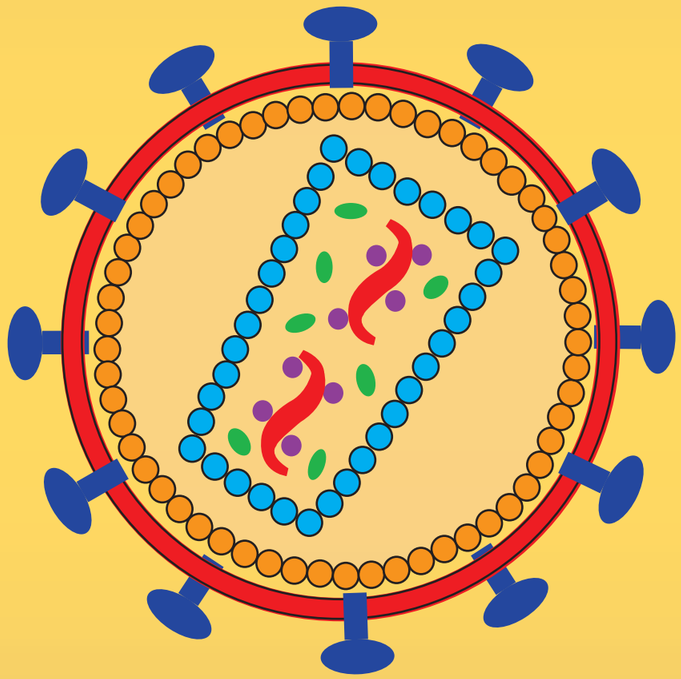
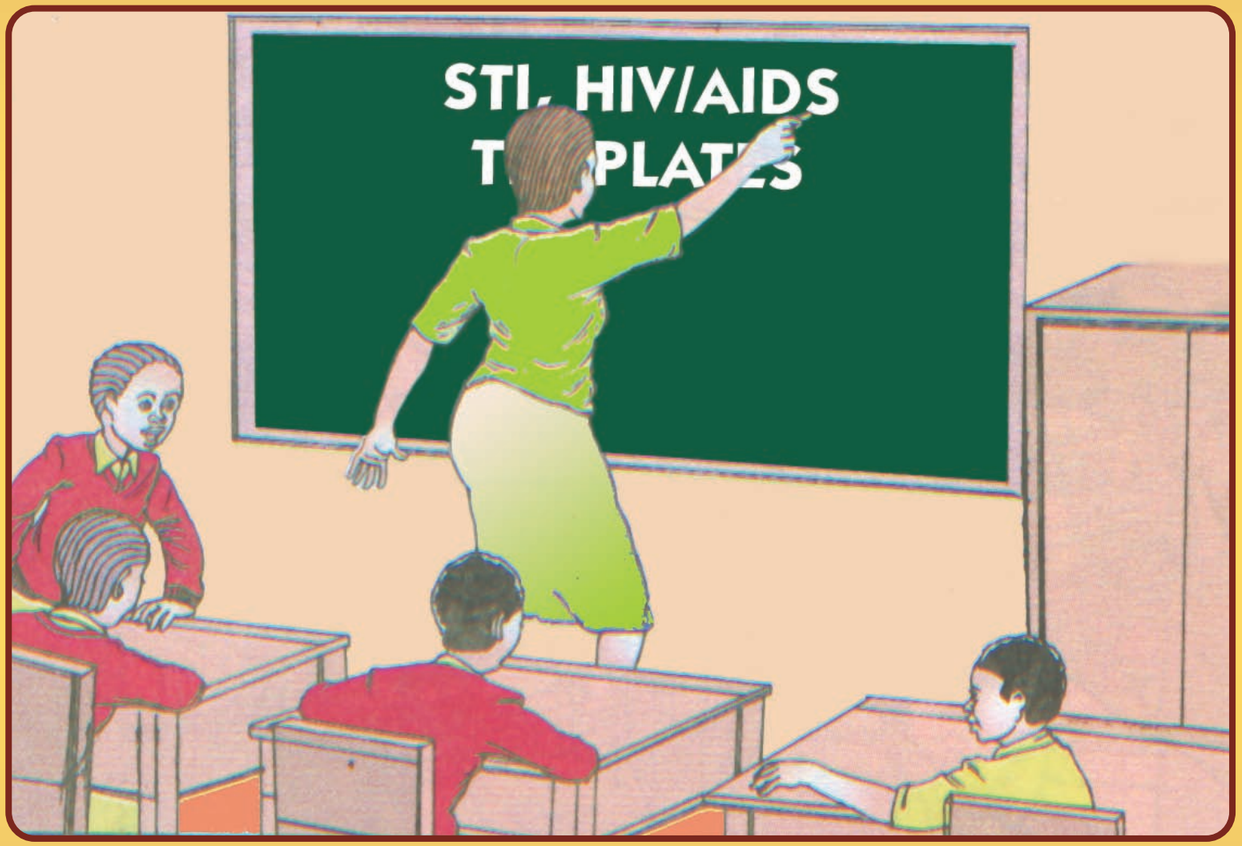
Republic of Kenya
MINISTRY OF EDUCATION

CfBT

STI,HIV/AIDS TEMPLATES





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DFID Department for International Development

CfBT
The **Power** *of* **Learning**

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STI,HIV/AIDS TEMPLATES

PRIMARY SCHOOL ACTION FOR BETTER HEALTH PROGRAMME

SCHOOL & COMMUNITY TRAINING

STI, HIV/AIDS TEMPLATES

COURSE OUTLINE

Project Purpose

To bring about positive behaviour changes in sexual relationships of Upper Primary pupils in targeted areas of Nyanza, Rift Valley Provinces, Central and Eastern Provinces such that the risk of HIV/AIDS transmission will be reduced. We aim to provide accurate information on prevention, promote abstinence and delay the onset of sexual activity.

Outputs

1. A cadre of adult community representatives (including Headteachers, Teachers, PA members and other community members) equipped to lead a sustained learning and communication process that will establish behaviour change to reduce the risk of HIV/AIDS transmission.
2. Resource materials to support education, communicating and behaviour change activities readily available in targeted schools.
3. Positive changes in the knowledge, attitudes and behaviour established among the Primary 6-8 student population such that the risk of HIV/AIDS transmission is reduced.

Approaches

1. Working through the existing education systems, including: integrated training teams from MoEST and MoH, use of HIV/AIDS schools curriculum, provision of Kenya Institute of Education teaching resources.
2. Two cycle training programme, split by a semester back at schools and incorporating the development of a School Action Plan for Better Health.
3. Based on Living Values and Life Skills and including a Peer Supporter component direct to pupils.
4. Responsive to the emerging issues in the intervention schools and communities.
5. Training of Zonal Inspectors to monitor school level implementation and collect research data.
6. Inclusion of pre-service teacher training colleges.

Main Activities

1. Training workshops for school/community representatives i.e. one Head teacher, Resource Teacher and Community Representative (parent) from each school.

2. Development of School Action Plans for Better Health (within the School Development Plan) and teaching and learning activities to support behaviour change for adolescents.

3. Selection, procurement, generation, and distribution of resource materials to teachers, schools and the wider community.

4. Capacity building of teacher to incorporate HIV/AIDS knowledge and awareness within the normal curriculum through the use of:
   - Improved resource materials (much of it self-generated)
   - Innovative teaching methodologies
   - Creative forms of student self-expression

5. Public activities such as inter-school and inter-zone competitions in areas of drama, music, art, public speaking, recitations, writings, sports and exhibitions etc.

6. Active inclusion of different opportunities for discussion and participation such as Question Boxes, Information Corners and School Health Clubs (Club Activity Kit developed).

7. Training of Education Officers in the monitoring of HIV/AIDS education in schools.

8. Training of Deans of Curriculum and Students from all Pre-service Teacher Training Colleges.

9. Substantial research and evaluation plan providing integrated quantitative and qualitative information.

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TEMPLATES

CHART ONE (1)

COURSE OUTLINE SESSIONS

1.	COUNSELLING IN HIV/AIDS	- 2 hrs
2.	INTRODUCTION	- 30 min
3.	TRANSMISSION OF HIV	- 1 hr
4.	DISEASE PROGRESSION	- 30 min
5.	SEXUAL NETWORKING EXPERIMENT	– 30 min
6.	SEXUALLY TRANSMITTED ILLNESSES + VIDEO	– 1 hr
7.	PREVENTION OF HIV/AIDS	- 30 min
8.	VULNERABLE GROUPS	- 30 min
9.	ANTI RETROVIRAL THERAPY & ROLE OF NUTRITION	– 45 min
10.	POSITIVE LIVING	- 15 min
11.	QUESTION BOX	- 30 min
TOTAL		**- 8 ½ hrs**

PRIMARY SCHOOL ACTION FOR BETTER HEALTH PROGRAMME
SCHOOL & COMMUNITY TRAINING STI,HIV/AIDS TEMPLATES

TABLE OF CONTENTS

Chart No.

ACKNOWLEDGEMENTS

We would like to take this opportunity to thank all those who have participated in one way or another on the PSABH programme.

Department of International Development, Kenya (DFIDK), health for funding the PSABH programme.
Ministry of Education, Science and Technology (MoEST) and Ministry of Health (MoH) for the collaborative approach for this intervention.
Futures Group for supporting us with the framework of the HIV and AIDS Prevention and Care programme (HAPAC)
University of Windsor, Canada, for helping us to interpret and use all the information we received from participants.
Members of the training teams from MoEST, MOH and other partner organisations.
School and community representatives, peer supporters who participated in the training and asked all the questions recorded here.

In particular we appreciate the successful completion of this publication by members of Afya Resource Associates, Drs; Albert Gachau, Catherine Mutisya Gladwell Kiarie, Hiram Kairu, Jackline Kitulu, Moses M. Kimani and Pamela Njuguna,

Thank you all for your contributions,

C*f*BT
Managers with the Primary School Action for Better Health Programme.
Mary Gichuru and Elena Mccretton

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti - retroviral Therapy
ARV	Anti – retroviral
ELISA	Enzyme Linked Immunosorbent Assay
HIV	Human Immuno deficiency Virus
HAART	Highly Active Anti retoviral Therapy
HPV	Human Papillona Virus
MTCT	Mother –to- Child Transmission
NASCOP	National Aids and STD Control Programme
PA	Parents Association
PCP	Pneumocytis Carinii Pneumonia
PLWHA	Person/People Living with HIV / AIDS
PMCT	Prevention of Mother -to- Child Transmission
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counseling and Testing

INTRODUCTION

This publication has been compiled after five years' implementation of an HIV and AIDS education programme in Primary schools in Kenya, called Primary School action for Better Health (PSABH). The purpose of the programme is to bring about positive behaviour changes among Upper Primary School pupils, such that the risk of HIV/AIDS transmission will be reduced. Specifically we aim to provide accurate information on prevention to promote abstinence and support delay of the onset of sexual activity.

During the programme we have worked with officials from the Education and Health sectors, Headteachers, Teachers, parents, Community leaders and church Representatives as well as many young people themselves.

It is our belief, from these experiences, that the effective answering of questions is both a critical and a challenging role for adults. HIV and AIDS is a sensitive topic as it has touched and changed all our lives on a practical and an emotional level. As the majority of infections are transmitted through sexual intercourse it is impossible to protect young people without being ready and able to answer their questions on sexuality and sexual relationships. Information on sexual issues has to be accompanied by clarification of values and moral context within which we live. At the same time, there is a significant level of technical information, which is needed to protect ourselves better.

The templates provide a sequence of presentation of the basic but valuable information on STI, HIV and AIDS.

Often we have found that by providing young people with the opportunity to ask their questions either in groups or anonymously through a question box or directly to a trained health worker, they have revealed both a tremendous knowledge about HIV and its impact on their lives and the gaps in the information being made available to them.

We hope that by providing an accessible summary of the topic we cover in our training programme, along with answers to the many questions that are asked frequently, we can help adults and teachers to feel confident in answering young people's questions and thereby help them to learn how to keep themselves free of HIV.

CfBT Projects Manager and Technical Adviser - Mary Gichuru

CHART ONE (1)

INTRODUCTION TO HIV/AIDS.

OBJECTIVES

1. To define terms.
2. To give facts and demystify HIV/AIDS.
3. To bring about positive behaviour change in sexual relationships through change in:
   - Attitude
   - Practise
4. To promote prevention as key to the control of the HIV/AIDS epidemic.
5. To encourage VCT for all.

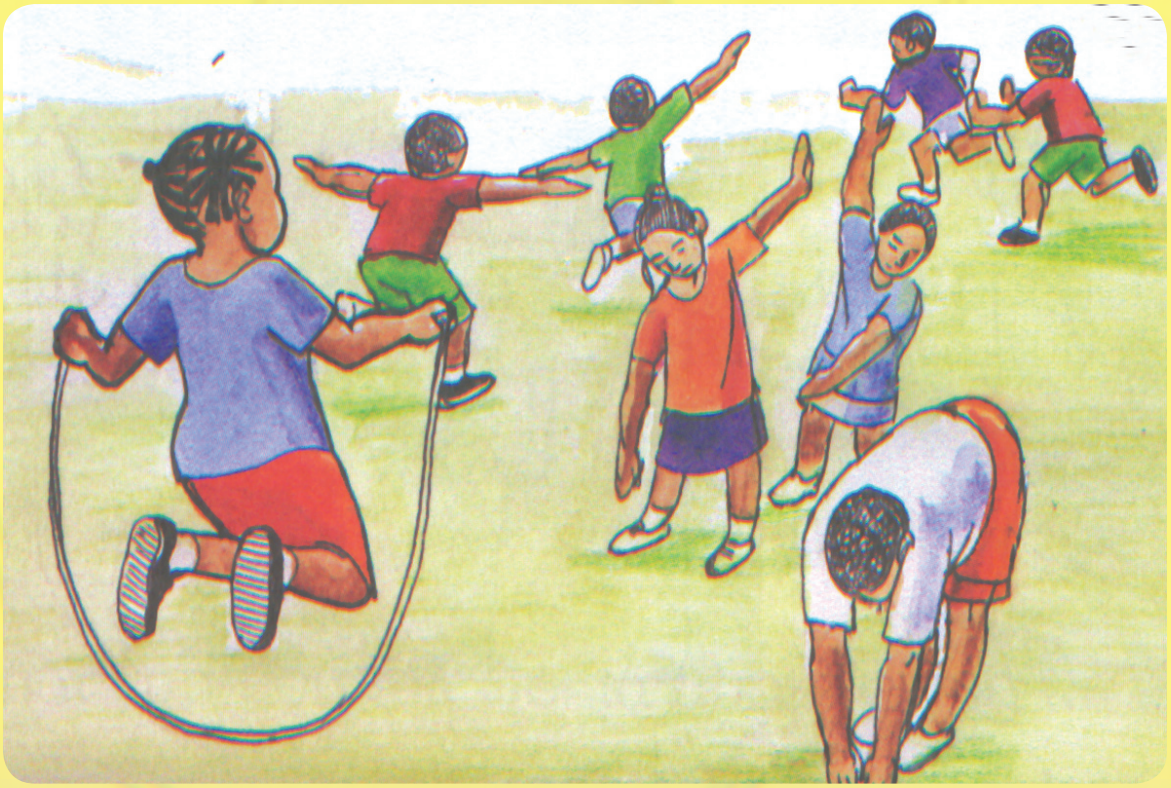


CHART TWO (2)

VOLUNTARY COUNSELLING AND TESTING (VCT)

Definition (VCT)

It is the process by which a person finds out whether or not he/she is infected with HIV the virus that causes AIDS.

Strong government intervention has given rise to high levels of HIV/ AIDS awareness but without corresponding behaviour change.

VCT therefore targets behaviour change. Knowing ones status empowers people to make informed decisions about their sexual lifestyle that would otherwise predispose individuals to HIV infection.

Teaching Notes

According to updates of KHDS 2004.

- 48% of women and 62% of men in Kenya know about VCT.
- VCT awareness is highest in Nairobi and Central province and lowest in North Eastern province.
- More men than women engage in risky sexual behaviours
- Risky sexual behaviour is highest in the 15-19 yr age group.

VOLUNTARY COUNSELLING AND TESTING (VCT)

Voluntary Counselling and Testing.

- VCT services should be completely voluntary and requested by the client.
- Informed consent is always required.
- Confidentiality must always be maintained.
- Anonymus services (no names)provided.

Voluntary **Counseling** and Testing.

- Pre-test and post-test counseling is always required.
- Counselling emphasizes behaviour change and prevention.
- Couple counselling is recommended.
- Counsellors should refer clients to other appropriate services if needed e.g treatment of opportunistic infections or home based care etc.

CHART THREE (3)

WHO SHOULD RECEIVE VCT?

1. Anyone SERIOUS about behaviour change should receive counselling.
2. Those with more than one sexual partner.
3. Those diagnosed with a Sexually Transmitted disease or TB.
4. Anyone 18 and over.
5. Couples before starting a relationship, before marriage, for pregnancy planning.
6. Mature minors (15 and 18) – who have already engaged in risky behaviour

NB:

Children under 15 should be served only with parental consent and only if there is a clear benefit to the child.

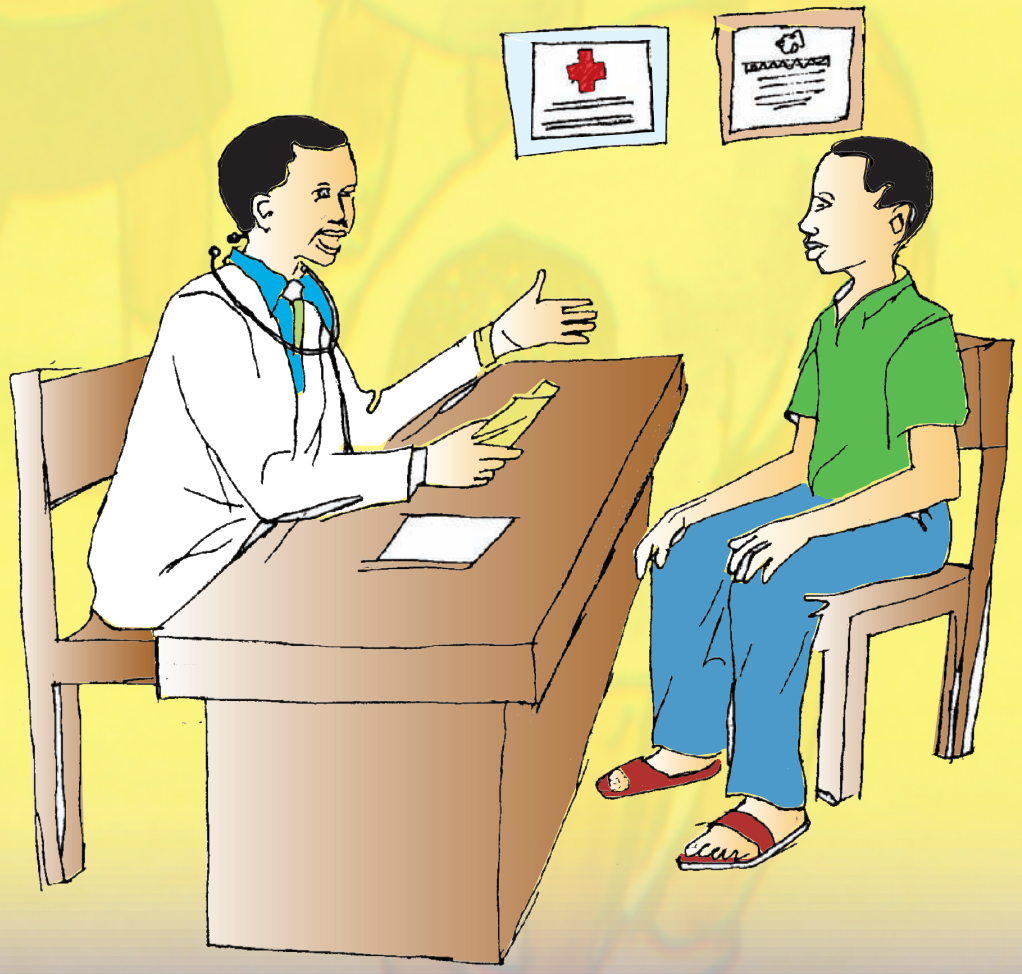


CHART FOUR (4)

BASIC STEPS INVOLVED IN COUNSELLING FOR HIV

- HIV and AIDS information.
- Pre-test and test decision counselling.
- Testing and test results.
- Post-test counselling.
- Plans for reducing risky behaviour.

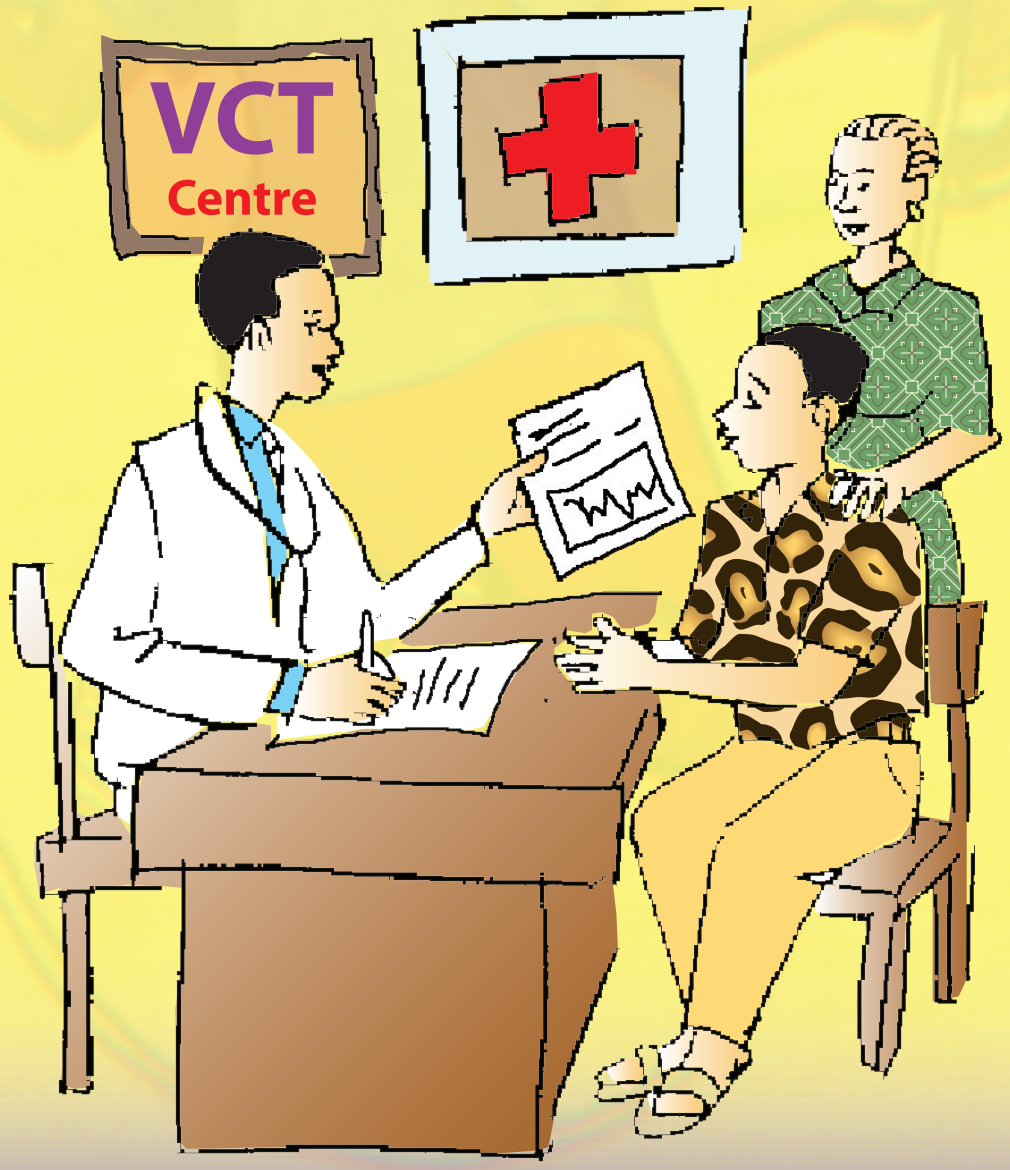


CHART FIVE (5)

BENEFITS OF VCT TO THE INDIVIDUAL

- Empowers the uninfected person to protect him/herself from HIV.
- Assists infected persons to protect others and to live positively.
- Offers the opportunity for treatment of infections associated with HIV.

CHART SIX (6)

BENEFITS OF VCT TO THE COUPLE AND FAMILY

- Supports safer relationships by enhancing faithfulness.
- Encourages family planning and treatment to help prevent peri-natal HIV transmission.
- Allows the couple/family to plan for the future.

BENEFITS TO THE COMMUNITY

- Generates optimism as large numbers of persons test HIV negative. (Currently >80% of people test negative at VCT centres)
- Impacts community norms (testing, risk reduction, discussion of status, and condom use)
- Reduces stigma as more persons go public about having HIV.
- Serves as a catalyst for the development of care and support services.
- Reduces transmission and changes the tide of the epidemic.

CHART SEVEN (7)

VOLUNTARY COUNSELLING AND TESTING (VCT)
TEST DONE AT VCT CENTRE

- A simple rapid blood test that tests for anti-bodies to HIV is done.
- The results are available within half an hour of being tested.

How accurate is HIV testing?

HIV test is more than 99% accurate. It will confirm your status with certainty.

Note

- VCT is absolutely free.
- VCT centres are found countrywide.

CHART EIGHT (8)

HIV stands for

Human - the virus infects human beings only

Immunodeficiency - body defence against illnesses (Related to)

Virus - smallest known germ

AIDS stands for

Acquired - to acquire means "to get"

Immunodeficiency - lack of something

Syndrome - collection of signs and symptoms

VOLUNTARY COUNSELLING & TESTING SUMMARY

VCT AS A CORNERSTONE OF HIV/AIDS PREVENTION AND MANAGEMENT

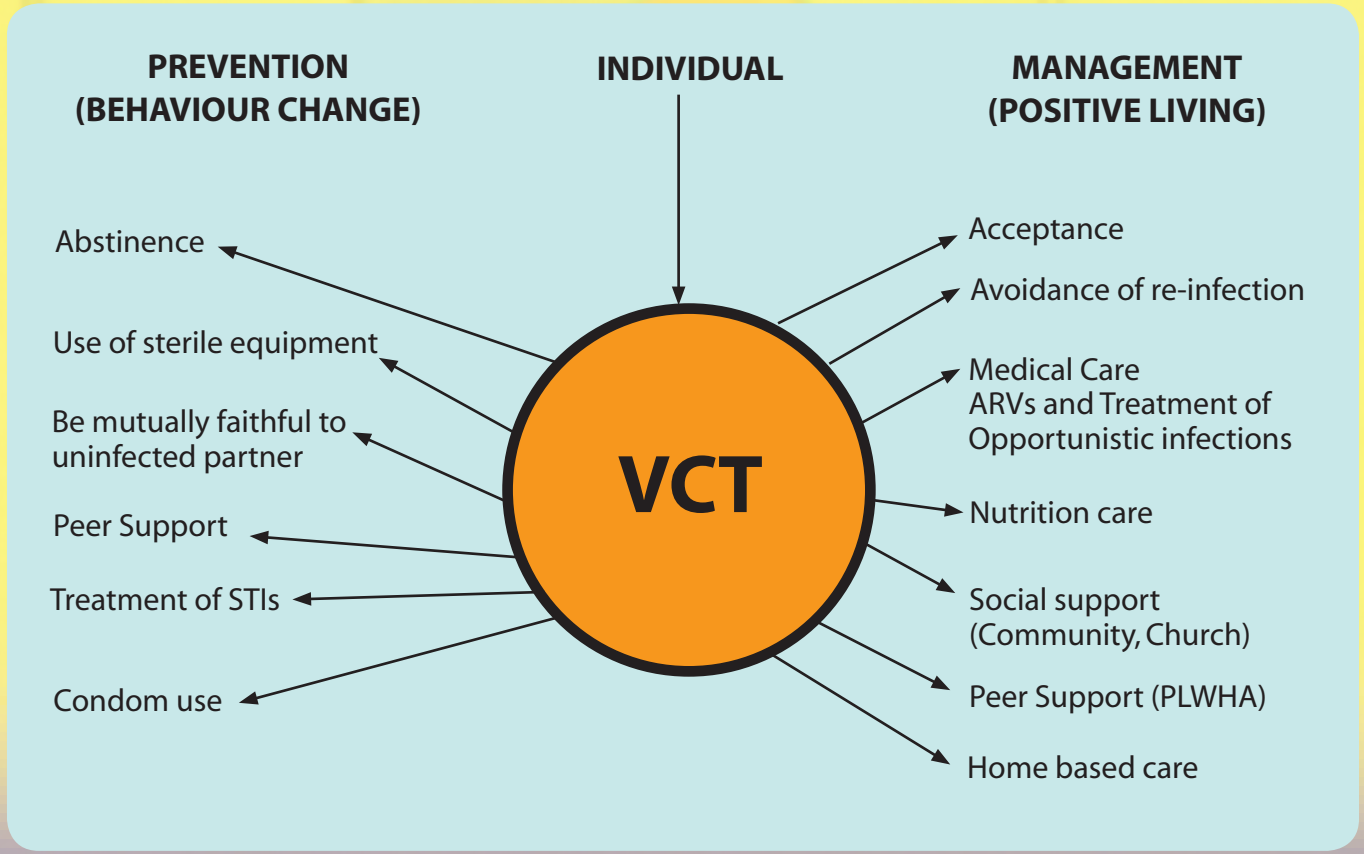


CHART NINE (9)

HISTORY OF HIV

1981 - AIDS described in gay men and I.V drug users in America.

1983 - Virus is isolated.

1984 - First Kenyan case described at KNH by Prof. Obel

1999 - AIDS declared a national disaster in Kenya by President Moi.

2003 - President Kibaki promotes VCT.

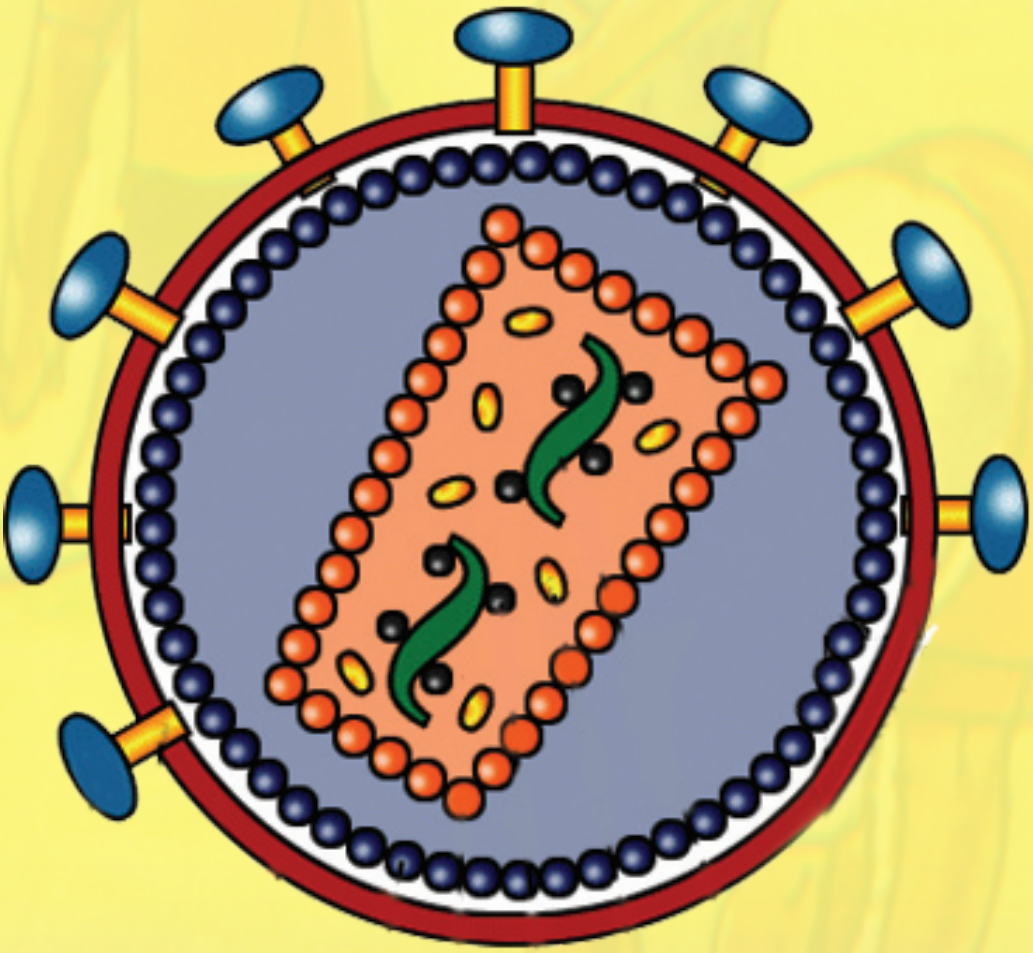


CHART TEN (10)

GLOBAL FIGURES – ESTIMATE FROM THE UNAIDS REPORT FOR 2004

People in the world living with HIV/AIDS - 39.4 million (35.9m– 44.3m)

HIV infections in

Sub-Saharan Africa - 25.4 million (23.1m – 27.9 m)

Global AIDS death in 2004 - 2.3 million

Global New infections - 3.1 million

GLOBAL FIGURES – UNAIDS REPORT FOR 2004

Sub Sahara Africa has 10% of worlds population yet has 60% of total disease burden

PLWA (15-24yrs)-	women	men
	6.9%	2.2%

CHART ELEVEN (11)

KENYAN FIGURES

(KENYA DEMOGRAPHIC HEALTH SURVEY REVISED 2004)

- Adults living with HIV/AIDS - 1.1 million
- Children - 150,000
- Number using ART - 24,000
- Number needing ARVs - 200,000
- National adult prevalence - 7 %
- Ratio F:M 1.9:1

NB:
3 out of every 5 people living with HIV/AIDS in Sub-Saharan Africa are female.

HIV Awareness as at end of 2004

		HIV awareness	Tested
• Men	-	99.3%	14.1%
• Women	-	98.4%	12.8%

NOTE

Age group		Prevalence		
		Women	Men	Mean
15 – 19	-	3.5%	0.5%	2.0%
20 – 24	-	8.7%	2.4%	5.8%
25 – 29	-	12%	6.5%	9.5%
30 – 34	-	11.6%	6.1%	9.1%
35 – 39	-	11.8%	8.6%	10.3%
40 – 44	-	10.8%	8.6%	9.4%
45 – 49	-	4.7%	6%	5.3%

CHART TWELVE (12)

NATURAL HISTORY OF HIV INFECTION

The HIV causes death of human cells by dividing rapidly in them

1. HIV attacks the CD4 lymphocyte (WBC)

- The virus attaches to a CD4 lymphocyte receptor. It attaches to CD4 receptor.
- It enters the cell and multiplies.
- CD4 lymphocytes die as virus multiplies.
- The body immune function is reduced by fall in number of CD4 lymphocyte.

2. HIV infection leads to immunodeficiency.

- Loss of CD4 cells = immunodeficiency in HIV infection.
- The patient becomes susceptible to "opportunistic infections"

3. Immunodeficiency leads to death.

Teaching notes

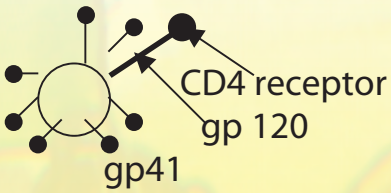
- The main target cells for infection by HIV are those that have on their surface a cell surface molecule called CD4, usually lymphocytes (WBC) [give other examples]. This receptor is recognized by the HIV, and then binds the virus before fusing and entering the susceptible host cell.

- Viral replication continues, even when an infected person looks healthy, with a high rate of cell infection and cell killing (productive infection).

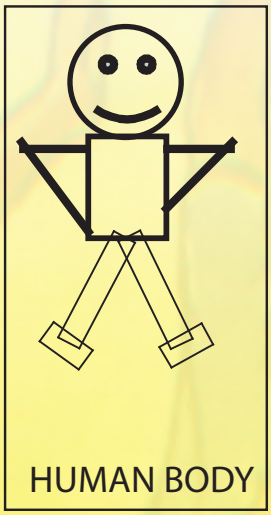
- Eventually, the WBCs are depleted and exhausted.

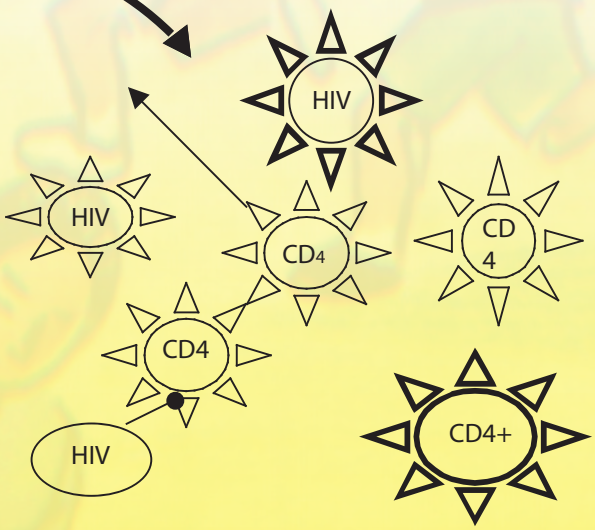
- The individual's immune function declines paving way to opportunistic infections.

CHART THIRTEEN (13)



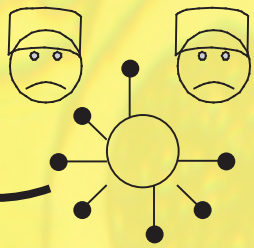
HIV VIRUS





Attachment of virus to CD_4+ cells
(gp 120 binds to CD 4 receptor)
Found in:
- White blood cells (WBC)
- Vagina, penis
- Sites of infections
- Penile foreskin

OTHER DISEASES INVADE THE BODY
e.g.
- Diarrhoea
- Tuberculosis
- Kaposis Sarcoma



Weakens, kills and prevent WBC from working.

- Dead WBC
- Few WBCs to fight infections

HUMAN BODY
Gets weaker and dies

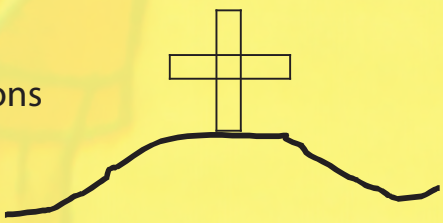


CHART FOURTEEN (14)

CLINICAL STAGES OF HIV INFECTION

		HIV TEST RESULTS
I.	Acute HIV infection (primary HIV infection)	 NEGATIVE
II.	Seroconversion	 POSITIVE
III.	Asymptomatic HIV infection	 POSITIVE
IV.	Full blown AIDS	 POSITIVE

Teaching note

The window period is the period between Stages I and II may last between 6 weeks and 6 months.

The window period is the interval between acute infection and seroconversion. An infected person may test negative because his body has not made enough antibodies to be detected by a HIV ELISA test.

CHART FIFTEEN (15)

FACTORS AFFECTING PROGRESSION OF DISEASE

The time interval from HIV infection to development of AIDS varies from person to person due to:-

- Genetics
- Diet
- Occurrence of Opportunistic infections
- Pregnancy
- ARVs and treatment of opportunistic infections
- A voidance of illicit drugs e.g. alcohol
- Avoiding reinfection with different HIV strains

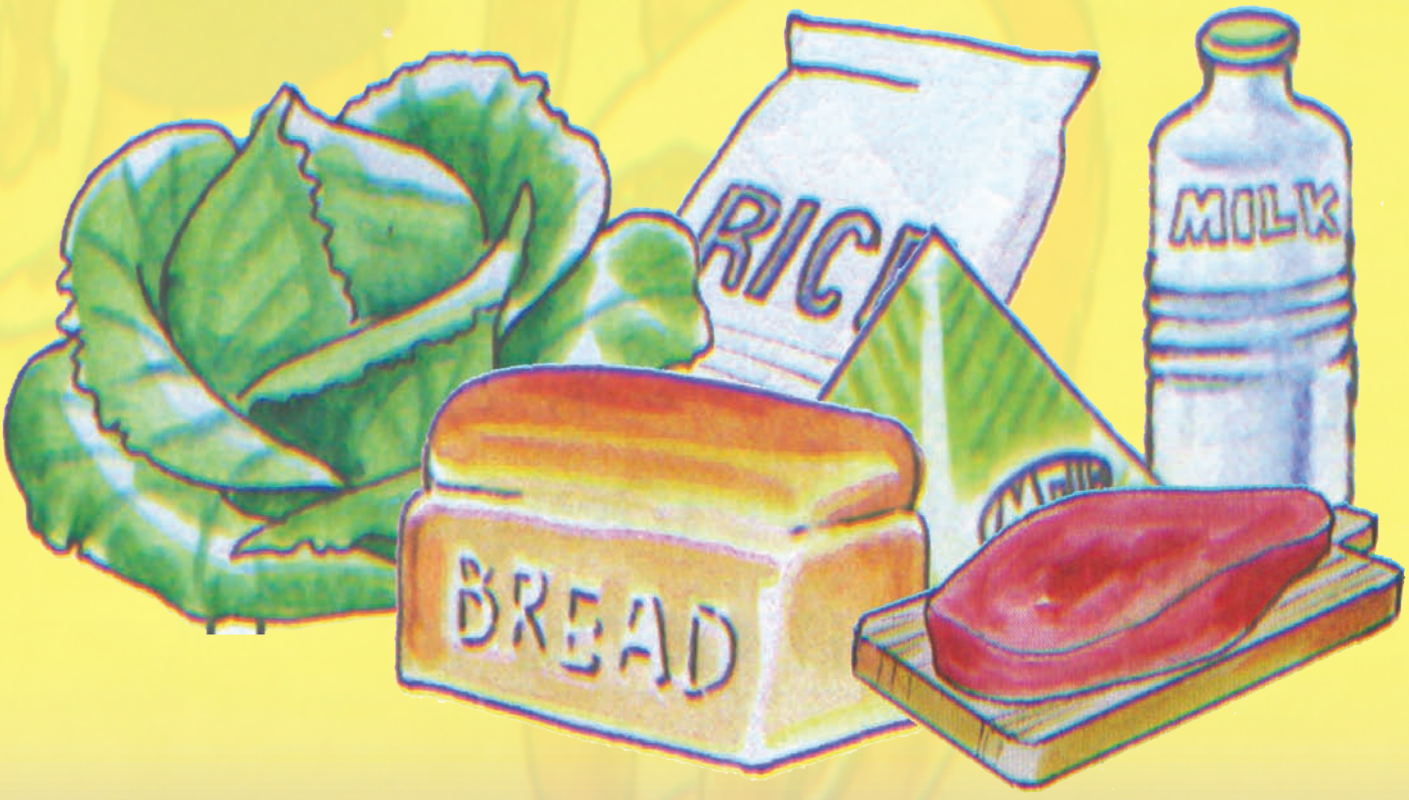


CHART SIXTEEN (16)

COMMON SYMPTOMS AND OPPORTUNISTIC DISEASE INFECTIONS IN HIV/AIDS

- Generalised lymphadenopathy.
- Oral/vaginal candidiasis
- Prolonged Fever
- Chronic Diarrhoea
- Lymphoma (cancers)
- Kaposis sarcoma
- AIDS dementia
- Weight loss
- PCP pneumonia (pneumocystis carinii pneumonia)
- Tuberculosis
- Herpes zoster
- Meningitis

CHART SEVENTEEN (17)

WHAT IS THE DIFFERENCE BETWEEN HIV INFECTION AND AIDS?

HIV infection: One is infected with the virus but remains without signs and symptoms. The HIV test is positive. The virus is actively multiplying and destroying CD4 cells.

AIDS: This is the stage when the CD4 cells have decreased to a state of immunedeficiency. Opportunistic infection begin to attack the body.

Why can't HIV infection be eradicated from the body?

- HIV hides in areas where drugs cannot reach it e.g testis, brain.
- The virus load can be reduced but never wiped off completely.

NOTE

Immunity against one subtype does not offer protection against future exposure to other subtypes. Those already infected should avoid reinfection by other subtypes.

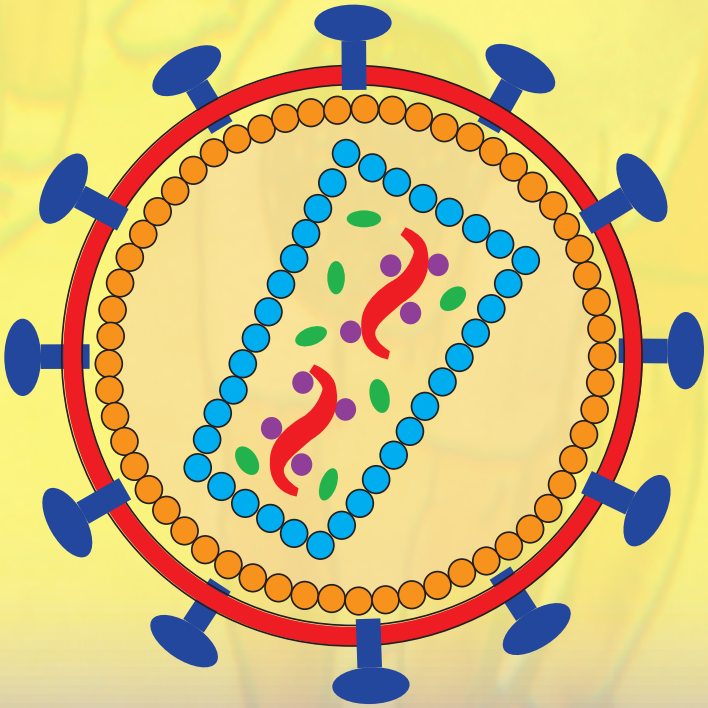


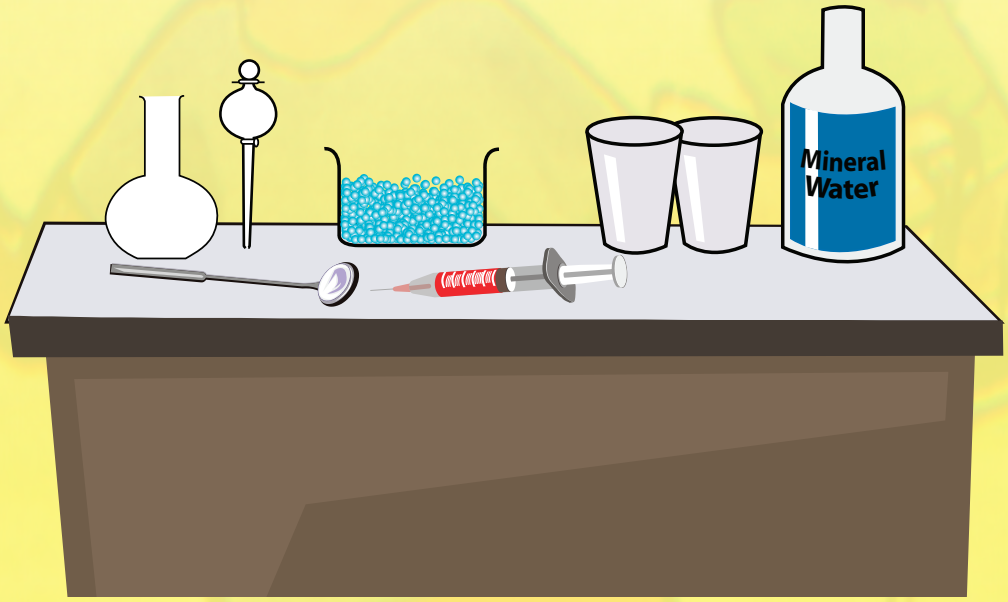
CHART EIGHTEEN (18)

SEXUAL NETWORKING EXPERIMENT

An example of 20 participants has been used

Apparatus

1. Glasses (42) been used
2. Phenopthalein (indicator)
3. Sodium hydroxide crystals: (NAOH)
4. Spatula or spoon
5. Syringes (22)
6. Sterile mineral water.



1. Prepare the experiment apparatus 1 to 2 hrs before. Determine no. of participants and arrange seats for the control group (special guest)

2. Arrange 40 glasses on the table. All of which should be clean and dry. Pour in water to ¾ full in 20 of them.

3. Select one glass and put in 2 teaspoonfuls of sodium hydroxide. Stir until all crystals are dissolved. The reaction is exothermic and glass becomes warm. Early preparation allows it time to cool.

4. This glass is arranged with the rest but should be noted. (Try and put 4mls of this fluid (NAOH) in an extra glass & put in indicator (1mls) to see of colour change is as desired.

5. Introduce the experiment emphasizing it is just an experiment called sexual networking demonstrating exchange of body fluids.

6. Once the 5 special guests are seated serve them with a glass with water and an empty glass. The NaOH one should not be among them.

7. Ask the rest of the participant to pick a glass of water each and an empty glass each. Note who picks the NaOH glass.

8. Demonstrate how they will divide their water in ½ and watch them doing it. The special guests also do it.

9. Ask them to look for a person they trust to keep one glass of water for them. Tell them that is their original fluid and should be kept safe. The special guests also do this.

10. Demonstrate using the syringe how exchange of body fluids will be done. Using 4 mls of fluid show how to aspirate and pour in the neighbours glass taking care not to touch their fluid.

11. Pass round the syringes. Let them practice how to manipulate the plunger. Allow them to mingle extensively among the 15 exchanging fluid 4 times.

12. When they finish ask 4 of the special guests to identify one person among the 15 to exchange with. One special guests should abstain from exchanging fluid.

13. Confirm all 15 have exchanged 4 times. Let them note who they exchanged with.
Emphasize the 4 special guest exchanged only once & one special guest abstained.

14. Ask them to come forward for VCT.

15. Put 1-2mls of the indicator in each of the 15 glasses in a positive test the fluid changes pink / red. Ask those whose fluid changes to pink – red to lift their glasses. Count them together.

16. Ask them to return their tested glasses to the table.

17. Test the special guests. Emphasize he who abstained is always negative

18. Ask them how may people they think were originally positive.
Let them retrieve their original fluid glasses. The special guests too.
Repeat the test in this fluid
Only one persons fluid tests positive this time. (The NaOH) one.

19. Correlate this to the total number of people who become 'positive; in the end.

20. Note that special guests some of those who exchanged only once become positive.

21. The only 100% safe person was the one who abstained.

CONCLUSION

- De 'role' all participants - it is an experiment. The status of any one person can only be confirmed by a blood test.
- Exchange of body fluids represents a sexual encounter.
- It is called networking because the positive person did not exchange directly with everybody who later tested positive.
- Only abstinence is 100% safe
- Even one sexual encounter can result in HIV infection.
- Only a blood test can confirm the HIV status.
- Nobody can tell who is HIV positive by appearance alone.

CHART NINETEEN (19)

TRANSMISSION OF HIV

Definition:

- To transmit is to pass "on something".
- In HIV/AIDS, transmission is the passing on of the virus from one infected person to another who may or may not be infected with HIV.

For HIV transmission to occur

- HIV must be present
- HIV must get into the blood–stream or genital area.

NOTE

Transmission risk is very high when HIV comes into contact with mucous membranes in the genitals, the anus and the rectum which have high number of CD4 cells and a rich blood supply.

CHART TWENTY (20)

RISKY FLUID

- Semen
- Vaginal secretion
- Pre-ejaculatory fluids
- Breast milk
- Blood

NON-RISKY FLUIDS

- Tears
- Sweat
- Saliva
- Mucus
- Urine
- Sputum
- Pus
- Faeces
- Vomit

NOTE

If any of these non-risky fluids have blood in them, they then have an element of risk.

CHART TWENTY- ONE (21)

MODES OF HIV TRANSMISSION

1. Sexual - 80%
2. Blood and blood products - 10%
   - Through transfusion
   - Contaminated needles and syringes
   - Sharing circumcision knives
3. Mother to child - 10%
   - During pregnancy
   - During delivery (carries the higher risk about 60-70%)
   - During breast feeding

TRANSMISSION ROUTES

HIV can enter the body through

- Open cuts or sores
- Directly infecting cells in the mucous membranes

NB:

Healthy, intact skin does not allow HIV to enter the body.

CHART TWENTY- TWO (22)

MYTHS AND MISCONCEPTIONS

YOU DO NOT GET HIV FROM:

- Hugging
- Sharing of toilets
- Sharing utensils
- Shaking hands
- Sharing clothes
- Living in the same house
- Insect bites e.g. mosquito bites
- Observation of hygiene is paramount.

CHART TWENTY- THREE (23)

- Define **STI/STD**?

- Which **STIs/STDs** do you know?

STI -Stands for Sexually Transmitted Infections. These are infections whose main mode of transmission is sexual.

CLASSIFICATION

A. Those that cause discharge from the genitalia or pain/burning sensation when passing urine.
- Gonorrhoea
- Chlamydia
- Trichomoniasis

B. Those that cause sores or ulcers in the genitalia
- Syphilis
- Chancroid
- Genital Herpes

C. Those that cause growths (projections) called warts.
- Human papilloma virus (HPV)

D. Others
- HIV/AIDS – very important
- Hepatitis B

Point of emphasis

Females may habour an STI and not know it yet transmit it.

CHART TWENTY- FOUR (24)

RELATIONSHIP BETWEEN HIV AND STIS

- HIV is an incurable STI.
- Other STIs highly increase the risk of getting HIV by 6 – 10 times.
- It is difficult to treat STIs in an HIV infected person.
- Both STIs and HIV infections are indicators of high risk sexual behaviour.
- One can get infected with HIV and an STI at the same time of exposure.

CHART TWENTY- FIVE (25)

NOTES ON STI TREATMENT

- Seek early and prompt treatment of STIs
- Follow the 4Cs

1. Counselling to avoid further risk
2. Compliance to recommended treatment.
3. Correct and consistent use of condoms.
4. Contact tracing and treatment of partners.

CHART TWENTY- SIX (26)

PREVENTION OF HIV TRANSMISSION

A• PREVENTION OF SEXUAL TRANSMISSION

A. ABSTINENCE and delayed onset of sexual activity.

B. BE MUTUALLY FAITHFUL to one uninfected partner.

C. CORRECT and CONSISTENT use of condoms

D. DRUGS – Treatment of STI

E. EARLY TREATMENT of STI's reduces risk of HIV by 40%

- Prophylaxis against HIV infection in cases of rape and accidental inoculation

CHART TWENTY- SEVEN (27)

B• PREVENTION OF TRANSMISSION THROUGH BLOOD

C• PREVENTION OF MOTHER TO CHILD TRANSMISSION

1. Use of anti-retroviral drugs.
2. Taking medicine for opportunistic infections.
3. Proper ante-natal care.
4. Going for VCT – At the earliest available opportunity (at best, before conception)
5. Avoiding additional exposure to the virus during pregnancy.
6. Avoid breast feeding her child after delivery (on doctors advice) i.e. using alternative milks or exclusive breast feeding and then abrupt weaning.

CHART TWENTY-EIGHT (28)

VULNERABLE GROUPS

Vulnerable means at risk or susceptible.

Vulnerable groups in HIV and AIDS are those at higher risk of getting infected with the human immunodeficiency virus.

Who are vulnerable to HIV and AIDS?

1. Women and girls.
2. Children and orphans.
3. Marginalised groups e.g. homosexuals, disabled.
4. Rape (Survivors of rape)
5. Migrant workers working away from home.

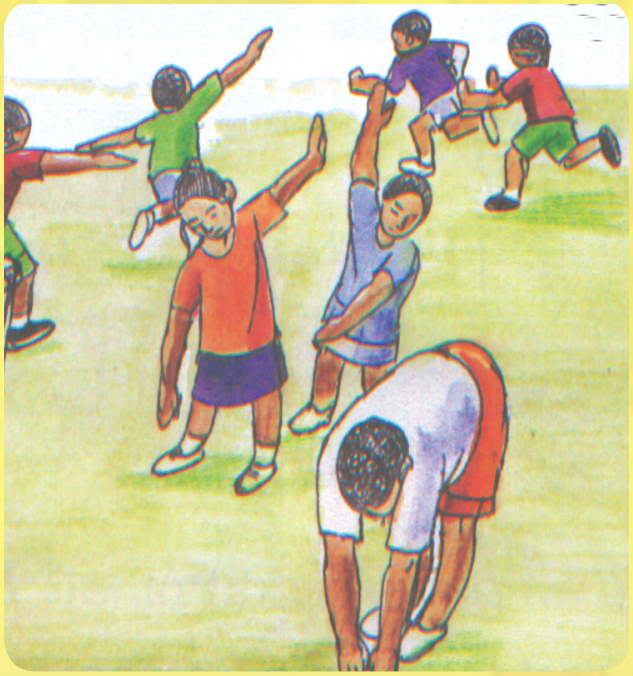


CHART TWENTY-NINE (29)

WHY ARE WOMEN AND YOUNG GIRLS VULNERABLE?

1. Women have an 8-10 times higher risk - biological
2. STDs increase risk due to wounds or mucosal inflammation allowing viral penetration.
3. Pregnancy.
4. Heavier workload, child bearing.
5. Poor diet due to poverty.
6. Wife inheritance.
7. Polygamy.
8. Fear of stigmatisation – afraid to reveal what spouse died of.
9. Prostitution and sexual harassment.

CHART THIRTY (30)

GENERAL CAUSES OF VULNERABILITY

1. Fear, denial and stigmatisation.

2. Lack of information.

3. Lack of education.

4. Lack of human rights.

5. Poverty.

CHART THIRTY- ONE (31)

HOW TO AVOID VULNERABILITY

1. Give correct information.
2. VCT.
3. Discourage discrimination of HIV positive people.
4. Address poverty.
5. Education level improvement.
6. Gender sensitivity.
7. Care of orphans and children.
8. Advocacy of human rights.

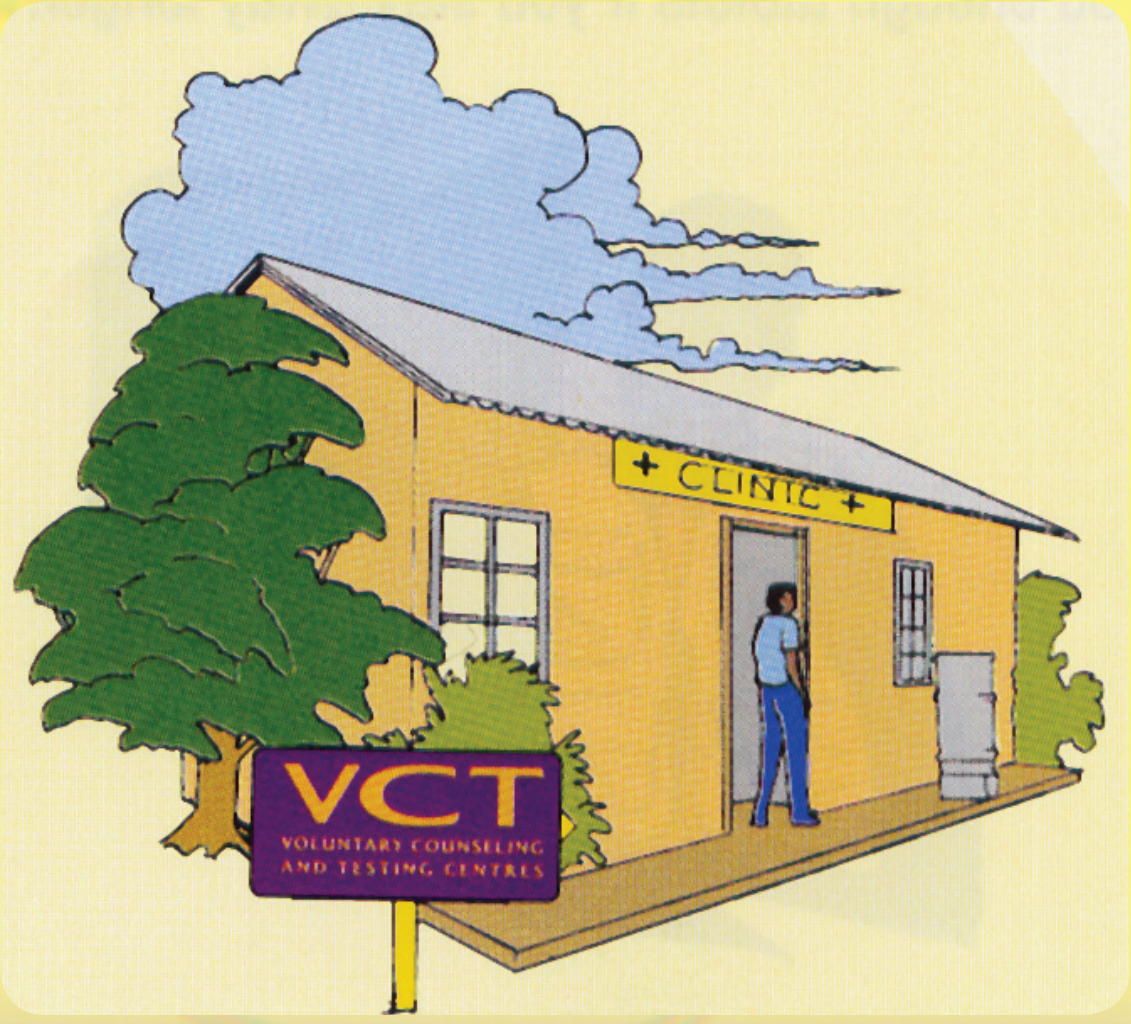


CHART THIRTY- TWO (32)

ANTI RETROVIRALS (ARVs)

Definition

These are drugs that have been developed to fight HIV/AIDS by :

- Delaying the progression of HIV/AIDS to an early death.

- Reduce the viral load burden in the body.

NOTE:

There is no cure for HIV/AIDS.

CHART THIRTY-THREE (33)

BENEFITS OF TAKING ARVs

1. To reduce plasma viral load levels.
2. Reduce incidence of opportunistic infections.
3. Boost immunity shown by increased CD4 cells.
4. Reduce mother to child transmission.
5. Prophylactic use in: (a) accidental inoculation - Health

   (b) Rape - within 72hrs
6. Increase life span of people living with HIV/AIDS. (there is still no cure).

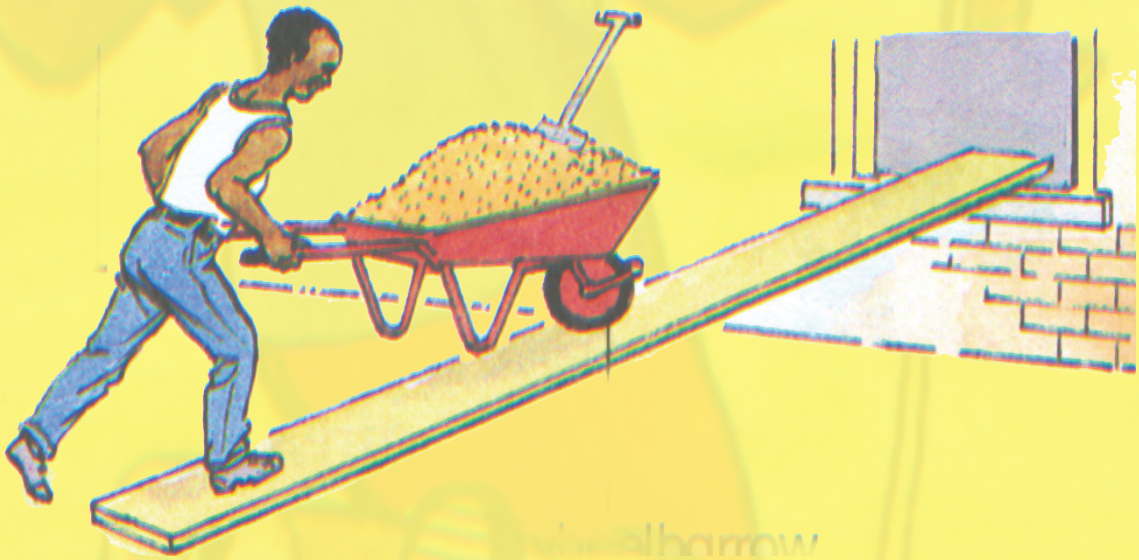


CHART THIRTY-FOUR (34)

A. The commonly prescribed anti-retrovirals are:

1. Zidovudine (AZT), Videx, Zerit
2. Stocrin, viramune
3. Indinavir, Ritonavir, Saquinavir

B. The gold standard of antiretroviral therapy is HAART (Highly Active Antiretroviral therapy)

NOTE

HAART is a combination of three or more antiretroviral drugs in treatment of HIV infection. HIV has the ability to rapidly develop resistance if one is used alone.

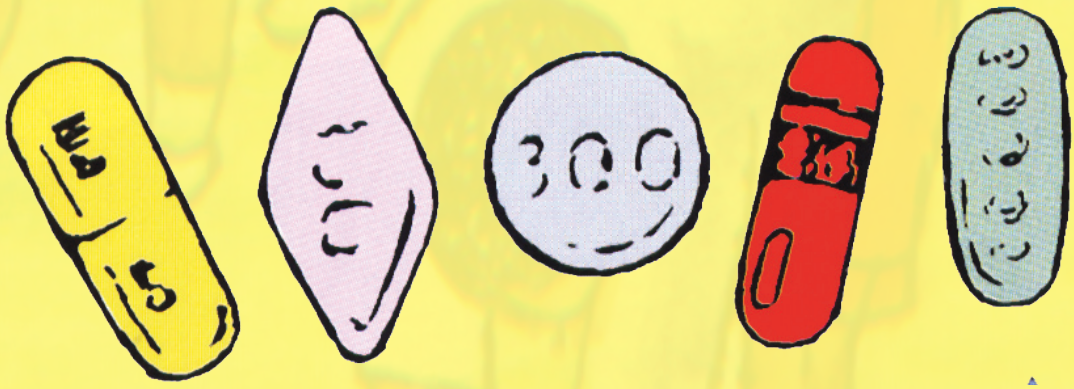


CHART THIRTY- FIVE (35)

The decision to start therapy should be made after considering:

- Patients acceptance or readiness.
- Probability of adherence/compliance.
- Clinical state i.e. symptomatic HIV
- CD4 cell count <200mm ^{3}
- Viral burden/load>100,000 copies/ml.

CHART THIRTY - SIX (36)

The access to drugs in Kenya is increased due to:

(a) Reduced cost

- Triple therapy (HAART) is now Kshs 100/= in Government of Kenya hospitals and Kshs 1,500/= (cheapest) combination in the private sector.

In KNH - 100 per month.

(b) Increased availability in many centres.

- Mission for Essential Drugs.
- Mission hospitals.
- Private hospitals - Aga Khan and Nairobi Hospital -ART clinics
- Coptic church hospital - those who cannot afford get free drugs on arrangement

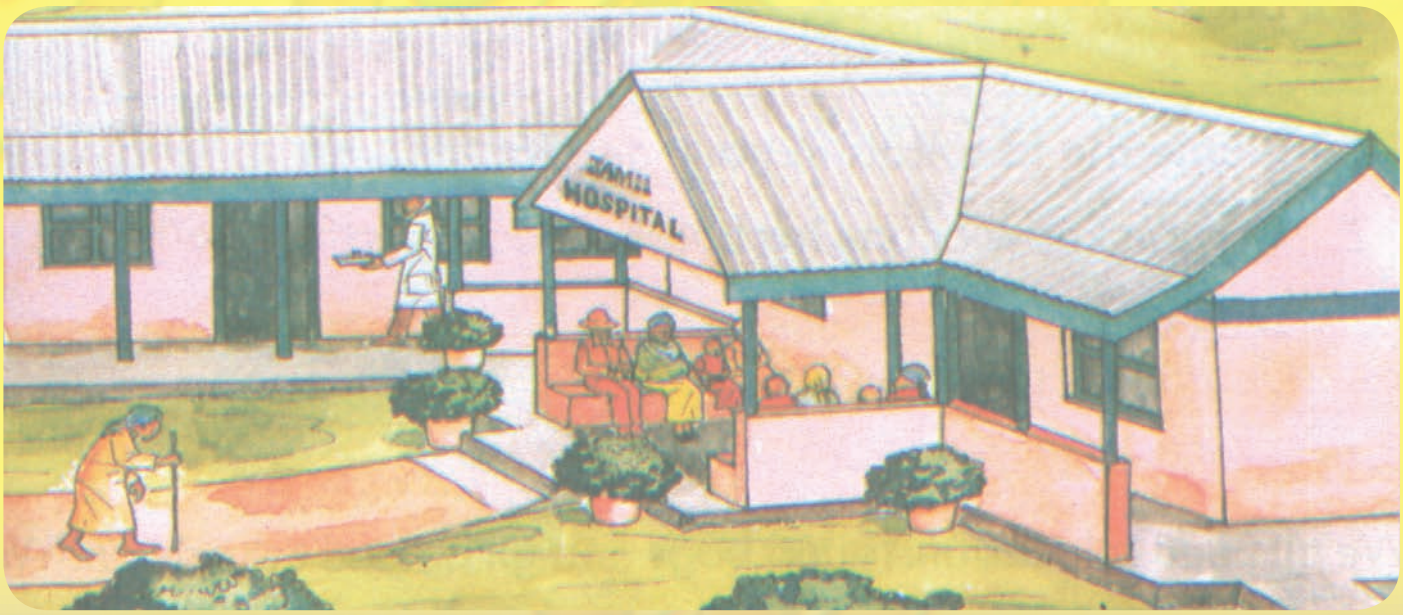


CHART THIRTY - SEVEN (37)

- ARVs need to be initiated by people trained in treatment and monitoring them.

- Compliance is very important to get desired results.

- Recommended drug combinations keep changing according to need, development of resistance and tolerability.

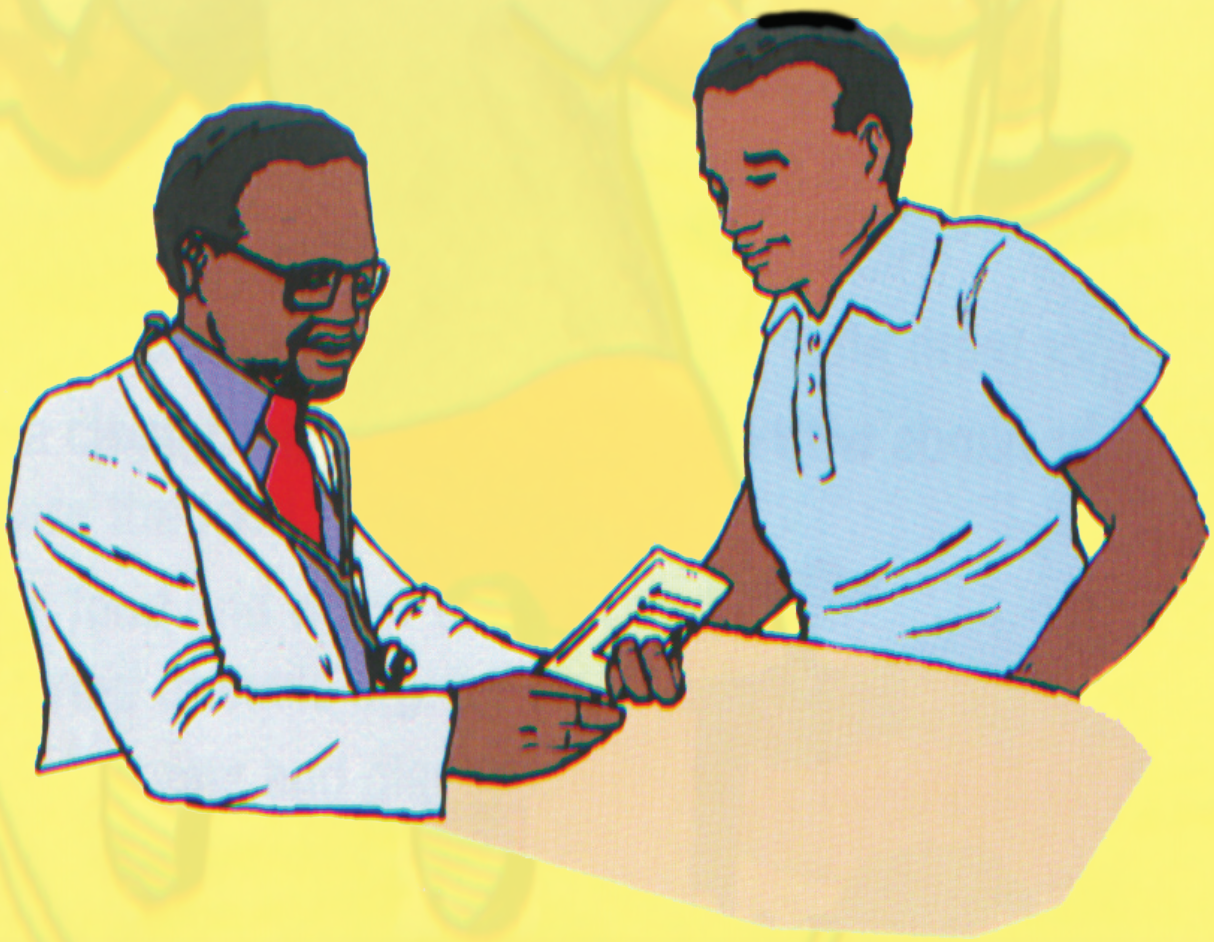


CHART THIRTY - EIGHT (38)

NUTRITION AND HIV/AIDS

Why do you eat?

Generally, we eat so that our bodies can:

a) Develop, repair and replace cells, tissues and muscles.

(b) Produce energy to keep us warm and enable us to move and work.

(c) Develop resistance and protection against infections.

(d) Fight and recover from sickness.

CHART THIRTY-NINE (39)

IMPORTANCE OF GOOD NUTRITION IN HIV

(a) It enables an infected person to cultivate healthy eating habits.

(b) Helps an infected person maintain good health and quality life.

(c) It reinforces the effect of medications.

(d) Nutrition education allows for "all time" food security.

NOTE:

Good nutritional status is important from the onset of HIV infection

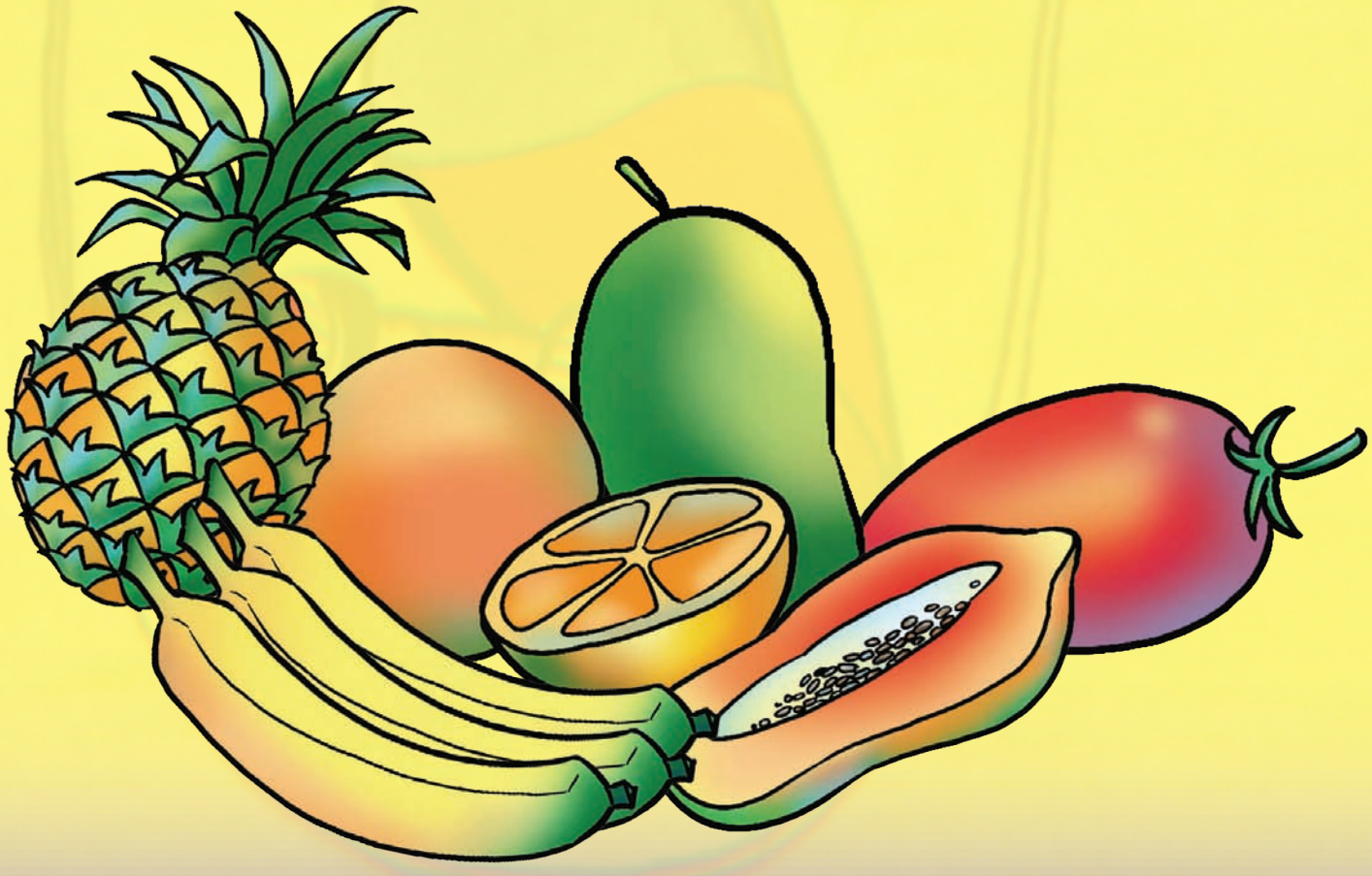


CHART FORTY (40)

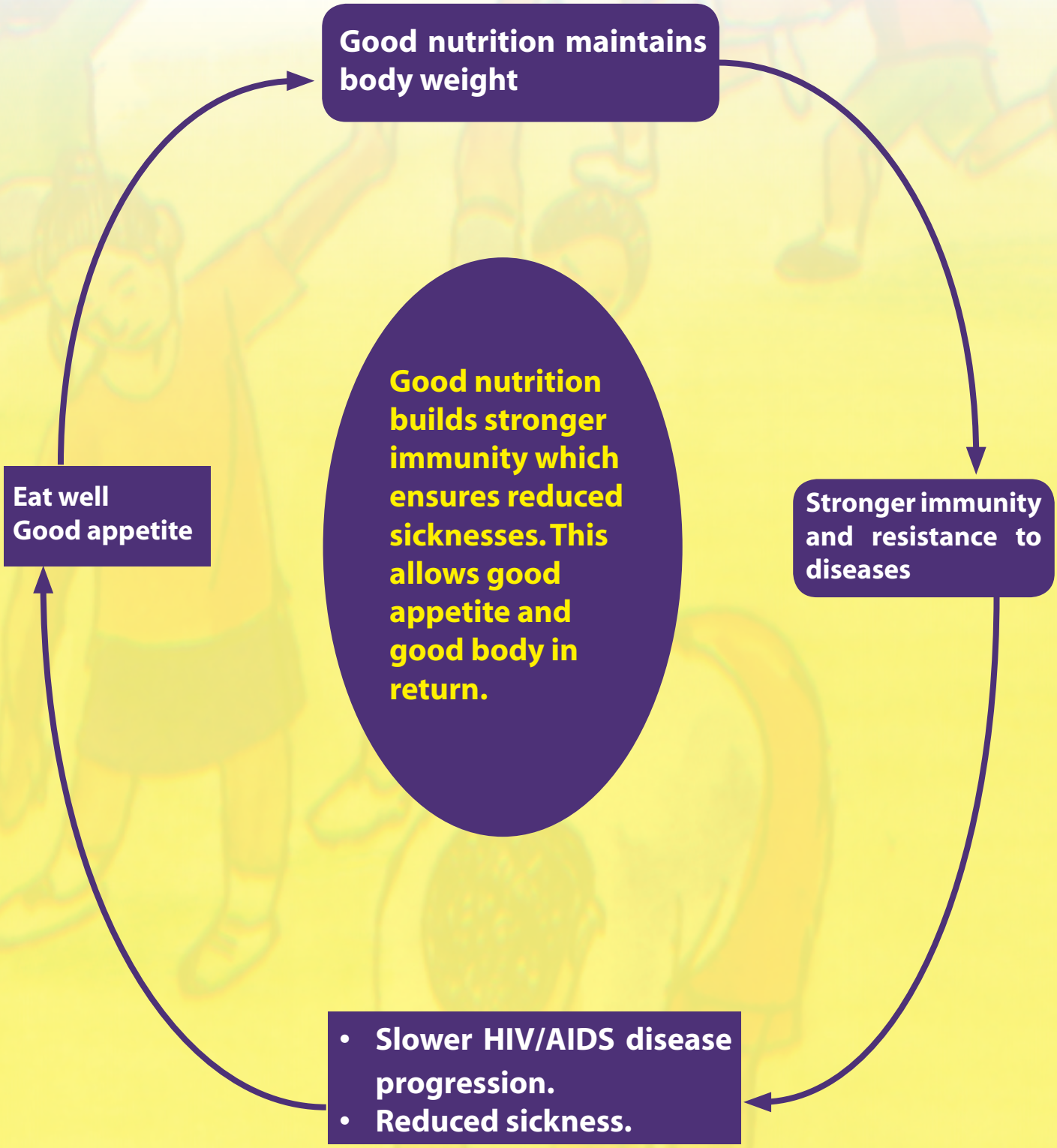


CHART FORTY- ONE (41)

WHAT SHOULD YOU REALLY EAT?

Enjoy a variety of foods in order to get adequate supply of all nutrients. They should include:

(a) Staple cereals with every meal e.g. rice, maize, irish potatoes, cassava, yams, banana. They supply energy and some proteins.

(b) Legumes e.g. Soya, peas, beans, groundnuts, simsim. They provide proteins, vitamins, minerals and fibre needed to develop and repair tissues as well as build muscle.

(c) Dairy and animal products e.g. eggs, fish, meat. They supply high quality proteins, vitamins and minerals which help to strengthen muscle and the immune system.

(d) Vegetables and fruits e.g. pumpkin, spinach, pepper. They help the body to fight infections.

(e) Fats, Oils and Sugar are a good source of energy and they also help stimulate appetite.

(f) Drink clean boiled water.

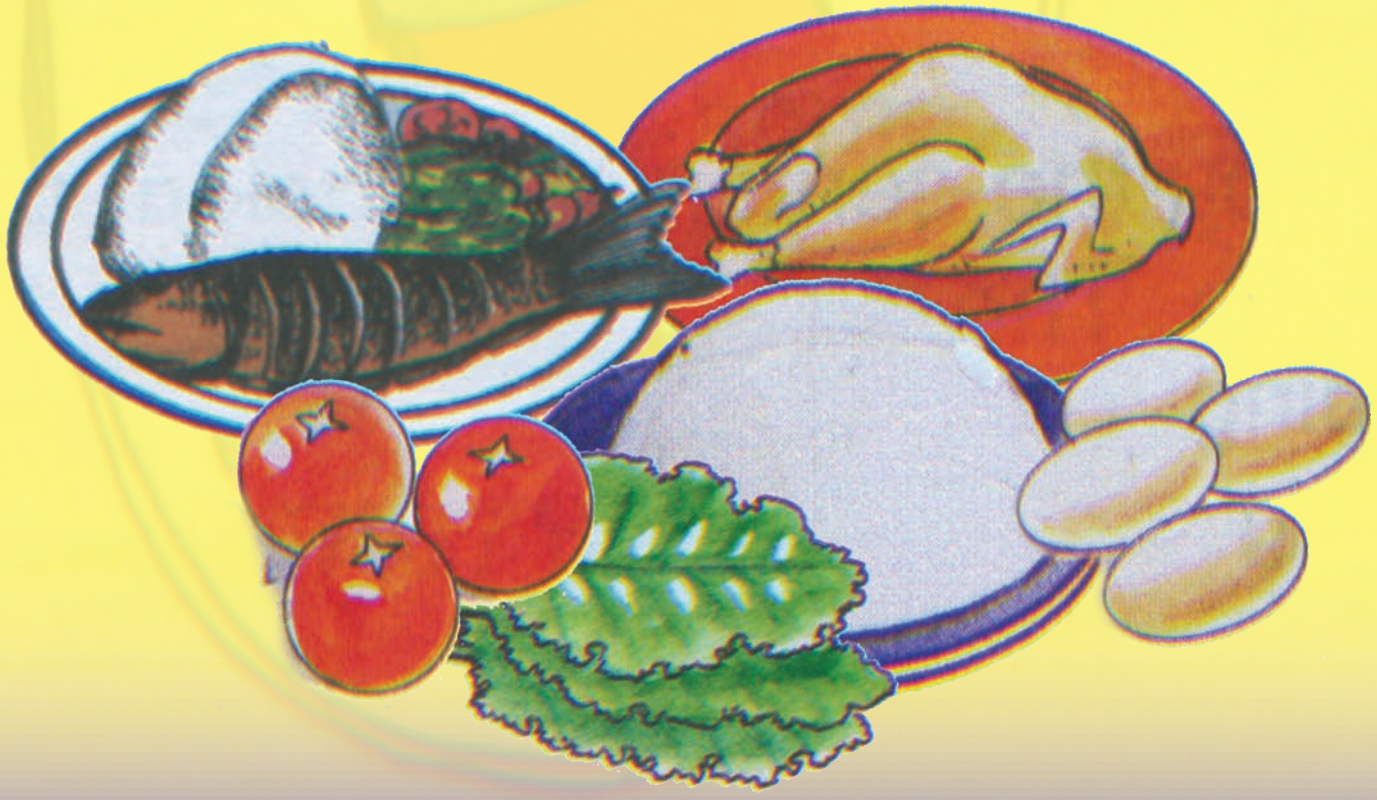


CHART FORTY- TWO(42)

POSITIVE LIVING IN HIV/AIDS

Definition

Positive Living encompasses what one needs to do to stay healthy longer when one is HIV positive.

In positive living, we advocate five basic/essential "Ls"

- Believe in yourself that you can do it.
- **L**earning all you can do.
- **L**istening to your doctor/health care provider.
- **L**eaning on others.
- **L**etting be (relieve stress, anger, negative emotion)

CHART FORTY- THREE (43)

POSITIVE LIVING ENCOMPASSES

1. Maintaining body weight through proper nutrition.

2. Maintaining personal hygiene.

3. Regular physical exercises.

4. Behaviour modification. Practising responsible sexual behaviour.

5. Continuing with work.

- Important as a means of raising income.

6. Continue with social life BUT avoid alcohol, tobacco and addictive drugs.

7. Seek medication and medical advice.

8. Regular counselling:

- To be able to share and explore your problems and situations.
- Helps to deal with day-to-day problems.