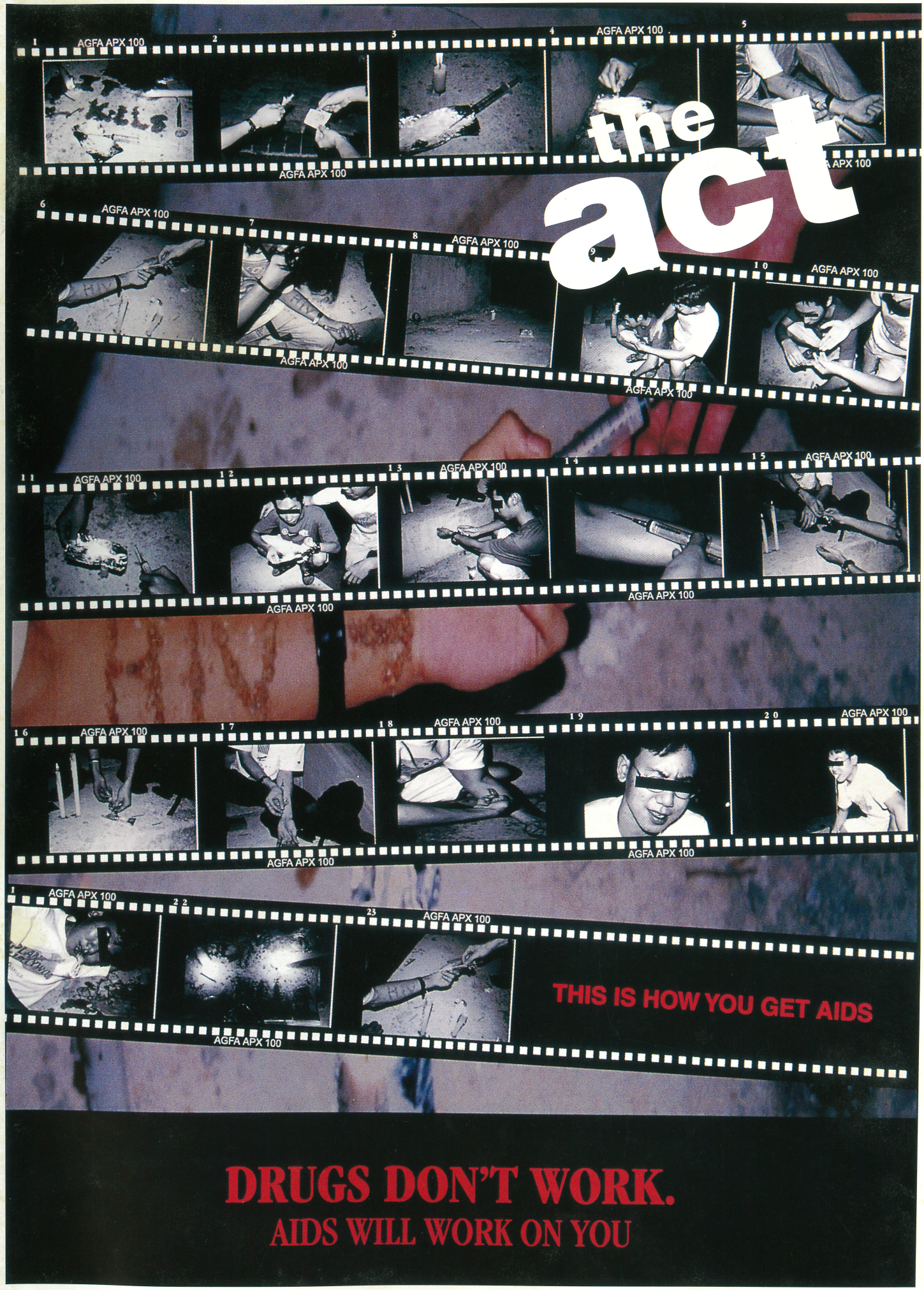


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cover synopsis:



Drugs Don't Work. AIDS Will Work On You

Sim Jeremy Leslie, 19 years old
Merit Award, Student Category, Art Against AIDS 1998

The poster highlights the dangers of sharing contaminated needles and syringes during intravenous drug use. The 5 picture strips depict a storyline showing the process of how these drug-users use the same needle and syringe to shoot drugs. A HIV-infected person, who is identified by the word "HIV" written on his forearm, is passing around the same syringe and needle that he has just used. Hence the message, "This is how you get AIDS." While it is true that drugs will work on you and make you "high', drugs will not help bring you joy and happiness. Rather drugs will only help infect you with HIV.

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mission statement

"Action for AIDS is committed to providing balanced and factual information on AIDS, to providing care and support to persons with HIV/AIDS (PWHAs), and to encourage research into issues related to AIDS in Singapore. We strive to end AIDS-related discrimination and for the acceptance of PWHAs as contributing members of our community."

contents

Editorial 1

Keeping Families Together - Fighting AIDS Discrimination 3

Gender Differences & Attitudes Towards Homosexuality Among Singapore Youth 7

Prevent Harm If We Cannot Prevent Use 11

Report on the 13th International Conference on AIDS 12

The Durban Declaration 13

True Love Waits Concert 15

17th International AIDS Candlelight Memorial 17

My Impressions by Benedict Jacob Thambiah on the 13th International Conference on AIDS 19

Singapore Press Reports 22

Chemical Equation: How HIV Drugs Can Interact With Illicit Drugs 27

AfA Projects & Programmes 32

Dr Roy Chan President, AfA

Having been intimately involved in various AIDS projects and programmes for several years, both locally as well as internationally, I am happy to report that there has been some progress made on several fronts, however there is still a lot to be done in many other fields. Here are some comments and observations on the situation in Singapore today.

Enormous advances in the biomedical sciences have uncovered and solved many of the mysteries of HIV/AIDS. There are now a host of effective anti-HIV medications that have made AIDS and HIV infection eminently treatable. Newer, more efficacious treatments are in the pipeline. While these medications may not be curative, they have nevertheless forever changed the concept of AIDS as a death sentence. These medications are significantly extending the lives of PWAs. HIV infection can now be considered to be a chronic disease, somewhat similar to chronic heart, liver and kidney disease, and cancer. This is a paradigm shift. We therefore must not regard PWAs as deserving less assistance than patients suffering from other chronic illnesses, because "nothing can be done for them". So long as they can remain fit and healthy - by receiving the medications that they need - PWAs can and will continue to be productive citizens of this country and contribute their energies and creativity towards greater economic growth.

Most of the anti-HIV medications are already available in Singapore, but unfortunately only a minority of our patients can afford them. The cost of a triple drug cocktail averages $1200-$1300 per month. In most developed countries and even in some developing countries, HIV treatments are subsidised by their governments and insurance schemes. Here in Singapore, patients have to fork it out on their own, or their families have to. And health insurance schemes specifically exclude coverage of AIDS and HIV infection. This is unfair and harsh. We must also think of ways to achieve reasonable pricing from the pharmaceutical companies which reap huge profits from the sale of these medications. In this regard I follow with keen interest the discussions on compulsory licensing in other countries. In the meantime for most PWAs here, no money means no medications, no hope, and death.

In the field of epidemiology, we know how HIV is and, more importantly, is not spread; we have known this for 15 years. Yet, and despite years of expensive educational campaigns, recent studies have shown that large sections of our population still cling on to myths about HIV transmission and to preconceived notions of who are at risk of contracting the disease and who are not. And these include significant sections of medical and paramedical workers.

The lesson we learn here is that the process of increasing awareness and dissemination of accurate AIDS information has to be ongoing, has to be factual - not sensationalistic, and has to be tailored and relevant to the different target audiences. We must constantly reevaluate our education programmes. We cannot avoid dealing with so-called sensitive and taboo subjects when we are dealing with AIDS - whether in schools, at home, in the office, or in the media. Failing to do so will make these programmes ineffective and a waste of time and money.

Denial, ignorance and discrimination regarding AIDS are still rampant in Singapore. PWAs deserve a fair deal. Fearful of being stigmatised and discriminated against, many PWAs do not reveal their status to their own families and friends, preferring instead to suffer in silence. Some lose their livelihoods when ignorant and scared employers learn of their condition. PWAs have no legal recourse for assistance in these matters and more often than not are too frightened and ashamed to fight for their rights. PWAs should not be seen as 'deserving' their condition, nor should they be shamed into oblivion. Instead they should be encouraged to continue to work, to live, to participate in and contribute to family life and to the community. Being HIV positive is not a crime; we should stop treating PWAs like criminals.

The recent series of events concerning HIV+ spouses is another good example of AIDS-related discrimination (see story in this issue). It exemplifies a warning that we have repeated on many occasions, namely that AIDS impacts not only people infected with HIV and those around them, but also on the whole society. While relieved that the problem has been resolved I feel that such decisions and measures should not have happened in the first place. It also demonstrates the importance of remaining vigilant in regard to AIDS-related discrimination, and how several parties working together can overcome this discrimination. It is also abundantly clear from this saga that factual information needs to be communicated to every office and strata of society, from the lowest to the highest.

I like to look at failure to stop HIV transmission to be as much a failure on the part of society and its institutions as it is of the individuals concerned. We need to ask ourselves whether we as doctors, public health experts, educationists, politicians, professionals, religious leaders, businessmen or what have you - have we done our share in educating, and preventing the spread of HIV in our community. Or have we instead turned our backs on this disease with taboo connotations, a disease, which only affects deviants and wierdos? There has been a reluctance to research and discuss the contextual determinants of HIV transmission, and fear and loathing in many circles to address the issue of AIDS in the past. We need to identify and remove obstacles to risk reduction and behavioral change.

How we deal with AIDS and how we treat PWAs is a good indicator of our society's tolerance and maturity.

We need to ask ourselves ... have we done our share in educating, and preventing the spread of HIV in our community.

Help for HIV Infected Pregnant Mothers - Whose Responsibility?

Over the years AfA has been called upon to assist several HIV+ pregnant mothers who cannot afford to pay for anti-retroviral medications during their pregnancy. In the most recent instance in August this year, the mother, Mdm K, was a non-resident wife of a Singaporean, in the third trimester of her pregnancy, who tested positive during routine antenatal HIV testing. The couple was too poor to afford medications that could prevent mother-to-child transmission of the virus. We were called to help because there was no one else that they could turn to for financial assistance. It costs about $600 per month for dual therapy which is felt to be the most effective prophylactic treatment at present.

AfA agreed to pay for Mdm K's medications in full during pregnancy. This however makes us ask the following questions -

- **What about the mother?**
  There is a very good chance that prophylactic treatment can prevent mother-to-child-transmission (MTCT). But who will pay for the mother's treatment after delivery. Inability to afford treatment will probably lead to the deterioration of her health and eventual demise. Who will look after the child? If both mother and father die from AIDS, we will have an AIDS orphan who will need to be cared for by relatives (if any) or the state. Is it better to pay for mother's treatment to avoid this eventuality?

- **Should there be schemes to assist poor couples found to have HIV infection during pregnancy?**
  There clearly should. MTCT is eminently preventable. Encouraging voluntary HIV testing in pregnancy should be accompanied by provisions to stop paediatric AIDS as well. Assistance can be from hospital budgets, Medifund, childrens charities, the Ministry of Health or other relevant organisations. While AfA will try to assist as much as it can, it should not be the only avenue of assistance. The burden must be shared.

Roger Winder

KEEPING FAMILIES TOGETHER–

Fighting AIDS Discrimination

On 27 May 2000, the Ministry of Home Affairs (MHA) made an announcement that entry into Singapore would no longer be denied to foreign HIV-positive spouses of Singaporeans. Knowing my involvement in the issue, many of my friends congratulated me for the 'victory' in this battle. However, I feel that while AfA did make significant contributions to the struggle, the significant parts played by many others have to be highlighted. I shall try to provide as comprehensive an account of the episode as I can to allow for a fuller appreciation of the contributions of the various parties involved in the struggle to keep families together.

What was the issue?

Under the Immigration Act, Section 8, subsections 1 and 3, people with HIV/AIDS are classified as "prohibited immigrants". It seems that this Act was enforced more strictly from mid-1998 and had distressing consequences for foreign HIV-positive spouses of Singaporeans. They had previously been allowed to enter Singapore on social visit passes. After the strict enforcement of the Act, however, they found that they were denied extensions to their passes and were denied further entry into Singapore. Heart-broken spouses and children were often left behind in Singapore.

How it all started ...

In mid-1998, the HIV-positive Thai wife of a Singaporean was given seven days to leave Singapore when her social visit pass expired. She was denied further entry into Singapore. Her HIV diagnosis was made during routine antenatal screening in 1997. Her Singaporean husband subsequently tested HIV-positive too.

The next known case was of a Malaysian married to a Singaporean female (woman?). He had been visiting Singapore on short-term social visit passes. He applied for a work permit in April 1999, was screened for HIV and tested positive. He was given two weeks to leave Singapore. His Singaporean wife, later adopting the pseudonym 'Madam Sharifah' in press reports, also tested HIV-positive but the couple's children tested HIV-negative.

Subsequently, at least 5 HIV-positive wives of Singaporeans were not given extensions of their social visit passes in February and March 2000. Appeals were made on behalf of the families to the Ministry of Health (MOH) and Singapore Immigration and Registration (SIR), but in vain. The Immigration Act was quoted to justify the denial of entry to the spouses.

The families act and the press gets involved ...

Finally, a Singaporean husband and his HIV-positive wife from China in desperation turned to the press for help. They had tried appealing with a letter from their Member of Parliament (MP) but this only got them a two-week extension of the wife's social visit pass. Outraged with this outcome, they invited reporters from Lianhe Wanbao, a Chinese language afternoon newspaper, to their home to hear their story. On 5 April 2000, coverage of their plight appeared in that newspaper, the first publicity the matter received. Photographs of the couple with their faces blurred were also included, as was the wife's name. As a result of the report, the couple received an offer of help from the Chinese embassy. The wife subsequently managed to obtain a 1-month extension of her social visit pass.

The next press report of the matter was in the 16 April 2000 issue of Berita Minggu, a Malay language newspaper. This time, the story was about Madam Sharifah's family. She had also approached the press out of desperation.

The first time the issue was publicised in English language newspapers was when coverage of Madam Sharifah's situation appeared on 6 May 2000 in a 2-page article in The New Paper. The public was made more aware of the matter when The Sunday Times covered it on 14 May 2000 in a front page article as well as in other articlesinside the newspaper, about the circumstances of particular families, including Madam Sharifah's and the case of the first HIV-positive spouse known to be denied entry into Singapore.

The coverage by The Sunday Times made a significant impact because of the extent of the coverage, and also because the issue was linked specifically to mothers as part of a Mothers' Day feature. This had the effect of appealing to the public's sympathy for mothers and children and led to a series of letters in the Forum page of The Straits Times (ST) (see below). On 21 May 2000, a sympathetic editorial appeared in The Sunday Times together with a cartoon depicting the breaking up of families.

The public responds ...

After the 14 May 2000 coverage of the issue, 6 letters were written by members of the public to the Forum page of the ST. The dates of the letters and their authors are listed below:

- 16 May : James Tak Tze Sin ("Let's show kindness to HIV-stricken families") and Lew Shiong Fong ("Test foreign spouses early for HIV")
- 17 May : Sebastian Tan ("Do not stigmatise Aids patients")
- 18 May : Dana Lam-Teo, President, Association of Women for Action and Research ("Let women with HIV stay on")
- 22 May : Steven Ang Beng Wee ("Moral, legal duty to let HIV spouses remain here")
- 26 May : Sunita Anne Abraham ("Keep families with HIV mums together")

All these letters to the Forum page opposed the policy of denying entry to HIV-positive spouses. The letters also sustained the attention of the public to the issue.

So, what was AfA doing?

In April 2000, the matter was brought to the attention of Action for AIDS, in particular Ms Lin Shiu Yi, a lawyer and AfA volunteerand to myself. A decision was made to draft an appeal letter on behalf of the people affected. We resolved to begin with research to document the cases involving repatriation of HIV-positive spouses. We discovered that apart from the six spouses known to have been repatriated, at least another 9 spouses faced a similar bleak fate in the next few months.

On 6 May 2000, we sent an appeal letter to the President of Singapore, Mr S R Nathan, signed by Lin Shiu Yi, Roger Ang (another AfA volunteer) and myself. Carbon copies were sent to the Ministries of Home Affairs (MHA), Health (MOH), and Community Development and Sports (MCDS). In the letter, we provided arguments for allowing the spouses to stay in Singapore. We also included two lists of the affected families, one of those who had already been broken up and the other of those who faced that prospect.

We also received requests for interviews after The Sunday Times articles and we gave 3 radio interviews with the British Broadcasting Corporation.

The official responses

About two weeks after sending the letter, we called the President's office and were told that we would not be receiving a reply. This was somewhat discouraging.

We were also discouraged by a letter to the Forum page of The Straits Times on 24 May, jointly signed by representatives of MOH and SIR. In that letter, the authorities justified the policy as being necessary to "safeguard the public health of Singaporeans" and to "prevent the import of cases of AIDS and HIV infection into Singapore where it can". They also made reference to the fact that the number of foreigners found to have HIV/AIDS "is almost three times more than the 1,200 locals found to be infected with the HIV virus". A reminder was included that "marriage to a Singaporean does not guarantee a foreigner the right to reside in Singapore automatically".

A similarly-worded letter from MOH, dated 25 May 2000 was sent to us. We did, however, derive some hope from the final statements in both letters that "all applications or appeals for stay in Singapore are subject to approval and considered on a case-by-case basis".

No official replies were received from MHA, SIR or MCDS

AfA acts again ...

We decided that an immediate reply to address the issues raised by MOH and SIR in their Forum page letter was needed to reassure readers that the HIV-positive spouses were not a threat in the way suggested by the authorities. We sent a letter, largely based on the letter we sent to the President, to the ST. It was printed on 25 May with a headline proclaiming "HIV-stricken spouses are not a threat to public health". A copy of our letter is included at the end of this article. In the letter, we also encouraged giving special consideration to the appeals from the spouses on a case-by-case basis. At this point, we were not hopeful for an official public change in policy with respect to the spouses. Instead, we were hoping for unofficial sympathetic consideration of the appeals.

The right time, the right place, the right person ...

Events then moved into a week devoted to attention on the importance of the family in Singapore. A forum on the family was held on 27 May 2000 and one of the panellists was the Prime Minister Mr Goh Chok Tong. During the question-and-answer session, a member of the audienceasked a question which probably had the greatest impact on the struggle. It highlighted the apparent contradiction between the extant emphasis on the importance of family ties and the breaking up of families affected by HIV/AIDS.

The PM's response was that the Infectious Diseases Act "is not meant to throw out people who are already permanent residents or visited on a tourist pass and married here or have been here for some time". He added that "the law cannot just apply without thinking of consequences to the family". His comments were extensively reported in the broadcast and printed media. With these statements, the struggle was over and there could be no doubt that things would change.

Afew hours later MHA announced that most of the repatriated spouses would be allowed to return and the appeals of spouses whose social visit passes were expiring soon would be sympathetically considered. This was announced in The Sunday Times the following day. Interestinglyit was reported in an article on 29 May that the MHA denied that their announcement was a result of the PM's comments.

On 1 June, we received a reply from MHAreiterating their concern with safeguarding public health but stating that "appeals on cases concerning HIV-infected foreign spouses of Singaporeans are being reviewed sympathetically bearing in mind the family". We were also advised "to inform the families to approach SIR so that their cases can be reviewed".

The aftermath ...

The issue remained in the public eye for a while longer, thanks to letters in the Forum page. Letters from Anthony Yeo (30 May), Ong Siew Hock (30 May), Han Hong Siew (31 May), and Tan Boon Huat (31 May) congratulated the authorities for changing their stand on the spouses with HIV. However, a doctor, Lee Pheng Soon, also wrote on 30 May to ask MOH to clarify their stand on the issue, especially since they had previously stated that the spouses were a threat to public health. According to Dr Lee, this encouraged speculation about "the innocuous nature of casual contact with the many more HIV-positive persons in our midst".

MOH replied to this, in the Forum page on 1 June. While their earlier letter had expressed concern about threats from the spouses to public health, their stand in this letter was that "HIV-infected foreign spouses ... pose a low public-health risk to the community as they are aware of their HIV status and are in stable families".

Subsequently, appeals were made to allow the re-entry of spouses who had been repatriated as well as for spouses who faced repatriation. Most of the latter group have been given extensions ranging from 2 weeks to a month while their appeals are being processed.

The first repatriated HIV+ spouse returned on 6 July 2000. Several other spouses who were repatriated have also had approval for their re-entry into Singapore. We are happy that that MHA has allowed their return.

So what helped and what didn't?

It seemed that getting help from MPs provided only temporary relief. Writing to the President with copies to the relevant Ministries did not seem to have contributed much either.

What did make a major contribution was the courage of the two affected couples who approached sympathetic reporters and raised public awareness of the issue. It was probably this publicity that led to the all-important question being asked by the member of the Family Forum audience. The public outcry in the Forum pages was also likely to have encouraged public sympathy and to have had some effect on the final decision to change the policy. What was also very crucial was broaching the issue publicly with someone who had the power and influence to change the policy at a time when the focus on issues was in our favour. It seems that we were very lucky this time around on many counts: that the issue was brought up when there was a focus on the family, that we had a sympathetic member of the forum audience, and that the Prime Minister was on the panel.

What was also tremendously helpful was that the people with HIV/AIDS (PWAs) involved in the struggle constituted the less stigmatised group of PWAs, namely heterosexual couples. If the PWAs involved had been singles, gay men or intravenous drug users, it is very doubtful that there would have been much hope. There was some concern that the nationalities of the foreign spouses would have a negative effect, but it seems that the public was open-minded enough to disregard that.

There will be many struggles ahead of us, and we are not sure that we will be so fortunate in future, but victories like this one give us hope that Singapore can become a better place for ALL Singaporeans (and their families) to live.

So ... who should we thank?

- The gutsy couples who 'came out' to the reporters;
- the very supportive and sympathetic reporters from Lianhe Wanbao, The New Paper, The Sunday Times and The Straits Times;
- the authors of letters to the Forum
- the people who helped draft the letters to the President and the Forum page - Shiu Yi, Sunita, and others who wish to remain anonymous; and
- everyone else who has been behind us .

I would personally like to thank Wendy Tan from The Sunday Times for her support and sympathy and for rushing to inform us of the good news the moment she learnt of it.

The letter that appeared in the Forum page, the Straits Times, 25 May 2000



We would like to thank Ms Julia Wong of the Ministry of Health and Ms Sharon Wong of Singapore Immigration and Registration for providing the official stands on the issue of the breaking up of Singaporean families affected by HIV in their letter dated 24 May 2000. We understand that the main concerns are safeguarding the public health of Singaporeans and preventing "the import of cases of AIDS and HIV infection into Singapore".

Safeguarding the public health of Singaporeans is indeed vital but we would like to show why allowing foreign spouses and parents with HIV to stay in Singapore does not pose a threat to public health.

HIV is only transmitted through sexual intercourse with an infected partner, sharing contaminated injecting needles and syringes, contaminated blood, blood products and organs, and from infected mother to child. Casual contact with HIV-positive individuals, e.g. touching, hugging, and sharing food or drinks, does not transmit HIV and HIV is not transmitted by airborne means. This means that the foreign spouses and parents will not be transmitting HIV to members of the public as the only type of contact they will have with members of the public is casual contact.

Furthermore, being aware of their HIV status and being in stable marriages makes it highly unlikely that HIV-positive family members will pose any risk of HIV transmission to others through the methods mentioned above. All persons with HIV/AIDS are provided comprehensive counselling at the Communicable Disease Centre, Tan Tock Seng Hospital, as well as through support groups and volunteers.

The number of people who have been and will be separated from their families is less than 30. Making an exception to the enforcement of the Immigration Act for them will not be opening the floodgates to foreigners with HIV.

We would next like to provide additional reasons why we should not break up these Singaporean families.

a. The families have already had to cope with the psychological, social, financial, and physical strains of having one or more family members living with HIV/AIDS. Needless to say, the presence of a husband, wife, mother or father provides significant emotional support. Robbing these families of a spouse/parent only further exacerbates the stigmatisation and trauma, and leads to a quicker deterioration of the health of the family member(s) with HIV/AIDS.

b. While it is lamentable that spouses are denied access to each other, the situation becomes inhumane when children are denied contact with one parent, quite often their mothers. As the parent remaining in Singapore usually has to work to support the family, the children are often left alone at home, especially if relatives are unwilling to be involved with family members who have HIV/AIDS. If the children themselves are HIV-positive, they are deprived of a parent to look after their extensive health needs.

c. Some of the HIV-positive wives of Singaporeans are diagnosed when they become pregnant and consent to the antenatal HIV screening recommended by the Ministry of Health. Many of them then make the painful decision to abort because of the potential risk of perinatal (mother-to-child) HIV transmission. Forcing these women to leave Singapore seems like an unnecessarily harsh punishment for following Ministry of Health guidelines. It is also a tacit encouragement for pregnant women NOT to test, especially if they face such dire consequences as repatriation.

d. Some of the spouses/parents are undergoing treatment for HIV in Singapore. Repatriating them means stopping life-prolonging treatment, because such treatment is often not available in their own countries.

e. There also need not be any concern that these HIV-positive foreign spouses/parents will become a financial burden on our healthcare system. They are not eligible for any of the subsidies available for Singaporeans; they pay the full cost of any treatment received. Furthermore, none of the effective anti-HIV medications are subsidised in Singapore.

We appeal to the authorities to show some compassion and caring to these Singaporean families and to affirm the value of family ties and support by avoiding the cruelty of breaking up these families. We hope that special consideration of the individual spouses/parents on a case-by-case basis will result in the families being allowed to remain together in Singapore instead of being further devastated by HIV/AIDS.

Yours truly

Ms Lin Shiu Yi, Member of Action for AIDS
Mr Roger V P Winder, Member of Action for AIDS

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GENDER DIFFERENCES AND ATTITUDES TOWARDS homosexuality among Singapore youth

Research in the area of homosexuality has gained prominence among organisational scholars and practitioners in the past decade. Much of this interest has been fueled by the appearance of the AIDS epidemic in the early 1980s. Extant studies suggest that negative attitudes towards homosexuals are generally prevalent in the west, typically in America and Britain, regardless of the nature of samples under study (e.g, Kite and Whitley 1996).

A key concept in helping us to understand the high prevalence of anti-homosexual attitudes within the heterosexual population is Bem's (1993) notion of the gender belief system. According to Bem (1993), the gender belief system consists of "a set of beliefs and opinions about males and females and about the purported qualities of masculinity and femininity". This belief system not only includes stereotypes about men and women and attitudes towards appropriate roles for men and women but also perceptions of those who deviate from societally prescribed gender roles (Kite and Whitley, 1996). Homosexuality, therefore, represents a threat to strongly sex-typed perceptions of what are defined by society as acceptable male and female behaviours.

One major stream of research on the issue of homosexuality focuses on gender differences in attitudes towards homosexuals. Generally, findings of extant studies reveal that heterosexual men tend to manifest higher levels of prejudice against homosexuals than do heterosexual women (e.g., Herek, 1988; Hansen, 1982). In a meta-analytic study of sex differences in attitudes toward homosexuals in USA and Canada, Oliver and Hyde (1995) found that men held more negative attitudes toward homosexuality than do women. This difference may result from the strong association of masculinity with heterosexuality in American culture, which generates much pressure for men to affirm their masculinity through rejection of what is not culturally defined as masculine (male homosexuality) and that which is perceived as negating the importance of males (lesbianism). On the other hand, heterosexual women are less likely to perceive rejection of their homosexuality as integral to their gender identity. Consequently, they hold less negative views towards homosexuals than men (Herek, 1988). Social role theory provides some insights to understanding this phenomenon. Social role theory suggests that inferences about presumed homosexuality are influenced by gender associated beliefs (Bem, 1981). Research has shown that when men are described as possessing female traits, occupying female roles, or having female characteristics, the probability of estimations that they are homosexual sharply increases (Deaux and Lewis, 1984). However, a person described as female but having masculine qualities is less likely to be associated with being a lesbian than is a man with non-stereotyped qualities (Oliver and Hyde, 1993). This suggests that violation of gender roles, including homosexuality, will be viewed more extreme for men than for women, thus explaining the existence of gender differences in attitudes towards homosexuals, with men holding more negative views when the target person being evaluated is a male homosexual.

Less consistent findings, however, were yielded with respect to gender differences in people's attitudes towards lesbians. While some studies found that women tend to hold more negative attitudes towards lesbians than men, other studies failed to yield significant gender differences. Extant studies generally reveal that both sexes evaluated lesbians negatively, though less so than they did gay men.

Much of the existing research on people's attitudes towards homosexuals focused on samples obtained in a western context (e.g., Herek and Capitanio, 1996; Kyes and Tumbelaka, 1994; Lance, 1987). To date, relatively, little attention has been devoted to an investigation of this issue in a non-western context. Several researchers have suggested that individuals in different cultures may hold varying attitudes towards the issue of homosexuality due to the gender belief systems prevailing in those cultures (Kyes and Tumbelaka, 1994). The present study represents an initial attempt to examine attitudes towards homosexuals in a non-western context, namely Singapore.

Singapore is generally a patriarchal society with Confucian ideology where gender roles follow a typically traditional pattern. However, in recent years, women have achieved much progress due to their improved educational levels. Women have made their presence felt in the employment market and improved education has led to women's greater employablity and gave them access to more rewarding jobs. Additionally, with increasing exposure to the Western principle of sexual equality which is in conflict with this Confucian ideology of male dominance, gender roles along traditional lines are blurred (Yuen and Lim, 1992). Western influences coupled with societal changes may bring about alterations in rules regarding gender behaviors and attitudes towards homosexuals. Against this context therefore, it is interesting to examine if there exist significant differences in men's and women's attitudes towards homosexuals in Singapore. Specifically, the aim of this study is two-fold. First, it examines the general prevailing attitudes towards homosexuals in Singapore.

Second, it investigates if gender differences whether attitudes towards homosexuals exist.

Methodology

Three educational institutions in Singapore (National University of Singapore, Temasek Polytechnic, SHATEC) agreed to participate in the study. Classes were randomly selected by the liaison persons of the three institutions for purpose of the survey administration. Each class of respondents in the respective institution was given a ten minute briefing on the aims of the study, its motivation, as well as instructions for the survey. The researcher was present during the survey administration to answer any queries raised by respondents. Each administration lasted an average of one hour.

A total of 413 respondents participated in the survey (males=141; females=272). The average age of respondents is 20 years old. Chinese comprise the majority of respondents (89%); while the remaining 11% comprised ethnic minorities (Malay, Indian, Eurasian).

Findings

Table 1 summarises the distribution of responses for items pertaining to respondents' attitudes toward homosexuals. Generally, results of our survey revealed that respondents harboured ambivalent attitudes towards homosexuals.

The majority of respondents (87%) reported that they would be disappointed if they realised that their child was homosexual. Furthermore, 72% of them reported that they would feel that they had failed as a parent if they learned that their child was homosexual. Such feelings of negativity corroborate those found in studies conducted in the west. With regard to the sexual orientation of their sibling, 80% of respondents surveyed, agreed with the statement that "I would be upset if I learned that my brother or sister was homosexual". This finding is rather consistent with those of extant studies conducted in the west (e.g., Proulx, 1997). Results from this stream of research generally suggest that respondents tend to report negative feelings regarding homosexuality, especially if they pertain to having a homosexual in the family.

A large percentage of respondents, about 69%, agreed with the statement "It would disturb me to find out that my doctor was homosexual" (item 5). While a third of our respondents agreed with the statement "I would feel uncomfortable if I learned that my neighbour was homosexual", another one third reported disagreement with the statement, and 37% were uncertain what they would feel. This finding suggests that people were generally more tolerant toward homosexuals if their interaction with the target person is at a less intimate level, for example being a neighbour as opposed to a doctor. Approximately 46% of respondents disagreed with the statement "I would feel comfortable if I learned that my best friend of my sex was homosexual" (item 8).

Turning now to the two items which pertain to respondents' attitudes toward working with homosexuals, findings of this survey reveal that generally respondents expressed ambivalence on this issue. About 44% responded that they were uncertain if they would feel comfortable working closely with a male or female homosexual (items 9 and 10) .

The majority of respondents (69%) responded that they would feel angry if a member of their sex made a sexual advance toward them (item 11), and 72% disagreed with the statement "I would feel comfortable if a member of my sex made advances toward me" (item 13). About 85% responded that they would feel uncomfortable if they learned that their spouse/partner were attracted to members of their own sex (item 2). Additionally, about 77% disagreed with the statement " I would feel comfortable if I found myself attracted to a member of my own sex" (item 15). When asked if they would feel comfortable knowing that they were attractive to members of their own sex, 57% of respondents disagreed with the statement (item 16).

A significant percentage of the respondents also expressed discomfort and nervousness in interacting or being seen talking to homosexuals (items 18 and 19). About half agreed with the statement " I would feel nervous being in a group of homosexuals" (item 18); 40% reported that they would feel at ease talking to a homosexual at a party, and 43% were uncertain about this (item 19).

An interesting finding in pertains to the issue of display of intimacy among members of the same sex in public. While 40% of respondents were unsure about their attitude toward this issue, generally respondents were more tolerant of public display of physical contact when it involves two women as compared to men (15% vs 43%, items 21 and 22).

A plausible explanation for this finding is that generally display of affection and physical contact among women are deemed more acceptable or tolerated by society. On the other hand, men are confined to narrower patterns of emotional and physical expression. Thus, any display of affection or physical contact between men are frowned upon.

Gender Differences

To investigate if gender differences exist in homophobic attitudes, t-tests were performed (see Table 2).

Gender differences exist in the following items which pertain to working with someone of a homosexual orientation. Women reported significantly higher means for item 1 - "I would feel comfortable working closely with a male homosexual". Men reported significantly higher mean for item 22 - "I would feel comfortable working closely with a female homosexual", compared to their female counter-parts. Male respondents reported a higher mean score for item 18 "I would feel uncomfortable if I learned that my boss was homosexual" compared to female respondents.

The similarity-attraction hypothesis suggests that people generally like those who hold similar attitudes, opinions and characteristics as themselves (Byrne, 1971). Thus, since male homosexuals would share more similar characteristics with heterosexual women than men, it is not surprising that women would feel more comfortable working closely with them. The same reasoning could also be extended to the finding that, compared to women, men reported that they would feel more comfortable working closely with a female homosexual.

Another noteworthy finding is that female respondents reported significantly higher means for item 11, pertaining to the sexual orientation of their siblings, "I would be upset if I learned that my brother or sister was homosexual".

Female respondents also reported significantly higher means for item 16 - "I would feel uncomfortable if I learned that my spouse/partner was attracted to members of his or her sex". A plausible explanation is that same sex attraction may be deemed more acceptable if it occurs among women than among men. Thus, women would feel more uncomfortable if they found that their spouses were attracted to other men.

Women scored significantly higher for item 5 - " I would feel comfortable knowing that I was attractive to members of my sex" and item 8 - "I would be comfortable if I found myself attracted to a member of my sex" compared to men. Male respondents were more likely to report that they would be offended if a member of their own sex made an advance towards them (Item 15). McCormick (1979) noted that these differences in the sexes may be attributed to the prototypical sexual scripts of men and women. While men's prototypical sexual script involves a considerable amount of information about making sexual advances, women's script deals more with avoiding unwanted sexual attention. Consequently, men may feel more threatened by the possibility of sexual advances from homosexual men. Women, on the other hand, may be less threatened by sexual advances of homosexual females because they are better able to handle and avoid unwanted sexual attention (Kite & Whitley, 1996).

Table 1 Attitudes towards homosexuals (N=413)

Items	Disagree (%)	Don't Know (%)	Agree (%)
1 I would feel disappointed if I learned that my child was homosexual.	5.6	7.8	86.6
2 I would feel uncomfortable if I learned that my spouse/ partner was attracted to members of his or her sex.	6.1	9.4	84.5
3 I would be upset if I learned that my brother or sister was homosexual.	6.8	12.9	80.3
4 I would feel that I had failed as a parent if I learned that my child was homosexual.	15.7	12.3	72.0
5 It would disturb me to find out that my doctor was homosexual.	13.1	18.4	68.5
6 I would feel uncomfortable if I learned that my boss was homosexual.	22.0	39.2	38.8
7 I would feel uncomfortable if I learned that my neighbour was homosexual.	32.4	36.6	31.0
8 I would feel comfortable if I learned that my best friend of my sex was homosexual.	45.5	29.5	25 .0
9 I would feel comfortable working closely with a male homosexual.	27.1	44.3	28.6
10 I would feel comfortable working closely with a female homosexual.	31.0	45.3	23.7
11 If a member of my sex made a sexual advance toward me, I would feel angry.	11.9	19.4	68.7
12 If a member of my sex made an advance toward me, I would be offended.	12.5	24.4	63.1
13 I would feel comfortable if a member of my sex made an advance toward me.	72.2	16.0	11.8
14 If a member of my sex made an advance toward me, I would feel flattered.	70.1	19.2	10.7
15 I would be comfortable if I found myself attracted to a member of my sex.	76.8	14.5	8.7
16 I would feel comfortable knowing that I was attractive to members of my sex.	56.7	25.2	18.1
17 I would feel uncomfortable being seen in a homosexual bar.	16.0	20.6	63.4
18 I would feel nervous being in a group of homosexuals.	20.1	29.9	50.0
19 I would feel at ease talking with a homosexual person at a party.	17.2	42.9	39.9
20 I would enjoy attending social functions at which homosexuals were present.	33.0	48.8	18.2
21 If I saw two men holding hands in public, I would feel disgusted.	14.8	41.9	43.3
22 If I saw two women holding hands in public, I would feel disgusted.	40.7	44.3	15.0

Conclusion

Findings of this study provide a preliminary and provocative glimpse of youths' attitudes towards homosexuality. Results of this study are instructive in that they suggest that our respondents harbour negative feelings towards homosexuals. The prevalence of such negative attitudes suggest that generally, youths in Singapore are still quite conservative in their attitudes toward gender roles and homosexuality. Additionally, findings reveal that like their counterparts in the west, Singaporean youths still hold rather rigid gender associated beliefs about male and female roles in society, though less so for the latter.

Our findings suggest that more needs to be done to change individuals' attitudes towards homosexuals in Singapore. To address the misconceptions and negative perceptions some recommendations may be considered for educational institutions. Attitudes and beliefs about homosexuality are formed in the early growing years of the individuals. As such, information about homosexuality and efforts to reduce prejudice and stigma about such individuals should begin in educational institutions. Educational institutions may be one of the best channels for generating awareness, understanding and acceptance of homosexual individuals. Not only are youths at an impressionable and formative age, they may also spend many years in schools. Thus, schools and other educational institutions should seriously consider including in their curriculum topics on workplace diversity and how to manage people of homosexual orientation so that future managers and workers will be sufficiently prepared to deal with this issue.

Table 2 t-tests on gender differences in attitudes towards homosexuals (N=413)

		Male	Female	t	Sig
1	I would feel comfortable working closely with a male homosexual.	2.83	3.12	-2.40	0.01
2	I would enjoy attending social functions at which homosexuals were present.	2.72	2.85	-1.16	0.12
3	I would feel uncomfortable if I learned that my neighbour was homosexual.	2.91	2.96	-0.49	0.31
4	If a member of my sex made a sexual advance toward me, I would feel angry.	3.94	3.80	1.33	0.09
5	I would feel comfortable knowing that I was attractive to members of my sex.	2.21	2.50	-2.33	0.01
6	I would feel uncomfortable being seen in a homosexual bar.	3.82	3.62	1.70	0.04
7	I would feel comfortable if a member of my sex made an advance toward me.	2.07	2.04	0.20	0.41
8	I would be comfortable if I found myself attracted to a member of my sex.	1.78	1.97	-1.75	0.04
9	I would feel disappointed if I learned that my child was homosexual.	4.35	4.26	0.93	0.18
10	I would feel nervous being in a group of homosexuals.	3.46	3.36	0.91	0.18
11	I would be upset if I learned that my brother or sister was homosexual.	3.97	4.16	-1.90	0.03
12	I would feel that I had failed as a parent if I learned that my child was homosexual.	3.88	3.83	0.46	0.32
13	If I saw two men holding hands in public, I would feel disgusted.	3.25	3.38	-1.26	0.10
14	If I saw two women holding hands in public, I would feel disgusted.	2.56	2.70	-1.45	0.15
15	If a member of my sex made an advance toward me, I would be offended.	3.88	3.62	2.48	0.00
16	I would feel uncomfortable if I learned that my spouse/ partner was attracted to members of his or her sex.	4.06	4.30	-2.62	0.00
17	I would feel at ease talking with a homosexual person at a party.	3.16	3.31	-1.46	0.17
18	I would feel uncomfortable if I learned that my boss was homosexual.	3.35	3.12	2.16	0.00
19	It would disturb me to find out that my doctor was homosexual.	3.94	3.68	2.98	0.00
20	I would feel comfortable if I learned that my best friend of my sex was homosexual.	2.83	2.59	1.96	0.01
21	If a member of my sex made an advance toward me, I would feel flattered.	2.13	2.15	-1.46	0.07
22	I would feel comfortable working closely with a female homosexual.	3.29	2.68	6.15	0.00
23	I would feel uncomfortable if my customer was homosexual.	3.06	2.80	2.51	0.00

Several limitations are inherent in the present study. First, we did not distinguish between male or female homosexuals in some of the items in the scale. Previous studies have suggested that some respondents may interpret "homosexual" to mean gay male and thus their attitude may be captured with this target individual in mind. Future attempts to replicate this study could perhaps clearly distinguish between male and female homosexual.

Secondly, we did not capture information regarding the sexual orientation of our respondents and whether they have had previous interactions with homosexual individuals. Future attempts to investigate this topic could perhaps take into account these variables.

Third, this study basically focuses on gender differences in individuals' attitudes towards homosexuality. Thus, further research on this topic can focus on the effects of other individual characteristics such as age, religiosity and ethnicity on individuals' attitudes towards homosexuality.

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Chris W. Green Jakarta Post, Sun, 25 June 2000

Prevent harm
if we cannot prevent use

JAKARTA (JP): "This is a drug-free area." So shout the banners displayed in many communities in Jakarta and around Indonesia. Paradoxically, banners like this are most prominent in the areas where everyone knows that it isn't true, in places where drug use has already become an epidemic.

There can be few who are not aware that drugs are an increasing threat to the future of the nation, although not many are fully aware of the scale of the threat. Even less clear is how to respond to it. Other banners exhort us to "Just Say No" to drugs, even though many of us know how difficult it is to say no to that most legal of drugs, tobacco.

Of course, the easy answer is prohibition. Eliminate the supply of drugs. Would that it was that easy! Around the world, billions of dollars are spent trying to reduce the supply of drugs, with little or no impact on availability or price. Profits from supply of illegal drugs far exceed what law enforcement authorities can afford anywhere in the world, let alone in Indonesia. Here, these profits probably already exceed the combined budget of the police and the armed forces. Huge sums of money are available for traffickers to bribe their way out of problems.

Of course, we must try. But we must also be aware that our efforts are almost certainly doomed to failure. And we must therefore find alternative strategies.

The obvious choice is prevention. Encourage our children to say no to drugs. But this is also by no means easy, especially if we leave the problem to others. We cannot pass the responsibility to teachers or preachers — rarely do they know much about drugs, and they spend only a very limited time with the children. In fact, research now shows that school-based drug programs are more likely to increase drug use, and at best make little difference.

Another mistake is to assume that our kids, being "good", will not be tempted. A combination of peer pressure and curiosity, both very prevalent among adolescents, will influence even the "best" children.

For prevention to be effective, it must start in the home, in the family, and start early — by the time the children reach the age of nine or ten they are already becoming aware of drugs and beginning to ask questions — usually to their peers who know no better than they do. Better they hear the right answers from us before that occurs.

Even the best parental guidance will have little impact upon those who are already addicted to drugs. Although patience and encouragement are crucial, success in curing addiction must start with a real commitment by the addict. Without this, relapse after treatment is almost inevitable.

Strangely to those of us who have never been under the influence of drugs and who only see the harm which addicts do to themselves, few are ready to make such a commitment. With all its problems, the world of addiction they live in seems better than reality — and as we know, reality in Indonesia can be hard!

Sadly, few addicts are really aware or concerned about the harm they are doing to themselves. Few consider the threat of death through overdose or from AIDS or other conditions. The risk of these harms is greatest among drug users who inject. In particular, HIV, the virus which causes AIDS, is most efficiently spread through the sharing of needles — once the virus has infected one member of a group sharing needles, the rest of the group can become infected within days. Experience around the world has shown that once more than 10 percent of injecting drug users (IDUs) in any community become infected by HIV, without extremely effective intervention that rate has usually exceeded 50 percent within a year.

There are signs that we are almost too late to prevent this happening in parts of Indonesia. Surveys have shown HIV rates already as high as 20 percent among IDUs in Jakarta. Extremely urgent action is needed to address this. We are too late to prevent these people using drugs; we cannot expect quick success in attempting to stop most of them using drugs. What we must do quickly is to reduce the harmful effects, including the spread of HIV. Again, experience around the world has shown that there are really only two responses that are effective — and these can be very effective, if controversial. The first is to try to encourage IDUs to stop injecting, usually by providing alternatives such as methadone, a cheap liquid drug that is taken orally. For those not ready to change to methadone, providing easy, cheap access to clean needles is really the only solution.

Neither of these approaches is ideal. But both work. Both will help ensure that when users are finally ready to make the commitment to stop using drugs (as most do sooner or later), they will still be healthy and able to play a productive role in society.

As we consider our options and look for solutions on the International Day against Drug Abuse and Illicit Trafficking on June 26, let us not ignore the large number of our young people who will not be reached by strident prevention messages. If these are to survive, they need our support to avoid the harmful effects of their drug use.

Dr Nick Paton
Head, Infectious Disease, CDC, TTSH

REPORT ON THE

13th international conference

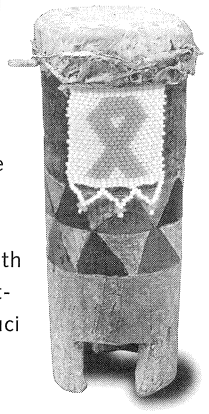
ON AIDS
DURBAN JULY 2000

XIII INTERNATIONAL AIDS CONFERENCE
DURBAN • SOUTH AFRICA • 9-14 JULY 2000

The 13th International Conference on AIDS, held in Durban in July 2000, represented a milestone in the series of world AIDS conferences. This was the first time that the conference had been held in a developing country, which is remarkable given that more than 90% of the people currently living with HIV reside in developing nations. The choice of South Africa as a venue was appropriate as the epidemic is rising at an alarming rate there, with 20% of the population estimated to be infected already with the virus. Although the scale of the epidemic in Africa is a major concern to all international agencies concerned with the problem of HIV/AIDS, the government of South Africa has failed to embrace prevention campaigns and enter into constructive dialogue about improving medical care for its people infected with HIV. Instead, President Thabo Mbeke has achieved international notoriety by publicly questioning whether HIV is the cause of AIDS and suggesting that the disease may be caused by the drugs used to treat it. With this background, the conference was rather political with many potential delegates boycotting the meeting, many pharmaceutical companies scaling down their input, and many of the delegates who did attend did so mainly to advance their own political agenda. Nevertheless, the conference succeeded in addressing many essential issues and advanced the debate on drug access and rational utilisation.

President Thabo Mbeke disappointed many listeners at his opening ceremony address by failing to renounce his maverick views on HIV and failing to make any commitments towards essential areas of HIV treatment and prevention in South Africa (especially prevention of mother-to-child transmission). This fuelled the highly charged atmosphere for the plenary session on Day 1of the conference. In his lecture entitled "The deafening silence of AIDS", **Justice Edwin Cameron**, a Judge in the High Court of South Africa who has declared that he is living with HIV, drew attention to the inequalities of care both in South Africa and in many other countries of the world where the difference between life and death depends on how much money a person can earn to pay for drugs. Judge Cameron emphasised the culpability of governments and individuals who fail to speak out and address the discrimination against individuals living with HIV. On a more positive note, **Professor Roy Anderson** from Oxford UK discussed the epidemiological aspects of the epidemic in different countries and the effects of different interventions for controlling the epidemic. His main point was that even in seemingly hopeless situations, interventions can still make a big difference to the ultimate scale of the epidemic, although the earlier they are implemented the greater the effect.

There were no major new scientific breakthroughs announced at the conference, although there were some important changes in approach to the treatment of the disease which are likely to have a big impact in the coming years. **Professor David Ho** from the Aaron Diamond AIDS Research Centre in New York, who has championed the "hit hard, hit early" approach to HIV therapy gave a plenary lecture on the 2nd day of the conference in which he reviewed the latest scientific evidence on viral dynamics. As always, he interpreted this as continuing to support his treatment philosophy. This lecture was followed immediately by one from **Dr Anthony Fauci**, Director of National Institute of Allergy and Infectious Diseases in the USA. Whereas Dr Fauci usually echoes the words of Professor Ho, providing evidence from an immunological perspective to support the aggressive treatment approach, he astounded delegates this year by reversing his previous position and making a case for a more conservative approach to therapy. He pointed to the failure of even the most potent regimens to eradicate the virus permanently from the body (including the latest attempts using IL-2), the evidence of waning compliance with long term medical therapy, and the emerging pattern of metabolic toxicities associated with treatment, as evidence in favour of delaying treatment of HIV until much later. How late that could be, he could not say. This new-found realism was welcomed by many European HIV physicians who had been arguing for several years in favour of a less aggressive approach to treatment. Dr Fauci caused further astonishment in the 10,000 strong audience when, in another totally uncharacteristic move, he presented very preliminary data on a small number of patients who had been treated with structured cycles of HIV therapy. Although several of the patients showed rebounds in virus to detectable levels, some patients appeared to enjoy continued suppression of virus with on-off therapy in short-term follow-up. Dr Fauci concluded that this approach might have



continued on page 14

THE Durban Declaration

A DECLARATION BY SCIENTISTS AND PHYSICIANS AFFIRMING HIV IS THE CAUSE OF AIDS

*5000 scientists who attended the 13th International Conference on AIDS in July in Durban, South Africa, have written and signed the "**Durban Declaration**", a document stating that HIV is indeed the cause of AIDS and the worldwide epidemic.*

Seventeen years after the discovery of the human immunodeficiency virus (HIV), thousands of people from around the world are gathered in Durban, South Africa to attend the XIII International AIDS Conference. At the turn of the millennium, an estimated 34 million people worldwide are living with HIV or AIDS, 24 million of them in sub-Saharan Africa (1). Last year alone, 2.6 million people died of AIDS, the highest rate since the start of the epidemic. If current trends continue, Southern and South-East Asia, South America and regions of the former Soviet Union will also bear a heavy burden in the next two decades.

Like many other diseases, such as tuberculosis and malaria that cause illness and death in underprivileged and impoverished communities, AIDS spreads by infection. HIV-1, the retrovirus that is responsible for the AIDS pandemic, is closely related to a simian immunodeficiency virus (SIV) which infects chimpanzees. HIV-2, which is prevalent in West Africa and has spread to Europe and India, is almost indistinguishable from an SIV that infects sooty mangabey monkeys. Although HIV-1 and HIV-2 first arose as infections transmitted from animals to humans, or zoonoses (2), both are now spread among humans through sexual contact, from mother to infant and via contaminated blood.

An animal source for a new infection is not unique to HIV. The plague came from rodents. Influenza and the new Nipah virus in South-East Asia reached humans via pigs. Variant Creutzfeldt-Jakob disease in the United Kingdom came from 'mad cows'. Once HIV became established in humans, it soon followed human habits and movements. Like other viruses, HIV recognizes no social, political or geographic boundaries.

The evidence that AIDS is caused by HIV-1 or HIV-2 is clear-cut, exhaustive and unambiguous. This evidence meets the highest standards of science (3-7). The data fulfill exactly the same criteria as for other viral diseases, such as poliomyelitis, measles and smallpox:

- Patients with acquired immune deficiency syndrome, regardless of where they live, are infected with HIV (3-7).
- If not treated, most people with HIV infection show signs of AIDS within 5-10 years (6, 7). HIV infection is identified in blood by detecting antibodies, gene sequences or viral isolation. These tests are as reliable as any used for detecting other virus infections.
- Persons who received HIV-contaminated blood or blood products develop AIDS, whereas those who received untainted or screened blood do not (6).
- Most children who develop AIDS are born to HIV-infected mothers. The higher the viral load in the mother the greater the risk of the child becoming infected (8).
- In the laboratory HIV infects the exact type of white blood cell (CD4 lymphocytes) that becomes depleted in persons with AIDS (3-5).
- Drugs that block HIV replication in the test tube also reduce viral load and delay progression to AIDS. Where available, treatment has reduced AIDS mortality by more than 80% (9).
- Monkeys inoculated with cloned SIV DNA become infected and develop AIDS (10).

Further compelling data are available (4). HIV causes AIDS (5). It is unfortunate that a few vocal people continue to deny the evidence. This position will cost countless lives.

In different regions of the world HIV/AIDS shows altered patterns of spread and symptoms. In Africa, for example, HIV-infected persons are 11 times more likely to die within 5 years (7), and over 100 times more likely than uninfected persons to develop Kaposi's sarcoma, a cancer linked to yet another virus (11).

As with any other chronic infection, various co-factors play a role in determining the risk of disease. Persons who are malnourished, who already suffer other infections or who are older, tend to be more susceptible to the rapid development of AIDS following HIV infection. However, none of these factors weaken the scientific evidence that HIV is the sole cause of AIDS.

In this global emergency, prevention of HIV infection must be our greatest worldwide public health priority. The knowledge and tools to prevent infection exist. The sexual spread of HIV can be prevented by monogamy, abstinence or by using condoms. Blood transmission can be stopped by screening blood products and by not re-using needles. Mother-to-child transmission can be reduced by half or more by short courses of antiviral drugs (12,13).

continued on page 14

continued from page 12

some value in minimising costs and treatment side effects in the future. This speculative presentation drew a great deal of criticism from prominent HIV clinicians who recognised that some patients might adopt this unproven approach to therapy (with or without the knowledge of their treating physician) and this might well have catastrophic effects by breeding drug resistance and blowing all their future options for therapy. This approach can only be safely pursued under rigorous controlled trial conditions (the NIH study was checking viral load daily!).

Another interesting and related theme which emerged from the conference was the feeling that the utility of viral load measurement in the decision of when to start therapy has probably been overplayed. **Professor Mario Schechter** from Brazil predicted that by the time of the next conference, people would be basing almost all treatment decisions on the CD4 count rather than the viral load. This theme was also developed in a later session by **Julio Montaner** from Canada who showed data illustrating that the outcome from starting antiretroviral therapy depended almost entirely on the pre-treatment CD4 count, with viral load having only a very minor predictive effect. Dr Montaner revised the USA treatment criteria in the light of this information and showed that with his revised guidelines less than 40% of the HIV infected people in the USA would need to be on treatment as opposed to the current guidelines which would effectively recommend that 90% of persons should be treated. This would have obvious benefits in terms of cost.

Another session which was relevant to reducing treatment costs was a debate on the use of hydroxyurea. Hydroxyurea is a relatively cheap drug, and although its use has not been widely accepted, there is good evidence that it has some anti-HIV effect. The debate was conducted by **Franco Lori** from Italy who has championed the use of hydroxyurea in HIV infection. He presented data from several studies looking at the use of hydroxyurea, the most impressive of which was a group of patients (the PANDA cohort) who still had undetectable viral load after several years on therapy with a combination of ddI and hydroxyurea. The counter argument was put forward by **Professor Bernard Hirschel** from Switzerland who drew attention to the toxicity of hydroxyurea when combined with d4T and ddI and also questioned the quality of the evidence supporting the sustained anti-HIV efficacy of hydroxyurea. The debate did not resolve the question of the role of hydroxyurea, but did make it clear that more controlled trial data was needed. The results of a study conducted in Singapore also attracted considerable interest at the conference. A group of patients were treated with a novel combination incorporating the ddI and hydroxyurea combination advocated by Dr Lori, but with the addition of hydroxchloroquine, a drug used in the treatment of arthritis and malaria for many years. Preliminary results of this study showed that this triple combination was safe and also moderately effective in patients with low viral loads at the time of starting therapy. The principal advantage of this combination is that it is cheap (about a third of the cost of conventional triple therapy), but further experience is needed in controlled research settings before this combination can be recommended.

In summary, the Durban conference was surprising in that many worthwhile issues were addressed constructively. Although no definite solutions were found to the difficult question of how make HIV drugs accessible to the majority of people in the world who need them, the debates helped to indicate possible collaborative ways to move forward. Hopefully it will not take another 15 years before the conference to returns to a setting where the key issues of drug access and economic and rational usage are forced to the top of the agenda.

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continued from page 13

Limited resources and the crushing burden of poverty in many parts of the world constitute formidable challenges to the control of HIV infection. People already infected can be helped by treatment with life-saving drugs, but high cost puts these treatments out of reach for most. It is crucial to develop new antiviral drugs that are easier to take, have fewer side effects and are much less expensive, so that millions more can benefit from them.

There are many ways to communicate the vital information about HIV/AIDS. What works best in one country may not be appropriate in another. But to tackle the disease, everyone must first understand that HIV is the enemy. Research, not myths, will lead to the development of more effective and cheaper treatments, and hopefully a vaccine. But for now, emphasis must be placed on preventing sexual transmission.

There is no end in sight to the AIDS pandemic. By working together, we have the power to reverse the tide of this epidemic. Science will one day triumph over AIDS, just as it did over smallpox. Curbing the spread of HIV will be the first step. Until then, reason, solidarity, political will and courage must be our partners."

守住一生的承诺

True Love Waits



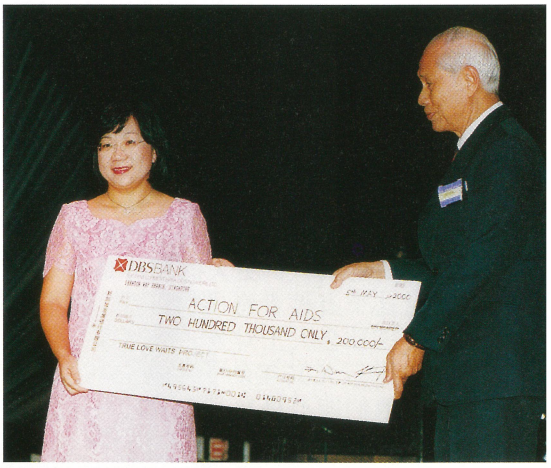
新加坡是一个相当保守的社会，对于爱之病许多人仍然一知半解，也避而不谈。但！问题永远是存在的，而且会愈拉愈大，已逐渐不只是别人家的问题，也会延伸到我家或是你家，危害到我们的家人与社会上年轻的一群。

当我向朋友提起将举办这样一个爱之病的活动时，得到的反应却让我大吃一惊，他们的反应竟是："这些人都是罪有应得的，是该死的，可怜他们等于是助长爱之病……"我立刻怀疑的反问："围绕在我们周围的亲戚朋友，有某些部份是有着将导致爱之病的滥交行为，但我们却视而不动？一旦这些朋友倒霉不幸罹患爱之病，我们便弃而不顾？但是他们一旦"幸运"地先得到癌症或其他致命的病症，我们却相反的对他们怜悯与相助吗？该死与不该死，已不是我们应该讨论的问题，重要的是给这群被认为该死的人施予援手，虽然他们的身体已败坏，但若以耶稣的爱使他们的灵魂得救，也可算是一件美事。"

记得有一回到家庭医生的诊所看病，医生好悲伤好无奈的告诉我："我刚判了一个从小看到大的男孩子死刑，他出生自好家庭背景，双亲受高等教育，这个男孩目前在服兵役，本来计划在服完兵役之后，再进修深造……没想到，才21岁就被我证实罹患了爱之病……"

进一步询问才知，原来这一位男孩有一天当兵放假日，队友带他到召妓的地方百般怂恿，他在经不住引诱的情况下，这么一次就种下了祸根。

试想爱之病的潜伏期在医学上证实有八年到十年的时间，如果那位罹患爱之病的男孩晚一点发病，假设他顺利完成兵役，上了大学，很有可能他会成为你家妹妹的男朋友，或是成为我家宝贝女儿的男朋友……谁说爱之病不会关系牵连到你我的家中呢？再继续联想下去，其实人人都有可能被危及到，家家











都有可能被介入，尤其色情海报、电影、卡带的泛滥各角落，现在就连一位四岁的小女孩都已经把拥抱、接吻当成非常普通的一回事，再这样下去还得了？

所以守住一生的承诺这个有意义的活动不只是要帮助已经罹患爱之病的病人，更大的期待是希望透过这个有教育意义的影片，进一步提高社会人士对爱之病更深一层的认识，尤其年幼学生与在职军人，使他们能严格执行自我约束，直等到结婚的那一天……

传神藉着守住一生的承诺活动呼吁：

1. 不试婚、不同居

2. 婚前没有性行为，婚后没有婚外情

同时，传神也联合了新加坡基督教四大宗派（圣公会、卫理公会、长老会、信义会）及独立教会（新加坡教会）展开爱心筹款活动，透过他们共筹得20万新币。除此之外新传媒九大艺人－－郑惠玉、钟琴、欧菁仙、王禄江、郑斌辉、陈毓芸、郭淑贤、郭亮、徐秀盈也积极参与守住一生的承诺慈善之夜的演出，当晚（4月30日）共吸引了八千人前赴国家室内体育馆参与盛会。

这一次慈善之夜，不仅为爱之病行动小组筹款而已，同时也打破了公众人士对爱之病患者负面的看法，透过影片及艺人的分享，不仅提高国人对爱之病的认识，同时也愿意为爱之病患者伸出援手。

接着下来，守住一生的承诺活动委员会发动了一个爱心签名运动，目的是作一份调查，看新加坡国人是否希望教育部将“认识爱之病”列入国民教育课程中，让学生们因着懂得爱之病的危险性，而不做出伤害自己的行为。

这只是我们真心与诚意的表达，希望大家能够明白与支持……







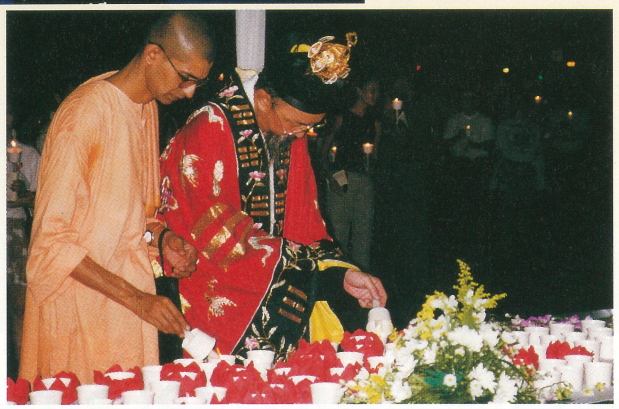
17th International AIDS Candlelight Memorial

AIDS Candlelight Memorial 2000

21 MAY 2000 , BRAS BASAH PARK



Our emcee Raymond Francis with the religious representatives: (l to r) Swami Punyatmananda (Hindu), Ervad Percy khambatta (Zoroastrian), venerable R Gnanaseeha and assistant (Buddhust - Theravada), Master Lee Zhiwang (Taoist), Rev Dr Anne Johnson (Protestant), Encik Sabri bin Omar (Muslim), Venerable Sangye Khadro (Buddhist - Mahayana), Rev Father Clifford Augustine (Catholic), Mr tan (Taoist), Giani Bikar Singh (Sikh), Mr Daniel Chu (Baha'i) - hidden.



Master Lee Zhiwang, President of Inter-Religious Organisation of Singapore and Swami Punyatmananda lead the lighting of the memorial candles.





Young and old were present to remember family, friends or lovers lost to HIV/AIDS and to lend support to those who live with the disease.



Each candle represents each of the more than 400 who have succumbed to HIV/AIDS.





The organising committee and helpers.

Special thanks to: Str Theresa Seow, Vice President of Inter-Religious Organisation of Singapore for her help in organising the religious representatives, Mr Rashid Saini for photography and all volunteers for their assistance and attendance.

Benedict Jacob-Thambiah

13th International Conference on HIV/AIDS - Durban, South Africa

My Impressions

Touchdown - Durban

I arrived in Durban from Singapore with Brenton Wong, AfA Honorary Secretary. As this was my first time to Africa, I was filled with trepidation for my safety. As a Singaporean coming to a place well known for its high rate of violent crimes, you could bet your last dollar I was scared stiff.

It helped immensely that Andy Quan from Australian Federation of AIDS Organisation (AFAO) gave useful information and safety tips to me and to the many delegates he'd met at the 5th ICAAP in Kuala Lumpur. Special thanks to him!

Special thanks also to the delegates from the Malaysian AIDS Council for being so hospitable and allowing me to use their booth as my de facto AfA booth during the Conference.

I was glad I had Brenton for company. He's a great cook though I must admit he's a lousy tour companion. Nobody I know flies 15,000 kilometres only to hole himself up in a room. Thankfully, his candidness and dry humour made me feel less homesick than I really was.

Personal Note: The people you are with and the ones that you meet make any conference meaningful and memorable.

'Indaba' - University of Natal-Durban Campus

Various topics were covered at the community forum or 'Indaba' (in Zulu) over two days at the University of Natal-Durban Campus. I attended the session on 'Youth and Sexuality' on the first day of the 'Indaba', chaired by **Ms Antigone Hodgins** from the US Department of Health and Human Services and also member of The International Community of Women Living with HIV/AIDS. The floor discussion was to remain, for me at least, the most fiery and energised discussion session of the whole conference. Young people from Africa and Asia spoke up on the need for acceptance from adults in respect to their lives. Among them was a 17 year-old South African boy, HIV+ since 15, who stood up to say that if the education system had been honest enough to tackle the issues of sexuality and of sexual safety, he doubted that he would have become HIV+. The boy pointed out, however, that he was not blaming the education system but on the fact that nobody felt the need or necessity to educate him and many others in this respect.

Another focal point was the controversy over the Catholic Church's move to denounce the use of condoms as the best available barrier to transmission of sexually transmitted diseases, thereby causing the rampant spread of HIV/AIDS to South America and other parts of the world where the Church held sway. A kindly Roman Catholic priest assailed Conference participants for constantly bashing the Church and its position on condom use without giving the Church a chance to respond. (I felt that he should have just left it at that, but he did not.) He related how in Zimbabwe, where he is resident, a shipment of condoms from Malaysia had to be condemned because almost 80% of the sampled stock had holes in them. He used this, as a 'fine example' of how unreliable and useless condoms were and that young people should have their thoughts elsewhere. Many of the participants rebutted him, including me. I pointed out that he should have submitted an abstract on this issue and lobbied for a panel discussion or oral presentation instead of presenting such potentially dangerous views that were not backed up by any fact or evidence. (Apparently, this same person also presented these views in other sessions at this Conference.)

Protest March - Durban City Hall

As no transportation was provided on the second day of the 'Indaba' — a sore point with many Asian participants — I headed towards Durban City Hall to join in a protest march in support of increased access to treatment and the cancellation of African financial debts by international agencies and Western governments. More than 8,000 South Africans and Conference participants took part in the march, which began with speeches from HIV+ persons representing their peers worldwide denouncing the rich countries of the world for turning their backs on Africa and other poor countries. The Deputy Secretary-General of the South Africa Communist Party, **Comrade Jeremy Cronin**, together with the leaders of the Anglican and Roman Catholic Churches and the Mufti of Cape Town also called on the world to save the children of Africa.

In an opening jibe at current South African President Thabo Mbeki, main rally speaker, **Ms Winnie Madikizela-Mandela**, former wife of Nelson Mandela, reiterated that HIV indeed caused AIDS. Ms Madikizela-Mandela called on pharmaceuticals to reduce the costs of their products, stressing that it was murderous of the rich pharmaceutical companies to ignore the pleas of the poor and to make their medicines available only to the rich communities within Africa. Ms Madikizela-Mandela also called for greater government involvement in the prevention and treatment of HIV/AIDS and greater acceptance of people with HIV/AIDS, and urged the South African people to use the experience they had gained in overthrowing the apartheid regime to fight the scourge of HIV/AIDS.

Conference Opening Ceremony - Kingsmead Cricket Stadium

More than 10,000 people attended the opening ceremony, which was held for the first time in an open area. In keeping with the Conference theme, 'Break the Silence', the ceremony was a gala of song and dance, with the thunderous beating of the African drums, the lighting of electric touch lamps and the angelic chorus of the 1000-strong, colourfully attired choir.

President Thabo Mbeki's arrival was met with a furious drumbeat roll, accompanied with catcalls and boos from the audience. Many of the participants chose to ignore the call to stand for the President, to register our dismay and disappointment with his position that HIV did not cause AIDS. The President spent of a good part his speech talking about poverty and its causes, and scarcely mentioned 'HIV/AIDS' or even the people suffering from the disease. Except towards the end, when, in obvious lack of irony, he said that his government would do all it could to alleviate the suffering of people with HIV/AIDS and to make access to treatment and care a primary objective.

What impressed me most at the ceremony was the speech by 11-year-old **Nkosi Johnson**, who spoke of his mother who had since died, the father he never knew and all the troubles that he faced as a young person with HIV/AIDS. But he wanted most was to be treated by his peers as a normal person. Nkosi called on the government of South Africa to help make access to treatment for PWAs and preventive treatment for HIV+ mothers possible, so as to stamp out mother-to-child transmission. Although you could tell it was a memorised speech, Nkosi's call was sincere and pertinent; and in my opinion, certainly not limited to the continent of Africa, but resonated throughout, to all the governments of the world, including Singapore.

Plenary, Oral Sessions

I made it a point to attend all the plenary sessions at the conference, although most were too scientific for me to remember what they were about.

I was very impressed by the first plenary session speaker, **Justice Edwin Cameron** from the South African Constitutional Court, the highest court of the land. Openly HIV+ and homosexual, Justice Cameron described his personal struggle with HIV, his initial attempts to keep his diagnosis private and now of his fight to make access to treatment a possibility for all South African PWAs.

In his speech, Justice Cameron announced the creation of a self-help group comprising wealthy PWAs like himself to help poorer PWAs gain access to treatment. Justice Cameron called for an immediate end to the silence surrounding the social issues surrounding HIV/AIDS, adding that as a South African Afrikaan person who openly supported an end to apartheid, the same energies should be employed to end prevailing disparities.

The lesson (to be?) learnt - Singapore needs to evolve a system of ensuring that no one should be left without essential life-enhancing anti-HIV drugs, just because that person lacks money to pay for them. The tag of non-standard and standard drugs needs to be removed. All drugs that enhance life and allow for survival should be treated as standard, and access to these drugs should be made available. It is criminal that it is not.

I attended two oral presentations sessions on MSM issues. In the first session, *"Keeping It Safe — Maintaining Gay Safe Sex Practices"*, various regional representatives presented papers outlining the HIV prevention and incidence among MSMs within their respective area of concern. It was quite disheartening to hear of the increase in HIV in MSM communities, contributed, in part to the blatant discrimination and plain lack of concern and support on the part of governments and societies in dealing with the needs of the MSM community. Presenters also highlighted the need for HIV+ MSMs to be further involved in education and awareness creation in their communities.

Speakers at the second session, "*HIV in MSMs*", dealt with similar issues. But the meeting took on some very distinct political hues as some American delegates pointed out that speakers should have used the term 'gay' or 'homosexual' instead of the generic 'MSM', which gay people in the West could not identify with, thus making outreach to these communities more difficult. Delegates from Asia and Africa countered that the term 'MSM' was adopted so as to be inclusive of men who do not identify themselves as 'gay, homosexual or bisexual'. They added that for effective preventive measures, appropriate terms and language had to be used.

Lesson learnt - As we conduct our own outreach programmes to and within the MSM community in Singapore, we must recognise the need to be increasingly inclusive. No one, for whatever reason, should be excluded. In fact, the Ministry of Health in Singapore, if they had been at the conference, could learn to tailor HIV education and awareness for MSMs, specifically and effectively.

The presentations at the session on "*Violence Against Women*" were full of passion and conviction. It was shocking to find out that in parts of Southern Africa, 40% of HIV transmission in heterosexual settings was through rape, including incestual rape by either the father or brother. It was quite upsetting that men, who were the primary perpetrators of violence against women, were missing from these sessions.

Lesson learnt - In educating our young, especially women, we should take a holistic approach. It is not enough just to teach them condom use and safer sex. We need to teach them their rights, including the right to say 'no'. Although Singapore has not reached the madness of some of these situations, it would be derelict of us to wait until an impossible situation of like that in Africa to overtake us before we take necessary action.

Mother to Child Transmission was another depressing subject at the conference. Questions were raised regarding the necessity and responsibility of caring for women who were HIV+, providing care for HIV-free babies born to HIV+ mothers, and the care of AIDS orphans. The pro-life and pro-abortion advocates present had no specific suggestions or answers but did not hesitate to 'point arrows' and lay blame at whoever was most convenient.

Conference Closing Ceremony - International Convention Centre

The closing ceremony was a riot of colour and gleeful noise, ending with a 'bang' in traditional Zulu style. The Mahatma of the second half of the 20th Century, **Mr Nelson Mandela** officiated. In his powerful, gripping and clearly well crafted speech, Mandela called for an end to stigma and discrimination of people with HIV. "If 27 years in prison have done anything to us, it was to use the silence of solitude to make us understand how precious words are and how real speech is in its impact upon the way people live or die. The challenge now is to move from rhetoric to action. Action on an unprecedented scale. We must break the silence. We must break stigma and discrimination. Those who are infected by this terrible disease do not want stigma, they want love." "We have to rise above our differences and combine our efforts to save our people," said Mandela, warning, "History will judge us harshly if we fail to do so and right now."

Mandela called on all present to double our efforts in preventing further infections and in educating our young on living a safe life. He urged the attendees to move forward in the struggle against HIV/AIDS and not to get distracted by argument and misquotes. Mandela also called on the scientific community to focus on seeking a cure for HIV/AIDS. In defence of the present South African government, Mandela highlighted that the government was doing all it possibly could for HIV/AIDS and those suffering from the disease. He said that attention had to be focused in curbing unemployment and poverty. Once these problems were dealt with, HIV/AIDS could be tackled in a more comprehensive manner.

Final thoughts

For all the sessions at the conference, there were many applicable things for us emulate. The question now lies before us: 'Do we have the courage to even consider them for use?'

I have learnt that many people will get infected and die of HIV/AIDS related causes because we have been criminally silent in taking bold and necessary steps in eradicating the scourge. We have been more concerned with saving face than with saving lives. This is criminal and it must end.

I was personally quite disappointed with the content of Nelson Mandela's speech despite his rallying call to fight stigma and discrimination faced by people with HIV worldwide. He, of all the South African leaders, had the moral authority to set a course for a rapid and compassionate response to the suffering caused by HIV/AIDS, yet he chose to walk the safe and politically prudent path.

Lesson learnt - It is easy to take the safe option but it takes real leadership to do what is necessary, humane and compassionate. It is wrong to do anything less.

Singapore Press Reports

The following series of articles and letters are taken from the **Berita Harian**, *the national Malay language morning paper. They are translated by Feisal Abdul Rahman, Chairman Anak Melayu/Islam Melawan Penyakit Unik HIV/AIDS (AMPUH), Action for AIDS. They provide a valuable insight into the opinion some members of the lay public have regarding AIDS prevention.*

BERITA HARIAN, 30 AUG 2000

CELOTEH - Beware when choosing partners

By Pak Oteh

During my younger days, before proposing, we had to make quiet inquiries. Inquiries upon inquiries, to find out the origins of our potential partner. Asking upon asking, so as not to regret in future. Everything was done by the older folks, who were certainly more experienced.

This long-standing practice of our ancestors now seems to have been cast aside. Because today, the young look for their own partners. Parents seldom get involved except when approached or when the situation demands it. Now this practice of making quiet inquiries is back, at least do a blood test. When I read a report about the need for young couples in a neighbouring country to do a blood test for AIDS, I expressed relief.

Don't, because of love, we take things lightly by assuming that our partners are okay. How do we know?

This is a smart move, because the disease is growing rapidly. It still brings death and there is no cure for it. I feel that this health inspection measure should be made a rule for all Muslim couples. So, besides attending marriage guidance classes, they should also examine their bodies and souls. Don't, because of love, we take things lightly by assuming that our partners are okay. How do we know? Don't regret later on, young man/woman. The results of the test would make us realise whether we are suitable or not. This is because marriage is a long-term investment. Healthy partners usually produce healthy offspring. But other factors, such as devoutness, manners and nature of employment should also be taken into consideration.

The reason why Muslims marry is because of their strong faith. The husband and wife would be of good character and would be able to raise a family. Sometimes we might feel odd that, against the backdrop of the sophisticated life today and the multiple choices for life partners, we actually need to take even more precautionary measures. But these are the reality of life. Verily, life has its risks and its benefits.

I realise that our society still faces a high drug addiction rate. Frequently this is the group that is most exposed to AIDS. So our society faces a high risk. This is a serious matter that we have to acknowledge.

BERITA HARIAN, 2 SEP 2000

FORUM PAGE - AIDS BLOOD TEST NOT THE RIGHT MOVE

I refer to Pak Oteh's commentary in the column 'Celoteh', entitled "Beware when choosing partner" (BH 30 Aug).

Although there are several benefits arising from compulsory HIV blood testing, especially in terms of early detection and rehabilitation, it is not a good way of overcoming the HIV/AIDS epidemic.

Action for AIDS would like to stress that any decision to make it compulsory for potential married couples to undergo HIV blood tests is not right and dangerous. Mass testing would require an immense amount of resources and energy, arising from the need for counselling before and after each blood test, as well as adequate referral and support services. It would be better if such resources and energy were channeled to other efforts that are more effective in the long term, such as public education and awareness programmes.

Compulsory testing does not guarantee that a couple would not be infected with HIV later on, especially if they practise high-risk behaviour, such as having unprotected sex outside marriage and sharing needles during intravenous drug use. Compulsory testing can also lead to a false sense of security. For example, wives may feel that they are not at risk of HIV infection because their husbands were once tested for HIV before their marriage, and vice versa.

Discrimination against those living with HIV/AIDS would also cumulate as a result of compulsory HIV testing. This is because if we were to follow the Johore proposal, "unless they are free from HIV infection, they would not be allowed to marry at any marriage registrar's office in the state" (BH 28 Aug). This measure is clearly not right. What would happen to those who are not allowed to marry? Who are we, merely God's mortals, to sentence them so harshly? We should also remember that there would always be those who have been together for a long time and would insist on marriage even though one of them is infected with HIV. The absence of an established support system for such persons with HIV/ AIDS would make compulsory testing rather pointless.

Any programme must provide alternatives and must never neglect the caring and humanitarian aspects.

Any programme must provide alternatives and must never neglect the caring and humanitarian aspects. Compulsory testing is not the solution to overcome the problem of HIV/AIDS. What is more important and right is to equip all layers of society with education and accurate information of the disease — regardless of whether they are young couples or couples who have been married for decades.

Young couples and those intending to get married can be encouraged to take the blood test as an affirmation of their love and commitment to each other. But they should be given the chance to take the blood test voluntarily, as responsible mature adults, not by force.

Feisal Abdul Rahman
Chairman Anak Melayu/Islam Melawan Penyakit Unik HIV/AIDS (AMPUH)
Action for AIDS

BERITA HARIAN, 6 SEP 2000

CELOTEH - Know your partner's risk

By Pak Oteh

I was overwhelmed reading the letter of a spokesman from local AIDS organisation.

He said my writing would lead to discrimination on AIDS patients. We all know that there is no cure for AIDS. It brings death when prevention measures are not enforced. In Africa, such as Zimbabwe, it is said that half of the population would die out because of AIDS. We pray that this cure would be quickly found, with God's grace.

I did not intend to deny the rights of AIDS patients. But where lies the happiness of the home, when we know that one of our partners has AIDS? And then we too could be infected, and our kids. It was on the grounds of preserving the family's welfare, that I supported the proposal that potential grooms and brides take the blood test. Furthermore, this suggestion comes from the religious leaders. Surely they would have made this suggestion after much consideration and thinking through its pros and cons.

Why would they make such a suggestion?

Let's picture this, i.e. firstly, I understand that there are half a million drug addicts in the neighbouring country. In fact, there are reports that mention almost a million (including those that have yet to be trapped/lured to drugs). In Singapore, half of the drug addicts are Muslims. Sometimes I'm not proud to write on this — like washing our dirty linen in public. But we have to accept it. AIDS often appears among drug addicts who share needles. They also often practise free/unsafe sex.

This is just the drug addicts. What about those who are not drug addicts but practise free/unsafe sex or adultery? Undergoing a medical exam is not a new thing when preparing to set up a household for Muslims. Often in Islam, when an emergency situation arises, as in the saving of lives, a ruling could be imposed, ranging from a "should" to a "must".

We need to remember that the intention of such examinations is not to deny the rights of AIDS patients. Actually we are trying to prevent the disease from spreading even more. Do we want many of us to suffer because of misplaced sympathy? Don't be that way, my friend. I support the efforts to allow AIDS patients to live like normal people — to be able to work, relax, etc. In fact, we should help them by organising Friday sermon on-the-spot donations, and others, so that they can live a life of dignity. But to let them set up a family is too much. It's different if AIDS patients are allowed to marry one another, but even then, they should avoid from having children.

Each of us cannot adopt the attitude that it's another person's problem. Because sooner or later, it would still creep up on us.

I am confident that AIDS patients realise this reality. There must be some, who deep in their hearts, feel remorse and that they should be the only ones to suffer rather than passing the disease to their descendants. I am certain that AIDS patients who realise this, also want to be role models. It is even better if we could let them campaign to encourage potential married couples to take this right step. At least, this move would become a provision for the future for these couples.

Our society faces a variety of big problems — from drug addiction, divorce, child abandonment and no forgetting, AIDS. Each of us cannot adopt the attitude that it's another person's problem. Because sooner or later, it would still creep up on us. That's why we should act and stop the disease as soon as possible through measures such as volunteer work, donations, advice and prayer.

Surely any measure needs to be tempered with humanitarianism. Remember the AIDS-infected mother? Her story reflects the tragedy when the blood of an AIDS patient was received and not inspected beforehand. This reflects the callousness on the part of society, including hospital staff. But what saddens the mother, a respected woman in the kampung, was the isolation she got from her fellow kampung residents. I felt sad but that's human nature. Let's not copy such an attitude. Instead, let's be sympathetic and help AIDS patients as much as we can.

I hope the local AIDS movement understands my intentions. We are like one human body. We would feel the pain when one of our body parts is hurt.

BERITA HARIAN, 12 SEP 2000

COMMENTARY - Letter: AIDS Testing for Premarital Couples

LET'S MAKE EDUCATION OUR SHIELD

I refer to Pak Oteh's commentary in the column, 'Celoteh' (BH, 6 Sep).

ASEAN Islamic leaders and scholars have already taken religious factors into account and unanimously declared at the end of the First HIV/AIDS ASEAN Regional Workshop of Islamic Religious Leaders in Jakarta at the end of 1998, that: "Marriage between a HIV-free individual and a HIV-positive individual is not prohibited or against religious law, although avoiding it is preferable."

They also opined that "divorce due to HIV infection/AIDS is lawful" and "a HIV-free wife can demand divorce from her HIV-positive husband. But based on the couple's consensus, their marriage may continue even though the husband is already HIV-positive." The ASEAN Islamic leaders, at the same time, cautioned that, "a married couple must use methods that can prevent HIV transmission whenever one of them is already HIV-positive." In addition, "the wife is urged not to become pregnant." But if the wife, by God's blessing, is granted a child, "abortion is not allowed even if that pregnant woman is infected by HIV." The declaration is available on the official ASEAN website < http://www.asean.or.id/function/hiv_wshp.htm>.

The consensus reached by Islamic leaders of the six participating nations, including Indonesia, Brunei, Malaysia, Singapore, Philippines and Thailand — three of which are Muslim countries — is very clear. Although AIDS is a great threat to the Muslim community in the region, the community can and must undertake efforts to reform itself while being patient in the face of this great challenge and test from God.

The religious leaders of the region were also giving a signal to all of us that although AIDS is a chronic disease, it is not a death sentence. Those suffering from the disease must be given a chance to lead normal lives, same as those suffering from other chronic diseases, such as cancer. This includes being given a chance to get married, set up households and have children. This is not impossible, in view of the existence of increasingly sophisticated HIV medication today, and so long as HIV patients are provided with adequate treatment and support systems, as is happening in advanced countries, such as the United States and Europe.

Although AIDS is a great threat to the Muslim community in the region, the community can and must undertake efforts to reform itself while being patient in the face of this great challenge and test from God.

The religious scholars of Johore may have made the decision to introduce compulsory HIV testing after being prompted by the high drug addiction and HIV infection rates within the Muslim community there, as compared to Singapore. Alhamdulillah (Praise be to God), the number of Singaporean Malay drug addicts has decreased from 2,111 at the end of December last year to 1,883 last March. Although our Malay/Muslim community has a higher drug addiction rate than the national average, it has not reached a critical level to warrant mass compulsory blood testing.

Action for AIDS commends Pak Oteh for his motivations behind his proposal to introduce mandatory premarital HIV testing, but his objectives cannot be realistically achieved through this measure. Let me elaborate.

If we could set religious considerations aside for a moment and analyse Pak Oteh's suggestion pragmatically, Pak Oteh assumes that the individual who has undergone testing will not engage in any high-risk behaviour after being tested. As I previously explained (BH, 30 Aug), testing just before marriage is no guarantee that the couple cannot acquire HIV later on. Second, Pak Oteh assumes that we would uncover a substantial number of cases through this method. Experience in other countries, however, shows otherwise. For example, when Illinois, in America, enforced a similar statute during over 20-months in the late 1980s, less than 0.02% of those tested were found to be HIV-positive.

In Louisiana, another state in the US that enforced mandatory premarital HIV-testing laws, but subsequently repealed them — mandatory testing successfully identified only two HIV-positive cases out of all premarital couples in 1988. It was estimated that each HIV-positive identification cost between US$70,000 (S$119,000) to US$85,000.

Illinois also experienced a sharp drop in the number of marriages because couples sought to avoid testing by getting married in neighbouring states. Illinois' marriage rate per 1,000 persons dropped from 8.3 in 1987, to 6.7 in 1988. This rate of 6.7 per 1,000 persons was the lowest in the whole of America for that year. Tax revenues and job opportunities also declined, with a 25% decrease in income in wedding-related services/industries, such as catering.

In general, premarital couples are a low-risk group. The Illinois experience revealed no evidence that the rate of HIV transmission was reduced or even stabilized during the tenure of the mandatory premarital screening program. Widespread testing in low-risk populations would only unveil a low number of HIV-infected persons. It could also result in falsely identifying persons as HIV-positive, because of testing and human errors. Telling someone he is HIV-positive when he is not, will unnecessarily lead to severe stress and possibly endanger his job, health insurance, and family relationships.

Beyond the inefficiencies of this mandatory measure, premarital testing would also divert valuable time of lab technicians, counsellors, nurses, doctors, administrators, and money from those in real need of care. The more resources that are diverted to ineffective ventures, the fewer resources would there be to develop truly effective public health programs.

Mandatory premarital HIV screening also raises the possibility of a breach of confidentiality. A mandatory HIV testing programme would reveal the fact that someone has been tested and the results of those tests to the government or medical personnel. People concerned with disclosure of their HIV status fear the loss of employment, insurance coverage, housing and family support, because of discrimination and social stigma.

If Pak Oteh fears that our drug addicts would heighten the risk and rate of HIV infection within our Malay/Muslim community, it is sufficient for us to educate and encourage them to take the HIV blood test voluntarily.

Let us not turn Islam into a religion of intolerance. Our faith values guidance and advice, not force and threat. Islam values upholding the dignity of others, not shaming them. Rather than requiring that premarital couples get tested for HIV, the Muslim community here should focus on education, i.e. providing AIDS education to premarital couples, drug addicts, and other groups within the community, based on our greatly honoured principles of Islam. Education should also emphasise the importance of prevention and voluntary testing. Education is like the immune system of an ummah (Islamic community). If it is strong, i.e. if every level of the ummah is equipped with accurate knowledge about the disease and always takes precautions, then the stronger would its immune system be, insha'-Allah (God willing). But if it is weak, i.e. if ignorance and prejudice are widespread and if treatment and support systems for its members who are ill are absent, then the more exposed would that ummah be to the risk of HIV infection.

Let us not turn Islam into a religion of intolerance. Our faith values guidance and advice, not force and threat.

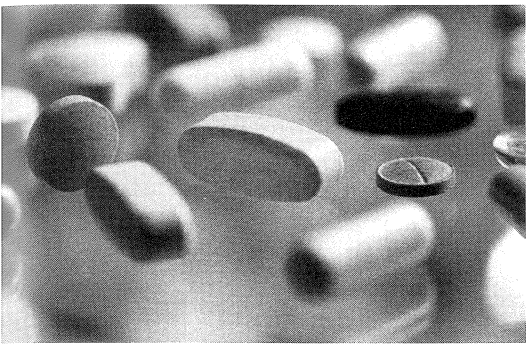
Let us all — religious scholars, Malay/Muslim organisations and the entire community — work hand-in-hand and undertake pro-active measures as part of these education and prevention efforts, while providing counselling services and an impeccable support system for our fellow Muslim brothers and sisters who are infected with HIV — something that has been conspicuously lacking since the epidemic began in Singapore in the early 1980s.

Feisal Abdul Rahman
Chairman, AMPUH
Executive Committee Member, Action for AIDS

Kirsty Machon

CHEMICAL EQUATION:

How HIV drugs can interact with illicit drugs



Reprinted with permission from HIV Herald, Vol. 9 no 4, 2000: Australian Federation of AIDS Organisations/National Association of People Living with HIV/AIDS

For the most part, there's not a lot of information about the way HIV antiviral drugs can interact with other, illicit drugs. Though this is changing, and information is slowly coming to light, there's still a lot we don't know, mainly because it's a difficult area to research. For a start, there are ethical issues around conducting clinical trials with illicit drugs. Under what circumstances, for example, might it be ethical to conduct a trial that involves the regular use of heroin or amphetamines?

Because of these issues, information about the way HIV drugs interact with non-prescribed drugs like heroin, amphetamines and cocaine has largely come from case studies, anecdotal evidence, theoretical models, and a small number of clinical trials. This means information about potential interactions between HIV and illicit drugs, or other drugs which people may use (like sedatives prescribed for other people) can be vague, contradictory and uncertain. People often want 'black and white' answers to questions such as: "Can I take speed and ritonavir safely"?

This is understandable. However, there isn't enough information to give such guarantees, and there are a number of variables within any drug combination that make blanket statements impossible. What you can do, however, is make some judicious decisions based on a combination of the limited amount of information we do know for sure, and following a number of principles which may at least minimise, though not entirely remove, the risk of severe or fatal interactions.

What is an interaction?

A drug interaction refers to the possible effects of taking two or more different drugs at the same time. Often, this is not an issue. Many kinds of drugs, even if taken together, do not affect each other. But some drugs do react together in potentially dangerous, or even lethal ways.

Drugs are broken down and absorbed into your body through the liver. A drug that affects the way your liver functions can also affect the way other drugs are absorbed (metabolised) into your body. If you are taking one or more drugs at the same time, your liver might be so busy processing one that it is unable to cope with the second drug. This doesn't happen with all drugs. But if it does, you could end up with a dangerously high dose of one of the drugs in your bloodstream, because it is not being properly broken down and absorbed. This could be fatal. It would amount, effectively, to an overdose. For example, the protease inhibitor ritonavir may have this effect on ecstasy in some people.

Other interactions can reduce the amount of a drug in your blood. The popular herbal medicine St John's Wort apparently has this effect on indinavir, causing it to be absorbed at very low levels (called a sub-therapeutic dose).If your anti-HIV drugs or other drugs get into your blood at lower than intended levels, they will not work as effectively. In the case of HIV, this could allow the virus to grow, change and become resistant to that treatment.



HIV drugs and illicit drugs

If you are taking HIV antivirals, or considering starting them, it is important to inform your doctor about all other drugs you take, including recreational or illicit drugs. You can inform your doctor about this without worrying about this information being reported to the police or other any other people. The law requires your doctor to keep any information which you discuss with them about your medical condition confidential. Your doctor cannot, by law, hand on any information about you, your health, or your drug use to police, other doctors, your friends or partners, or your family.

It is important to be honest with your doctor about this information, because your doctor needs this information to give you the best advice on which HIV drugs you should, or shouldn't, use. He or she can also then talk through any specific risks.

You may be concerned that talking about drug use could cause the doctor to discriminate against you. This can happen, but you don't need to put up with this or continue to see a doctor who isn't doing the right thing.

What we know

Taking recreational or illicit drugs with HIV antiviral drugs can certainly be dangerous. To be perfectly safe, HIV antivirals and illicit drugs shouldn't be combined. The effects of combining illicit drugs and prescribed HIV drugs together are unpredictable, but are influenced by a few variables. These are:

- the level of anti-HIV drugs in your body (the time at which you took the last dose);
- how well your liver breaks down certain drugs (there is no way of measuring this);
- the potency, purity and amount of other drugs you take.

What we don't know

We don't know about all the possible interactions between HIV treatments and illicit drugs, or other prescribed drugs. There could be interactions or effects which have not been recorded or reported before. US HIV researcher Dr Donald Abrams, interviewed on page 16, believes that deaths in the United States caused by interactions between HIV antivirals and illicit drugs do happen, and that it might not be as rare an occurrence as people may think. In particular, he says, there is a frightening lack of information about some newer "designer" drugs, popular in the US gay and club scenes, and which have smaller but growing markets in Australia. These include the drug GHB, which has been associated with deaths among club-goers in Australia (though not, it should be said, in relation to HIV antivirals), and methamphetamine ("crystal meth"), a kind of speed.

Some drugs, like ecstasy, can damage your liver with long-term use. Many anti-HIV drugs can also inflame your liver. If you have hep C, it your liver is not functioning as well. The three factors together could be dangerous.

The strength and quality of illicit drugs will vary, on the source. They are probably cut with other things. This makes it even harder to make blanket statements about interactions. It's usually impossible for people to guarantee the purity or vouch for the strength of drugs, especially those obtained from unfamiliar sources, or in street or club deals.

The following information may therefore be useful, but it is a guide only. None of this information has been tested in trials, and is not meant as an endorsement of taking HIV drugs in combination with any illicit drugs.

FIRST THINGS FIRST

Taking the following sensible precautions may reduce the risk of interactions between HIV drugs and illicit drugs. These are principles that can be applied regardless of the specifics of particular interactions (discussed after). he following measures may reduce the risk of interactions.

Less may be more

- Reduce the amount of any illicit drug you take. Take only a quarter to one third of the amount you usually take. You can always take more once you're sure there's no interaction.

Talk about it

- Discuss any illicit drugs you use or plan to use with a doctor you can trust.

Time apart

- Try not to take other drugs at exactly the same time as your HIV antiviral medication. This may interfere with normal blood levels of illicit drugs. Still, some HIV antivirals, including nevirapine and ritonavir, stay around in your blood for quite a while, and could still be affecting your liver. Taking your drugs a little while apart could reduce the chance of interactions, but it won't necessarily prevent it.

Rehydrate

- Always have plenty of water at hand to prevent dehydration. You should drink roughly 600 mls, or just a little more than half a litre of water, per hour.

Short treatment breaks are the worst

- It might be tempting to stop taking your HIV antivirals if you're planning to party for a while, or have a big weekend or holiday planned. This could be bad news. Your anti-HIV drugs prevent the virus from replicating. You need to maintain them at the right levels in your blood for them to work. So-called drug holidays - stopping your treatments for short periods of time - puts you at risk of treatment resistance.

Get into trouble?
Get help.

Most importantly, if you think you are feeling really weird, or think you might be having a drug interaction (like vomiting, nausea, dizziness, or feeling like you're about to pass out) don't be afraid to call an ambulance, or go to straight to a medical centre or hospital casualty department.

SPECIFIC INTERACTIONS

Ecstasy and protease inhibitors

There is some evidence that HIV protease inhibitors, particularly ritonavir (Norvir) can interact dangerously with speed or with ecstasy. The interaction between ritonavir and ecstasy has been linked to the death of at least one man in the UK. It is thought that ecstasy and ritonavir (and other protease inhibitors) are absorbed and broken down through the same pathway in the liver, so using the two drugs together could possibly push up the level of ecstasy in the bloodstream, causing an E overdose. Don't take E and ritonavir (or another protease inhibitor) at exactly the same time. Wait a few hours between taking each of the drugs, so that your liver has a chance to begin breaking each one down separately. It would be a good idea reduce the amount of E you take if you are taking ritonavir or another protease inhibitor, especially if you are not sure of the purity of the E, whether it might be cut with other things like speed or smack, and if you have never taken the two drugs together before. Take a third to a quarter of your usual amount, and increase it once you're sure there's no reaction.

Make sure you have plenty of water available, to protect against dehydration.

Speed and protease inhibitors

Combining other amphetamines - like speed - with protease inhibitors could cause potentially fatal interactions. Take about a third to a quarter of your usual amount of speed, particularly if you are using drugs from an unfamiliar source or supplier, and are not certain of the composition or purity of the drug. Snorting or bombing rather than injecting may be advisable, until you have a sense of the quality and strength of the speed.

Cocaine

There is very little information about cocaine and HIV drugs. There are no well-documented reports of particular interactions. Some recent (test-tube) research does suggest that cocaine may cause HIV to multiply faster. It's not clear what the implications of this information would be.

Heroin

There is very little information available on the subject of heroin and HIV antivirals. However, it does not appear that protease inhibitors increase levels of heroin in the blood.

Methadone

Methadone and ritonavir, however, are contraindicated. Your doctor should not prescribe them together.

Nevirapine may cause methadone to get into your blood at lower levels than usual. This is thought to have even caused symptoms of withdrawal in some people, so you need to talk to your doctor about whether you need a dose adjustment.

Cannabis and efavirenz

Some HIV antivirals, especially efavirenz (Stocrin) can make you feel a little disoriented. Cannabis or dope might make these feelings worse. Some people taking efavirenz, particularly for the first 2-3 weeks, say the drug makes them feel dizzy, and report symptoms similar to 'being stoned', or 'tripping'. They also report extremely vivid and sometimes frightening dreams. This could affect your judgment in different ways, for example, your ability to drive a car safely. Some doctors recommend that you don't smoke dope, take trips or take potentially mind-altering drugs during the first few weeks of using efavirenz, to avoid compounding any effects.

Sedatives, anti-depressants and sleeping pills

Some drugs (certain sedatives and antidepressants) can interact with ritonavir and possibly other drugs. Sedative drugs like Valium and other benzodiazapams should also not be used with ritonavir. You could overdose on the sedative. If you need sedatives, sleeping pills or anti-depressants, you should always make sure your doctor knows exactly what other drugs you take, especially HIV antivirals. He or she can then prescribe a suitable medication. For this reason, you should never use other people's prescription drugs if you're taking HIV antivirals. Taking drugs not prescribed for you could be dangerous.

Viagra

Overdoing it with the anti-impotence drug Viagra has caused a small but significant number of deaths. Viagra can interact with both prescription and illicit drugs. For example, ritonavir can raise levels of Viagra in the bloodstream by up to 300 percent. In addition, the blood levels of Viagra when used by people taking ritonavir remained very high for a much longer period of time. Viagra mnaufacturer Pfizer have recommended that patients on ritonavir should not exceed a maximum single dose of 25mg of Viagra over a 48 hour period. The normal dose at which people start Viagra is 50mg, but it also comes in 100mg doses, so check with your doctor about which dose you are on.

The other, and possibly fatal interaction which Viagra may have is with amyl nitrate and other poppers. Viagra can dilate the blood vessels causing the blood vessel walls to relax.

dear Makchik

This is Makchik's final article for The Act as she is leaving Singapore for a while; we bid her "bon voyage" and thank her for all the good work over the years.

When I have sex I use a condom but get vaginal juices at the base of my penis and pubic hair. Should I worry about this?

First, if you have several sexual partners, the chances of you getting HIV are increased. It is good that you are using condoms, but make sure that you store them correctly and do not use them past their expiry date. If you get vaginal fluids anywhere on your penis, there is a risk if you have a cut on it. To become infected with HIV, the virus must pass directly into the blood stream through broken skin. It's unlikely that you'll have a cut on the top of your penis unless you have a concurrent sexually transmitted disease or you and your partner have had some vigorous foreplay. If you are worried, examine your penis for cuts or sore skin before intercourse and wash it when you've finished. But Makchik's best advice is don't sleep around. Find yourself a one-man woman and in turn, be a one-woman man.

Why does the President of South Africa say that HIV is not the cause of AIDS?

There has always been a small and vocal group of scientists who say that HIV does not cause AIDS. President Mbeki has recently subscribed to this point of view but overwhelming clinical evidence still points to HIV being the culprit, and AfA agrees with this. We believe that the South African president has done a grave injustice and disservice to his country which is facing one of the most catastrophic AIDS situations in the world. (see the Durban Declaration).

Is it a good idea to test all foreigners working and living in Singapore for HIV when the consequences have been so inhumane?

A contentious question! Let's start by saying that the duty of any State is to protect its population from illness and disease. It does that by its health programmes and legislation. In Singapore's case, the government has an AIDS awareness programme, voluntary HIV screening of pregnant mums, testing of donated blood, hospital facilities for infected patients, and the power of legislation.

Until this year, only lower paid workers - those who clean your houses and build them for example - had to be tested for HIV upon arrival, as did those applying for permanent residence. And according to official figures, several thousand workers have been found to be infected and have been repatriated since testing began several years ago. Now, all foreigners are tested including CEOs of multinationals. We now have a level playing field of testing and repatriation.

Why the law was changed is anybody's guess. At the simplest level, there could have been a perceived danger that Singaporeans would have sex with infected foreigners; or, infected foreigners would turn to the State for their treatment and thus constitute a financial burden. The experience of AfA is that a very tiny minority of Singaporeans acquired HIV from foreigners residing in Singapore. Most became infected overseas or from other Singaporeans. You want Makchik's opinion? The money spent on organising and administering the compulsory testing of foreigners is better spent on educating Singaporeans about HIV and AIDS. There is still a lot of confusion about how HIV is spread and more importantly, how it is not spread. Ironing out these misconceptions will arm all Singaporeans with the knowledge to safely manage their sex lives with each other and with foreigners.

I'm working in Singapore. If a member of my family contracts HIV will he or she have to leave?
The law as it now stands states that any foreigner with HIV is required to leave the country. So if your son becomes infected for example, he will have to leave and it's most likely you will want to leave too. However, the recent case of infected foreign wives of Singaporeans who had to leave the country and the subsequent statements from the government that their appeals to return would be treated compassionately, could work in your favour. The government's about face was based on their 'family policy'. In practical terms it means that families should not be broken up if mum or dad for example, is infected with HIV. Whether this would be extended to non-Singaporean families remains to be seen. The logic is strong but until the law is amended, the reality of deportation remains.

How on earth can we justify separating foreign wives from their Singaporean children and husbands because they have HIV?
Makchik was pleasantly surprised by the depth of feeling among Singaporeans about the deportation of foreign wives. Among the people she spoke to and the letters to the daily newspapers, there was unanimity that a wrong had been done. Clearly, the effect of the new legislation that deports the infected, is totally at odds with the government's family policy. Whoever implemented the amendment to the immigration act, thought little about its consequences. AfA was as surprised as anyone at the way the law was implemented. If it had been, the negative effects could have been avoided. The Prime Minister himself seems to have been caught unawares about the deportation of the wives. And judging by his televised comments, the impetus to review their cases came from him. Let's hope the amendment is being scrutinized and that it will be changed to prevent a repetition of this sorry story.

I'm getting married and I want both of us to have HIV tests first as we've both had partners in the past. My fiancée refuses. Is the government going to introduce mandatory HIV testing for couples tying the knot?
Only the government can answer that question. Going by the recent change to the immigration act, they see the risk of infection coming from foreigners residing here, rather than from Singaporeans themselves. Yet AfA's experience of working with the HIV-infected tells us that Singaporeans are much more at risk from each other. So why not a law which tests all married couples or indeed all Singaporeans? At first glance there may seem to be some merit in this since the vast majority of Singaporean wives with HIV were infected by their husbands. And, many of the people coming down with AIDS infections contracted the virus many years ago, did not know it, and could possibly passed it to their sex partners. So the early testing of Singaporeans seems to have merit. Whether it should be mandatory is another question all together. Civil libertarians would say it is an unnecessary intrusion into the private lives of citizens. And to be effective, the testing would have to be life long and at frequent intervals. Makchik, being a consistent lady, thinks the best prevention is education, education and education. The government could do much more than it does informing all citizens about how HIV is and is not transmitted and the responsibilities we have to each other when it comes to sex. But this doesn't solve your problem. My best advice is that you talk to your man about the consequences of HIV: that there is a strong possibility that one of you could infect the other and that your unborn children could be born with HIV too. AfA can help with this is you both come to our anonymous HIV testing clinics where an experienced counsellor can talk through the options with you. Details of these testing sites are printed at the back of the ACT.

On a local internet chat line, I saw somebody offering bareback riding. What does this mean?
Bareback riding is a euphemism prevalent amongst gay men for anal intercourse without a condom. Yes, it's amazing that with all that gay men have been through with the AIDS epidemic and the knowledge about HIV transmission, they strill put themselves and their partners at risk from unprotected intercourse. Why? It could be that they have little regard for themselves or others. A more likely explanation is that bareback riders have become complacent about HIV because of the effective, though expensive drugs we have to control it. At all cost, avoid anyone offering unprotected intercourse.

ACTION FOR AIDS SINGAPORE (AFA)

Projects & programmes



AfA was formed in 1988 in order to -

i. provide general and targeted HIV/AIDS information, and raise awareness of the disease
ii. provide support and welfare to persons living with HIV/AIDS (PWHAs), their families and loved ones
iii. fight discrimination against PWHAs
iv. encourage research in HIV/AIDS and related issues in Singapore

AfA is a private non-governmental organization and a registered charity.
Activities are planned, implemented and coordinated by volunteers and a small number of staff.
AfA is entirely privately funded, through the generous donations of private individuals and organisations.
In order to realise our objectives the following are some of our main activities.

I EDUCATIONAL PROGRAMMES

The ACT
This publication has articles dealing with medical, social, cultural and personal issues. It also reviews and updates AfA's activities. It is distributed free to members and volunteers, to schools, libraries, community organisations, medical and dental clinics and hospitals.
Editor - Roy Chan
charo@pacific.net.sg

www.afa.org.sg
Online since 1 January 1997, the webpage contains information on HIV/AIDS and AfA activities, the latest HIV/AIDS statistics, a Q & A page, and links to other AIDS web pages local and foreign.
Webmaster - Roy Chan
charo@pacific.net.sg

HIV Education and Workplace (HEW)
Education is the most important strategy to prevent the spread of HIV. We have trained educators who can speak to groups and organisations to help raise AIDS awareness. They are also trained to help organisations develop workplace policies relating to HIV and HIV-infected workers.
Coordinator - Douglas Ong
Pager - 92050225
bigboss@douglas-ong.com
Coordinator - Lalitha
Telephone - 2939648
Fax - 2994335
lalitha_dsc@hotmail.com

MSM Outreach Programme
This programme is designed to reach out to and educate homosexual and bisexual men to adopt and maintain safe sex practices. We are looking for volunteers to plan and coordinate this programme. If you are interested please get in touch with Brenton Wong, brenton@pacific.net.sg

AMPUH (Anak Melayu Islam Melawan Penyakit Unik HIV/AIDS)
AMPUH is a group of Malay/Muslim volunteers under the auspices of Action for AIDS. It was set up to tackle the rising number of Malay/Muslims infected with the HIV virus or suffering from AIDS. It hopes to enhance awareness about HIV/AIDS within the Malay/Muslim community; to promote active community participation and involvement in HIV/AIDS education and awareness; and to enhance community support for Malay/Muslim PWAs.
Coordinator - Feisal
Telephone - 96751517

II PATIENT SUPPORT AND WELFARE PROGRAMMES

Endowment Fund for Medications
The AfA Endowment Fund subsidises anti-HIV medications for needy PWAs. These medications are not sunsidised by any other fund or organisation in Singapore.
Coordinator - Roy Chan
charo@pacific.net.sg

The Buddies Programme
Volunteers are trained to provide counseling to PWHAs, care for terminally-ill patients, crisis counseling, advice on sexual problems, and therapies. Volunteers are assigned to work in home-care teams or as personal counselors to PWHAs.
Coordinator - Roger Winder
Telephone - 8360445
rwinder@pacific.net.sg

Life Goes On (LGO) and Club Genesis (CG)
LGO and CG are self-help patient support groups funded and supported by AfA. They also network with self-help groups regionally and share experience and information that are mutually beneficial. Through LGO and CG, PWHA interests and rights are represented in all of AfA's activities, at both organisational and participatory levels, with confidentiality preserved.

LGO caters to infected heterosexual men and women, while CG caters to infected homosexual men. PWHAs plan, coordinate and perform hospital, home support and welfare activities, and also to assist in other AfA activities.
LGO Coordinator - Roger Ang
Pager - 93241659
rogerang@cyberway.com.sg
CG Coordinator - Benedict
Telephone - 2540212

Survivors
This support group helps network relatives and friends of PWHAs who have passed on. Survivors 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.
Coordinator - Iris Verghese
Pager - 95131591
Telephone - 3577918
Iris_Verghese@notes.ttsh.gov.sg

III CLINICAL SERVICES

Anonymous HIV Testing & Counselling Centres
These are the only places where anonymous tests are available in Singapore. Experienced counsellors are on-hand to provide pre- and post-test counselling for our clients.
Immediate HIV tests are available. Instead of waiting a few days for the result, it only takes 30 minutes at our test sites.

The DSC Clinic
Blk 31, #02-16 Kelantan Lane
Saturdays from 1 to 4 pm.
Wednesdays from 6:30 to 8:30 pm.
Coordinator - Lalitha
Telephone - 2939648
Fax - 2994335
lalitha_dsc@hotmail.com
Coordinator - Sheung
sheung@pacific.net.sg

AIDS Information & Counselling Hotline (Tel - 2540212)
The Hotline provides information and counselling services on all aspects of AIDS. Phone lines are manned by trained volunteer counsellors between 6.30-9.30 pm on Tuesdays, Thursdays and Fridays.
Coordinator - Jane Bishop
bishjane@singnet.com.sg
Coordinator - Benedict
afa@pacific.net.sg

AFA EXECUTIVE COMMITTEE

President	**- Roy Chan**
Vice-President	**- Douglas Ong**
Secretary	**- Brenton Wong**
Asst Secretary	**- Dawn Mok**
Hon Treasurer	**- Jeffrey Poh**
Committee Members	**- Iris Verghese**
	- Lee Cheng Chuan
	- Roger Winder
	- Roger Yeo
	- Feisal Abdul Rahman

IV OTHER PROJECTS

Research
We have funded behavioral and intervention studies on various groups with high-risk activities, and prevention/intervention programmes in Singapore.
Coordinator - Roy Chan
charo@pacific.net.sg

Legal Assistance
We provide free legal advice and assistance to PWAs and their families on how to deal with difficult employers and workplace issues, draw up wills, and advice on issues related to the Advanced Medical Directive. We have also been asked to assist and investigate in specific instances where discrimination against PWAs has occurred.
Volunteer Lawyer - Chng Bee Peng
Mobile - 97435392
beepeng03@pacific.net.sg

The Candlelight Memorial
This is an annual international event held to remember those who have died from AIDS. For them there are no funeral service and no time for relatives and loved ones to mourn and grieve. The Memorial provides them this opportunity, to come to terms with death and AIDS.
It has become a powerful symbol of the presence of AIDS in Singapore, and a timely reminder for the community to renew its commitment to fight AIDS discrimination. The memorial is held on the last Sunday in May.
Coordinator - Daniel Tan
Pager - 94098302
Coordinator - Benedict
Telephone - 2540212
afa@pacific.net.sg

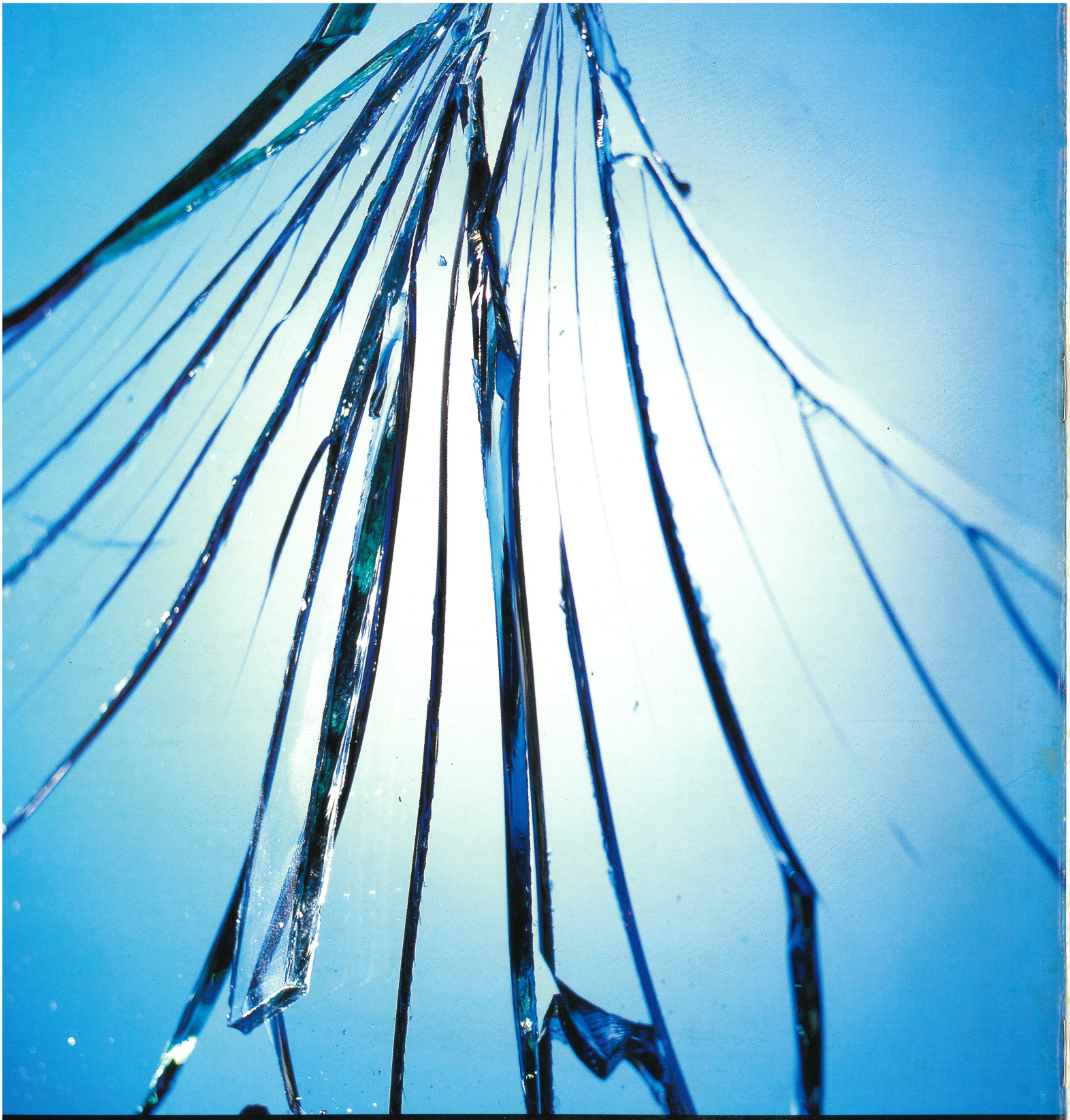
Singapore AIDS Conference
The first multisectorial conference on AIDS was successfully organized in conjunction with CDC/TTSH in December 1998. Over 400 delegates from government and nongovernmental organizations, volunteers, the press, and businesses attended. The second Singapore AIDS Conference will take place on 25th & 26th November 2000.

Art Against AIDS 2000
Art Against AIDS 2000 is the third Art Against AIDS art competition, which first began in 1996. This biannual competition uses art as a medium to help raise awareness about AIDS and to encourage community participation in AIDS prevention. Art Against AIDS 2000 will cover two genres/ artforms: fine art and posters. Each genre will have two categories — Open and Student (16 years and above).
Coordinator - Feisal
Telephone - 96751517

If you would like to make a donation, please make your cheque out to "ACTION FOR AIDS SINGAPORE", and post it to Action for AIDS, c/o DSC Clinic, Block 31, Kelantan Lane #02-16, Singapore 200031. All donations are tax deductible.

If you would like to be a volunteer, do write to us at the above address, or via our website at - www.afa.org

Alternatively, you may call or email Benedict at 2540212 and afa@pacific.net.sg respectively.



2nd SINGAPORE AIDS CONFERENCE

BREAKING DOWN BARRIERS • WORKING TOGETHER

25-26 NOVEMBER 2000

VENUE:
SINGAPORE INTERNATIONAL
CONVENTION & EXHIBITION CENTRE

Tan Tock Seng HOSPITAL

ACTION FOR AIDS
爱之病行动小组