the act

ACTION FOR AIDS SINGAPORE

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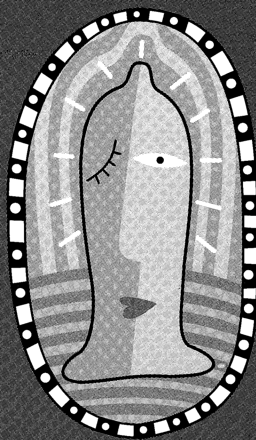

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How will we pay for the drugs?

There has been an accelerated pace of antiretroviral drug development, testing and registration. Zidovudine or AZT *(Retrovir, Glaxo-Wellcome)* which was introduced in the late 1980s was the first of the nucleoside reverse transcriptase (RT) inhibitors. It was used as monotherapy for the treatment of HIV disease, initially for advanced cases but later for asymptomatic infections as well. For several years this was the only drug available. Zidovudine is not subsidised in Singapore, however, patients can use their Medisave to claim partial payment for zidovudine.Enchantment with the medication has diminished; reports on long-term effectiveness have demonstrated that monotherapy with zidovudine in patients with early HIV infection does not improve survival after 3 years of use.

In the early 1990s 2 new nucleoside RT inhibitors were registered viz zalcitabine or ddC *(Hivid, Hoffman La-Roche)* and didanosine or ddI *(Videx, Bristol-Myers Squibb)*. For the most part these were used in combination with zidovudine or singly when patients developed side-effects or continued to deteriorate whilst on zidovudine. However neither of these 2 drugs has caught on locally in any major way. An important reason for this is that payment cannot be subsidised by Medisave. In the last 18 months 2 new RT inhibitors have been approved in the USA, viz stavudine *(Zerit, Bristol-Myers Squibb)*, 3TC also called lamivudine *(Epivir, Glaxo-Wellcome, see the ACT #12)*.

A new category of very promising antiretrovirals called protease inhibitors is now coming on line, these by and large have been tested in combination therapy with nucleoside RT inhibitors (see this issue). There are several of these drugs, the 3 which have been most studied are indinavir *(Crixivan, Merck)*, ritonavir *(Norvir, Abbott)*, and sasquinavir *(Invirase, Hoffmann LaRoche)*. Combination treatment has been shown to improve significantly the outlook for PWAs and therapy with 2 or 3 antiretrovirals will become the standard recommended treatment for HIV infection in the near future, the exact combinations and dosages however will take some time to be fine tuned. New virological and immunological research has also indicated that starting treatment earlier rather than later is the best hope for PWAs.

The problem is this - who will pay the bills? A month's supply of zidovudine costs approximately S$250; a month's supply of either didanosine or zalcitabine costs around S$300 each. The prices for stavudine or 3TC are yet to be released as neither are registered here yet (at press time).

The price for the protease inhibitors, when they do get here, will probably be

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even higher than the RT inhibitors. Combination therapy will therefore set a patient back over one thousand dollars a month. How many of our patients can afford this? Add to this the cost of medications for treating opportunistic infections, consultation and laboratory fees and the bills become astronomical. For example a month of maintenance therapy for CMV retinitis with i/v ganciclovir costs over $2000! So far hospital bills have been mainly borne by patients or their families directly or by Medisave (which is applicable for inpatient costs and for zidovudine),a number have successfully applied to Medifund for assistance, but there are very strict guidelines for this and the majority of non-standard drugs are not covered. All employers with very few exceptions do not pay, and private health insurance generally does not cover HIV/AIDS. *Governments* must examine the cost-effectiveness of AIDS control programmes - will subsidising medications encourage testing, contact-tracing and patient compliance, and lead to more effective disease control? *Pharmaceuticals and medical professionals* have to look to less expensive sources (including traditional medications) and more expedient ways to test new drugs, and at the same time be careful in making claims of efficacy and success. *Patients* have to temper their demands and expectations of miracle cures and free medication with a better understanding of the facts and the limitations of medical science. *NGOs* (*non-governmental organisations*) and self-help groups must look for ways to reduce the cost of medical care and expedite the registration and use of proven drugs. Solutions for this problem, as for all other problems with AIDS/HIV, will need urgent action and cooperation between all parties concerned.

CORIGENDUM:
In issue #12 we failed to credit Dr. Laurence Leong as the author of the article "Space and Place in Gay Singapore". We apologise for this error.

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AIDS: How It's Perceived in Singapore

George D. Bishop examines a recent survey about Singaporeans' perceptions of AIDS and offers his insights on how some common misconceptions can be combatted.

It's certainly no secret that AIDS is a misunderstood and stigmatised disease. All one has to do is to talk with people about AIDS, answer calls to the AfA Helpline, or simply read the newspaper to begin to realise that many people have serious misconceptions about AIDS and how it is spread, as well as stereotyped and often derogatory and judgmental attitudes toward persons with AIDS.

But exactly what do Singaporeans think about AIDS? Answers come from a recent survey of more than 400 randomly selected Singapore households that replied questions about HIV and AIDS as part of a more general survey of health attitudes and behaviours. The results of this survey offer both good news and bad news.

GOOD NEWS

The good news first. Singaporeans very clearly have gotten the message that HIV is transmitted through sexual contact with a person infected with HIV and by sharing needles during IV drug use. When asked about these risk behaviours, more than 90% of the respondents in the survey stated that it is either somewhat or very likely that a person could get HIV in these ways. Also nearly 80% of respondents indicated that a person can contract HIV through receiving blood transfusions. This latter belief is realistic since, even though blood in Singapore itself is screened for HIV and thus the likelihood of contracting HIV through a blood transfusion locally is very low, this is not true of some other countries in the region.

BAD NEWS

The bad news? Well, to begin with, many Singaporeans apparently do not know how HIV is not transmitted. Despite the fact that AIDS education programmes have repeatedly stressed that HIV is not spread through such casual contacts as kissing, shaking hands, being sneezed or coughed on or working near someone with AIDS, a significant percentage of respondents in the survey believed that these were likely ways of getting AIDS. For example, more than 60% of respondents believed it somewhat or very likely that a person could get HIV through "French" kissing; nearly 40% believed that AIDS is likely to be passed from one person to another through coughing or sneezing and approximately 25% believed that one can get

AIDS by working near a person with AIDS. In addition, more than half of the respondents believed that it is somewhat or very likely for a person to get HIV through donating blood, more than 40% believed that one can get HIV from mosquitos or other insects and roughly 30% believed that HIV is spread through the use of public toilets. These beliefs were expressed even though there is no evidence whatsoever that HIV is transmitted in these ways.

MORE BAD NEWS

Other bad news comes from some of the other attitudes expressed by survey respondents about AIDS and who is at risk for it. For one thing, a significant number of Singaporeans seem to believe that AIDS is confined to certain "high risk" groups. For example, more than 40% agreed that AIDS is a homosexual disease while nearly 50% endorsed the idea that "AIDS can only affect homosexuals, drug addicts, prostitutes and others like them who belong to the high risk groups." Further, more than 20% believed that AIDS cannot be transmitted through heterosexual relationships, despite the fact that since 1991 the majority of newly reported HIV infections in Singapore have, in fact, been attributed to heterosexual contact.

PUBLIC APATHY

Given these beliefs, it is not particularly surprising that nearly half of all respondents stated that they were not concerned about AIDS, feeling that it has little to do with them. Also troubling is the fact that fully one fourth of the respondents agreed with the notion that "AIDS is God's punishment for immoral behaviour." Although AIDS is spread through behaviours that are heavily sanctioned and stigmatized in society, such attitudes too often serve as a pretext for concluding that PWAs have only themselves to blame for the disease and therefore there is no reason to show compassion or concern for them.

To be sure the beliefs and attitudes expressed by Singaporeans in this survey are not unique to Singapore. For example, research in the United States has found similar results. The Singapore findings do, however, tell us about what Singaporeans believe and have implications for AIDS education here. For one thing, they tell us that AIDS education to date has been at best only partially successful. Singaporeans have absorbed the important facts that AIDS is transmitted sexually as well as through IV drug use. This by no means insures that people will act in accordance with this information through cutting down high risk activities but it is an important start.

Just as clearly there is much to be done with respect to combatting misconceptions about AIDS. Beliefs that HIV can be spread through casual contact or through mosquitos and insects die hard. Despite repeated efforts to convince people that HIV is only transmitted through very intimate forms of contact, such as sex with an infected person or contact with infected blood and other body fluids, beliefs to the contrary persist. One reason may be that experts can never state categorically that casual transmission absolutely cannot occur. To the best of everyone's knowledge such casual transmission has not occurred in the past and is extremely unlikely. However, even this minuscule possibility is seen by some as evidence that such transmission can occur and may therefore be likely. Also the fact that HIV is a virus may bring to people's minds their experiences with other viruses, such as those causing the flu or the common cold, that are transmitted casually. This kind of association, though erroneous, may lead people to persist in their beliefs concerning casual transmission of HIV.

Regardless of the reasons for the persistence of such beliefs, the attitudes and beliefs uncovered in this survey point to the need to redouble efforts to educate the public about HIV and how it is and is not transmitted as well as encourage more realistic and compassionate attitudes about AIDS and those living with it. Only in this way can we make headway in stopping this growing epidemic and countering the epidemic of fear and stigma that too often accompanies it.

George D. Bishop is Associate Professor in the Department of Social Work and Psychology at the National University of Singapore. He is author of the textbook, Health psychology: Integrating mind and body (Boston: Allyn & Bacon) which, among other topics, discusses both the immunological and psychosocial aspects of AIDS. He has been involved in research and teaching related to AIDS for more than a decade.

Thalidomide

Thalidomide is an old drug which was used extensively in Europe during the 1950's and 60's as a sedative until its teratogenic effects became apparent. Most people think that after the thalidomide disaster the drug was shelved forever, but actually it has been studied extensively in autoimmune disease research, and it happens to be very useful for managing a consequence of leprosy. It is now routinely and safely administered to people with leprosy around the world.

The rationale behind the use of this drug in HIV disease is somewhat involved and paradoxical. In HIV disease, the immune system actually over produces certain chemical messengers called cytokines which immune cells use to communicate. Cytokines are potent, and some serve more than one function. It is not surprising that too many messengers and messages could cause more harm than good. Excessive levels of one cytokine in particular, tumour necrosis factor, or TNF, have been associated with the development of apthous ulcers, dementia, fevers, fatigue and wasting.

Not only does HIV stimulate TNF production, but TNF can in turn enhance HIV replication.

The capacity of thalidomide to inhibit TNF was demonstrated by researchers at The Rockerfeller University, and interest in thalidomide has blossomed in the past year, given its multiple possibilities and the expanding research into TNF. The drug is under study in a number of HIV-related clinical trials in Europe and North America. A company, Celgene, is currently developing several new TNF inhibitors which are chemically analogous to thalidomide but might be safer or more effective.

Current trials

Many people with HIV are bothered by recurring, painful oral ulcers that are frustratingly difficult to treat. The ulcers are apparently not caused by an opportunistic agent, and so they are described as apthous, meaning simply that they occur on a mucous membrane. A biopsy should first be performed, which will determine if an ulcer is not indeed herpes, which would make a difference in the choice of treatment. The common treatment for apthous ulcers has been to suppress, broadly, the immune response, which includes TNF production. This is easily accomplished with corticosteroids like prednisone, but long term use of these steroids may have serious side effects, and is not a tenable permanent solution. A better solution, theoretically, would be to inhibit TNF production more specifically such as with thalidomide. There are at least 38 clinical studies testing thalidomide for HIV.

Wasting is an even more serious problem for many people. It has been well documented as a cause of death even in the absence of opportunistic illnesses. The origins of wasting are complex and variable, and include loss of appetite, poor intestinal absorption, low testosterone production, and high TNF production.

Wasting now has quite a few possible treatments, including endocrine modifiers like human growth hormone, testosterone, nandrolone or oxandrolone, and appetite/nutritional enhancers like megestrol acetate, dronabinol, and total parenteral nutrition (TPN). None of these, however, work by decreasing TNF levels, and this use of thalidomide is being tested at several clinical sites in the USA.

Anyone taking thalidomide must understand the gravity of its danger to developing fetuses and absolutely avoid starting a pregnancy.

Since thalidomide causes drowsiness, it is best taken before sleep. Unfortunately, some people have experienced a serious allergic reaction to the drug, especially in the higher dose range (300-400 mg daily). The reaction may appear several days after starting the drug, and involves a rash, high fevers and extreme flu-needed (but not to exceed a daily dose of 400 mg).

WASTING

Few symptoms of AIDS are as striking as weight loss. Severe weight loss or wasting sometimes even precedes an AIDS diagnosis. In fact, wasting is a hallmark of HIV infection in Africa, where it is known as "slim disease."

Unreversed weight loss in AIDS is associated with fatal consequences, independent of the immediate cause of wasting. The data available suggest that life ends when physical resources are exhausted: critical metabolic substances may no longer be available, or muscles may be so weak that basic functions such as coughing or breathing cannot be accomplished. The data also suggest that survival can be prolonged if body mass is maintained.

There are several reasons for HIV-related wasting. The first two are easily understood. Decreased food intake may be due to lack of appetite, which may occur as the result of disease, depression, or drug side effects. Swallowing food may be difficult because of nausea or oesophageal or oral conditions. The second reason is malabsorption, which happens quite often due to HIV-related diseases in the gastrointestinal tract or HIV infection itself.

However, AIDS related wasting differs from starvation . In starvation, the body's protein stores and muscle mass are conserved while basic metabolic rates slow and fat deposits are broken down for energy. During AIDS, the reverse happens. Metabolic rates are elevated, and lean body mass decreases as the protein in muscles and other tissues is metabolised. In this case, eating alone does not ensure recovery as it does in starvation. The body is set in a basic wasting mode that may be useful for mobilising resources to meet the challenges of acute infection, but which becomes inappropriate when the immune system cannot quickly counter the cause of illness.

Increased production of TNF, a naturally occurring protein substance, has been identified as one possible cause of wasting syndrome. TNF alone does not cause wasting, but the interaction of a whole set of hormonal and cytokine changes during HIV infection results in an inflammatory condition conducive to wasting.

Clearly, the first thing to do in preventing wasting is to treat any opportunistic infection present. TB and CMV, for example, greatly accelerate wasting. Diseases of the digestive tract also are a prime cause of weight loss because they may cause eating difficulties, nausea, diarrhoea and reduction in nutrient absorption.

Other therapies may include the following:

Appetite Stimulants:

Megace and Marinol.

Exercise:

To build up lean body mass, resistance exercise, such as bodybuilding is more important than aerobic exercise.

Human Growth Hormone:

hGH is now undergoing extensive human testing in people with AIDS. It does not seem to require exercise to be effective, and is devoid of sexual side effects. The downside is that weight gain does not last after therapy stops, so life long therapy with this enormously expensive substance may be needed.

Steroids:

Testosterone, nandrolone, oxandrolone plus exercise.

Patients should go through a complete workup to look for any obvious causes of weight loss, such as parasites or other intestinal disease, MAC or certain other infections, lymphoma, inadequate food intake, etc. These specific causes need to be considered first, and the potential weight loss/wasting treatments here are tried when such specific causes cannot be found.

Drug, Regimen	Length of therapy	Side effects	Comments
Megestrol (Megace) 400 mg daily (800 mg necessary)	Indefinite	Nausea, vomiting, oedema, depression, progestin side effects (hyperglycaemia, decreased testosterone)	Megestrol can increase appetite and cause fat accumulation with weight gain. Uncertain whether this weight gain improves health. Usually well tolerated.
Dronabinol (Marinol) 2.5 mg twice daily 30 min- 1 hour before meals. Maximum 20 mg a day	Indefinite	Restlessness, irritability, insomnia, loss of coordination, psychomimetic effects, fatigue, tachycardia	Increase appetite and can cause weight gain. Uncertain whether this weight gain improves health. Anti-nauseant.
Human Growth Hormone Preparation, dosage, and indications not established	Unknown	Arthralgias, joint stiffness, carpal tunnel syndrome, hyperglycaemia, hypertriglyceridemia	Studies of recombinant human growth hormone (r-hGH, Serostim) 0.1mg/kg/d SQ, average 6mg/d demonstrated increae in exercise endurance and weight gain characterised by increase in lean body mass and decrease in fat. Experimental. Not approved by FDA.
Anabolic steroids preparation, dosage, and indications not established.	Unknown	Oedema, jaundice	No satisfactory studies. Not indicated for patients with normal testosterone. Treatment MUST be accompanied by exercise. Unknown whether anabolic steroid theraphy improves health.

What are protease inhibitors and how do they work?

Nucleoside analogues like AZT, ddI, ddC, d4T, and 3TC inhibit the HIV enzyme reverse transcriptase, which is at the beginning of the viral assembly line, before the virus has invaded an uninfected cell. Protease inhibitors at a late stage of viral assembly, after the virus has been incorporated into the cell and is ready to begin mass production of new copies of the virus. Protease inhibitors have been shown to be effective in preventing the production of infectious virus in chronically infected cells. The older class of drugs known as nucleoside analogues has no effect on viral production in chronically infected cells that HIV has already invaded, as reverse transcription is no longer required for viral replication. In effect, the older drugs work by preventing the virus from productively infecting new cells, while the new protease inhibitors work by preventing cells which are already infected from making additional copies of the virus. There is no fundamental reason to believe that either approach is inherently more useful than the other. Perhaps the most important benefit of protease inhibitor drugs is simply that they open up a second, different line of defence against HIV.

Resistance

Test tube studies show that resistance can develop to all known protease inhibitors. Most of the clinical studies indicate that some degree of resistance develops after 12 weeks of therapy. As with the nucleoside analogues, resistance is likely to develop at different rates at different stages of disease progression. There is some cross resistance between the protease inhibitors (someone who has developed resistance to one protease inhibitor may also see diminished benefit from drugs which show cross resistance to that same protease inhibitor). However, the level of resistance is lower compared to that of the nucleoside analogues. In addition, the reduction in viral load with the protease inhibitors is greater than that seen with the nucleoside analogues.

Drug Interactions

Since most protease inhibitors are metabolised in the liver, chances are there will be some possible interactions with other common HIV/AIDS therapies that are metabolised in the liver, including: clarithromycin, TMP/SMZ (Bactrim or Septra), rifabutin, rifampicin, fluconazole, and the non-nucleoside reverse transcriptase inhibitors like delavirdine and nevirapine.

Saquinavir (Invirase®)

On December 6th, 1995, the Food and Drug Administration (FDA) finally approved the first of a new class of anti-HIV agents known as the protease inhibitors. The new drug, saquinavir (Invirase®, Hoffmann LaRoche) was approved for use in combination with one or more nucleoside analogues (e.g. AZT, ddC, ddI, d4T, 3TC). No particular combinations were specified even though data are only available for combination therapy on saquinavir with AZT or ddC.

Saquinavir does not cross the blood brain barrier, which limits its efficacy in HIV-related pathologies of the brain. No data has been available on its effects on HIV-related dementia.

It is likely that physicians will continue to favour AZT in untreated patients, ddC or other nucleoside-analogue in AZT-intolerant or failed patients, and saquinavir and the upcoming protease inhibitors in combination with other anti-retrovirals.

Saquinavir should not be taken at the same time as rifampicin, since this may reduce the serum concentrations of saquinavir by as much as 80%. Use only with caution when the patient is on rifabutin, since this may similarly reduce serum saquinavir concentrations by up to 40%. Likewise, use with caution whenever the patient is on any other hepatic enzyme inducer.

The current recommended dosage of saquinavir is 600 mg (3 x 200 mg) three times daily within 2 hours of a full meal. Lower doses have not shown antiviral activity. In fact, this dose is at the bottom of the dose-response curve. There is no data on use of saquinavir in patients less than 16 years old.

There have been some reports that drinking grapefruit juice may increase serum saquinavir levels.

At least two other protease inhibitors are awaiting FDA approval, with studies currently underway. They include ritonavir (Norvir®, Abbott Laboratories) and indinavir (Crixivan®, Merck).

The latest news on protease inhibitors comes from the 3rd Conference on Retroviruses and Opportunistic Infections held in Washington, D.C. from January 28 to February 1, 1996. The biggest news at the conference regarded preliminary results from studies on these two protease inhibitors, which showed excellent efficacy against HIV especially when used in combination with existing anti-HIV drugs.

Ritonavir (Norvir®)

This is the first time that a protease inhibitor has actually been shown to reduce the risk of death. The study carried out by Abbott Laboratories was designed to measure the reduction in viral load (the amount of HIV in a person's body), and compared the use of ritonavir vs. placebo (i.e., no drug) in combination with up to two additional anti-HIV drugs. A 43% reduction in the risk of death was found at about 6 months, and the study was stopped prematurley because of these encouraging results.

The dose used in this study was 600 mg twice daily of ritonavir. However, up to 17% of patients had to stop taking the drug due to overwhelming side effects, and ritonavir does have another major disadvantage. It interacts with many other drugs by preventing them from being metabolised by the body, causing the normal dose of some drugs to become a dangerous overdose. Some medications can be used with appropriate dose adjustments; others cannot be combined with ritonavir at all.

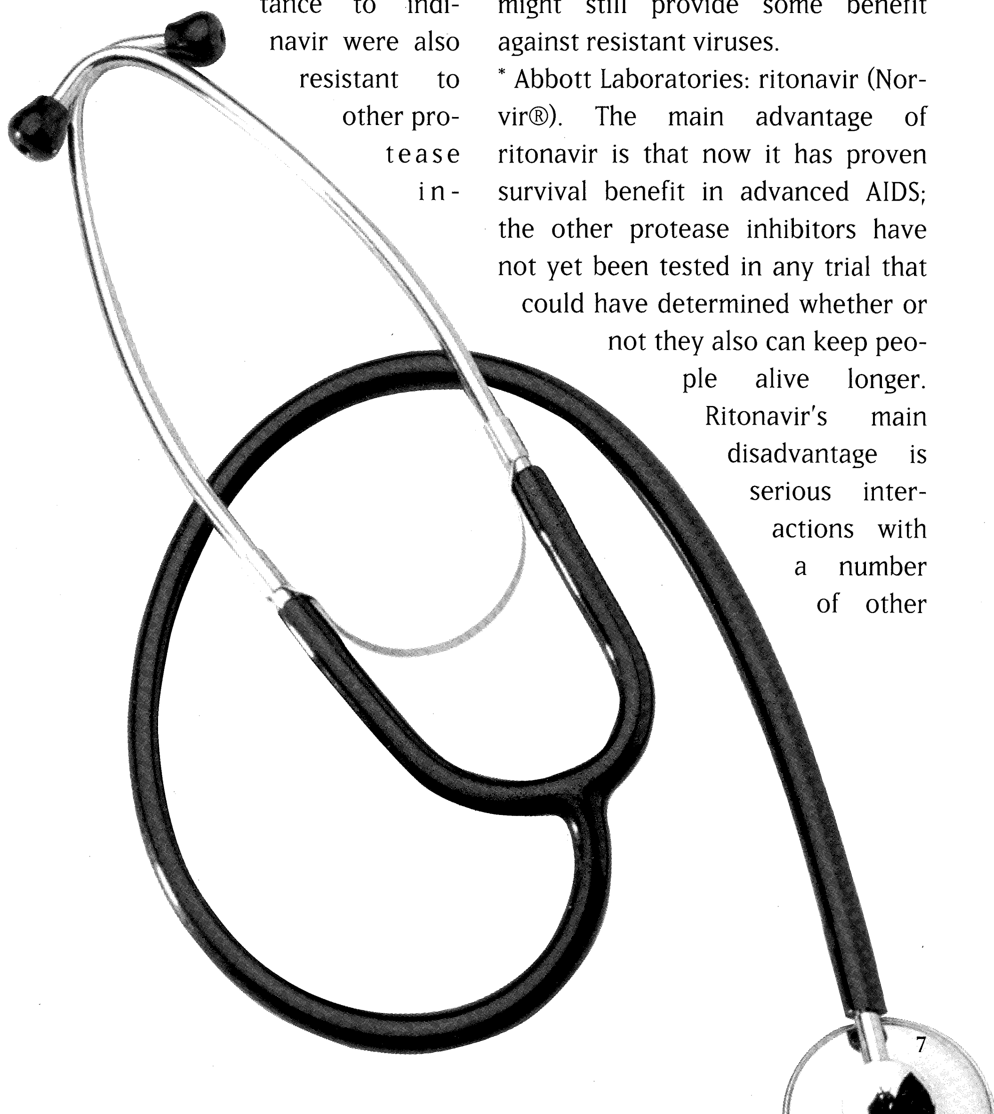
The Merck protease inhibitor indinavir (Crixivan®) has much less of a drug-interaction problem, and probably at least as much ability to suppress HIV as ritonavir does. But it does not have data proving that it prolongs survival.

Indinavir (Crixivan®)

The two studies reported by Merck studied primarily the effect of combination therapy on viral load. One studied indinavir vs. placebo, plus AZT and 3TC, and the second study used ddI instead of 3TC.

Both studies showed phenomenal reductions in viral load, producing 92% and 59% of patients who had undetectable viral levels at 16 weeks and 20 weeks respectively. These numbers were sustained even later in the study. Similarly, CD4 counts were increased by a mean of 146 and 90 respectively.

However, early studies of indinavir alone, in doses that are no known to have been too low, found that the resistance developed fairly rapidly; the virus usually returned to about its starting value within 24 weeks. Persons who developed resistance to indinavir were also resistant to other protease inhibitors. This problem of resistance and cross resistance is the reason for the advice to start protease inhibitors with an adequate dose, and in combination with other anti-HIV drugs; the hope is to reduce HIV replication enough to greatly delay the development of resistant mutants. This is also the reason patients are advised to take these drugs on schedule and not interrupt treatment. (The resistance and cross resistance problems appear to be less with saquinavir.



In Summary

* Merck & Co.: indinavir (Crixivan®). This drug appears to be generally the best regarded among treatment activists at this time. It has very good viral suppression, and apparently limited side effects. The main disadvantage is that viral resistance and cross resistance can develop rapidly, especially if the drug is used improperly. It is possible that indinavir might still provide some benefit against resistant viruses.

* Abbott Laboratories: ritonavir (Norvir®). The main advantage of ritonavir is that now it has proven survival benefit in advanced AIDS; the other protease inhibitors have not yet been tested in any trial that could have determined whether or not they also can keep people alive longer. Ritonavir's main disadvantage is serious interactions with a number of other

drugs. Also there are often gastrointestinal side effects, at least with the current formulation.

* Hoffmann LaRoche: saquinavir (Invirase®). This is the only protease inhibitor which is FDA-approved at this time. It seems to have less viral resistance problem than the Merck and Abbott drugs. Its main disadvantage is that it was approved at a dose which is clearly too low; drawbacks to just taking more include the drug's great expense, and the lack of much safety data at higher doses. The dosage problem is being corrected, with a new formulation which will deliver a higher dose economically; however, it will take some time to get enough clinical-trial experience with the new dose and formulation for the FDA to be confident of safety, and approve this formulation for marketing.

Conclusion

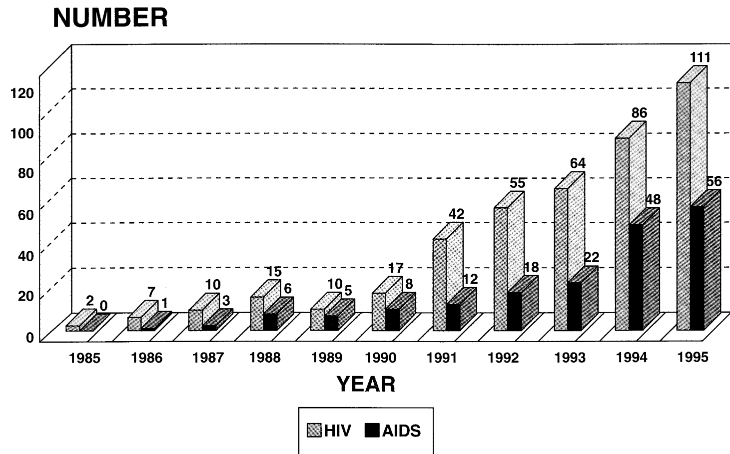
The protease inhibitors represent am important new class of drugs. Early results suggest that when used at the right doses and in combination with other drugs, these work very well. Long term toxicities of these drugs are still unknown at this time, but in view of the short life expectancy of late-stage AIDS patients, and the consistently good data supporting the efficacy of this class of drugs, protease inhibitors will find an important place in the therapy of AIDS.

(Currently, Roche is seeking registration of Invirase® in Singapore, but is not yet available except as an exemption drug. Crixivan® and Norvir® are pending FDA approval, and are only available through expanded access programmes through their parent companies, or through clinical trials.)

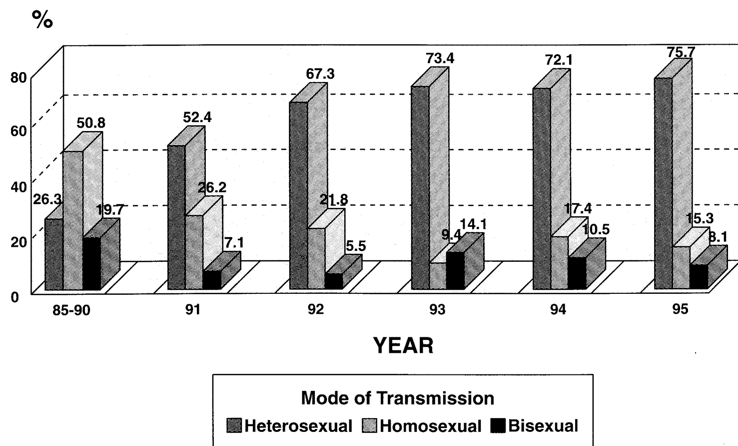
Stuart C.Y. Koe, Pharm.D.

INCIDENCE OF HIV AND AIDS (SINGAPOREANS) 1985-1995

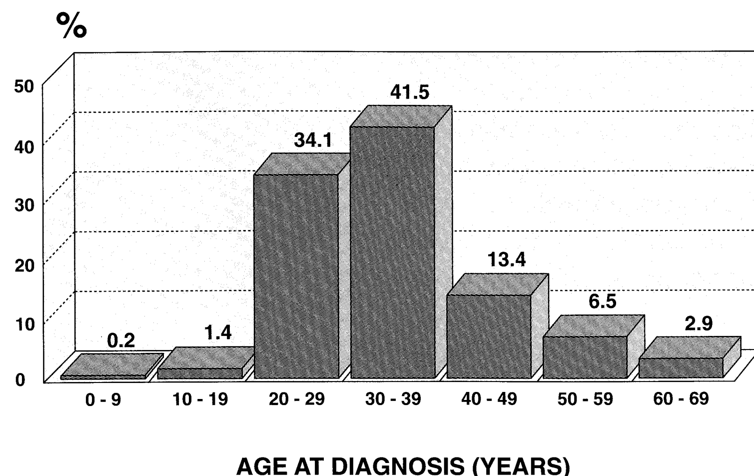
Total number of HIV = 419
Total number of AIDS = 179



TRENDS IN THE INCIDENCE OF HIV INFECTIONS BY MODE OF TRANSMISSION (1985 TO 1995)



HIV INFECTIONS BY AGE AT DIAGNOSIS



Information Provided by The Ministry of Health

Bitter Gourd and HIV Infection

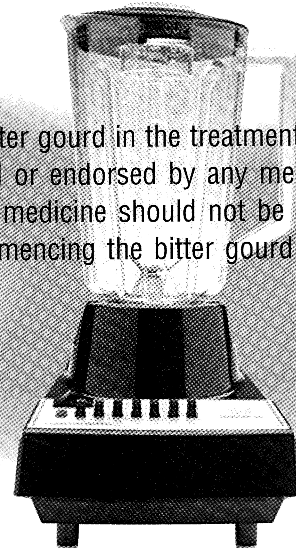
Recent research in the US has indicated that bitter gourd (more commonly known there as 'bitter melon') could have beneficial effects in treating HIV. This article summarises some of the findings, and outlines the ways in which bitter gourd can be prepared and used as treatment.

Researchers at New York University have isolated a protein from the bitter gourd, named MAP-30, which inhibits HIV replication, direct cell-to-cell infection, and the formation of syncytia (in HIV-positive people, this is the process whereby hundreds of CD4 cells clump together, thus disabling themselves and eventually die).

Treatment usually involves use of the bitter gourd vines and leaves. There are basically two common methods of preparation. The first involves cooking about fine hundred grams of the leaves and vines, finely chopped, with two litres of boiling water. After the mixture is brought to boil, it is left to simmer for 60 to 90 minutes at reduced heat with occasional stirring. The resulting mixture is allowed to cool, and then strained to remove solid particles. It should be kept in tightly capped containers and stored in the refrigerator where it will keep for up to ten days. The second method uses no heat. A blender is filled with two cups of water and finely chopped leaves and vines, then run at high for several minutes. The mixture is then strained to remove solid particles. This mixture does not keep well, and then should be made fresh daily and stored frozen for later use.

Observable benefits seem to arise when about 200ml of the mixture is consumed per day for every 45kg of body weight. For example, a 70kg person would use 300ml per day. The treatment is a long-term one; several months may pass before noticeable improvements show up in the blood. It is also necessary to continue with the treatment; its gains will be lost if you stop.

The following should be borne in mind before one considers taking bitter gourd as a treatment:



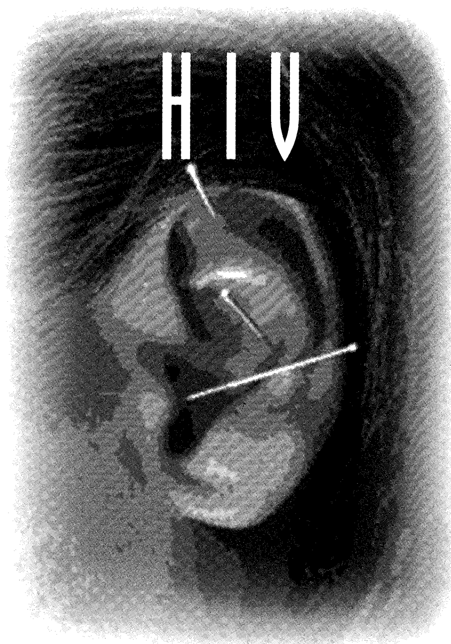
The use of bitter gourd in the treatment of HIV is not established or endorsed by any medical body. Prescription medicine should not be discontinued when commencing the bitter gourd treatment.

Your physician should be informed, so that you can be monitored during the treatment. An initial drop in CD4 count for a short time has been observed in some people who have taken bitter gourd. This might be dangerous for people with extremely low CD4 counts.

Syncytia formation is retarded by bitter gourd, and this is beneficial against HIV infections. During pregnancy, however, certain forms of syncytia are essential, especially in the placenta. If there is any possibility, therefore, that a woman with HIV may become pregnant, she should not use bitter gourd.

Extracted from HIV Herald Vol. 5 Nos. 7 & 8 (Aug/Sep 1995)

ACUPUNCTURE AND HIV



Traditional Chinese medicine has often been regarded, even in western countries , as being particularly effective at treating certain illnesses. In an interview with AIDS Treatment News recently, Thomas M. Sinclair, M.S., L.Ac., Diplomate, National Board of Acupuncture Orthopedics, USA, spoke about the use of acupuncture in treating people who are HIV-positive.

Acupuncture is currently licensed and regulated in 27 states in the USA. This helps to ensure a minimal level of competency in the practitioners. These practitioners get referrals from a number of sources, including local physicians and HIV centres. There is also the National Commission for the Certification of Acupuncturists (NCAA). They have been accepted as the standard in a number of states that do not have their own state licensing exam.

It is important that HIV-positive people who wish to explore acupuncture as a treatment choose a practitioner who has experience in treating this very complex disease. One can usually also choose between treatment at a private practitioner and group treatment at a clinic. In San Francisco, private practitioners charge an average of US$55 per hour. Clinics generally charge less. In addition, there might be financial assistance packages available through various HIV groups. Some medical insurance programs also provide coverage.

Certain HIV-related symptoms are more responsive to acupuncture as a treatment than others. Peripheral neuropathy, sinusitis, pain-related problems, night sweats, headaches and fatigues are examples of areas in which acupuncture and other traditional Chinese treatments have had considerable success. Conditions like Kaposi's Sarcoma, on the other hand, have not been very successfully treated by acupuncture.

One should also understand that acupuncture is a long-term therapy that sometimes yields little or no results in the early stages. Regular sessions with the acupuncturist is crucial to successful treatment.

Acupuncture is also frequently combined with herbal medication as an integrated treatment program.

Physicians have come to realise that acupuncture does not present itself as a challenge to Western medicine, but as a viable alternative treatment that can be integrated into a more conventional one. Thomas Sinclair points out that with HIV, there is no one right way of treatment that has not manifested itself its limitations. Most HIV-positive people, he thinks, just need to use everything they can to stay healthy and alive.

AIDS WALK '95

Several hundred supporters from the International School of Singapore, organisations like the Singapore Fitness Instructors Association, NKF, members and volunteers of AfA, persons with HIV/AIDS, and members of the public turned out to participate in the AIDS Walk. The event was flagged off at the Civic Plaza of Ngee Ann City by Mr Gerard Ee, President of AfA. The route took the walkers down Orchard Road and up Orchard Boulevard .

Over $13000 was raised from the Walkathon. AIDS awareness literature, red ribbons and tee-shirts were distributed.

Hard Rock Cafe Concert

A host of celebrity artistes including Jacintha, Mark Chan, Douglas O, John Molina, Construction Site, Kumar, Melissa Sidek, Naked, Joe Augustin and Alfred George performed to a packed and screaming audience from 9 pm to 2 am. The show was hosted by Hamish Brown. AfA volunteers were on hand to distribute information materials and teeshirts. Condomania gave away specially packed gold coin condoms to an appreciative crowd.

Pop memorabilia including a bustier belonging to Anita Sarawak were auctioned off.

Net proceeds of $11,000 were donated to AfA on behalf of Hard Rock Cafe by Mr Colin Sin the Managing Director.

Public Forum: Aids Sex + Sexuality

Coorganised with Guardian Pharmacy, this forum was well attended, with an audience of 200 persons. Speakers were from AfA and Singapore Planned Parenthood Association. Topics discussed touched on various aspects of AIDS, STDs, and sexual behaviour. A lively Q & A session followed the presentations by the speakers.

WORLD AIDS DAY 1995

Red Ribbon Carnival in Johor Bahru

In conjunction with World AIDS Day 1995, the Malaysian AIDS Foundation and the Malaysian AIDS Council decided to hold their yearly event in the state of Johor. The event targeted for the whole family was launched by the Chief Minister of Johor, YAB Tuan Haji Abdul Ghani Othman.

Zapin Robic (Aerobics in a Malay dance step) kicked off at 7.30pm led by the Chief Minister himself. Activities such as mountain bike rides, a red ribbon run, Puma soccer demo, go-kart rides, quizzes and lots more activities kept the carnival going. There were talks from time to time throughout the day.

Apart from the activities, NGO tents were also set up. One of the participants was Action for AIDS, Singapore. Packed with red ribbons & stickers, literature and information, our tent was teeming with action from as early as 7 in the morning. Our volunteers were busy selling WAD T-shirts and greeting cards, too.

A concert was scheduled at 8pm but because of a sudden downpour, it was delayed for approximately an hour. Artistes from Malaysia and Singapore (Najib & Construction Site) entertained the audience in spite of the rain. The day ended with the Chief Minister and President of the MAF/MAC releasing red and white balloons.

This was the first time that Action for Aids Singapore, participated in MAF/MAC activities. We look forward to working together again and providing all the support that we can give.

AfA Coordinator
J. Jantan

AIDS Conference in Chiangmai

The Chiang Mai conference commenced from the 17th through to the 21st of September 1995. It kicked off with a grand official opening by the Crown Prince of Thailand. In his keynote speech, Mr Meechai stated that we have performed inadequately and ineffectively because we have dumped the responsibility of HIV/AIDS on the health profession and on the Ministry of Health. Mr Meechai urged HIV/AIDS be viewed as a multi-sectional problem and presented his formula to stem the threat of HIV/AIDS in 7 realities or commandments :

1. HIV/AIDS must not be considered as just a health problem but a social and development problem as well.
2. All responses to HIV/AIDS must match the magnitude of the problem.
3. All parties must understand the situation clearly by being honest and open minded.
4. All sectors of society must be involved.
5. The top echelons of government must take leadership; heads of government must lead the National AIDS Committee.
6. All government ministries must be involved.
7. There must be no discrimination. People with HIV/AIDS are our best teachers.

The round table and free paper sessions covered a spectrum of subjects ranging from "Care for PWAs" to "Alternative Sexualities." What they actually missed out was the involvement of PWAs in relevant sessions. As a woman PWA rightfully pointed out, there wasn't any representation from a positive woman in the session on "Women and AIDS in the Asia Pacific."

Another bitter feeling among the PWAs was the lack of sponsorships for PWAs to attend the conference. PWAs who have the support from their local NGO (Non-Government Organisation) like AfA Singapore were able to obtain support to attend. However, there were many more PWAs within the Asia Pacific region who were unable to attend due to the lack of sponsorships which was not taken into consideration during planning.

There were altogether 4 PWAs from LGO Singapore who were sponsored by AfA to attend the conference. The feedback was that despite the lack of PWA involvement in the conference paper, PWAs from Singapore did find some of the sessions beneficial to them. One particular session was "Care for PWAs." They acquired knowledge through lectures on how to become better care providers for AIDs patients in Singapore. Another LGO member also found the session "AIDs in the Workplace" ex-

tremely helpful in developing the programme in Singapore. As for the two other PWAs, this conference was an eye-opening experience for them since it was the first time they attended a conference of this scale.

Besides the verbal sessions, there were also poster exhibitions and display booths. AfA Singapore had a booth which was manned by 4 AfA volunteers and 4 LGO members. AfA's booth proved to be popular as all materials brought up to Chiang Mai like The ACT, condoms, educational booklets, posters, book markers and telephone booklets were all snapped up within the first two days of the conference.

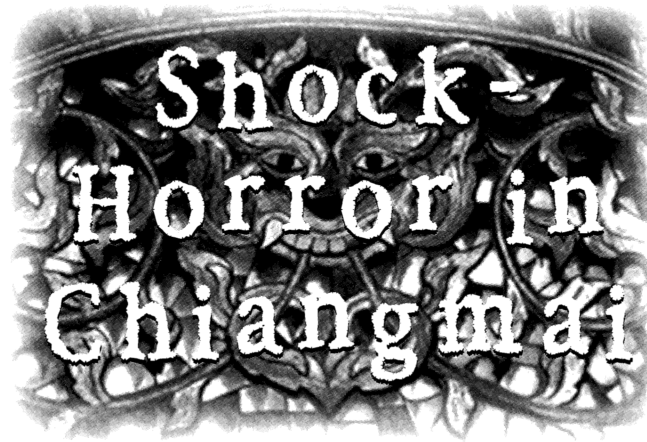
There were also numerous requests for posters by various organisations worldwide. The general opinion was that our poster with the headline that read "Another Singaporean family talks about AIDS" drove home a popular message of how Singaporean as well as many other Asian societies react when they are confronted with the issue of AIDS.

Unfortunately, while much talk and discussion were focused on discrimination against PWAs, the conference organisers discriminated against PWAs as well. One example was the provision of a lounge and medical services for PWAs attending the conference. The lounge had to be planned and manned by PWAs themselves with the support from APCASO. Moreover, there weren't any medical services available for the PWAs. This issue was brought up during the closing ceremony, informing future organisers of the conference especially within the Asia Pacific region, to keep PWAs in mind when planning.

During the closing ceremony, two PWAs from Singapore and Thailand went up on stage to speak their peace on how they were treated during the conference. They requested the various organisers to consider all issues raised by PWAs within the Asia Pacific region. They asked all PWAs within the Convention Hall to gather their courage, to put stigma behind them and to come forward to be united as one. The response was so enthusiastic that the Thai Foreign Minister went up on stage to congratulate them.

The conference ended on a pleasant note with the Foreign Minister giving his assurance that he would have a personal dialogue with the Thai Prime Minister regarding the PWAs request. In addition, a group of Lesbians, Gays and Sex Workers made their way up on stage to rally for Human Rights declaring that Lesbians, Gays and Sex Workers' rights were also Human Rights. This group of activists drew tremendous attention from the various press and media representatives.

The next test for the conference organisers (in the treatment of PWAs) will be seen in the 11th International Conference on AIDs in Vancouver from the 7th to the 12th of July 1996.



Veteran conference-goer Clive Wing walks you through his attendance at the Chiang Mai Conference on AIDS and gives you his personal take.

"You mean you really expected this conference to be useful"? Said a distinguished Australian delegate and professional conference goer as we bussed to Chiang Mai airport. "I never attend any sessions at these sort of meetings. They're a waste of time." This gentleman did not explain how he had spent his time but it's clear he thought it idiotic that I was disappointed with the culture and religion session. Was his cynicism well placed? Yes and no. But that doesn't mean that I found the meeting unrewarding.

If the discussions and sessions strayed from the point, one could always count on the Australian AIDS activists to bring us back to earth with a bump, as they did in the first session I attended. 'AIDS and the Media' held a certain amount of promise. A professor of communications from Universiti Sains of Malaysia, Penang, skillfully analysed the Malaysian newspapers for their reporting on and attitudes to HIV and AIDS. An Indian journalist described the struggles to convince editors to carry stories on the subject. All speakers agreed that the English language Asian press has been responsible in its reporting while the vernacular press sensationalises, distorts and often ignores the facts. Next, an Australian with "down-under" support in the audience lambasted the speakers for their choice of words. They were "disgusted" and "shocked" that 'AIDS patients' and 'victims' were terms used by the speakers. What they failed to understand is that the same words have different meanings in different places. It might not be PC to use them in Australia, but 'AIDS patient' is not yet a term of abuse in Asia and is readily understood throughout the region as a person with AIDS, nothing more.

The next session was disgraceful and it was the one I was most looking forward to. Many of us agree that the fight against AIDS in Asia will be lost or won through education programmes whose effectiveness will often depend upon the inter-relationships between culture and religion. Hence the session on this topic should have been an opportunity for us to understand the synergy between the two; where the boundaries are between public policy and religious teaching and orthodoxy; what has worked or not worked in Asia; what we need to take into account when designing education and prevention programmes and so on. Instead the three speakers displayed their ignorance of these important issues by hardly mentioning culture and religion at all. No results from the field were described and no practical or empirical evidence presented. Ms Marina Mahathir from the Malaysian AIDS Council summed up our feelings when she said from the floor that the session was insulting to us all. Our time would have been much better spent if the organisers had selected a Mullah, Priest, Bhikku and Acharya. Even if they argued amongst themselves, we would have learned something.

For those wanting to see enthusiasm, dedication and results from the front line, the free paper sessions were the places to be. Although methodologies were sometimes suspect, there was much to learn from the voluntary organisations engaged in education and intervention strategies. Whether it was promoting condom use amongst Thai prostitutes, educating street children in Manila or persuading patrons of Bombay brothels to use condoms, the results were often encouraging. One paper from Thailand which tracked nationalities and condom use in Chiang Mai brothels, reported that while all Caucasians used condoms, 20 percent of Chinese men from Singapore, Taiwan and Hong Kong did not. If this figure is reliable, it means that we have a significant number of men in Singapore putting their own lives and that of their wives and unborn children at risk.

What was very noticeable however was that in five days of session-going, I did not hear one speaker talk about abstinence or monogamy. The

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INADEQUATE GLOBAL RESPONSE TO AIDS PUTS WOMEN AT RISK OF HIV

Millions of women are facing avoidable risk of contracting HIV because of an inadequate international response to the epidemic, the World Health Organisation (WHO) warns.

According to WHO, between 7 and 8 million women of child- bearing age have HIV, and this figure is expected to double by the end of the century. By the year 2000 it is estimated that 14 million women will have contracted HIV, of whom 4 million will have died of AIDS.

"There are signs of a growing political commitment to AIDS in general, but despite increasing evidence of the vulnerability of women to HIV/AIDS socially, biologically and economically, the specific needs of women are going largely unmet. We cannot allow this to continue when worldwide, the epidemic is increasing faster among women than in any other group," said Dr Aleya El Bindari-Hammad, coordinator of the WHO delegation to the International Women's Conference in Beijing held last September.

She also added, "The sexual and economic subordination of women fuels the HIV/AIDS pandemic. To break the cycle of neglect which affects women across their lifespan and across generations, it is essential to undertake actions which allow women to make informed choices and enable them to improve the quality of their lives. Given the growing dimensions of the HIV/AIDS pandemic, the need for change is literally a matter of life and death."

Dr Hiroshi Nakajima, Director-General of WHO, said it was no longer possible to work for improving the status of women without seeking ways to reduce their vulnerability to AIDS. "Informing women about AIDS is essential but only a first step," he said, "The real challenge is empowering women to avoid exposure to infection, and supporting them to cope with AIDS. In all cases, men must take on their fair share of the responsibility for AIDS care and preventing transmission."

A special adviser on HIV at the WHO, Dr Dorothy Blake, said the route of transmission to women was overwhelmingly through heterosexual intercourse. "It is important to remember that as local epidemics mature, the net of infection is cast wider and wider, drawing in women with only one sexual partner. In many countries throughout the world, pregnant women attending antenatal clinics are showing a high prevalence of infection. Studies of women attending antenatal clinics find that many are monogamous and have been infected by their one partner - their husband."

Source: National Aids Bulletin (Australia) Vol.9 No.6

WOMEN TALK ABOUT HIV/AIDS

"I was aware my husband was having casual sex when not with me, but I was too ashamed to ask him to take precautions. I kept telling myself, next time. My advice to young mothers is, "Don't ever wait for next time." Now I have big regrets. I'm so lucky that I didn't have any more children after I was infected."

- South Pacific

"I told my husband that it was better to use condoms, the doctor said so. The doctor had also given me some to use at home. My husband became angry and asked who gave me permission to bring those condoms home."

- Kenya

"I am 24 years old and have a 4 year old daughter, Sara. I've been HIV-positive for 3 years. I was a virgin when I married a man whom I loved very much, but he died 2 years ago of AIDS. Now I need to care for myself, my house and Sara's future, and I'm all alone. I need to work, but I often suffer from episodic diseases which keep me from the labour market. So I work on a daily basis, cleaning houses."

- Brazil

"When a person is infected with HIV, that does not mean that sex disappears from her or his life, even though some people think those living with HIV/AIDS should never have sex again. Of course, none of us living with the virus wants to pass it on to others ... We want to have sex for the same reasons you do: because we like it, to express love, to gain consolation or security. In that, we are like everyone else."

- Netherlands

"It's very difficult to be told that you're HIV-positive when you've been honest to your man. I was a lady who stayed with one man even when I was hungry, but I got the virus."

- Zimbabwe

Source: Facing the Challenges of HIV/AIDS/STDs: A Gender-Based Response, published by the GPA.

Shock-Horror in Chiangmai

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starting point was always condoms and it got me wondering if we have all been bought by the condom companies? Or are we just bowing to reality? That it's inevitable young people will have sex, so preach condom use instead?

As with the absence of celibacy and monogamy messages, I did not notice any studies on keeping free from HIV the partners of HIV people. This is of supreme importance countries with high seropositivity rates such as India, Thailand, Myanmar and Cambodia. Many will find this a strange statement. After all, why would an infected husband continue to have sex with his wife and risk cross infection? The answer is we don't know, but they do. All countries in the region will report that physically and sexually abused wives continue to live with their husbands because they have nowhere to go and are economically dependant on their spouse. It is because of this that many delegates at the meeting would tell you that sex between uninfected and infected partners is probably not uncommon. This deserves far more attention than it has received.

One of the most interesting sessions was a round table discussion on Alternative Sexualities. The panel consisted of gay men, a Bacia (an effeminate Filipino man), a lesbian, a transgendered female (a biological male who has undergone reassignment surgery) and others. Several of the panelists who identified with alternative sexualities were university professors from the region and they agreed with a comment from the floor that the session would be better called Other Sexualities. The reason being that reportedly, Asia has a wide variety of "other" sexual expression that is deeply rooted in the culture. It is only with the western paradigm of gay, straight and bisexual being forced on ancient cultures, that what was considered innocent behavior, is now seen as deviant.

For example, several countries reported the raising of a boy as a female in the absence of daughters. In adulthood the child is called aunty and can take a ,male sex partner. In India, eunuchs (castrated men living as women) have for centuries performed rituals at Hindu celebrations; and the huge number of men in the region who are happily married, have sex with men and do not identify as gay or bisexual, present yet another sexual variation. The point of the discussion was to address such diverse sexuality in the context of HIV and AIDS. It did not really accomplish that because gay issues from gay participants hijacked consideration of the other sexualities. Nonetheless, all participants will have been enriched by the presentations of the panelists who described their own sexuality and their struggle for recognition and acceptance.

What this session confirmed is that the Western gay model into which is lumped all men who have sex with men, is not appropriate to much of Asia. I'm convinced that gay men are fewer in number than men who have sex with men and bisexual men in many Asian countries from India to the Philippines, and that if we are to reach them we need to develop different HIV/AIDS messages, delivery routes and services. On Singapore we could start by quantifying the extent of non-gay same-sex through a small research project.

This was not a bad conference. What the organisers didn't get to grips with is that in Asia, our problems are overwhelmingly societal: religious objection to condom use, absence of sex education in the home and at the school, public distaste of open debate on sexuality and AIDS, political understatement of the AIDS epidemic, as well as the culture of casual sex in many Asian societies, and the position of women at the bottom of the family hierarchy. They all deserve greater consideration especially Asian women and the anguish they face from abusive or philandering husbands. I've often said that the AIDS crisis in Asia is a women's crisis. Nothing I heard in Chiang Mai changed this point of view.

Volunteers at Home

by Rashid Saini

I have been a volunteer with AfA for a number of years now. Sometimes I hate it, but most of the time I actually love it. I guess that is why I am still around. Although I feel my days in AfA are numbered, I feel compelled to tell all new volunteers and the ones who are still in AfA that if they focus and be patient, AfA is a great home for volunteer work.

A lot can be said about AfA's very laudable resume. You have to be in AfA long enough to know how much work it has accomplished. It would be unbearably tiresome for me to list out its achievements since its inception back in 1988. Besides, this is not an AfA advertisement.

Perhaps as volunteers, we rightfully look for a solid foundation in an organisation. There is that inevitable need to know who is at the helm of what; how information is disseminated, and how to get involved.

AfA has an Executive Committee (ExCo) and subcommittees in charge of different activities. However, this structure is not always clear. Perhaps, because volunteers are constantly recycled, navigators' roles and identities, and routes of work are sometimes blurred. Read this as nothing more than a shortage of manpower, which unfortunately has been misinterpreted as a structural handicap. See it however you like, but see that AfA needs volunteers as the bottom line.

However, while AfA cries insufficient volunteers, many lament insufficient work. By insufficient work I refer to those who remain idle (through no fault of their own) and those who call in but never get satisfactory replies.

I cannot deny this to be untrue as I keep seeing recycled volunteers. In this case, work could have been better delegated. Nonetheless, I do not see enough volunteers coming forward taking charge of projects to counter the claims of insufficient work.

Very few realise the versatility of AfA. AfA's apparent foible - an organisational inadequacy, not a structural flaw - is its greatest handicap which can work to our advantage.

AfA makes room for just about anybody to engineer flagships of different projects. And the size of the project can be best suited to your own capacity. With ample training, anyone can pilot a project. So why aren't volunteers doing exactly that? Or are we comfortable just tailing the flow? If so, perhaps we should not be so quick in faulting AfA for not delegating enough work to enough people?

Basically, the core of the problem is finding a base to link the work to the volunteers. Sometimes, when there is a project, the question is self-answered. Eager volunteers are accordingly channelled - sometimes thrown into the deep end. There is cause for scrutiny here. Up until now, AfA does not have full-time personnel to monitor and follow-up on enquiries and volunteer lists. I offer an explanation not a pro-AfA excuse. The problem becomes bigger when the person who picks up an enquiry call has no centralised base to record the names and have them systematically sorted out. As a result, project leaders may not receive these names. This is a problem - not a flaw - which AfA has seemingly left unresolved.

AfA Executive Members, on the other hand, are not faultless either. While few have overworked themselves, the rest remain seemingly dormant. The politics do not interest me, but I can see that a lot of volunteers are wondering who and where the ExCo members are, and what exactly it is they do. The voice of ExCo members matters. It accounts for volunteers' trust and loyalty to AfA. Volunteers look for a strong foundation and are con-

cerned with AfA's organisational structure. The existence of such concerns make it imperative for ExCo members to make their presence and/or existence more noticeable.

I urge more ExCo members to be more involved with the volunteers. It will stiffen their (volunteers') resolve to stick around longer - if not to do more work. So many good volunteers have left. Perhaps it is time to evaluate how we can retain them and why.

Volunteers also need to know that they are appreciated for the services they render - this has to come from the ExCo members. Volunteer project leaders may express appreciation for other volunteers, but the appreciation is not necessarily interpreted as that of AfA's.

On a different train of thought, the residents of AfA can also make it difficult to focus on the work. Understand that AfA itself is just a big old half-way house that needs a lot of fixing. Apart from being instrumental to its cause, it is not perfect. By no means does this allow for poor project execution, but sometimes people forget that many volunteers work to their bones and still fail to extend themselves far enough. Regrettably, volunteers don't always get it right either.

Volunteers are not immune to negative criticisms or constant bitching. Who can be? So patience may well be an indispensable virtue. Volunteers need to give themselves time to feel their way through AfA's network and stay blind to the politics, the ego trips, the differences of opinions, views and stands.

Concentrate on the work! Perhaps AfA is messy and disorganised, but you can self-orientate because problems - if not work-related - are often dismissable.

Working in AfA is sometimes crazy, difficult and butt-headedly painful. However, it can also be fun, wonderful and if I may say it - bloody damn good! You meet and work with so many fun and wacky people with a sense of humour as crass as their honest intentions.

Bottom line: It can be a great experience to be an AfA volunteer. Don't use AfA's shortcomings as an excuse for feeling inadequately utilised. Focus on the work because that's what it is all about, really. Isn't that the spark of your interest to begin with?

For those of you who are always waiting to be contacted and asked for your opinions and suggestions, for Pete's sake ... when does waiting ever get you anywhere? Devise your own enterprise or submit a proposal. Tell AfA what you would like to do. It's really up to you to make AfA whatever you want it to be. We should not wait to be called because sometimes volunteers miss a few names. Let's not make that an issue.

Finally, while patience is an indispensable virtue, it is also just to note that there are legitimate reasons to bow out (temporarily, seasonally or permanently) of AfA. We all have our own lives. Don't feel guilty. Reasons for walking out can be just

Makchik Agony Dearest

How can I locate a sex partner who is HIV positive like me?

In Singapore, unlike the USA and a few other countries, there is no dating service for people infected with HIV. The closest you can get to one is on the Internet where there is at least one America-based service. If they wanted to, infected Singaporeans could post messages on this service as a means to meet each other. There are dangers though. You have no guarantee that those who reply might not have other motives in mind, like blackmail.

Society at large might also find objectionable, a dating service for infected people. So it is unlikely that one would ever be started in Singapore.

There are other considerations too which HIV infected people cannot ignore. First, pregnancy should be avoided. The chances of an infected baby are high. Second, although we cannot be certain, repeated exposure to HIV through unprotected sex (intercourse without a condom) could hasten the destruction of the body's immune system. And third, unprotected sex will also increase the risk of becoming infected with other strains of HIV.

AfA has a support group for HIV infected people to meet and discuss matters concerned with living with HIV. Please call Tel: 295 1153 for more information.

My best friend is going out with a man who's had lots of girl friends and visits prostitutes. I'm worried he might give her HIV. What should I say to her?

First of all, convince her that as a friend you are concerned about her health and well-being. Tell her that if she becomes infected with HIV, marriage and children will be out of the question. Then explain the consequences of casual sex: the more partners you have, the higher the risk of HIV infection. If she and her partner are not using condoms, encourage her to do so. You should also suggest that they both take a HIV test. If one or both tests positive, AfA can provide high quality impartial service. If they both test negative but either partner continues to have casual sex with other people, suggest to your friend that condoms always be used during intercourse.

AfA provides anonymous HIV tests and counselling every Saturday afternoon from 1 to 4pm at the DSC Clinic, Kelantan Lane off Jalan Besar. Telephone 293 9716 or 293 9648. If your friend prefers to speak to a counsellor by phone, encourage her to call AfA's hotline, 295 1153, which is manned by trained counsellors every Tuesday, Thursday and Friday night between 6.30 and 9.30pm.

Because my husband won't use condoms and I don't like the Pill, we've been doing anal sex for years to prevent pregnancy. But now I'm worried that he's paying for sex and might give me AIDS. What can I do?

Although we have scant evidence in Singapore of the frequency and preference for anal intercourse between men and women, worldwide HIV and AIDS research suggests that it is more common than had previously been suspected. There are several reasons why. They include contraception; one or both partners enjoy it; husbands complain their wives' vaginas are loose after childbirth; and so on.

Because the lining of the anus and rectum is thin and easily broken, it provides a perfect route for HIV to enter the body. Indeed, infection during anal intercourse is responsible for a huge number of AIDS cases around the world, especially amongst gay men. So the message is clear: if either partner, male or female, had or currently has more than one sex partner, a condom should be used from start to finish or, this form of sex should be stopped altogether and replaced by something less risky. It should also not be forgotten that condoms, although very reliable, do not provide 100 percent protection. They can and do slip off or burst. By far the best option is to persuade your husband to stop seeing other women and for both of you to take a HIV test at the AfA anonymous testing clinic or a government facility.

Why has there been a dramatic increase in child prostitution in Asia?

In India, thousands of little girls are raised in brothels and sold to the highest bidder because many men believe that sex with a virgin will enhance their own sexual prowess. In Thailand, the Philippines and elsewhere, impoverished families sell their daughters to brothel owners for the income it produces. And whilst for the vast majority of us this causes intense revulsion, it is true that child prostitution is registering dramatic increases throughout Asia. Most are largely due to the misconception that sex with children has restorative powers and that there is no likelihood of HIV infection from child to adult. The latter cruelly and ironically illustrates that government messages linking HIV to prostitution are working. Men who would have patronised adult prostitutes are now turning to children as young as ten years old in the mistaken belief that they cannot catch HIV. Tragically, evidence throughout Asia and especially from Thailand, shows that child pros-

titutes too have HIV in increasing numbers. Any Singaporean who has sex with children, and our national newspapers have reported that Singaporeans have been seen in large numbers at Thai brothels specialising in child sex, are putting themselves at risk and are probably breaking national laws. But most importantly, they may be infecting a child with HIV and are certainly contributing to a sickening trade which robs children of their childhood and condemns many of them to death. Several countries, including Australia and New Zealand, have passed laws criminalising sex with children wherever it takes place. AfA hopes similar measures are being considered by our own authorities in an effort to protect children and discourage our own citizens from having sex with them.

Why don't I see people with AIDS in Singapore?

The major reason is that there are few people in Singapore who have progressed from HIV infection to AIDS. Currently, the number of people who have developed AIDS to date is over 170, of which over 50 have passed away. Second, if somebody with AIDS is well enough to go out, you cannot tell if they have the disease. They could look very thin and have difficulty walking, but this is true for other diseases such as cancer. For some, a tell tale sign is Kaposi's Sarcoma (KS), a skin cancer which produces purple/brown blotches on the skin. Also important is that people with AIDS tend to stay home partly because they are ill and partly because they do not want other people to know or suspect that they have AIDS. The fact that few people in Singapore have been found to have HIV and AIDS should not lead to a false sense of security. We have increasing numbers of people being infected among whom are many more heterosexuals, especially women. And we really do not know the exact number of Singaporeans with HIV. It could be a few hundred to several thousand.

My boyfriend and I like to vary our lovemaking with sex toys. As I've used them with previous partners, could they carry HIV?

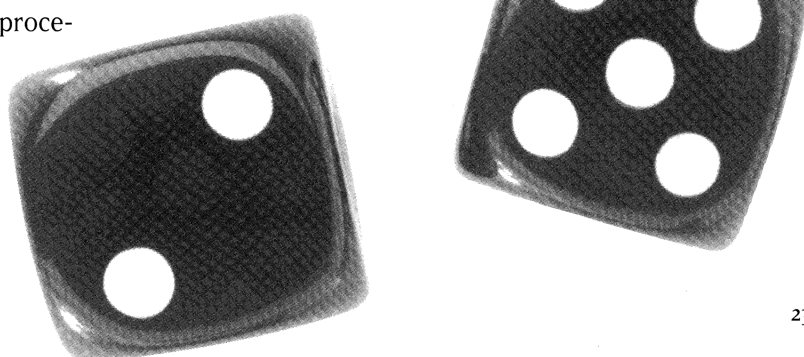
HIV is a very fragile virus. It is killed by soap and water but it must be said that our knowledge of how long HIV can live outside the body, on your sex toys for example, is imperfect. Most experts would say a few hours at the most. But is a few two or six? As the difference could mean life or death, here are a few tips to keep your toys clean and you and your boyfriend fit and healthy. Before vaginal or anal penetration wipe your toy with a clean,damp cloth and put a new condom on it. Add extra lubrication if you need it. If he is going to use the toy after you, remove the condom, wipe the toy with a clean damp cloth impregnated with a small amount of detergent or dish washing liquid, rinse the cloth, wipe the toy and store until the next time. Remove the batteries if it's going to hibernate for a while.

Why did an American with HIV recently have a bone marrow transplant from a baboon and when will we know whether the treatment is successful?

Doctors say that the baboon bone marrow cells transplanted into the AIDS patient Jeff Getty have failed to grow and function. They are surprised, though, that Getty's health has improved anyway. The details have yet to be published by the doctors, who wanted the public to know that Getty's improved health was not the result of the transplant. The procedure was considered successful because it showed that the radiation and drug therapy used to prepare the patient was safe - Getty's doctors say that they will explore the use of radiation for AIDS treatment, since it seemed to have a positive impact.

My bisexual boyfriend tells me that bisexual men often have the riskiest sex of all. Is this true?

We have little hard evidence in Singapore or from any part of the world on the sex practices of bisexual men, men that have sex with women and men. Anecdotal evidence suggests that bisexualism is far more prevalent in most societies than one might think. And we certainly believe that bisexual men have more than their fair share of risky sex. The reason for this is that the type of sex they have with men is often far more varied than the type of sex they have with their wives or girlfriends. Sex with men involves oral sex, anal intercourse without condoms and probably everything in between whereas bisexual men often report that because of cultural norms and Asian conservatism, sex with women may not go beyond vaginal intercourse. Bisexual men might therefore be putting themselves and their wives, lovers and unborn children at risk. The difficulty health educators have is reaching them with appropriate messages about prevention of HIV transmission because they are even more closeted than gay men. Your boyfriend could help by passing on to his friends and sex partners the facts about safer sex.



Projects & Programmes

HIV Education and Workplace (HEW) Committee
Coordinator: Douglas Ong
-9205 0223

Education is still the mainstay in preventing the spread of HIV. With this aim in mind, HEW - the public education arm of AfA - trains volunteer lecturers to speak to interested groups and organisations to help raise AIDS awareness. Lecturers are also trained to help organisations develop workplace policies relating to HIV and HIV-infected workers. HEW welcomes people interested in becoming volunteer lecturers and requests for talks. If you know of any interested organisations with such requests, please get them in touch with Lalitha at Tel: 293 9716.

The ACT
Coordinator: Roy Chan
-250 9495

This is AfA's in-house publication which provides medical, social and personal articles and updates AfA's activities to its members and volunteers, as well as schools, libraries, organisations, clinics and hospitals. We need writers and journalists to contribute their writing talents to help raise AIDS awareness.

Outreach Programme For Homosexual Men
Coordinator: Calvin Tan
-476 6602

This programme is designed to reach out, educate and empower men who have sex with men (MSM) to adopt and maintain safe sex practices. Volunteers are needed to help plan, implement and evaluate programmes.

AfA Malay Group
Coordinator: Abdul Fakar
-253 4455

Formed to meet the challenges of educating the Malay-Muslim public on the AIDS epidemic, this initiative supports AfA's public education projects through various Malay-Muslim organisations. We need volunteers interested in giving talks and tackling the long-term issues of HIV/AIDS in the Malay community. Volunteers with connections with Malay community groups are especially needed.

AfA Research Committee
Coordinator: Roy Chan
-250 9495

AfA funds HIV-related research. It invites proposals from medical, paramedical and social workers and researchers.

Club AIDS Project (CAP)
Coordinator: Dawn Mok
-216 6491

CAP coordinates AIDS-awareness events at local nightspots and develops party packs complete with educational materials for distribution at these venues.

Information & Counselling Hotline (Tel: 295 1153)
Coordinator: Gerard David
-278 0278

AfA provides information and counselling services on AIDS and related issues. Phone lines are manned by trained AfA volunteer counsellors between 6.30 - 9.30 pm on Tuesdays, Thursdays and Fridays. Interested and reliable volunteers needed. Training will be provided.

SOCIAL SUPPORT & WELFARE

Buddies & Friends Support Group
Coordinator: Iris Verghese
-354 9508 / 359 9591

This is a support group for people living with HIV/AIDS (PWAs) and their families. We need volunteers to provide support, care and concern for PWAs. If you have experience in dealing with HIV, terminally-ill patients, crisis counselling, sexual problems and alternative therapies, you will be of valuable use to this group. The necessary training will be provided and volunteers will be assigned to work in home care teams or as personal counsellors to PWAs.

Life Goes On (LGO)
Coordinator: Vincent
-9202 2345

While death is a part of AIDS, so is life. LGO is a self-help group organised by PWAs and funded by AfA. Besides being a support group, LGO also networks with similar self-help groups regionally and shares experiences and information that are mutually beneficial. Through LGO, PWAs' interests and rights are represented in all AfA activities, in both organisational and participatory levels, with confidentiality preserved. LGO meetings are restricted to PWAs and their spouses. There are separate support circles for heterosexual men, married couples, homosexual men and women.

Women & AIDS Committee

The rising number of women contracting HIV has prompted an urgent need to tackle the unique issues and problems that women will face in dealing with the AIDS pandemic. Now, more than ever, we need caring and committed women volunteers to help achieve these goals. WANTED: Caring and committed women volunteers to join and spearhead this committee.

The Quilt & The Candlelight Memorial
Coordinator: Daniel Tan
-9409 8302

Both annual events help draw people into the circle of AIDS awareness by allowing friends and relatives to openly express their grief and emotion of coming to terms with death and AIDS. These events have become powerful symbols of the presence of AIDS in Singapore and the world.

Survivors
Coordinator: Iris Verghese
-359 9504 / 359 9591

This support group helps link relatives and friends of PWAs who have passed on. Members help each other come to terms with their losses and move on to help others learn to live with AIDS in their families and relationships.

Legal & Ethics Working Group
Coordinator: Wilfred Ong
-326 0851

The group provides free legal advice and assistance to PWAs and their families.

CLINICAL SERVICES

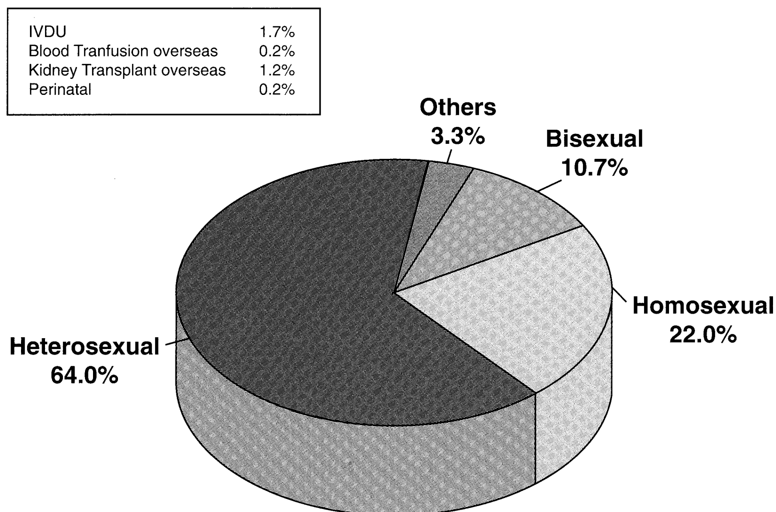
Anonymous Testing & Counselling
-293 9716

This programme provides pre- and post-test counselling for voluntary, anonymous HIV testing at DSC Clinic, 31 Kelantan Lane, #02-16 (200031) on Saturdays between 1 to 4 pm (except public holidays). It is the only anonymous test-site in Singapore.

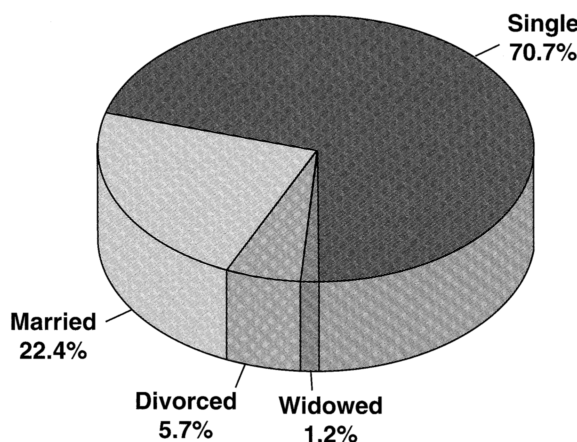
Funding For Medications

-AfA provides funding for selected medications to PWAs, such as aerosolised pentamidine and anti-pneumococcal vaccine, which would otherwise be out of their reach.

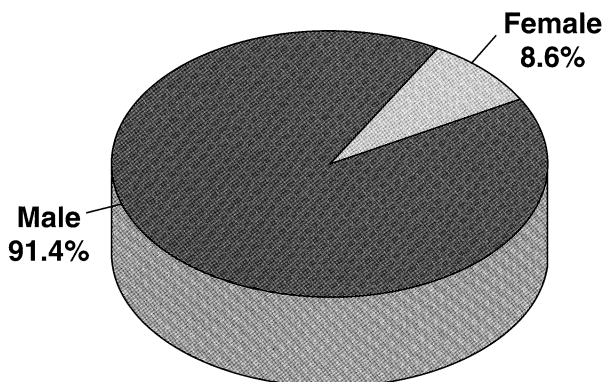
HIV INFECTIONS BY MODE OF TRANSMISSION



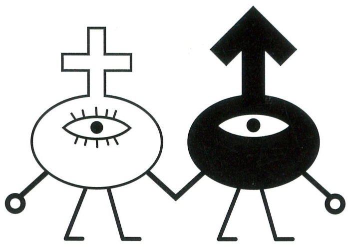
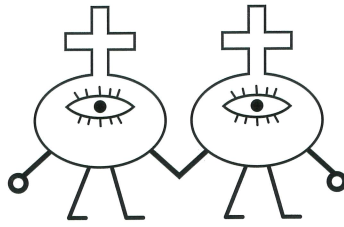
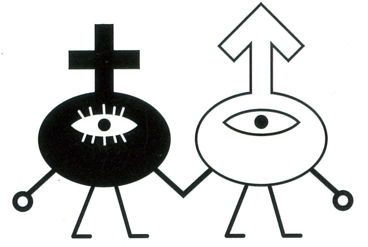
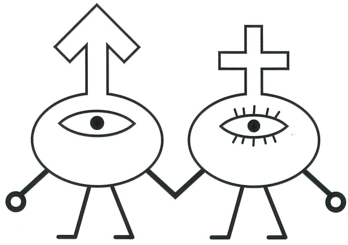
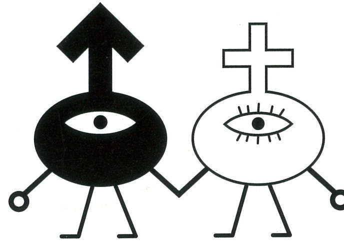
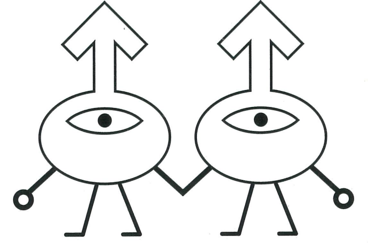
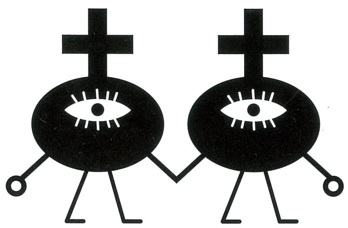
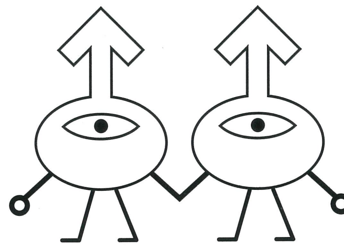
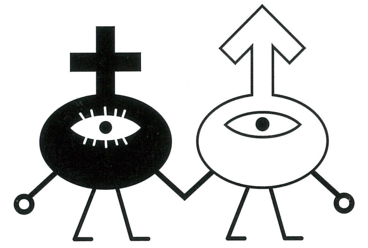
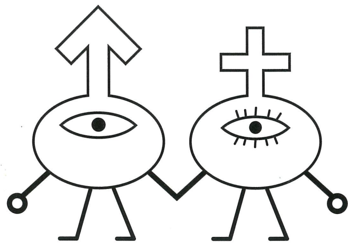
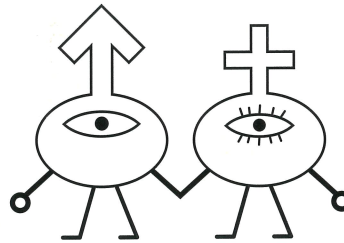
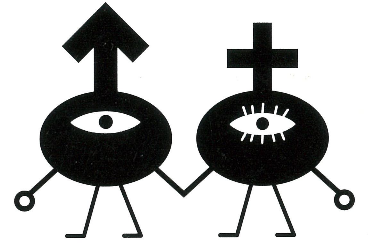
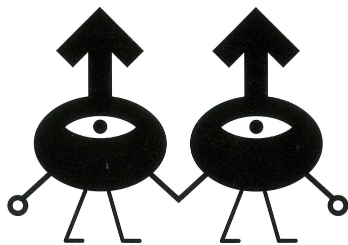
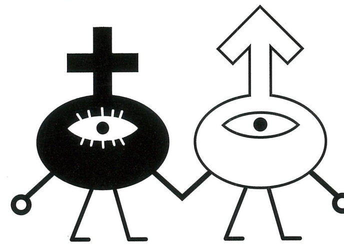
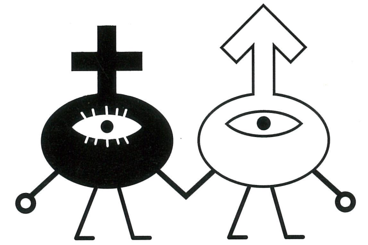
HIV INFECTED SINGAPOREANS BY MARITAL STATUS



HIV INFECTED SINGAPOREANS BY SEX



Information Provided by The Ministry of Health

Shared Rights
Shared Responsibilities

ACTION FOR AIDS SINGAPORE