme.
- Identify all HIV exposed infants.
- Reduce mortality.
- Identify all HIV positive pregnant women and initiate ART therapy.

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**Star newspaper 08-06-2014**

**Nevirapine saves 58 000 babies from AIDS**

BY MAJOREN PARK

In three years, Nevirapine has saved nearly 50,000 newborn babies in Guangxi from contracting HIV/AIDS.

Aids had the anti-retroviral not been administered to some 300,000 women in labour, the authorities say 20% of the babies born to HIV-positive women would get infected.

The transmission rate is instead 1%, translating to 60-70 babies.

For mother Zemetlisa Thakau, 26, the effects of nevirapine were as good as she had hoped.

She was admitted to hospital with a fever and a high temperature.

The infection was caused by HIV, something she had never been aware of.

The treatment for HIV is provided by the government.

As for the patient, she said, "I had no idea about the infection." She said she never had any symptoms.

A leaked report in 1999 in Hillevile, an AIDS exhibition in the US, had shown the effectiveness of the drug.

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2.8. SIGNS AND SYMPTOMS OF HIV AND AIDS

Main symptoms of AIDS

Neurological
- Encephalitis
- Meningitis

Eyes
- Retinitis

Lungs
- Pneumocystis pneumonia
- Tuberculosis (multiple organs)
- Tumors

Skin
- Tumors

Gastrointestinal
- Esophagitis
- Chronic diarrhea
- Tumors

Figure 12. Signs and symptoms of HIV and AIDS
2.8.1. STAGES OF HIV AND AIDS

Figure 13. Stages of HIV and AIDS
### Factors associated with increased or decreased risk of HIV transmission

<table>
<thead>
<tr>
<th>Factors associated with Risk of Transmission</th>
<th>Male to Female</th>
<th>Female to Male</th>
<th>Male to Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anal intercourse</td>
<td>Yes</td>
<td>Unknown</td>
<td>Yes</td>
</tr>
<tr>
<td>No. of sexual contacts</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Primary HIV infection</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Advanced HIV disease</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Genital sores/infection</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lack of male circumcision</td>
<td>Possibly</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>Cervical ectopy</td>
<td>Yes</td>
<td>Possibly</td>
<td>N/A</td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>Yes</td>
<td>Unknown</td>
<td>N/A</td>
</tr>
<tr>
<td>IUD use</td>
<td>Possibly</td>
<td>Unknown</td>
<td>N/A</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Unknown</td>
<td>Possibly</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Factors associated with decreased risk of Transmission

<table>
<thead>
<tr>
<th>Factors associated with decreased risk of Transmission</th>
<th>Male to Female</th>
<th>Female to Male</th>
<th>Male to Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom use</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>ARV therapy</td>
<td>Possibly</td>
<td>Possibly</td>
<td></td>
</tr>
<tr>
<td>Spermicide use</td>
<td>Unknown</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
2.9.  STIs, DISEASE AND HIV

2.9.1. WHAT ARE SEXUALLY TRANSMITTED DISEASES

Sexually transmitted infections and diseases are those infections and diseases that are transmitted through sexual contact by various micro-organism (viruses, bacteria, fungi, protozoa and cancers) from an infected person to an uninfected person. This happens during penile-vaginal sexual intercourse, penile- anal sexual intercourse, oral sex (fellatio), cunning -Lingus, and skin contact. These are:

- Gonorrhoea
- Chlamydia
- Pelvic Inflammation
- Herpes simplex and herpes Zoster
- Trichomonas
- Syphillis
- Vaginal Candidiasis
- Anal Squamous Intraepithelial Neoplasia
- Genital Ulcerative diseases
- Genital Warts
- Hepatitis B.

2.9.2. SIGNS & SYMPTOMS OF STIs AND STDs

Sometimes it is very difficult to find out if one has STI or STDs as some of them are silent (there are no signs or symptoms especially for women).

2.9.3. WHAT IS THE RELATIONSHIP BETWEEN STIs & HIV

A person who has an STI is more likely to become infected with HIV if they have unprotected sexual contact without a condom with an HIV infected person. People infected with an STI that causes genital ulcerations/cuts/open sores on the vagina or penis or around the pelvic area.

Transmission occurs when cuts and open sores provide an easy entry for HIV to enter the bloodstream. Genital ulcerations are from diseases such as syphilis, chancre, gonorrhoea, trichomoniasis and scabies.
2.9.4. **STI AND HIV**

Alarming rates of infections with sexually transmitted infections and diseases like syphilis and gonorrhoea which are often overlooked. Few people realise the connection between STI infection and HIV infection. Most people do not realise that by treating STI’s, they can decrease the risk of HIV infection. A person with STI such as gonorrhoea, syphilis or herpes are more likely to acquire HIV infection.

If an HIV infected person has an STI as well, the risk is high on infecting another person due to:

- **Increased susceptibility** – intact skin is an excellent protect against any diseases including HIV. STI creates a site for HIV to enter the blood and infect the individual.
- **Chlamydia** do not cause ulcers but stimulate the white blood cells of the immune system to concentrate in the genital area to help fight the STI.
- **The increased concentration of white blood cells** means there are more CD4 cells for HIV to infect.

2.9.5. **OTHER INFECTIONS**

HIV infected people who are also infected with STI have a higher concentration of HIV in their genital fluids. Men who have HIV and gonorrhoea are found to have a significant number of HIV in their semen than HIV infected men who are not infected with gonorrhoea in their genital fluids. Chances are, HIV infection concentration with gonorrhoea are higher on unprotected sexual contact.

Treatment of STI and HIV reduces risk on studies done on women with ulcerative STI lesions. There were high levels on the presence of HIV in their genital fluids. After treatment, the amount of HIV in the genital fluids decreased to levels similar to women without ulcerative STI. Treatment of STI, not only decreases the HIV risk in individuals, but it also decreases infection rates in the entire populations. HIV is greatly reduced if a person is on STI treatment, because the levels of HIV in genital secretions is reduced.

If there is access to STI treatment, there is less HIV infections. Planning HIV Prevention Programs educational campaigns should include comprehensive STI prevention, education and treatment information to decrease sexual transmission of HIV.
Figure 14. Sexually Transmitted Infections and Diseases
2.10. SAFER SEX

2.10.1. ISOLATION OF BODY FLUIDS

- HIV has been detected in blood, semen, cervical secretions of infected persons
- HIV exists in saliva, tears, and urine in low titers and there is no research documenting cases of HIV transmission by these fluids
- Evidence of sexual HIV transmission in support of HIV infections is abundant in:
  - Male-to-male
  - Male-to-female
  - Female-to-male
- Risk of female to female HIV transmission is largely attributed to other risk factors (sex with men and IDU)
- Female to female transmission is uncommon only with rare cases by this route
- Number of sexual partners in homosexual men with different partners, serial partners, or multiple partners
- Choice of high risk sexual partners (IDU, STI, or sex-workers)
- Specific sexual practices, evidence exists of receptive partners in anal-genital sexual intercourse

2.10.2. HIV AND AIDS PREVENTION TOOLKIT

INDIVIDUAL LEVEL

Prior to Exposure
- Information education and communication on HIV/AIDS, STI & TB
- Sexual practices that lead to risk behaviour.

A. Behaviour Change
- Self-awareness
- Perception of Risk
- Abstinence
- Sexual faithfulness partner/s
- Reduction of multiple partners
- STI and sexual practices that expose to risk of HIV infection
- Safer sex practices/Use of condoms - {male condoms and femidoms}
- HIV/AIDS Vaccines
- Pre exposure Prophylaxis (PREP)
Point of Exposure

- Male and Female condoms
- Anti-retroviral Therapy
- Present mother to child transmission
- Microbicides
- Post Exposure Prophylaxis (PEP)

Figure 15. Different kinds of latex condoms

Figure 16. Handwashing procedures to prevent infection from micro-organism

HIGH ACTIVE ANTI VIRAL THERAPY (HAART)

HART - ART - ARV

- Care of PWA
- Education and behaviour change
- ART Care

GROUP EXERCISE

SELF/GROUP ASSESSMENT:

1. List 3 main ways in which HIV is transmitted into our body.
2. How do we prevent HIV from mother to unborn child?
3. How does our body defend us from germs/infections?
4. What is the relationship between HIV and STI’s?
5. How do we prevent sexually transmitted infections?
6. “All sexually transmitted infections can be cured.” True/False?
LEARNING OUTCOMES

After completing this module, you should be able to:

1. Identify the diagnosis of HIV – current types of tests.
2. Explain the importance of pre and post-test counselling.
3. Demonstrate an understanding of the procedures and technical involved in pre and post-test.
3.1. **DIAGNOSIS OF HIV**

**INTRODUCTION**
High antiretroviral Therapy advances since the mid-1990s have improved the length and quality of life for people living with Human Immunodeficiency Virus (HIV) but as yet, there is no cure.

Counselling before and after HIV testing will help you understand what behaviours put people at risk and how to reduce the risk of becoming infected. If one tests positive, counselling will address the immediate needs for support and information aid plus teach people what they need to know to decrease the chance of infecting others.

The National Policy on Testing for HIV sets out the circumstances for when and how HIV Testing should be done:

3.2. **TESTING ON HIV**

- Testing for HIV may only be done with informed consent (except in a few cases, set out in the policy).
- Pre-testing counselling must be given to each person before the test.
- Post-test counselling must be given after the person gets the test result.
- If the result is negative, then the person should be advised to remain negative and told about the possibility of the window period.
- If the result is positive, the person should be given emotional support and discussion can take place about who to inform and how to reduce the risk of HIV infection to their sexual partner/s.
- If a hospital or clinic is not able to do counselling, it must refer the person to another place for counselling.
  - Informed consent
  - Information
  - Permission

With an HIV test, a person must know what the test is, why it is being done and what the result will mean for him/her agreeing to their blood being taken.
3.2.1. PRE-TESTING COUNSELLING

- The purpose of pre-test counselling is to provide individuals who are considering being tested with information on the technical aspect and possible personal, medical, social, psychological, legal and ethical implications of being diagnosed as either HIV positive or HIV negative.
- Pre-test counselling is to find out your HIV status, nature and extent of previous and current high-risk behaviour and steps that need to be taken to prevent becoming HIV infected or if HIV positive to transmit HIV infection to others.

3.2.2. PROCEDURES

- Reasons for testing
- Assessment of risk
- Beliefs and knowledge about HIV infection and safer sex
- Information about the test
- The implications of an HIV test result
- Anticipation of the test results
- Informed consent
- Ongoing support for the client

3.2.3. POST-TESTING COUNSELLING

- Not many things in life could be as stressful as receiving an HIV test result. For many clients it feels as if the counselling holds the key to the future of their lives in their hands.
- Counselling after testing will depend on the outcome, be it the test may be a negative result or a positive result or inconclusive result.

Post test includes
- Sharing the result with the client
- Coping with the clients reaction to a positive/negative/inconclusive result
- Respond to the clients' needs
- Crises intervention
- Arrange follow-up visits / counselling for client
- Support systems
- Advice about health and sexuality
- Medical check-up if positive test result
3.3. HIV TEST

- HIV infection is usually not noticed in the first few years after infection and the HIV antibody test is often the first and only definite evidence of HIV infection.
- It normally takes 4 – 12 weeks after infection with HIV for these antibodies to appear in the blood. In some individuals, HIV antibodies may appear even later, but this is not common.
- Antibodies are proteins released into the body by immune cells to help fight off infecting viruses by interacting with antigens. Antibodies are found in blood, mucus, tears, saliva and breast milk.
- Infected adults usually have detectable antibodies by six (6) months after infection.
- An individual who has tested positive for HIV antibodies is called, HIV POSITIVE.

The WINDOW PERIOD is the stage during which:
- The person is infected with HIV
- The HIV antibody test result is still negative (called a false-negative test result).
- The virus can be passed to others

3.4. INTERPRETING THE TEST RESULTS

If the HIV test is Negative
- It could mean the person has not been exposed or infected with HIV. This is a ‘true’ negative test.
- It may be a false negative test. This means that the person has been exposed and infected with HIV, but the test has been done too soon after infection and he/she is still in the ‘window period’. If this person has a test in a further twelve (12) weeks’ time, the test will usually become positive.

If the HIV test is Positive
- It means that the person is HIV infected and can spread the virus to others during sex, through blood or during pregnancy, childbirth or breast feeding.
- It does not mean that the person has AIDS.
- A positive test cannot determine when the person will develop AIDS.
- A positive test cannot determine when the person first became infected or when the person will develop AIDS.
- All positive results are confirmed with another test called a confirmatory test.
If the HIV test is indeterminate
- It means that it is not possible to tell if the person has been infected with HIV based on the test results.
- This does not occur very often, but can happen to people who have had multiple pregnancies/miscarriages, multiple blood transfusions, received dialysis, liver disorders or some types of cancer.
- The person should be re-tested again in three months

3.5. **anti-body Tests**

- Oral Quick Test: is the first kit for home testing antibodies against HIV in body. Oral fluids, blood or plasma results are available within 20 minutes.

- Rapid HIV Test: Blood test (Needle Prick) Antibody test are qualitative immunoassays screen test intended to detect antibodies against HIV for use in point of entry of HIV Care to aid in the diagnosis of HIV infection within 5-30 minutes.

- ELISA Test: enzyme-linked immunoassay (EIA) was the first screening test commonly employed for HIV antibody test to determine whether the antigen is present. Also used as a confirmatory test for rapid testing.

- Western Blot: or protein immune blot, blood test to diagnose the presence of HIV in the bloodstream. Also used as a confirmatory test.

- p24: is an antigen test used to detect specific antigen p24 presence of HIV -1 in the blood. Mostly used in new-borns and infants.

- Genotype Assay: set of genes carried by each organism.

- Phenotype: observable characteristics of physical and biochemical properties organism as it interacts with its environment.

- Viral Load: numerical expression of the quality of the virus to monitor the progress of the treatment and the disease.

- CD4 Count: measure the molecular biology of cluster differentiation cells, a glycoprotein found on the surface of the white blood cells (monocytes, macrophages, and dendritic cells).
GROUP ACTIVITY

SELF/GROUP ASSESSMENT:
1. What is a negative HIV test?
2. What is a positive HIV test?
3. If we say a couple has “discordant” results, what does it mean?
4. How often must a person take a HIV test?
LEARNING OUTCOMES

After completing this module, you should be able to:

1. Brief definition of TB and its causes
2. Discuss the signs and symptoms of TB
3. Discuss different medications for TB
4. The difference between MDR-TB and XDR-TB
5. Discuss the DOTS strategies
4.1. TUBERCULOSIS

INTRODUCTION
Tuberculosis (TB) is a chronic bacterial infection that is spread through air, it usually infects the lungs. While most people who are affected with TB do not have symptoms (latent form of the disease), the active form of the disease is more serious, killing nearly two million people each year. Treatment involves taking several antibiotics for at least six months.

4.1.1. HISTORY OF TUBERCULOSIS

It is believed that tuberculosis has been infecting humans for thousands of years. Bone marrow dating back to 4000 BC show evidence of tuberculosis. A tuberculosis cure was developed (through the testing of streptomycin) more than 50 years ago. TB continues to kill between two to three million people a year worldwide. The World Health Organisation (WHO) estimates that 36 million people will die of TB by 2020 if it is not controlled.

4.1.2. WHAT IS TUBERCULOSIS

Tuberculosis (TB) is a chronic bacterial disease caused by Mycobacterium tuberculosis. It is spread through the air and usually infects the lungs, although other organs and parts of the body can be involved as well. Most people who are infected harbour the tuberculosis bacterium without symptoms. This is known as latent tuberculosis.

If the body’s resistance is low because of aging, malnutrition, infections such as HIV, or other reasons, the bacteria may break out hiding and cause active tuberculosis.

According to World Health Organization (WHO) estimates, each year, eight million people worldwide develop active tuberculosis and nearly two millions die. One in 10 people who are infected with tuberculosis may develop active TB at some time in their lives. The risk of developing the active disease is greatest in the first year after infection.
4.1.3. CAUSES OF TUBERCULOSIS

The cause of the disease is a bacteria called Mycobacterium tuberculosis. This bacterium attacks the lungs. TB can also attack any part of the body such as the kidneys, spine and brain. If not treated properly, TB can be fatal.

4.1.4. TRANSMISSION OF TUBERCULOSIS

Tuberculosis is spread through the air from one person to another. The bacteria are put into the air when a person with active TB of the lungs or throat coughs or sneezes. People nearby may breathe in these bacteria and become infected.

People cannot get infected with TB through handshakes, sitting on toilet seats, or sharing dishes and utensils with someone who has TB.

4.1.5. SYMPTOMS OF TUBERCULOSIS

- TB has no symptoms
- Do not feel sick
- Cannot spread TB to others
- Usually have a positive TB skin test (PPD test) reaction

Some people with the latent form of the disease can develop active TB if they do not receive treatment. If the body’s resistance is low because of aging, malnutrition, infections such as HIV, or other reasons, the bacteria may break out of hiding and cause active tuberculosis. In these cases, symptoms can include:
  - Unexplained weight loss
  - Fever
  - Chills
  - Night Sweats
  - Weakness of fatigue
  - Loss of appetite
  - Cough that lasts 3 weeks or longer
  - Pain in the chest
  - Coughing up blood or sputum
4.1.6. **DIAGNOSIS OF TUBERCULOSIS**

Specific tests will help the doctor make diagnosis and determine whether it is the disease which is active or latent. These TB tests can include a TB skin test, (PPD Test), TB blood test, or other tests i.e. chest X-Ray and samples of sputum.

4.1.7. **DIAGNOSIS OF TUBERCULOSIS**

Treatment options involve taking several different antibiotics for at least six months (and some cases, up to several years). In most cases, by taking medication, TB can be cured. A TB cure relies on close cooperation between patient and health care worker in order that the right amount of medication is taken for a shorter period of time otherwise a TB cure is less likely. Furthermore, there is a greater chance a person will develop drug-resistant TB, a condition that is more difficult to cure.

4.1.8. **PREVENTION**

- Tuberculosis is a largely preventable disease. Prevention focuses on:
- Preventative treatment in people who have a positive TB test without symptoms of tuberculosis (latent tuberculosis).
- Precautions at hospitals and clinics
- BCG vaccine
- Reducing exposures when a person is infected.

4.2. **LATENT TUBERCULOSIS**

In most people who breathe in the tuberculosis bacteria and become infected, the body is able to fight the bacteria to stop them from growing. The bacteria become inactive, but they remain alive in the body and can become active later. This is called latent tuberculosis. People with latent tuberculosis:

- Have no symptoms of TB
- Do not feel sick
- Cannot spread TB to others
- Usually have a positive skin test (PPD test) reaction

*Some people with latent TB can develop active TB if they do not receive treatment.
4.3. **MEDICATIONS FOR TREATMENT FOR TB**

The most common medicine used for active TB treatment are:
- Isoniazid (INH)
- Rimfampin (RIF)
- Ethambutol
- Pyrazinamide
- Radiation
- Artificial Pneumothorax
- Chemotherapy
- BCG vaccine for children and health care workers.

For a person with latent form of TB, treatment usually consists of isoniazid for TB at least 6 months.

4.4. **KNOW THE RISK FACTORS**

Research has shown that people with certain risk factors are more likely to develop TB. A risk factor is anything that increases a person’s chance of developing a disease.

Specific TB risk factors include:
- Alcoholism
- IV Drug use
- Crowded living conditions
- Homelessness
- Poverty
- Immigration and refugees status from other countries
- Low body weight
- Certain medical treatments (such as corticosteroid treatment or organ transplant

Certain medical conditions such as:
- HIV and AIDS
- Diabetes Mellitus
- Silicosis
- Cancers such as Leukaemia or Hodgkin’s disease
- Severe kidney disease
- Certain treatments for rheumatoid arthritis
4.5. **TB AND HIV POSITIVE PEOPLE**

Because TB can spread through the air, increase in active TB among people infected with both TB and HIV results in:

- More transmission of TB bacteria
- More people with latent TB
- More TB disease in the whole population.

People with latent TB are increasingly becoming infected with HIV, and many more are developing active TB because HIV weakens the immune system. People who are co-infected with both HIV and latent TB have greater risk of developing active TB disease.

Most become infectious as compared to people who are not infected with HIV and opportunistic infections, because OIs take advantage of the opportunity offered by a weakened immune system. TB is an HIV related opportunistic infection. A person that has both HIV and active TB has an AIDS-defining illness.

The AIDS epidemic is reviving an old problem in well-resourced countries and greatly worsening an existing problem in poorly–resourced countries. There are several important associations between HIV and TB epidemics:

- TB is harder to diagnose in HIV positive people.
- TB progresses faster in HIV-infected people.
- TB in HIV positive people is more likely to be fatal if undiagnosed or left untreated.
- TB occurs earlier in the course of HIV infection than other opportunistic infections.
- TB is the only major AIDS- related opportunistic infection that poses a risk to HIV-negative people.

4.6. **KNOW THE RISK FACTORS**

It is vitally important for people with HIV to have treatment if they are active with TB. This will cure them and prevent transmission to other parts of the body and other people. Even in areas where antiretroviral drugs are unavailable, it is crucial that the health care system is able to offer HIV positive people the simple antibiotics needed for Directly Observed Treatment (DOTS).
For some people it can be difficult to take drugs for both TB and HIV at the same time, some HIV drugs can also interact with some TB drugs making the treatment more difficult. It is important that the TB treatment is taken more regularly and exactly as prescribed. If the drugs are not taken regularly, the bacteria can become resistant to the drugs and his can be dangerous.

As one of the first opportunistic infections to appear in HIV-infected people, TB may be one of the earlier signs of HIV infection. Addressing TB offers the opportunity for early HIV intervention. Although treatment of TB can improve the quality of life of HIV positive people and prolong their life, it cannot stop them from dying of AIDS. This is why access to antiretroviral treatment is also important.

Around the world, attempts are being made to improve collaboration between TB and HIV programmes. It is being proposed that everyone diagnosed with TB should be tested for HIV and vice-versa, and that treatment programmes should share facilities and expertise. However, achieving such collaboration is not easy.

4.6.1. **MULTI-DRUG RESISTANT TB (MDR-TB)**

When a strain of TB is resistant to two or more “first-line” antibiotic drugs it is called multi-drug resistant TB or MDR-TB. When is resistant to three or more “second-line” antibiotics as well, it is classed as extreme drug resistant TB, or XDR-TB.

Drug resistant usually arises when TB patients do not or cannot take their medication as prescribed, and drug-resistant mutations of the TB bacteria are allowed to replicate. People can also catch MDR-XDR-TB from others.

MDR-TB is difficult to treat and it is a serious problem. In normal first-line treatment, patients take the isoniazid and rifampicin (most effective drug available) plus two or three other first-line drugs for six to eight months.
If a person is resistant to isoniazid and rifampicin, they are said to be MDR-TB and will need to change to a regime containing newer and less widely-available “second-line” drugs. Treatment with second-line drugs can take a long time, and is usually far more expensive than standard dots therapy because most of the drugs are still under patent.

XDR-TB is even more serious. If someone has XDR-TB, it means they are not only resistant to isoniazid and rifampicin, but to three or more of the six available second-line drugs too. This can make it virtually impossible to formulate an effective treatment regime for them. Many people with XDR-TB will die before it is even realised that they have extreme resistant strain.

4.6.2. WHAT IS DOTS

Tuberculosis is completely curable through short-course chemotherapy. Treating TB cases who are sputum-smear positive (and who can therefore, spread the disease to others) at the source, it is the most effective means of eliminating TB from a population.

DOTS or Directly Observed Treatment Short course is the internationally recommended strategy for TB control that has been recognised as highly efficient and cost effective strategy. DOTS comprise five components:

1. Sustained political and financial commitment: TB can be cured and the epidemic reversed if adequate resources and administrative support for TB control are provided
2. Diagnosis by quality assured sputum-smear microscopy: Chest symptomatic examined this way helps to reliably find infectious patients
3. Standardized short-course ant-TB treatment given under direct and supportive observation (DOT): helps to ensure the right drugs are taken at the right time for full duration of treatment.
4. A regular, uninterrupted supply of high quality anti-TB Drugs: Ensures that a credible national TB programme does not have to turn anyone away.
5. Standardized recording and reporting: helps to keep track of each individual patient and to monitor overall programme performance.
Six Essential Elements:

- Sustaining, improving and accelerating quality DOTS expansion
- Addressing TB-HIV, MDR-TB and other special challenges
- TB/HIV collaborative interventions
- DOTS- Plus for MDR-TB
- Reaching vulnerable, high risk groups
- Contributing to health system strengthening
- TB control innovations that strengthen health systems
- Adaptation innovations from other TB control programmes
- Practical Approach to Lung Health
- Engaging all care providers
- Public-private partnerships
- Ensuring equitable access to international standards of care for TB to all
- Empowering patients and communities
- Advocacy. Communication and social mobilisation
- Community based TB care
- Enabling and promoting.
4.8. ROLE OF DOTS-SUPPORTER GROUP ACTIVITY

GROUP ACTIVITY

SUPPORT SYSTEM FOR PEOPLE WITH TUBERCULOSIS ON TREATMENT:

1. DOTS strategies are successful when there is collaboration with HIV Prevention campaigns
2. Facilitate local support systems for people suffering from tuberculosis to celebrate Global STOP TB Day Campaign
3. Family and community awareness programmes are conducted in accordance with identified needs.
4. How can we use DOTS Strategy for ART Therapy?

GROUP ACTIVITY

SELF/GROUP ASSESSMENT

1. List the signs and symptoms of Tuberculosis (TB)?
2. What is MDR – TB and XDR – TB?
3. How long must a patient remain on TB treatment?
LEARNING OUTCOMES

After completing this module, you should be able to:

1. Understanding of HIV and AIDS and the Law in South Africa
2. Demonstrate an understanding of the Bill of Rights and the Equality Clause for People Living with HIV and AIDS
3. Discuss HIV/AIDS as grounds for non-discrimination in the equality act
4. Explain some of the Socio-Economic rights.
5.1. INTRODUCTION

Under the Constitution of South Africa, 1996, all men and women are equal as stated in the Constitution. The Bill of Rights is the cornerstone of our democracy. All people have rights, which are respected by all spheres of government. It governs relationships between the state and individuals and relationships between individuals. The Bill of Rights grants all South Africans equal political rights and civil rights. However limitations on these rights will only be allowed in exceptional circumstances as found in section 36 of the Constitution.

For this training we will discuss a few important laws/rights, one being The Promotion of Equality and Prevention of Unfair Discrimination Act, 2000.

5.1.1. GROUNDS FOR NON-DISCRIMINATION

The Equality Act makes it illegal to unfairly discriminate against any person for any of the following grounds:

- Race
- Gender
- Sex
- Pregnancy
- Marital Status
- Ethnic Origin
- Social Origin
- Sexual Orientation
- Disability
- Religion
- Language

5.1.2. HIV and AIDS AS GROUNDS FOR NON-DISCRIMINATION IN THE EQUALITY ACT

The Equality Act does not have HIV status separately from disability as a ground for non-discrimination, but the Act does recognise that HIV/AIDS status – whether real or perceived levels of discrimination.

At the moment the Equality Act allows the courts to decide in each case whether HIV/AIDS should be interpreted as: 1) a disability, or; 2) on its own as a separate ground.
5.1.3. HIV and AIDS AS GROUNDS FOR NON-DISCRIMINATION IN THE EQUALITY ACT

1. HIV/AIDS is a national epidemic that affects many people in South Africa
2. PWA or affected by HIV/AIDS face a wide range of unfair discrimination and stigmatisation in all aspects of life, the Equality Act should recognise to ensure non-discrimination on the basis of HIV/AIDS
3. By making HIV status a separate prohibited ground it is easier for PWA/PLWA to show a court that there is unfair discrimination on a ground of HIV status, or the ground for disability
4. Unfair discrimination can arise where a person is treated differently because of their HIV status at:
   - Work; or
   - Medical Aid Schemes; or
   - Insurance Companies; and
   - Communities who stigmatise and isolate infected

5.2. SOCIO-ECONOMIC RIGHTS

<table>
<thead>
<tr>
<th>CIVIL RIGHTS</th>
<th>Right to equality</th>
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<tbody>
<tr>
<td>POLITICAL RIGHTS</td>
<td>Right to free, fair and regular elections</td>
</tr>
<tr>
<td>SOCIAL</td>
<td>Right to freedom of association</td>
</tr>
<tr>
<td>ECONOMIC RIGHTS</td>
<td>Right to have access to healthcare providers/services</td>
</tr>
</tbody>
</table>
| OTHER RIGHTS | • Right to a healthy environment  
• Right of access to land and land restitution  
• Access to adequate housing  
• Children’s rights to nutrition, shelter, basic healthcare services and social services  
• Right to basic education including adult education  
• Prisoner’s rights to dignified orison conditions, including nutrition and medical treatment. |
5.3.  HIV and AIDS AS A DISABILITY

The Equality Act does not specifically list HIV/AIDS as a ground for non-discrimination, but it does say disability may not be a justification for unfair discrimination.

5.3.1.  HIV - DISABILITY OR DISABILITY INCAPACITY

Incapacity means a person is unable to function. Disability rights activists look at the way society stops people with disabilities from participating as equals.

GROUP ACTIVITY

Case Study 1
Sandile is unable to walk and uses a wheelchair, she reads and writes as well as anyone else, and has qualified as a computer operator. Sandile, however, cannot find a job because most offices have stairs and she cannot get up those stairs. Sandile's disability does not prevent her from doing the job it is the way the offices are built that handicaps her and makes it difficult for her to do her job.

Questions
1. Is Sandile being unfairly discriminated against? Substantiate your answer
2. List 5 grounds for unfair discrimination except for disability under the Equality Act.
3. What do you think the courts would order the offices to do so that they comply with the Equality Act?
GROUP ACTIVITY

Case Study 2
Peter applies for a job as a teacher in a German school situated in Sandton but he cannot speak German. Mark another applicant can speak German. Mark is given the job because he can speak German, this is ‘fair’ discrimination because a German-speaking teacher is better qualified to do the job as a teacher in a German school.

Questions
1. Had Peter been able to speak German but he was a gay man and he was not chosen would this still be ‘fair’ discrimination?
2. What ground for unfair discrimination would Peter then raise?

GROUP ACTIVITY

Case Study 3
Mandy also applies for the job, she too can speak German. She has even better qualifications than Mark. She does not get the job because she is a woman. This is ‘unfair’ discrimination as Mandy is being treated unequally because of her gender.

Questions
1. What ground for unfair discrimination would Mandy then raise?

5.4. HIV/AIDS AND RIGHTS

The Constitution includes many rights but most important for people living with HIV and Aids are the socio-economic rights, such as the right to basic health care, education, social services, shelter, and so on. The government has a duty over time to make it possible for people to use their socio-economic rights.
THE PILLARS OF THE CONSTITUTION

Between 1994 and 1996 South Africa’s first fully democratic parliament, sitting as the Constitutional Assembly, drew up South Africa’s new Constitution. It contains guarantees of equality more extensive than anywhere else in the world. At its heart are seven fundamental values which are represented by the pillars in this courtyard: democracy, equality, reconciliation, diversity, responsibility, respect and freedom.
## 5.5. BILL OF RIGHTS

<table>
<thead>
<tr>
<th>SECTION IN THE BILL OF RIGHTS</th>
<th>WHAT IT MEANS FOR YOU IF YOU ARE LIVING WITH HIV OR AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>**Section 10</td>
<td>Human Dignity**</td>
</tr>
</tbody>
</table>
| **Section 12 | Freedom and Security of Person** | The right to:  
  - Make decisions about reproduction  
  - Security and control over your body  
  - Not be subjected to medical or scientific experiments without your informed consent. You have the right to take your own decisions about medical treatment and pregnancy e.g. you cannot be forced to have an HIV test. You may not be treated in a cruel or degrading way by any person or institution. |
| **Section 14 | Privacy** | Everyone has a right to privacy. You have the right to keep the fact that you have HIV or AIDS to yourself. An employer or hospital cannot force you to tell them, or force you to have an HIV test. |
| **Section 16 | Freedom of Expression** | Everyone has a right to freedom of expression, which includes freedom to receive or impart information or ideas. Proper information can be made available in schools or prisons about how to prevent HIV. |
| **Section 18 | Freedom of Association** | Everyone has a right to freedom of association. You can join any organisation you choose. You cannot be forcefully separated from other people. |
| **Section 21 | Freedom of movement and residence** | Everyone has the right to:  
  - Move about freely  
  - Enter, remain in or leave the country  
  - Reside anywhere in the country. You are free to move around the country. You cannot be forced to live in a separate place, away from the rest of society. |
| **Section 22 | Freedom of Trade, Occupation and Profession** | Every citizen has a right to choose their work freely. You can choose what kind of work you want to do e.g. you may not be told that you cannot be a teacher or a health care worker. |

<table>
<thead>
<tr>
<th>SECTION IN THE BILL OF RIGHTS</th>
<th>WHAT IT MEANS FOR YOU IF YOU ARE LIVING WITH HIV OR AIDS</th>
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</thead>
</table>
| **Section 24 | Labour Relations**  
Everyone has the right to fair labour practices. | This right may be important for people living in a state institution such as a prison or psychiatric hospital. |
| **Section 26 | Housing**  
Everyone has the right to have access to adequate housing. No-one may be evicted from their home, or have their home demolished without a court order. | You may not be refused a subsidy or loan to buy a house because you have HIV or AIDS. 
It is unlawful to evict you from your home because of your health. |
| **Section 27 | Health care, food, water and social security**  
- No-one may be refused emergency medical treatment.  
- Everyone has the right of access to:  
  - health care services, including reproductive care  
  - social security, including appropriate social assistance if they are unable to support themselves and their dependants | Hospitals or medical people cannot refuse to treat you. 
You have the right to a disability grant if you are too ill to support yourself or your family. |
| **Section 29 | Education**  
Everyone has a right to basic education, including adult basic education | You have the same right as anyone else to education. A school cannot refuse to educate you or your child because you have HIV or AIDS. |
| **Section 32 | Access to information**  
Everyone has the right to see any information held by another person that they need in order to exercise or protect their rights | If for example you feel your rights are being violated because of a company policy, you can demand to see the policy and may then challenge it in court. You have the same right with private institutions or the state, for example an organisation, or your medical records at a state hospital. |
| **Section 33 | Just administrative action**  
Everyone whose rights have been negatively affected by administrative action, has the right to be given written reasons. This includes reasons for very long delays. | If you believe that you are being refused a social service (e.g. a house or education) you may then decide to challenge the decision. |
| **Section 35 | Arrested, detained and accused people**  
Anyone who is detained, including every sentenced prisoner, has the right to conditions of detention that are consistent with dignity. | Prisoners cannot be discriminated against or treated in an undignified way just because they have HIV or AIDS. |
In terms of the Employment Equity Act testing to determine an employee’s HIV status is prohibited unless the testing is considered to be justified by the Labour Court. The Act does not, however, stipulate the grounds upon which the Labour Court may authorise the testing of an employee to determine his/her HIV status. In fact, the Act prescribes only the conditions that the court can impose when it grants an order in terms of which the HIV testing of an employee is authorised.

However, in Joy Mining Machinery, a Division of Harnischfeger (SA) (Pty) Ltd v NUMSA & Others, the following factors were stipulated as circumstances under which HIV testing would be allowed:

1. To prevent unfair discrimination.
2. If the employer needed HIV testing to determine the extent HIV in the workplace in order to place itself in a better position to evaluate its training and awareness programmes, and in order to formulate future plans based on the outcome of the tests.
3. If the purpose of testing was that the employer needed to know the prevalence of HIV at its workplace in order to be pro-active in its prevention amongst employees, and in order to treat the symptoms and to plan for contingencies, including the fair distribution of employee benefits, medical aid and the training of replacement labour.
4. If medical facts indicate the need.
5. If employment conditions required testing.
6. If social policy required testing.
7. If the inherent requirements of the job require it.
8. If particular categories of employees/jobs required such testing.

It was made in the case of Irvin & Johnson Ltd v Line Fishing Union & Others that the court’s sanction was not necessary if the testing was voluntary and anonymous, as there could be no discrimination in such circumstances.

Case Study 4
Tuba Enterprises wants its employees to be tested for HIV/AIDS on a voluntary and anonymous basis. The employer argues that it requires information on the prevalence of HIV/AIDS in its workplace in order to assess the impact of HIV/AIDS and to implement effective proactive measures to prevent employees from becoming infected with HIV/AIDS.

Questions
1. Does Tuba Enterprises need to apply to the Labour Court for an order that such testing is authorised before it can proceed with the testing?
LEARNING OUTCOMES

After completing this module, you should be able to:

1. Difference between Adherence and Compliance
2. What is Adherence and the importance thereof
3. Discuss Treatment Regimens and different types of Antiretroviral drugs
4. Discuss side effects, and resistance
5. Discuss changing treatment regimens
6. Why is history taking important
7. Patient - Provider Relationship
6.1. ADHERENCE VS. COMPLIANCE

6.1.1. COMPLIANCE
The extent to which the patients ‘behaviour (in terms of taking medications, following diets, or other life styles) coincides with medical or health advice”. The term “compliance” has been viewed by many as having value statement and a directional bias. It assumes that guidelines are accurate and patient response measured according to these guidelines.

6.1.2. ADHERENCE
Adherence is the degree to which a patient follows a treatment regimen which has been designed in the context of a (consultative) partnership between the client and the health care worker/counsellor. It encourages discussion about the various factors in this client’s life that influence the ability to exactly follow the final preparation.

6.1.3. FACTS ON HIGH ACTIVE ANTIRETROVIRAL THERAPY (HAART)
High Active Antiretroviral therapy (HAART), or ART as is commonly known, is not a cure for HIV and AIDS. In order for us to understand how ART works, we need to understand how HIV works. While scientists have not yet figured out how to kill off this incredibly smart complex virus, they are continuing to learn how it works. We know that HIV is a retrovirus. This means that HIV is constantly mutating or changing. HIV replicates by changing its genetic material RNA into DNA copies by using the host’s cells. This is where ANTIRETROVIRAL treatment comes in.

6.2. QUESTIONS
The following sections answers a number of questions about adherence, compliance, HIV, ART, HAART and drug therapies, among others.
6.2.1 Questions & Answers

**How does HIV replicate?**

In order to replicate, HIV targets (mostly) the CD4+ T-Lymphocyte cells in the body. These can be measured with CD4 cell count test which determine the extent to which the immune system is suppressed. In order for the virus to replicate, once it has attached to the host cell (intracellular viral replication), HIV uses three key enzymes which it brings with it. The enzymes are:

1. The Reverse Transcriptase Enzyme (RTE)
2. Integrase Enzyme (IE)
3. The Protease Enzyme (PE)

The enzymes are essential for infecting the body’s immune cell (i.e. CD4 cell) further replicating HIV and developing more infections of HIV.

**What is Triple Therapy, Combination Therapy or HAART?**

Triple therapy: as it states, involves the use of three types of drugs for treating (not curing) HIV. In the early days of the epidemic (1988), monotherapy (1 drug) in the form of AZT used to delay the onset of AIDS. Later on, dual therapy (2 drugs) was seen to be better than monotherapy until triple-therapy or combination drugs were discovered. In order to maintain the ongoing viral suppression as long as possible, combinations of ART enzymes are highly recommended. Triple-/combination therapy is also known as High Active Antiretroviral Therapy (HAART). Combination therapy for HIV infection has led to decreased mortality rates and more effective long term control of the disease.

**How does triple therapy acts on the three ART to suppress viral replication?**

Triple therapy ART acts on the three different enzymes of HIV in order to reduce viral replication and to prevent the development of resistant strains of the virus. The drugs that are currently available can only inhibit the reverse transcriptase enzymes or the protease enzyme. There are no drugs available integrase enzymes.

**Primary goals of ART?**

The primary goals of Anti-retroviral therapy are:

1. To suppress the viral load as much as (and as long as) possible;
2. To restore and/or preserve the immunological functions;
3. To improve the quality of life
4. To reduce HIV related morbidity and mortality.
WHAT ARE THE DIFFERENT CATEGORIES OF ART DRUGS?

<table>
<thead>
<tr>
<th>CLASSIFICATION OF ART DRUGS</th>
<th>ABBREVIATION</th>
<th>ENZYME INHIBITOR</th>
<th>SPECIFIC ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nucleoside reverse transcriptase inhibitors</td>
<td>NRTIs</td>
<td>Reverse transcriptase</td>
<td>Mimics the normal building blocks of HIV DNA</td>
</tr>
<tr>
<td>Non-nucleoside reverse transcriptase inhibitors</td>
<td>NNRTI</td>
<td>Reverse Transcriptase</td>
<td>Directly inhibits reverse transcriptase</td>
</tr>
<tr>
<td>Protease inhibitors</td>
<td>PIs</td>
<td>Protease</td>
<td>Inhibits late stages of HIV replication</td>
</tr>
<tr>
<td>Integrase inhibitors</td>
<td>IEs</td>
<td>Integrase</td>
<td>Inhibits replication of the Pro-DNA to viral RNA</td>
</tr>
</tbody>
</table>

N.B. For which drugs are available in SA see the Annexures. Health Care Workers should keep up with the latest available medication as new treatments are regularly published.

WHEN SHOULD ONE START ART?

<table>
<thead>
<tr>
<th>Symptomatic Patient</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of HIV-related symptoms, current or previous HIV associated disease</td>
<td>Treatment recommended</td>
</tr>
<tr>
<td>CD4+ count &lt; 200</td>
<td>Treatment recommended</td>
</tr>
<tr>
<td>CD4+ count 200-350</td>
<td>Monitor CD4+ count and commence treatment if the CD4+ annual decline is in excess of the expected 20-80 cells/year, or if the CD4+ count approaches 200</td>
</tr>
<tr>
<td>CD4+ count &gt; 350-500</td>
<td>Initiate treatment</td>
</tr>
</tbody>
</table>

*These include AIDS-defining illnesses (except tuberculosis – see section below), unexplained weight loss > 10% of body weight, unexplained diarrhoea lasting > 1 month, oral candidiasis or oral hairy leucoplakia.

**Primary Infection. HAART started early in primary infection leading to viral suppression, which appeared to maintain HIV-specific immunity in significant proportions of cases of people who became slow progressors with a low viral load after discontinuing HAART. The duration of treatment is uncertain at the present time. It is important to note that it is primarily a doctor’s role to assess the patient’s physiological stage of readiness for beginning ART.
WHAT IS ADHERENCE?

Below is a definition of adherence as it applies to patient’s taking medications:
Adherence means that the medication is taken according to the prescribed instructions:
• The recommended dose, at the recommended time and the recommended way.

Studies have shown that in order for one to be adherent, on average this may entail taking at least all tablets as prescribed on the prescription (as today triple therapy has decreased the number of tablets a person takes).

WHAT IS NON-ADHERENCE?
Non-adherence means that any one of the three criteria is not taking place i.e. for whatever reason, the client is NOT:
1. Taking the recommended dose, OR
2. Taking it at the recommended time, OR
3. Taking it in the recommended way.

Some examples of non-adherence are:
• Missed doses (e.g. due to holidays, travel, forgetfulness)
• Delayed doses(e.g. not taking the dose on time)
• Failing to follow guidelines (social pressures, misinformation)
• Experimenting with dosing (e.g. trying unapproved once-daily regimens)
• Drug holidays (e.g. structured interruptions, transient aversion to taking pills)

WHAT IS DRUG RESISTANCE?
HIV is a retrovirus and, therefore, mutating (or changing its genetic structure) at an extraordinary rate on a daily basis. The result is that some strains of HIV develop that are naturally resistant to the presence of ART. HIV drug resistance refers to a reduction in the ability of a particular drug or combination of drugs to block replication of HIV.

HOW DO YOU KNOW IF YOU ARE DRUG RESISTANT?
Viral load tests can determine from a blood sample how much virus is replicating in the body. If the viral load increases substantially whilst a person in on a combination of ART, the most likely culprit is drug resistance. Unfortunately, viral load tests cannot tell which particular drug the HIV is resistant to.
WHEN CAN A PERSON CHANGE ART?
Changing of ART Treatment Regiments
The indication for changing antiretroviral treatment regiments are:
- Patient intolerance of the drugs
- Significant adverse effects to the drugs
- Treatment failure
- Drug resistance

6.3. INTERRUPTING ART TREATMENTS
There are many reasons why the patient or their doctor may decide to temporary or permanently discontinue ART. It is important to remember that if there is a need to discontinue any ART medications, it is most advantageous to stop ALL ART agents SIMULTANEOUSLY - rather than continuing with one or two agents. This will minimise the chances of resistant viral strains developing.

6.4. STRUCTURED OR SUPERVISED TREATMENT INTERRUPTIONS
Structured treatment refers to a supervised break in HIV treatment for a specific period of time. This concept arose out of the realisation that complete viral eradication is unattainable. The concepts underlying structured treatment interruptions vary according to the patient populations. There are at least three major strategies behind this:

1. As part of salvage therapy (where the virus has developed significant ART drug resistance).
2. For ‘auto-immunisation’ and better immune control of HIV.
3. For the sole purpose of allowing less total time on ART.

In the last two population types, the individuals have maintained viral suppression below the limit of detection for prolonged periods of time and they have relatively high CD4 cell counts. Besides the advantage of giving the individual a break from thereby, reintroducing some viral activity, the individual’s immune response is strengthened.

NB: Due to insufficient data on Structured Treatment Interruptions are not recommended for use in general clinical practice.
Clinical trials have shown strong evidence for treating patients with CD4+ T cell counts of less than 200/mm³. This is currently the international guideline for practice and is also guiding the interventions in South Africa. However, research is still inconclusive about when the optimal time to initiate antiretroviral therapy for asymptomatic patients with CD4 cell counts of more than 200.

What has been found to be utmost important, though, is:

**The strength of recommendation for therapy must balance the readiness of the patient for treatment.**

A variety of accepted guidelines (including those proposed by the DoH), recommends that the two or three sessions are conducted with the client prior to writing out the first prescription.

The dual aim of these sessions are:

1. To provide the client with the necessary information about ART and its related aspects (i.e. adherence education);
2. To assess the client’s “readiness” to take ART medication.
3. Antiretroviral therapy should be deferred until patients are prepared to commit themselves to long – term treatment and to maintaining good adherence to the therapy.
4. Adherence is an important determinant of early virological response to HAART. In drawing up a recipe for successful ART outcomes, there would be a number of critical ingredients. The key ingredients are:
   - Information/education/support prior to ART initiation
   - HIV and ART education
   - Belief in the need for treatment and adherence
   - Information on difficulties of following drug plan, on side effects
   - Establish foundation for long-term adherence
6.6. COMPONENTS OF THE ‘ART’ READINESS ASSESSMENT

A. Medical Components (usually performed by a medical doctor)
   1. Complete history and physical
   2. Complete blood count, chemistry profile
   3. CD4+ T- Lymphocyte count
   4. Plasma HIV RNA measurement
   5. Other routine tests (including gynaecological examination tests, prevention of OIs.

B. Client’s HIV History
   1. Year of HIV diagnosis
   2. The client’s reasons for taking the HIV test at the time
   3. The client’s story (encourage sharing about the client’s history)

C. Disclosure
   1. To whom and when has the client disclosed
   2. Reactions from others to the disclosure
   3. Partner disclosure (previous, current and future partner/s
   4. Reasons for not disclosing to certain people (if applicable)
   5. Household awareness of HIV status (do the people with whom the client lives know about his/her HIV status?)

D. Factors Influencing Adherence
   1. Client’s lifestyle (job, sleep partner/s, addictions)
   2. Client’s personality traits (level of self-discipline, organisation, order, responsibility)
   3. Prior medication adherence (TB, contraception, other conditions i.e. diabetes or hypertension)
   4. View towards being on medication again or as well as other medication (if applicable).
E. Holistic Self-Care since HIV Diagnosis
1. Client’s attitude towards their HIV status
2. Patterns of sexual behaviours and intimate relationships
3. Treatment and prophylaxis for Opportunistic Infections
4. Dietary patterns
5. Rest and stress patterns (current life demands, management thereof)

F. ART Readiness
1. Client’s motivation for beginning ART
2. Client’s views about whether they can commit to the ART regiment
3. Client’s perceived emotional responses to beginning ART (fears, excitement, hopes realistic or unrealistic)

6.7. PLANNING FOR ART & ADHERENCE
Counselling, together with the health care team, should encourage or work together with the client to develop personalised plans to ensure adherence to multi-drug regimens.

- Encourage the clients to be participants in their own treatment.
- Give clients access to education materials that describe how to take pills and what side effects will be.
- Provide information about where and how to access physical, social and psychological supports.
- Provide practical support (or where to receive these) in the form of pill boxes and charts.
- Help clients to identify lifestyle characteristics that interfere with the treatment plan. See how you could link drug regimens with established daily routines.
- If client is interested, the counsellor could assist with doing a (trial run) with dummy pills (smarties, jelly tots etc.). This could help to give a feeling of what it will be like to be on ART, assess the degree of adherence and potential obstacles.
- Help the client with developing tools for assessing the treatment plan. (e.g. medication diaries).
6.8. TOOLS TO IMPROVE ADHERENCE

There are a number of ways in which to improve adherence. These centre around ensuring that the patient understands the importance of adhering to medication, consequences of poor adherence, and providing medications which minimise changes to the patient’s lifestyle.

- Patient and Physician education
- Patient support systems
- Easy incorporation into patient lifestyle
- Dosing not affected by food and fluid intake
- Convenient and simple dosing
- Good tolerability
- Manageable side effect profile
- Maintained quality of life
- Few, compact, easy to swallow tablets

Several strategic tools to improve treatment adherence are listed. Support groups can bring their own reminders. Those that should be considered prior to initiation of HAART include education regarding the disease and antiretroviral therapy (ART) options. Commitment from the physician and patient that adherence is recognised as an important factor in the success of any ART.

Potential life-adjustments required for ART regimens chosen should be discussed prior to initiation of therapy. Once ART has been initiated, it is important to follow up soon after the initiation of ART to discuss any side effects or other factors that may be affecting adherence.

6.9. CONTENT OF ADHERENCE COUNSELLING

1. Before ART Initiation:

- Patient education on HIV infection and HIV disease stage
- Risks/Benefit of ART
- Full commitment to the therapy and development of trust in the health care team. This may take several visits.
2. ART Initiation
   - Tailor the regimen to the patient’s.
   - Start when the patient is ready, when the patient is committed to the selected regimen, including dosing schedule and side effects.
   - Follow-up visits soon after initiation are very important: side effects, comfort, and convenience?
   - Prompt response to any problems, side effects: adjust, change, or stop?

3. Treatment-related Strategies
   - Simplification of ART regimen: reduced pill numbers, dose frequency, simplified food requirements*.
   - Avoid drug interactions and minimize side effects.
   - Directly observed therapy: not ideal for the long-term – costly, time-consuming, not feasible lifelong.
   - Treatment of associated conditions: depression, anxiety, psychotic disorders.
   - There is evidence that simplified regimens with reduced pills number and dose frequencies improve adherence. Fortunately, an increasing number of effective regimens have no specific food requirements*.
### 6.10. Predictors of ART Adherence

<table>
<thead>
<tr>
<th><strong>GOOD ADHERENCE</strong></th>
<th><strong>POOR ADHERENCE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of emotional and practical life supports</td>
<td>Poor clinician-patient relationship</td>
</tr>
<tr>
<td>The ability of patients to fit the medication into their daily routine</td>
<td>Lack of patient understanding and knowledge</td>
</tr>
<tr>
<td>The understanding that poor adherence leads to resistance</td>
<td>Inability of patients to identify their medication</td>
</tr>
<tr>
<td>The recognition that taking all medication doses is important</td>
<td>Low illiteracy (this should be part of the assessment)</td>
</tr>
<tr>
<td>Feeling comfortable taking medications in front of people</td>
<td>Medication side effects</td>
</tr>
<tr>
<td>Optimal viral suppression is associated with keeping clinic appointments</td>
<td>Lack of reliable access to primary medical care or medication</td>
</tr>
<tr>
<td>Not having to take ART in secret</td>
<td>Domestic violence</td>
</tr>
<tr>
<td></td>
<td>Discrimination</td>
</tr>
<tr>
<td></td>
<td>Active mental illness in particular depression</td>
</tr>
<tr>
<td></td>
<td>Active drug and alcohol abuse</td>
</tr>
<tr>
<td></td>
<td>Mobility lifestyle</td>
</tr>
</tbody>
</table>
Case Study - Traditional Beliefs

Ntombi is a 23 year old from Kwazulu Natal in Eshowe. She has been living with Benny for a few years now. In fact, Benny has been Ntombi’s boyfriend. When Benny and Ntombi expressed a desire to get married they independently decided that they would have a “white wedding” (civil marriage). This went against their traditional practice where they had to pay “lobola” and have a traditional wedding first.

A year later, Ntombi discovers that she is pregnant and visits her local ante-natal clinic. At the clinic, she is diagnosed HIV positive. She did not receive pre-test counselling, so she did not know anything about HIV and AIDS. Ntombi has heard that when you have HIV you are going to die of AIDS.

Ntombi also thinks that because she and Benny did not follow her traditional practice that is why the ancestors are punishing them. She never received any blessings from her parents to marry Benny, this has resulted in this terrible HIV diagnosis.

Ntombi is shocked and cannot believe this is happening to her. She is thinking of suicide and she feels helpless, withdrawn and she isolates herself. Ntombi does not think Benny could be responsible for her HIV status. She only blames herself and that she did not do the right thing by living with Benny before she was married according to her customs. She cannot tell anyone about her HIV status, she is afraid to tell her family and friends.

Discussions:
1. How can Ntombi be helped or advised?
2. Can Ntombi be a candidate for ART?
3. What should be done for Ntombi to receive ART?
4. Do you think Ntombi if she took ART, can adhere to ART regimen?
6.11. CLIENT COUNSELLOR PARTNERSHIP

Involves the Client
- The client must be informed before deciding on ART
- Have a say in the choice of taking ART regimen
- Ask questions
- Make sense of the information
- Decide when to start ART
- Decide when and how frequent they would like a consultation

Involves the Counsellor
- Providing ALL the necessary information
- Completely disclosing information with regards to side effects
- Checking the client’s understanding
- Responding to and taking account of the client’s various emotions
- Addressing the client’s doubts about beginning ART
- Anticipating future challenges in client’s life
- Encourage the client to find information by themselves about ART

GROUP ASSESSMENT

1. What is the difference between compliance and adherence?
2. Discuss how you would motivate or support a group member in taking their ART.
3. Discuss treatment initiation and counselling.
4. Patient-Provider Relationship.
LEARNING OUTCOMES

After completing this module, you should be able to:

1. To discuss the difference of HIV and AIDS between men and women
2. Why women are vulnerable more than men
3. Discuss prevention strategies and interventions
7.1. WOMEN & AIDS

INTRODUCTION
The South African population is 51.7 million people of whom 26.3 million or 51.3% are women. The Department of Health (DoH) cited in the NSP 2012-2016 a National Development Goals Country Report 2013 that a total number of 5.63 million women, girls and boys are living with HIV in SA.

The HIV incidence rates are higher among young women in the age group of between 15 - 24, than men, and peaking at age group 24 - 25 for women. Socio-Structural Gaps in HIV infection rates explain some of these variances. Findings reveal:

- Direct correlation between high incidence and economic disempowerment of women
- Unemployment rates are higher amongst women in SA, especially women in rural areas.
- This is made worse by poverty and gender inequality as this makes one more vulnerable to acquiring HIV infection due to unemployment.
- Black women largely unemployed with rates of 30% which can be linked to black women’s increased risk to HIV.
- Women and girls carry the burden of caring for the sick, spending more time in care and household activities than men.

7.2. WHY WOMEN ARE AT RISK & VULNERABLE

Physical factors: Heterosexual sexual intercourse though vaginal or anal intercourse puts women at risk of HIV transmission because of trauma to the vaginal wall and the rectal wall. Most of sexual transmission is insertive and creates the HIV or STI infections to easily enter the bloodstream. Women are most likely to get infected with HIV from men as men are from women.

Social & Economic factors: Most women stay at home to care for the children and extended families and playing multiple roles, especially in the rural areas. Men work in the cities and monies are seldom sent home.

Prostitution & Commercial Sex Work: Women, in many cases due to unemployment and low illiteracy rates, end up practicing prostitution or sex work to take care of themselves and their families.
**Traditional Customs & Practices:** Most girls are not educated because families put more emphasis for boys to be educated and they become unemployable. Girls are married off early and start families and loose out opportunities of schooling. Patriarchal rules governing women’s place in sexual relationships.

**Inequalities:** Major inequalities exists between men and women in all aspects of living from employment opportunities, availability in education, poverty and choices in relationships. Many women are still unable to choose their sexual partners or who they marry made for them by men in their families.

**Gender Violence, Sexual Abuse & Rape:** Women still bears the brunt of gender violence, sexual abuse and rape. Violence against women and the inadequate enforcement of the law against perpetrators make women not to come forward to report cases. Many women are killed by their loved ones or by people who know them.

**Drugs & Alcohol Abuse:** Drugs and alcohol abuse is a social problem. Women as much as men are afflicted by the scourge of injecting drugs and abusing alcohol, and they become at risk for HIV infections.

### 7.3. PREVENTION STRATEGIES & INTERVENTIONS

Hereafter are stories from ooNonkululeko who participated in the Positive Women Network’s Gender and HIV Study’s focus discussions groups. Participants are to discuss and come up with prevention and intervention strategies based on the stories from ooNonkululeko:

**Example 1 | Young schoolgirls and poverty**

‘Young women and girls from poor families in particular would miss school because they do not have sanitary towels. Some stay up to 50 days without going to school. This level of destitution needs interventions because we want them to stay in schools but at school they cannot go without sanitary towels.’

**Example 2 | Safer sex**

‘He will tell you that he only has the one person at home so why should you use a condom? And because of the things he is giving me, and that when I want something he gives it to me, so I do not think about the other person at home. I only think about what I am getting.’
Example 3 | Income Generating

‘So when I try to talk to women … I can’t because they are hungry… if you are giving education to communities there should be something tangible you are giving them besides education (treatment literacy) … if we have a way to make sure that people do not get hungry it will help. At least there is something we can do.’

‘But ooNonkululeko often that their attempts at income generation are impeded by stigma and discrimination.’

Example 4 | Income Generating with the Youth

‘We also try as support group members to encourage youths to do something meaningful with their lives. Unfortunately some lack even R100 to go and attend skills building sessions.’

‘How then do we get out of this mess when we do not have any skills and any money? I encourage organisations and companies to partner with people living with HIV and enrol them in FET colleges so that they get out of the dependency syndrome but a focus on getting the bread for today makes us not to think long term.’

Example 5 | Testing for HIV

“After being married for 20 years we trust each other and you can’t talk about testing as the husband will tell you off or even beat you up.”

‘To go and test at a health facility is not possible for many adolescents, but we are trying to have more youth friendly service as we partner with clinics.’

GROUP ACTIVITY

SELF/GROUP ASSESSMENT:
1. Discuss the reasons why women are vulnerable to HIV transmission than men.
2. How can we promote healthy sexual lifestyles amongst women to prevent HIV transmission?
3. Demonstrate the use of a female condom with a group of women who are working as commercial sex workers.
4. Discuss how women can empower themselves to make a difference in their lives.
LEARNING OUTCOMES

After completing this module, you should be able to:

1. Define gender, gender inequality and gender based violence in the context of culture and religion.
2. Discuss the role of gender, gender inequality and gender violence plays in AIDS Epidemic.
3. Define stigma and discrimination and the role they play in HIV and AIDS.
4. Discuss Gender based strategies to reduce the women’s risk and vulnerability to HIV infection and AIDS.
8.1. GENDER & HIV and AIDS

The Joint United Nations Program on HIV and AIDS (UNAIDS) estimates that there are more than 17.7 million more HIV positive people than in 2003. In Sub-Sahara Africa, approximately 58 percent of all people living with HIV are females and that every day more than 4,000 young people aged 15 to 24 years become infected with HIV around the world.

In some countries girls between ages of 15 to 19 years are infected at rates that are three times higher than among boys their age. Gender roles and relations powerfully influence the course of, and the impact of the AIDS epidemic. Gender related factors shape the extent to which men and women, boys and girls are vulnerable to HIV infection. Gender inequalities are also the major driving force behind the AIDS epidemic. Men and women are assigns roles that affects their ability to protect themselves against HIV and AIDS.

8.2. GENDER

Gender means sex (genital organs) this is a universal, biological, and natural constant that define women and men. It cannot change naturally. In social science, gender is a social construction (made up) indicating the differences in roles and relations between men and women given by society and is changeable.

Gender roles are learned behaviours assigned by societies, communities and other social and religious groups. “Male” and “Female” are sex categories, while “masculine” and feminine“ are gender categories. What does this mean, it means sex characteristics such as women menstruating, developing breasts, having wombs and giving birth cannot change. On the other hand, men have testicles, massive bone structure, develop beards etc. cannot also not change. Sex characteristics will not change naturally, whereas gender roles and relations can change.

These social construction assigns different work to men and women. Women are expected to do house chores, cook and look after families, whereas, men are heads of families and household, they are expected to work outside the home, look after the resources of the family and in most societies and cultures are taken care by women. In most human societies gender roles are determined by the societies itself. This can create inequality in the society between men and women because of differences in roles and responsibilities.

Men become rich and powerful, get status and prestige (status) whilst women become lack power, have poor status and are economically and intellectually disempowered.
8.3. GENDER INEQUALITIES

The society is shaped historically by males. Socially, politically, and culturally, men controls the economy, education, resources, sports, education, religion, and households. The policy makers all over the world are mostly men, and therefore, it is not surprising that many societies reflects those biases which exist as a result of gender inequality. Inequalities starts in families, communities, communities, cultural and religious organisations and political institutions.

The consequences of these inequalities cause injustices, biases, untold misery, poverty and illiteracy, lack of economic and political power for women to take decisions for themselves. In poor countries, especially in Africa, inequalities leads high incidences diseases, nutritional deficiency, poor health care and diseases including HIV and AIDS. Women and girls’ life expectancy is low, genital surgery (circumcision) leaves women and girls damaged with lifelong health problems.

Girls in the rural areas experience marriage at an early age, resulting in illiteracy, they left with large families and they end up very poor. Their husbands work in the cities and very seldom get financial support. Gender inequality is centuries old, and must be understood in terms of sociological factors that cause women to have unequal benefits, wages, and job opportunities as their male partners.

Inequality of men and women can take many different forms and gender inequality exists in many parts of the world and differs from country to country. ‘Gender exists when some people have greater share of power or prestige than others’ (WHO; World Bank, 2001).

8.4. GENDER BASED VIOLENCE & SEXUAL ABUSE

Article 1 of the United Nations Declaration on the Elimination of Violence against Women (DWEVW), proclaimed by the UN General Assembly in its resolution 48/104 of 20 December 1993, defines the term ‘Violence against Women’ as:

‘Any act of gender-based violence that results in, or likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (Unesco 1999p 53). The definition is general, and does not include different grades of violence like torture, which is severe pain and suffering whether physical or mental.’
8.4.1. TYPES OF GENDER BASED VIOLENCE

1. Physical, sexual and psychological violence in the family: wife-battering, sexual abuse of female children, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women and exploitation.
2. Physical, sexual and psychological violence in communities: rape, sexual abuse, sexual harassment and intimidation at work and education institutions, trafficking in women and forced prostitution.
3. Physical, sexual and psychological violence: perpetrated or condoned by the State, whenever it occurs.

Most violations on all levels, concerns women’s sexuality, reproductive capacity and their right to decide over their own body. Subjection to torture or other cruel and inhuman and degrading treatment and punishment. A recent WHO analysis in London School of Hygiene and Tropical Medicine and the Medical Research Council based on 80 countries found that globally 35% of women have experienced either physical and/or sexual intimate partner violence.

Gender-based violence in South Africa is disturbing. According to the South African Medical Research Council (MRC) report on female murders between 199 and 2009 was on the decline. In 2009, one women was killed by a partner every six hours. The South African government intervention on the Gun Control Legislation in 2000 reduced killings of women greatly.

8.4.2. PREVENTION TO STOP VIOLENCE AGAINST WOMEN

Violence against women and the girl child is rooted in gender-based discrimination, social norms and gender stereotypes that perpetuate such violence. Efforts are focused on the responses and services for survivors. The best way to prevent gender –based violence is to prevent it from happening in the first place.

- Educating early in life boys and girls to promote in respectful relationships and gender equality.
- Working with the youth in eradicating all forms of violence
- Public policies and interventions that start early in life around values and norms on gender equality are forged.
• Respect for Human Rights as defined in the Bill of Rights in the Constitution of South Africa.
• Participation of Women on programs that empower women and in decision-making in home and relationships, public life and politics.
• Raising awareness-raising, advocacy and mobilisation of communities as well as social media.
• Education of girls and participation in the World Association of Girl Guides and Girl Scouts.
• Voice against Violence training designed for age-groups 5-25 years to provide girls and women with tools and expertise to understand the root causes of violence in their communities.
• Working with boys and girls on new technologies and educational programs that prevent gender-based violence.

GROUP ACTIVITY

Group Activity | Social constructs created for men and women

1. List the difference sexual difference between men and women (physical, psychological, personalities, emotions).
2. List the different roles and responsibilities given by society for men and women and boys and girls (different chores).
3. Name the different cultural, traditional and customs between men and women, boys and girls (example coming of age, i.e. circumcision, virginity testing etc.).
4. Name the different religious beliefs that are created by social groups (role of the churches in gender).
8.6.  DEFINITION OF STIGMA & DISCRIMINATION

HIV related stigma and discrimination refers to prejudice, negative attitudes and abuse directed at people living with HIV and AIDS. Consequences of stigma and discrimination are wide ranging from some people are shunned by family, peers and the wider community, whilst others face poor treatment in health care centres and educational settings, erosion of their human rights and psychological damage. These all limit access to HIV testing, treatment and other HIV and AIDS services.

8.6.1.  WHY IS THERE STIGMA AROUND HIV/AIDS

The fear surrounding the emergence of the AIDS Epidemic in the 1980’s still persist today. At that time, very little was known about how HIV was transmitted which made people to be scared of those who were infected with HIV due to fears of getting the infected themselves. This fear coupled with many other reasons meant that people believe:

- HIV and AIDS are life-threatening conditions associated with death.
- HIV is associated with behaviours that many people disapprove e.g. homosexuality, drug abuse, sex workers, and promiscuity.
- HIV is transmitted through sexual intercourse which carries a moral baggage.
- HIV infection is the result of personal irresponsibility
- Being infected with HIV is the result of moral fault (deviant behaviour)
- Ignorance due to inaccurate HIV and AIDS information result in non-disclosure of HIV status
- Stigma and discrimination affects key populations often directed at vulnerable and marginalised groups
- The World Health Organisation, 2014, released Specific set of Guidelines on HIV services for key affected populations focusing on need for HIV prevention initiatives for these groups.
- The Epidemic of fear, stigma and discrimination has undermined ability to include families and communities to protect themselves, provide support and reassurance to those affected hindering the ability to negotiate prevention behaviours and use of family planning.
- The International Centre for Research on Women (ICRW) study findings reveals the following:
  - Self-stigma
  - Loss of reputation
  - Child-bearing options
  - Poor care within the health care settings
  - Withdrawal of homecare giving
  - Loss of hope
  - Government stigma
  - Employment stigma and many others.

8.6. **GENDER BASED APPROACHES**

Globally, there must be strong political will to eradicate and control gender based inequalities in societies in the economic, education, cultural and religious and political spheres.

- **Universal Declaration of Human Rights:** Internationally, countries of the world, through the United Nations, UNICEF, UNAIDS, UNESCO, CEDAW (to mention a few) are signatories to Universal Declarations of Human Rights, elimination of gender based violence, sexual abuse, HIV and AIDS and other forms of inequalities that are directed at women, girls and children.
- **Elimination of Gender Based Inequality:** To eliminate all forms of gender harmful norms and practices around the world there has to be change in the laws that create unequal societies, eliminate disparities and discrimination between men and women, and girls and boys.
- **Radical change in Policies:** Change in national policies, strategies and plans, Convention on Elimination of discrimination against women (CEDAW) is key to legal reforms and other steps aimed at countering violation of women’s human rights and protecting women who are infected and affected with HIV and AIDS.
• Comprehensive and Prevention and Care Programs: Comprehensive and prevention strategies that take into account the social, cultural, economic, and political factors. Political commitment that take into account gender dimensions of the epidemic in CEDAW and the National AIDS policies, plans and strategies.

• Voices of women: to be heard in World Forums “Women and girls are free by nature, equal in dignity and entitled the same rights, the same protection and the same opportunities as men” (Secretary of State Condoleezza Rice in Women’s Forum).

‘Human Rights break social norms and cultural taboos to speak out campaigns.’

• Reclaiming Women Rights: reclaiming women rights that challenge social conventions and entrenched beliefs by risking their own alienation from colleagues, and family and friends”.

• Provision of Services: provision of information, care and other services are improved and provided in a culturally appropriate and gender-sensitive manner.

• Development of messages: Sex specific gender balanced information on HIV and AIDS/STI and TB to all women, men, girls and boys in different settings.

• Community and Family: harmful norms and harmful practices to be eliminated in societies especially in families and communities. Gender sensitivity and equality in dealing with women and men, girls and boys.

• Innovative Activities: Activities that target boys and girls to promote more equitable attitudes and behaviours especially sexual relationships.

• Target Antipoverty Programs: Programs that extent credit and other forms of support to both women and men in need and measures addressing widows and orphans and child-headed households. (United Nations Special Session on HIV and AIDS. Global Crisis-Global Action 25-27 June 2001. New York.

• Women in conflict and War: participation of women in the United Nations meetings on Enhancing Women’s Participation in Peace Building initiatives

• Sexual and Reproductive Rights for Women: these are a variety of rights that gives women the power to control their rights to their bodies, sexual decisions, contraception and the right to have children and/or abortion.
The following are clause from the Universal Declaration of Human Rights:

1. “No one must be denied their right to adequate housing, food, water and sanitation, education and health care”.
2. “Everyone is entitled to the realisation of the economic, social and cultural rights indispensable for his or her dignity” (Universal Declaration of Human Rights).
3. “No one must be denied their rights to adequate housing, food, water and sanitation, education and health care”.

GROUP ACTIVITY

Group Activity

The Minister of Social Services and the Minister of Police are visiting your township to hold dialogues with your communities.

1. Discuss in groups; ‘STRATEGIES TO STOP AND PREVENT GENDER-BASED VIOLENCE‘ in your Township.
Hooper E, The River. A Journey Back to the Source of HIV and AIDS


Saloner K. Counselling For Anti-Retroviral Treatment Adherence. Centre for the Study of AIDS. University of Pretoria. 2004
POSITIVE WOMEN'S NETWORK
FOR WOMEN LIVING WITH HIV/AIDS