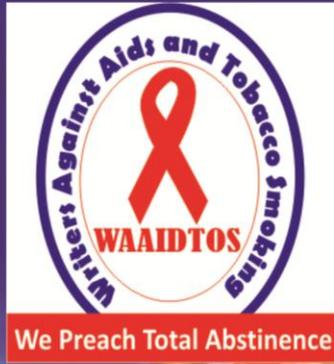


Writers Against Aids and Tobacco Smoking

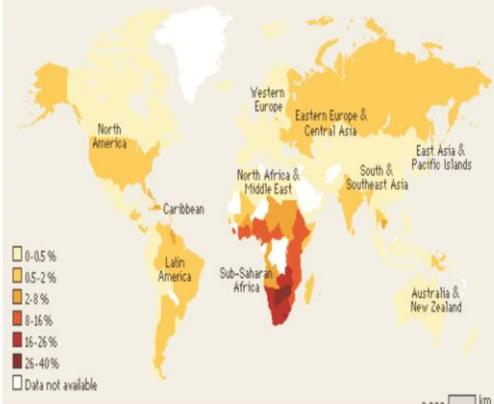


HIV/AIDS A TIMELESS SCOURGE

(A Collection of Poetry, Essays and Articles on HIV/AIDS)



PERCENT OF PEOPLE AGED 15 TO 49 INFECTED WITH HIV IN 2002



Edited By;
Wole Adedoyin

**A Publication of the Society of Young Nigerian
Writers**

Compiled by:

Wole Adedoyin



For The Literary And Creative Development Of Nigerian Young Writers

Dedication

Dedicated to all the Contributors.

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FORTRESS

As snares are laid
around
With enticing fruits, I
Battle with an array of
Conflicting pills to swallow

As the desires quell
The multiple aches within
Heightens, pictures of comparisons
Of after effects begin to
Play itself before my eyes

Should I indulge or wait till
The foxes are roosting?

As I glance deeper steel into
The scenario, the after effects of
Quelling each ache begins to
Play out itself before me

As my choice of pills is settled
I ascend into a level of inner
Tranquility and elements of defense

Sprout all around me
Enabling me to fortify my
Undiluted freshness for
A future festivity

**PATRICK CHUKWUEMEKE DACO
OLISEHAMAKA**

But prefers to be addressed as Emeke Daco. He hails from the Ibo speaking part of Delta state, Nigeria. Attended crèche, primary and secondary schools in Nigeria. Subsequently moved to South Africa to reside and further his education. He still lives in South Africa.

TEENS WITH HIV TAKING MORE RISKS

Teenagers infected with HIV are more likely to engage in risky sex and drug use since the introduction of powerful medicines that effectively keep AIDS at bay, a new study finds.

The trend, which began surfacing after highly active antiretroviral therapies (HAART) were introduced in 1996, points to the need for targeted interventions to reduce risky behavior and improve quality of life for those in this group, the researchers noted.

Roughly a quarter of the 40,000 new HIV infections in the United States each year occur in people under the age of 21, according to the federal Centers for Disease Control and Prevention.

"Young people, post-HAART, are engaging in more unprotected sex and engaging in more substance abuse, and are more emotionally distressed and have a lower quality of life," said lead researcher Marguerita Lightfoot, an assistant research psychologist at the University of California, Los

Angeles' Center for Community Health.

This finding was surprising, Lightfoot added. "I had a hypothesis that the young people who are taking HAART would be healthier, because they had more hope, they were living longer. And I was surprised that that wasn't the case."

In the study, Lightfoot and her colleagues compared behaviors among 349 teens with HIV from Los Angeles, San Francisco, New York City and Miami from 1994 to 1996, with 175 teens with HIV in the same cities from 1999 to 2000.

The two groups did not include the same people, but they were a similar mix of sex, age, race and ethnicity, as well as socioeconomic factors, according to the report in the March issue of the American Journal of Health Behavior.

The researchers found the post-HAART group was almost two times more likely to have had unprotected sex. The post-HAART teens had almost twice the number of sex partners, compared with pre-HAART teens. And post-HAART teens were more likely to have a sexual partner who used injected

drugs.

In addition, the post-HAART group was diagnosed with HIV at a younger age and was in worse health than the pre-HAART group, Lightfoot's team found.

Lightfoot said there are a number of reasons for these findings. She noted the powerful drug regimen isn't perfect. "There are increased expectations for HAART," Lightfoot said. "But not everyone is successful on HAART."

Lightfoot also noted that teens infected with HIV are more apt to be involved with the juvenile justice system and spend time in jail. "Maybe it says something about the kind of young people who are more likely to be infected with HIV. These are the people who are most at risk," she said.

In addition, because being on HAART makes people feel safer, they are more likely to engage in unprotected sex. People also feel that HAART makes HIV a disease that they can live with, Lightfoot said. This attitude is also found among HIV-positive adults, she noted.

"The ones who are getting infected are the ones who are not getting the prevention messages," Lightfoot said. "We are seeing that as a trend among people of color, who are the fastest-growing population getting HIV."

"We need to be targeting these young people for interventions, not only to prevent them from transmitting the virus, but we need to be helping them with their emotional distress," Lightfoot said. "We have a real opportunity to prevent the further spread of HIV if we focus on the young people who are actually living with it."

Another expert found the study conclusions disturbing.

"It is distressing that things had gotten worse for the more recent group of teens living with HIV," said Freya Sonenstein, a professor and director of the Center for Adolescent Health at Johns Hopkins Bloomberg School of Public Health.

Sonenstein focuses on the type of teens who are most likely to become infected with HIV to explain the findings. "An explanation for the study findings is that the teens living with

HIV have become selectively more disadvantaged," she said.

"HIV transmission is now more likely among disadvantaged teens than it was in the earlier period. Still, I think that we should expect the care and support systems for this group to improve, and the call for improved programming is justified," Sonenstein added.

In some good news, a report in the Feb. 28 issue of the Archives of Internal Medicine found that HAART is indeed effective at keeping HIV patients from progressing to AIDS, and also in preventing the development of opportunistic infections associated with HIV/AIDS.

In this study, British researchers collected data on 12,574 patients over three years.

"In this large, multi-cohort study, we demonstrated a significant reduction of the incidence of opportunistic events, regardless of etiology," the authors concluded.

OPPOSITION TO STATE-MANDATED

PREMARITAL HIV SCREENING

When screening for HIV became possible in mid-1985, debates began concerning the role of such screening in controlling the spread of AIDS. One such debate concerned state-mandated premarital HIV screening. This policy was proposed to the CDC conference in February of 1987, but never received much widespread support, because it satisfied neither the proponents of public health nor the proponents of civil liberties (Reamer 37). This essay will show that the state is unjustified in enacting such policy and hopefully also shed some light on why such policy received so little support.

In a liberal society such as the United States that values both civil liberties and public health, it is often unclear which policies best address the threat posed by the AIDS epidemic. It is clear that on the one hand, the United States is committed to respect the privacy and personal autonomy of its citizens. Though not expressly written in the constitution, the right to privacy is implicit in the right to deny illegal search and seizure of home and explicit in the

recent laws that protect the privacy of internet and credit card users. On the other hand, the United States is also committed to "promote the general welfare", meaning it has a moral obligation to promote public health. Traditionally, in the struggle between civil liberties and public health, the United States has given precedent to civil liberties but yielded to departures when it was proven that doing so was justifiable by the resulting benefits to public health. AIDS, however, challenges the balance between civil liberties and public health like no other previous epidemic, due to the strong threat it poses to public health and the intimate nature of its mode of transmission.

In his essay, "Mandatory HIV Screening and Testing", James Childress identifies conditions which justify departures from the prima facie principles of personal autonomy and privacy in order to promote public health:

"First, it is necessary to show that a policy infringing these rules will probably realize the goal of public health...Second, it is necessary to show that the probable benefits of a policy infringing rules outweigh both the moral rule infringed and any negative

consequences...Third, if it is possible to protect the public health without infringing liberty and privacy (and other moral rules), then the society should do so...Fourth, even when a liberal society is justified in infringing its moral rules to protect the public health, it is obligated to seek policies that least infringe its rules." (Reamer 54-55).

Using these conditions as his framework, Childress analyzes the ethical value of state-mandated premarital screening. Although such screening is in fact a mix of a voluntary choice to get a marriage license and a compulsory act to get tested, those seeking marriage cannot be said to have voluntarily given up their right to privacy. Hence, we may still analyze such state policy under the framework of justifiable departures from prima facie bindings.

There is not much information on the subject of whether premarital HIV screening would actual promote public health or not. The closest analogy that exists is premarital syphilis screening. Notwithstanding the disagreement in the effectiveness in such screening, a major difference between syphilis and HIV is that syphilis is curable, whereas HIV is

not. Still, there is some data from the state of Illinois, which passed a law requiring premarital screening that was repealed six months later (Reamer 63). Of the 70,846 applicants for marriage, 8 tested positive for HIV (Reamer 63). Half of those that were seropositive admitted to having engaged in risky behavior. Clearly, the first two conditions of our ethical framework for infringing on privacy and personal autonomy are not met (Reamer 63). The cost of the testing program used in Illinois was estimated at \$2.5 million (Reamer 63). Because of the incredible low prevalence of seropositive individuals in this target group it is unjustifiable for the state or for those seeking marriage licenses to bear the burden of this program in the name of public health. Furthermore, because half of those found seropositive admitted to having engaged in risky behavior, they could probably have been identified through programs aimed at groups with a higher prevalence of seropositives. Hence, the last two conditions of our ethical framework are also not met.

Using an ethical framework borrowed from Childress, it is clear that a state committed to upholding the civil liberties of its citizens as well as promoting public health is

unjustified in mandating premarital HIV screening. Such screening infringes on civil liberties and does not promote public health in an efficient way. The state is obligated to seek other policies by which to promote public health, such as voluntary testing and educational programming for married couples, which do not violate civil liberties and which more efficiently target those who are seropositive.

ADULT BEHAVIOR PATTERNS THAT CONTRIBUTE TO THE SPREAD OF AIDS/HIV

Introduction

It is during the ages of 18 and 24 that time of life that many adults are sexually active but not always in monogamous relationships. It is a time of life when one can easily contract either AIDS or another STD due to behavior. Young adults are working during the day and doing their socializing at night, and this socializing almost always includes substances such as alcohol and drugs to help alter their mood, or judgments. Thus causing the person to become easily overcome with doing “what feels right” and not “what is safe or will protect them.”

Behavior is key in controlling AIDS. AIDS is a leading cause of death among Americans between the ages of 25 and 44 (“Miss America” PG). More than 340,000 have already died from AIDS and The CDC estimates that between 40,000 and 60,000 Americans are becoming newly infected with HIV each year (PG). Estimates are that one quarter of all new HIV infections in the United States occur in people between the ages of 13 and 20 and many of these young people are gay or

black (PG).

Body

Since the 1990s the epidemic is now beginning to favor women (Ross 56). The epidemic is shifting toward women and although women accounted for 28% of HIV cases between 1981 and 1999, they represented about 32% of reported cases that occurred between June 1999 and July 2000 (56). In fact, the spread of AIDS is certainly attributable to behavior as it is suggested that when abstinence is practiced, or programs are launched that preach an absence of sex, AIDS rates drop. But other method of reducing AIDS and HIV results when "safe sex" is practiced.

Colin Powell was criticized for suggesting that using condoms is better than not when engaging in sexual intercourse. The reasons for the criticism include the fact that people perceived the authority figure as endorsing sex, and further and most importantly, giving the false impression that condoms automatically prevent AIDS from spreading. While condoms do help, they do not completely protect people from contracting AIDS. It is still possible to get the disease while practicing "safe sex." While many do believe that condoms

are very effective, the truth is that using condoms to prevent HIV "does not...eliminate all risk" ("A response" PG). Although it is the case that condoms are not 100% effective, they are certainly important in preventing AIDS and so one can say that safe sex behavior is important in the prevention of HIV and AIDS.

A survey had been taken to show that people with higher levels of education were more likely to believe that condoms are very effective in AIDS prevention ("Public" PG). Approximately 47% of college graduates report that condoms are very effective, as compared with 37% of those who had only completed high school (PG). Also, it has been noted that 28% of adults who did not complete high school believed in the effectiveness of the condom (PG). Age is further an important demographic in that reportedly 49% of 18 to 24-year-olds suggest that condoms are "very effective," as compared with 27% who are in the 55-64 age group (PG). Seemingly, younger people are more likely to believe that condoms are good protection, and while they are correct, they must realize that using condoms for AIDS prevention mandates its consistent and correct use. Young people are more likely to be lax about protection and so perception,

while correct, may have drawbacks. The complaint--and which is why Powell got into trouble--is that abstinence works best and there is a false sense of security in believing that condoms are very effective.

The above chart demonstrates that younger generations are more informed, but again, the information is a double edged sword. While the condom is effective, a person should not and cannot take its capacity for protection for granted. There are those who find the idea of contracting AIDS either appealing, or at least the risk is somewhat tempting. There have been stories of orgies where one infected person is in the room and the thrill is similar to that of playing Russian Roulette. Of course, such risks are devastating to the spreading of AIDS. There is also some evidence that a section of the homosexual community exists that deliberately tries to get the AIDS virus ("Death Wish" 48). A practice called "bare backing " is engaging in anal sex without the benefit of condoms; here, the HIV-positive partner is considered a "gift giver," where someone seeking the virus is considered to be a "bug chaser " (48).

I can not understand why people would deliberately try to

acquire a deadly disease, one Toronto "barebacked" named Paul explained that AIDS is no longer the death sentence it once was and he adds: "... I'm a person that likes to play the odds...Yeah, people will think I'm nuts, and they're more than welcome to think I'm nuts. I'm taking back my sexual freedom " (48). Part of it is a desire for freedom not to worry about getting sick. Young adults are risk takers and so the younger set--say between 18 and 24--are probably at greatest risk (48).

Conclusion

People try to protect themselves by using condoms and minimizing sexual contact. Some remain celibate until they are married. I have met a growing number of young adults who have made the choice to abstain from sexual intercourse. Young adults are most at risk due to the fact that they are more likely to have more than one sexual partner until they are older and marry. A program, which involves teenagers who have already engagement in sexual intercourse, are making a pact to become "born again virgins." These young adults are getting involved in support youth groups that promote this type of responsible sexual responsibilities. My younger cousin who is very active within her church youth

group helps to organize the outings and group meetings for a similar program within her church. She herself is still a true virgin and knows the importance of abstinence. She explained that the young teens in her group feel that by pledging and practicing abstinence they are getting a second chance at becoming responsible sexual adults in the future. They are more informed, but are also more likely to take risks. Because condoms are seen as very effective in preventing the spread of AIDS, they rely on it, not thinking about the slight risk. In any event, behaviors do affect outcome and risky behaviors can accelerate the spread of AIDS and HIV.

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REDUCING THE RISK OF HIV AMONG ADOLESCENT GIRLS

According to the CDC, the majority of female adolescents will have had at least one sexual partner by the time they reach the age of 18. Once reserved for high school students, sex ed is now being introduced in junior high and even elementary schools. It is undeniable that our teenagers are becoming sexually active earlier and inevitably, are vulnerable to sexually transmitted infections and HIV. While it is impossible to alter the choices of sexually active teens once they have been made, it is a mandate for those who interact with them to equip teens with the proper resources to make smart choices and offer suggestions to modify risky behavior.

The aim of this particular study was two-fold. First, the authors studied the possibility and practicality of reducing the HIV risk among adolescent girls through the utilization of a small group, community-based setting. Secondly, the effectiveness and usefulness of such an intervention was determined and further analyzed using a controlled design. In the examination of statistical conclusion validity pertaining to this study, one threat that is imperative for the

reader to consider lies in the low statistical power of the study. With 129 girls recruited, less than half (62) attended either the HIV or control intervention groups with only 48 completing the three month follow up session. Polit and Beck states that studies with low statistical power may not succeed in establishing a relationship between the variables. As a pilot study, it is hardly dismissive and worth noting that, at best, a relationship may be present or could be present between the two variables, however, the low statistical power causes me to hesitate to assign an irrefutable relationship between the intervention group and reduced risk behavior as demonstrated by the behavioral changes (decreased substance abuse, increased knowledge on HIV prevention, fewer engagement in risky sexual behavior). The authors acknowledged this threat to the statistical conclusion validity but also noted that outcomes were “encouraging”.

Attrition presents a threat to both statistical conclusion and internal validity. In the aforementioned statistics, it is obvious to deduce that attrition was a direct result of the unavailability of many girls, which consequently resulted in low statistical power. The attrition rate in this study can be considered random as it was blamed on work schedules and inability to form contact and did not alter extraneous

characteristics of those remaining in the study. The attrition rate along with selection bias that may have occurred make it difficult for me to determine a resolute causal inference between the intervention and the outcome. The outcome could have also been influenced by the girls' desire to please the researchers, "give them what they're looking for", or motivated by the monetary reimbursement. Again, as a pilot study in which the efficacy and feasibility of such interventions is also studied, this study can act as a catalyst to strengthen future studies of similar nature.

Perhaps the most exigent validation tool in the notion of design validity, construct validity observes whether the cause in a study, when operationalized, represent what the investigator(s) say they are representing. In the discussion of confounding of constructs in which a treatment is "more than" what it is conceived to be, one potential source of confounding may that of participant expectancies. In providing a group-based setting in which discussions were facilitated, we cannot eliminate the possibility of the participants gradually viewing the "treatment" as more of a support group or safe haven for discussion of sensitive topics and for answers to urban legends or myths in relation to sexual behavior and HIV. Following this, participant

expectancies are altered and may present a threat to construct validity. In this case, altered participant expectancies can be considered an insignificant threat due to the fact that the altered participant expectancies may actually enhance or contribute to the outcome.

In assessing whether an inadequate pre-experimental explication of the effect is a threat to the construct validity, I believe this study pointed towards a reasonable and plausible outcome for its treatment. While there are many opportunities to further strengthen the study's statistical conclusion and internal validity, the effect of the treatment was appropriate and did not present a threat to the study's construct validity.

The external validity of a study is looked upon to evaluate whether the findings can be generalized to other situations and populations. This study was fashioned after a study conducted by Casey et al., 2000 in which African American women were also randomized to HIV risk reduction or a control group. Our study included girls aged 15-19 with 59% whites, 29% blacks, 10% Hispanic, and 2% Asian whom were all sexually active. The study cannot represent male adolescents nor can it be generalized to include adolescents

from rural or suburban environments. The representation of this study can be considered generalizable to other urban populations, however, because of the small number of subjects, the external validity is not considered to be solid. This follows Polit and Beck's argument that it is impossible for a study to be externally valid if internal validity is lacking.

The study's threat to validity could have been decreased through the careful retention of study subjects through follow-up phone calls or emails and also through the initial recruitment of more study subjects. Extensive recruitment for a larger sample size is also held to practical limitations of manpower and finances. If the researchers had chosen to extend the longitudinal aspect of this study design with a follow up study say, one year down the road, the lifestyle and behavioral change or retention of education received could therefore be studied and taken into account. The limitations of a follow up study one year down the road in addition to the three month follow up is that an even higher rate of attrition can be expected.

The authors were relatively successful in this pilot study in that despite the low statistical power and high attrition rate,

the study proved the feasibility and efficacy of the intervention and pioneered a path for future evaluations and studies (with larger samples) to reduce HIV risk among the vulnerable. The authors qualified their findings adequately by being realistic and willing to acknowledge the limitations and inadequacies of their study. In conclusion, this was a significant pilot study for educators and healthcare workers alike who seek to create new and effective methods of reducing the risk of HIV and changing sexual lifestyles among teens. Extending beyond just sexual education, this study attests that teens enjoyed the ability to express their concerns and to have misconceptions clarified about HIV risk and other sexuality issues that are not addressed at school or through parents. This study can benefit from further research and evaluation.

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US GOVERNMENT MISINTERPRETS UGANDAN HIV/AIDS SUCCESS STORY

The United States Government should embrace a comprehensive HIV prevention policy that emphasizes condom use, rather than the current policy which is largely based on misinterpretations of the Ugandan HIV success story.

According to the United States Agency for International Development (USAID)—which manages most of President Bush’s “Emergency Plan for AIDS”—in 1991, 15 percent of Ugandans were infected with HIV. By 2001, the rate was 5 percent, a drop unmatched anywhere in the world. How this was done and what this means for the shape of Washington’s programs to fight AIDS overseas has been tragically misinterpreted by the US Government.

According to Dr. Justin Parkhurst, who wrote his dissertation on Ugandan HIV prevention policy at the University of Oxford, Uganda was successful for reasons different than the US Government officials would have you believe.

A frequent mistake, he said, is the notion that declined prevalence was due to a few specific interventions by the Ugandan government. He emphasized that the government was but one player—among numerous NGOs, church groups, community activists—in the fight against the virus. He also emphasizes that condom use, rather than abstinence and being faithful, was the most important behavior change that influenced declined HIV prevalence.

“Unfounded claims of Ugandan success have persisted in international policy discourse,” he noted. Although the Ugandan experience could provide invaluable information to other nations in their prevention efforts, he said, “inappropriate recommendations based on poor interpretations of evidence must not be used as the basis for policy.”

Such misguided policy pervades the US Government’s HIV prevention activities. While the Director of UNAIDS-Uganda, Dr. Ruben de Robiene, commented, “I don’t know what the

Uganda Model is, no one knows,” the religious right within the US Government is convinced that it knows Uganda's secret: abstinence and being faithful.

According to a USAID report, “Condom social marketing did not play a major role” in Uganda’s relative success. Dr. Anne Peterson, a physician and the USAID director of global health who is responsible for overseeing US anti-HIV programs, says, “Kids are willing and able to abstain from sex. The core of Uganda's success story is big A, big B and little C.”

Dr. Peterson said the US’s HIV prevention policy is not an ideological balm for religious conservatives or any other group beholden to the Bush administration. “I am a public health physician. I take data seriously,” says Dr. Peterson, who spent nearly a decade working for Christian organizations before joining USAID.

Furthermore, according to Dr. de Robiene, “The US is taking its own, erroneous version of the Uganda model to other African nations.” But only by understanding the entire program can one grasp Uganda's success and build models for other countries.

“When I hear this debate I get very annoyed,” said Sophia Mukasa Monico, who until 2001 was the director of TASO, Uganda's largest NGO helping the infected. “It is so unfair to pull out one element of a bigger picture—a very small percentage of the whole picture—and say, ‘This is what works.’” Uganda is indeed a model for nations fighting AIDS, but it is not quite the model the religious right would like to believe.

Dr. Parkhurst, Dr. de Robiene and other experts believe condom use played the most important role in Uganda's relative success. During the 1990s in Uganda, “The use of condoms in high-risk groups rose to the highest level in Africa.” Ugandan Army Major Rubaramira Ruranga, who has been infected with HIV since 1983, said, “I'm not even sure HIV prevalence has actually decreased [in Uganda], but if it has, it's mostly because of condom use and has very little to do with abstinence and being faithful.”

Uganda's AIDS prevention program resists an ideological label. It does emphasize abstinence and monogamy, and does work closely with religious organizations. But Uganda also promotes condom usage and has been able to make condoms available to those who need them. Uganda also promotes

AIDS education among prostitutes and gay men. Its work with these high-risk groups is nonjudgmental, to avoid stigma and driving the epidemic underground. As a result, condom use is around 95 percent among prostitutes in Kampala, the capital—up from virtually zero before the epidemic hit.

Any US Government embrace of the Uganda strategy must include the full spectrum of anti-AIDS efforts. Instead of misdirecting anti-HIV funds, the US Government should promote the behavioral factors, especially condom use, that have been crucial to Uganda's success. Such a change in policy would ultimately benefit people in developing countries who are ultimately affected by US-led international HIV prevention programs.

Alex Bradford is a Senior at Stanford University. He is founder of the AIDS Treatment Access Initiative, and has taught a course on Global AIDS at the Stanford Medical School. He is author of the book *Generation Y for the Global Village*. He was recently named a 2005 George Mitchell Scholar. He was also recently named to the USA Today “Top 20” Academic First Team.

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DIFFERENCES IN GAYS AND LESBIANS

HIV/AIDS is one of the leading causes of death according to the World Health Organization in 2004. Imagine the numbers of infection and death have steadily been increasing over the years, it probably has moved up in ranking. HIV is commonly transmitted by bodily fluids, but it is more highly transmitted when men have sex with men. I will be discussing the different variables that come into effect when gay men and lesbians are transmitted with HIV and how to avoid it.

Gay, Bi sexual , and other males that have sex with men are , “approximately 2% of the US population, yet are the population most severely affected by HIV and are the only risk group in which new HIV infections have been increasing steadily since the early 1990s,”(CDC, 2006). In the year of 2006 in the United States , males who have sex with other males where accounted as more than half of the new HIV infections , “53% ,” (CDC, 2006). Males who have sex with males are known has MSM , MSM with previous known history of injection drug use were an additional, “4% of new infections,” (CDC, 2006). Towards the end of 2006 , more than half of the 53% were MSM or MSM that used injection

drugs, accounted for the population living with HIV in the United States. The beginning of the epidemic in the United States the MSM have been a consistent representative of the biggest percentage of people diagnosed with AIDS and those living with the diagnoses. They still remain the a big part of HIV and are learning different ways in remaining HIV free.

The study was able to break up what ethnicity of homosexuals are getting infected and what are the age groups, the age groups are broken into 13-29, then 30-39, and 40-49. First the Caucasians accounted for almost half of the “46%,” of the new HIV infections in MSM (CDC, 2006). The biggest infection rate was through the ages of 30-39 years then it was followed by 40-49 years. Then came the Blacks with the highest infections out of the Caucasians and Hispanics/Latinos being infected with HIV during the age groups of 13-29 years. “All blacks represent approximately 12% of the U.S. population, they account for almost half (46%) of people living with HIV in the US, as well as nearly half (45%) of new infections each year,” (Hall et.al, 2008). The black population is the leading ethnicity with most infections no matter if one is MSM or non MSM. The young MSM of blacks was twice the figure of whites and more than

double of young Hispanics. The Hispanic group of MSM they did not have big numbers such as the Caucasians and Blacks, but their biggest age group was also young 13-29 years of age. The Centers of Disease Control and Prevention showed that in , “ in 2007, 73% of persons living with a diagnosis of HIV infection were male adults or adolescents,” (CDC, 2010) More than half of men with HIV in 2008 were infected by MSM contact, around 30% diagnosed were infected by heterosexual sex, and 10.5% by injection drug use.(CDC, 2010). In male graph of HIV contraction, male to male contact was 72%, in heterosexual it was 15% , in injection drug use 9%. In females the most common way to get HIV is through heterosexual sex ,which the percentage is 84% and then injection drug use at 15%. Males need to be aware that not being gay still means they can contract HIV through a women. Women have to take into condensation that not all males are straight that they may not identity as gay or bi sexual, but still have intercourse with other males.

Females that have sex with other females are known as Lesbians. “Some lesbians have unsafe sex with men, on British study found that 85 percent of women who have sex

with women reported also having sex with men,” (Mecer, 2007). Female to female sex, there has been no confirmed cases of HIV transmission in the United States. But , “ However, case reports of female-to-female transmission of HIV and the well-documented risk of female-to-male transmission indicate that vaginal secretions and menstrual blood are potentially infectious and that mucous membrane (for example, oral, vaginal) exposure to these secretions has the potential to lead to HIV infection,” (CDC, 2005).

The only way to prevent gay males, bi sexual ,or even those that are neither need to use protection against the epidemic. Lesbian women need to protect against HIV even though some say they are lesbian many have had sexual intercourse with men, (Mecer, 2007). For males and females the risk of oral sex transmission of HIV being passed is very low. It can be increased if a women have sores or cuts in her mouth, or if the partner getting oral sex has same. In females cases if the women is having her period as well, due to blood carries the infection. For women, oral sex can be safer if there is use of a dental dam, to stop menstrual blood or vaginal fluid coming into the mouth. Oral sex in males can also be prevented by a latex condom or if not available, one can take out penis

before ejaculation. Oral sex on the anus should also use a dental dam in order to avoid fluids. Sharing sex toys between lesbians and males can be very risky such as a dildo , it can contain vaginal fluids, semen, faeces or blood on them. Make sure to keep them clean and to clean they very well every time. Also rough sex can lead to bleeding or breaks or cut in the lining of vagina or anus is very risky due to bodily fluids coming out. Mutual masturbation can lead to contraction of HIV if there is a wound on the hand of person performing it. If the sexual partner is an acquaintance the hands and fingers should be examined. For males penis to anus penetration HIV can be avoided by latex condom, there is still risk of infection. Making sure there is lubricant and anus is soft before entering is a good way to avoid bleeding and tares.

VIRAL DISEASES (AIDS)

GAY, LESBIAN, BISEXUAL ISSUES - HIV POSITIVE CHILDREN MUST BE ALLOWED TO ATTEND SCHOOL

Do you remember when Ryan White tried to attend public school in the 80's? Remember the media blitz and all the panic of the community? Parents and teachers were afraid to let HIV+ children attend public school. There was a fear that children with AIDS would somehow infect their healthy classmates. The truth is, AIDS is a disease which is not transmitted by casual contact. Normal play and interaction with HIV+ children is no threat to healthy children. So in recent years, fears have subsided and the policies of many school districts have changed. In Oklahoma for example, the Putnam City School District now allows HIV+ children to attend its schools. As a result of the District's decision, the people involved in the schools are reaping life-enriching benefits.

First of all, the healthy children who attend Putnam City schools experience significant benefits by routinely interacting with classmates who have AIDS. Perhaps the most important benefit healthy children gain is they learn to

fear the disease itself, not persons afflicted with it. Healthy children soon realize they can not only talk to but also study beside and even play with their AIDS infected classmates without fear. On the other hand, they clearly learn to fear the disease itself, for children who are friends with HIV+ children watch their friends slowly die. Christy's experience with her friend, Mark, is a typical example. Christy had known Mark since they were in kindergarten. Mark was a hemophiliac who had contracted AIDS at the age of seven via the clotting factor medication he had to take for his condition. When he was 11, Mark developed full-blown AIDS, and AIDS claimed him when he was only 15. Christy and Mark were great friends, and it was very difficult for her to watch her life-long friend slowly deteriorate. However, though it was a painful lesson, Christy and other children who had grown up with Mark now clearly understand the seriousness of AIDS. Though they had received instruction about AIDS in their sex education classes, this real-life experience brought the lessons home. They now know that anyone can contract AIDS, and they know how important it is to protect themselves.

Not only do healthy children at Putnam City schools benefit

by such real-life experiences with HIV+ classmates, but their parents also profit. Naturally, parents routinely worry about the welfare of their children. But sometimes their worry can become paranoia. Such was the case for years with regard to AIDS. But through increased understanding over the last ten years, the hysteria has died down. Parents have gradually come to realize that there is no reason to fear their children contracting AIDS casually from HIV+ classmates. The healthy interactions of their children with AIDS infected classmates have helped the parents get over their paranoia and the discrimination they felt towards people with AIDS. Another way parents have benefited is they find it much easier to begin discussions with their children about sex. Parents down through the ages have found that the hardest part about discussing sex has been just getting started. Today, because of the relationship between AIDS and sexual conduct, the subject is out in the open. It's very natural to move from a discussion about how a classmate like Mark is doing to a discussion about AIDS in general, then to other sexually transmitted diseases, then to sex in general, and finally to pregnancy. When such discussions are more relaxed and free-flowing, children feel less like they are being lectured to and are more likely to retain the

information. Also, there is greater trust established, and it is more likely that the children will be honest about their own sexual activity. In addition to the benefits which healthy children and their parents gain from HIV+ children in public schools, the HIV infected children themselves also gain immeasurably.

Children with AIDS who attend Putnam City schools reap the greatest rewards of all, for they are able to lead almost normal lives. Most importantly, they are able to attend school. These children attain the enjoyment and rewards learning has to offer. Even though they will most likely not be able to go to college or join the work force, the process of learning is still extremely rewarding. Take Mark, for example. Mark found great pleasure in being able to work on many science projects for the science fair each year. When he was 13, his project concerned the effects of different types of light on growing plants. He had done considerable research and had invested many hours in his project. Even though he was beginning to be quite sick, he still enjoyed the work, and it kept his mind off his illness. That year, he won first place at the fair. Not only do HIV+ children get to learn, they also get to interact with other children their own ages. All people

need to interact with their peers in order to remain mentally healthy. The importance of association and friendship is immeasurable. When any child is isolated from other children, he or she will become depressed. HIV+ children are no different. Those HIV+ children who attend Putnam City schools are able to play like normal children and, at least for periods of time, forget about their deadly disease. In addition, as these children grow older, the bond between them and their healthy friends strengthens, and they are included in social activities beyond the school environment, such as going to the mall, the movies, and restaurants. These opportunities help the AIDS infected young people enjoy a happier life, even if it is tragically short.

It is unquestionable that Putnam City School District's policy of allowing HIV+ children to attend their schools has benefited all involved. First, parents' fears that their healthy children would be in grave danger from casual contact with AIDS infected children have been proven false. Second, healthy children have gained a respectful fear of a deadly disease, a wisdom they probably would not have gained had they just been isolated from the horrors of AIDS. And finally, HIV+ children have taught their peers and adults alike that it

is people who count, that all people need friends, and that all have the right to be educated.

Among the current fields of research in Biotechnology, research on drugs and vaccines targeting viral diseases such as HIV/AIDS has been of major importance given the high prevalence of these diseases across the world. HIV (Human Immunodeficiency Virus) is a type of virus that causes AIDS (Acquired Immune-deficiency Syndrome) (HIV and AIDS, n.d). The virus devastates the body's defense mechanism, leaving a victim highly susceptible to opportunistic infections such as those caused by bacteria, fungi, parasites, and viruses. AIDS epidemic has presented a major challenge among researchers given the high rates of mutation and replication of HIV in host cells (ABU, DEAN, & JEFF, 2010). In addition, limited access to antiretroviral drugs in some of the most affected regions such as the Sub-Saharan Africa has slowed down the fight against the epidemic. AIDS is associated with other devastating diseases such as Kaposi Sarcoma and liver diseases which calls for more research efforts to find an effective vaccine. Apart from the increasing cases of HIV infection through sexual intercourse and drug injecting paraphernalia, mother-to-child transmission has also been cited as a major culprit (Majid, 2010). Despite a wide range of challenges facing the faculty of drug and vaccine

development, considerable progress has been made. This paper presents the major challenges facing the area of viral disease research and specifically HIV/AIDS. It incorporates this discussion with a literature review of the research efforts that have been made towards tackling the challenges.

It is almost three decades since HIV and AIDS was discovered and the lives of millions of people have been claimed by the pandemic. At the same time, the pandemic has had a deleterious impact on the health patterns in the world as it has changed the progression patterns of various diseases (Gould & Woods, 2003). According to Eilbert (2008), more than 20 million people have succumbed to HIV and AIDS since it was discovered back in 1981. Eilbert also asserts that the pandemic is leading in terms of causing many deaths with the most affected being people aged between 15 and 59 years (2008). The number of infected people across the world stands at 40 million with about 67% of this population living in the sub-Saharan Africa. In Botswana for example, the infection rate among the adult population is 37%. In the United States, the current level of HIV infection is about 1 million and more than 0.5 million people have died from the disease (Eilbert, 2008).

The rate of HIV infection among children has also escalated especially in developing countries. Research has associated this increase with the rise in the number of women who have attained childbearing age but who are HIV-infected (Claudia, 2001). However, considerable steps have been made to reduce cases of mother to child transmission both during birth and breastfeeding. According to Rivera (2011), transfusion of infected blood products was one of the ways through which children got infected with HIV before 1985. However, due to intensive research on screening methods, this means of transmission of the virus has been eliminated (Rivera, 2011). Nevertheless, vertical transmission of HIV remains a major problem as indicated by the World Health Organization data. Rivera notes that the 2009 WHO report estimated the number of children living with HIV to be 2.5 million. During the same year, cases of new infection were 370, 000 (2011). Though this is a big number, records depict a drop of 24% from the 2004 data. This is an indication of efforts that have been made to reduce new cases of vertical infection (Bennett, 2011). Through research, Bennett (2011) notes that two strains of HIV that is HIV type 1(HIV-1) and HIV type 2

(HIV-2) have been identified. In addition, in an effort to concentrate resources in the most important area, research has helped to identify HIV-1 as the most common strain among HIV positive patients. However, Rivera points out that there are cases where AIDS patients may test positive for both strains of HIV (2011). One area of research in curbing HIV infection and progression to AIDS has been antiretroviral therapy. According to Eilbert, research has facilitated the discovery of about 24 new types of antiretroviral drugs since the mid 1990s (2008). These developments have achieved marked progress in fighting HIV/AIDS as the disease has been transformed into a chronic illness that can be relatively suppressed as opposed to being uniformly fatal. Eilbert underscores this point by noting that life expectancy following diagnosis of a patient with HIV was 7 years in 1993 compared to the current 24 years (2008). Despite these remarkable achievements in research, Eilbert (2008) alludes to the fact that prospects of creating an effective HIV vaccine remain elusive given that viral isolates exhibit wide genetic variability.

Availability of adequate funding to facilitate more intensive and focused research has also been a challenge despite

several organizations committing colossal sums of money towards HIV/AIDS research. Among these organizations include the National Institutes of Allergy and Infectious Diseases (NIAID) which distributes its funds for HIV/AIDS research via its Division of AIDS (DAIDS) (Georgiev, 2009, p. 337). The National Institutes of Health (NIH) also remain instrumental in providing resources for AIDS research. Georgiev (2009, p. 337) hints the problem of antibiotic resistance as presenting a major challenge particularly in light of the global threat of tuberculosis epidemic. Georgiev notes that HIV/AIDS epidemic has been fueled mainly by tuberculosis epidemic since the early 1990s (2009, p. 337). Research has shown that people who are infected with HIV become highly susceptible to TB among other opportunistic infections. It is estimated that the sub-Saharan Africa has encountered millions of new TB cases as a result of the high prevalence of HIV/AIDS in the region (Diacon & Lüthi, 2011). This problem has been aggravated by the development of multi-drug resistant tuberculosis (MDR-TB) as well as extreme drug resistant tuberculosis (XDR-TB). These conditions develop mainly due to lack of adherence to drug prescription, leading to fast replication of bacteria that have gradually mutated to attain drug resistance. Tuberculosis has

been cited as the major cause of death among HIV/AIDS infected patients. This challenge calls for concerted efforts towards developing aggressive treatment regimes for TB menace in HIV/AIDS patients (Tuberculosis and MDR-TB, n.d).

Among the top items on the list of agenda for NIAID include developing more effective ways of preventing vertical transmission of HIV/AIDS as well as developing a wide range of effective antiretroviral drugs. It is also in the interest of NIAID to ensure that effective, safe, and cost effective HIV vaccines are developed in a bid to prevent HIV infection. Research has made a lot of progress in fighting the major obstacle of drug resistance and widespread genetic variability of rapidly mutating viral strains. Greater efficacy has been found in using combination therapy whereby different drugs acting through diverse mechanisms are administered as opposed to monotherapy where a single drug is used (Jucker, 2001, p. 4).

Jucker (2001, p. 4) notes that combined therapy has a number of advantages over monotherapy including reduction of side effects, dosages, and chances of a virus developing resistance. At the same time, combined therapy triggers synergistic effect which contributes to greater drug efficacy.

Montefiori, Barouch, & Letvin (2002) indicate that researchers have developed diverse ways of fighting HIV, including the use of reverse transcriptase inhibitors. However, the major obstacle encountered in this approach is the significant levels of toxicity to the host and chances of drug resistance of the virus due to mutations (Huang & Chen, 2010). Among the most commonly used inhibitors of HIV reverse transcriptase include stavudine, zidovudine, and zalcitabine (Jucker, 2001, p. 4).

However, Jucker (2001) does not dismiss the fact that inhibitors of reverse transcriptase play a major role in blocking an early step in the replication cycle of HIV. This is especially evident in newly-infected cells. However, Jucker (2001) cautions that antiretroviral drugs that act on the basis of this mechanism cannot prevent virus production in situations where viral DNA has already been transcribed and integrated into the host DNA. Recent developments in HIV/AIDS research have focused on overcoming this challenge. The most significant development is the discovery of new drugs that would target HIV protease (John, Wang, Chen, & Shih, 2006). These drugs have found important use in combination therapy and have revived the hopes of achieving effective

ways of preventing HIV replication. Jucker (2001, p. 6) indicates that through relentless efforts by researchers in this area, three approaches have been applied in designing protease inhibitors. The first approach is transition-state mimetic. This approach entails the use of phosphinic acid, reduced amide, difluoromethylketone, hydroxyethylene dipeptide isostere, hydroxyethylcarbonyl mimetics, statine, hydroxyethylamine, and difluoromethylketone (Jucker, 2001, p. 6).

In the second approach, Jucker (2001, p. 6) notes that researchers base their research on rotational symmetry which is two-fold. This relies on the native enzyme as well as the interaction of the protease inhibitor through specific hydrophobic interactions and hydrogen bonds. In this new development, researchers have realized the need to improve HIV protease inhibitors' pharmacokinetic profile. To achieve this, Jucker alludes to the use of non-peptidal strategy which is based on the first two approaches. There are a number of protease inhibitors that are currently available on the market. These include Fortovase, indinavir sulfate, saquinavir mesylate, and amprenavir (2001, p. 6).

This paper has discussed the various trends in HIV/AIDS

infection and some of the major factors contributing to these trends. It has also highlighted the major challenges faced by HIV/AIDS research and some of the steps that have been made to overcome these challenges. It is noted that the fight against HIV/AIDS has been complicated by the complexity of the viral genome. In addition, development of drug resistance in viral strains has also posed a major set back in finding effective vaccines and drugs. Rampant spread of multi-drug resistant TB especially in the sub-Saharan Africa has also had a toll on HIV/AIDS research. However, researchers have applied different approaches including reverse transcriptase inhibitors and HIV protease inhibitors to develop a remedy for the pandemic.

AN EPIDEMIC

HIV/AIDS: Conquering an Epidemic Through Community Outreach

Human Immunodeficiency Virus (HIV) and Acquired

Immunodeficiency Syndrome (AIDS) is a pandemic disease that has gained worldwide attention over the past few decades affecting populations both in the United States and internationally. Diseases such as these are the very reasons epidemiology evolved into a medical science. HIV/AIDS is part of the era of eco-epidemiology where both local and global health patterns are analyzed (Allender, Rector, & Warner, 2010, pp. 173-175). It is estimated that over 1 million Americans are living with HIV or AIDS, and many of these people are not even aware that they carry the virus (Centers for Disease Control and Prevention, 2010). Life expectancy has increased for those who have HIV/AIDS, but they still suffer from many associated health conditions that require thousands of dollars in medical care on an annual basis. Adherence to prescribed therapies is also an issue as well as stigmatization of individuals diagnosed with HIV/AIDS (Larsen & Lubkin, 2009). Primary preventative care has become a central focus across the United States especially among high-risk populations.

Nationally, Florida is second for the number of adult and adolescent reported AIDS cases in the United States with

4,392 cases reported in 2009 (CDC, 2010). Duval County reported 274 cases of HIV/AIDS between 2008 and 2010 placing itself fifth in incidence rate in the state of Florida (Florida Department of Health, 2010a). Among the population within Duval County, 30 people per 100,000 are HIV/AIDS positive compared to the state average of 22 (Florida Department of Health, 2010a). It should also be noted that although the rest of the state of Florida has trended down in the number of cases in the past three years, Duval County has remained stable in its number of reported cases. Peak infection rates for HIV/AIDS for the state of Florida occurred during 1995-1997 (Florida Department of Health, 2010a). The Black community was the most affected with an infection rate of 110 per 100,000 compared to the infection of Whites at 20 per 100,000 (Florida Department of Health, 2010a). Although the infection rate for both ethnicities has declined steadily over the past decade, Blacks still have a three times higher infection rate than their White counterparts (Florida Department of Health, 2010a). It is also important to note that since confidential HIV reporting became mandatory, there has been a 20% increase in reported cases in Duval County each year following (Florida Department of Health,

2010b). The leading modes of transmission through 2009 in the state of Florida was heterosexual contact (31%), males having sex with males (44%), IV drug users (18%), combined males having sex with males and IV drug use (6%), and “no identified risk” (2%) (Henry J. Kaiser Foundation, 2009a). When considering age at the time of infections, the greatest portion of these cases occurred among 30-39 year olds (35%), followed by 20-29 year olds (27%), and finally 40-49 year olds (25%) (Burns, 2004). Adult non-Hispanic males have been steadily increasing in the number affected, but the most affected group currently is non-Hispanic black women with heterosexually acquired infection (Duval County Health Department, 2003).

Considering the previous statistics, it is imperative to focus primary preventative measures in the community on high school and college age students with a special focus on minorities. Institutions such as the University of North Florida (UNF) are answering this necessity with programs housed within their Health Promotions Department that focus on educating the student body, providing confidential HIV screening, counseling, and promotion of safe sex practices. Although researching UNF’s physical zip code

within Duval County of 32224 reveals a mortality rate from HIV/AIDS related deaths is only 0-1 per 100,000 (Florida Department of Health, 2010c), it is important to consider that in a university environment students are commuting from all over the county, state, and even out of state to attend. This makes community sites such as this a unique opportunity to reach out to a diverse population of people within the targeted age range. Community level prevention strategies like the one previously mentioned include social marketing interventions to increase condom use and information regarding the risk of sexual activity and needle sharing. The focus should be on both behavioral and biomedical strategies (Burns, 2004).

Darrow, Montanea, & Gladwin (2009) define AIDS related stigma as “prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV, as well as the individuals, groups, and communities with which they are associated” (p. 1178). Fear, misinformation, cultural gaps, lack of education, and language barriers all contribute to the stigmatization of individuals with HIV/AIDS. In a survey of over 2,000 minority households ages 18-39 years old in Broward

County, Florida, over one half of respondents stated that they would feel uncomfortable having their child attend school with another child infected with AIDS (Darrow et al., 2009). Although a reassuring finding was that 60% of respondents thought they themselves, their families, and communities were responsible for preventing AIDS within their community (Darrow et al., 2009). One of the main reasons for the stigma surrounding HIV/AIDS is due to the fact that (change to because or since) society views the infection as a result of socially deviant behavior and has the attitude that it is a self-inflicted condition. The concern is that stigma can result in inequitable treatment of affected individuals and their families leaving them isolated from needed treatments and services (Larsen & Lubkin, 2009). Since much of the money allocated by the Center for Disease Control (CDC) is allocated towards surveillance, support, and testing; little is left for community mobilization programs and mass media campaigns directed towards the most vulnerable populations (Darrow et al., 2009). In 2009, the CDC allocated slightly over \$36 million of its annual budget for HIV/AIDS prevention, which is a mere 7% of its national budget (Henry K. Kaiser Foundation, 2009b). Given the lack of funding available, it

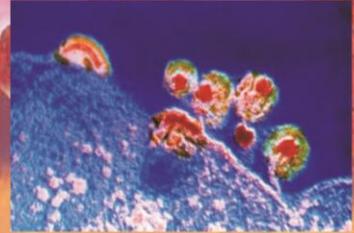
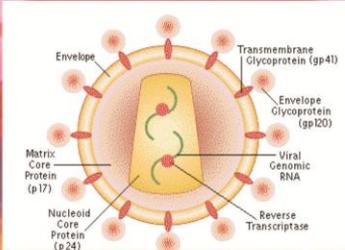
will take community effort to combat the stigma surrounding HIV/AIDS rather than focus on individual outreach such as testing services.

As treatment protocols for HIV/AIDS advance, the healthcare community is facing new challenges that will have to be incorporated into an already multi-faceted, challenging illness. In its 2010 profile, the CDC states that they are taking a comprehensive approach by incorporating surveillance, research, and interventions (CDC & NCHHSTP, 2010). They are currently supporting the state health department, 17 community-based organizations, and two providers to help accommodate the increasing need for HIV prevention programs (CDC & NCHHSTP, 2010). The CDC also states that they are taking into consideration cultural aspects, high-risk communities, and community planning needs when designing future steps to prevent the spread of HIV in the state of Florida (CDC & NCHHSTP, 2010). This is a positive approach that will hopefully encourage the downward trend in infection rates that has been seen over the past decade. Despite the optimistic outlook, it cannot be ignored that Florida is reporting over twice the national average in new cases

annually, and has done so continuously since mandatory reporting began in 1998 (Henry K. Kaiser Foundation, 2009c; Florida Department of Health, 2010a). There is obviously a lack of communication between the current prevention strategies and the multi-cultural, multi-lingual people of state of the Florida. This must become the focus over the next decade.

RYAN WHITE STDS/HIV-AIDS CORRESPONDENCE COURSE

By Postal and E-mail



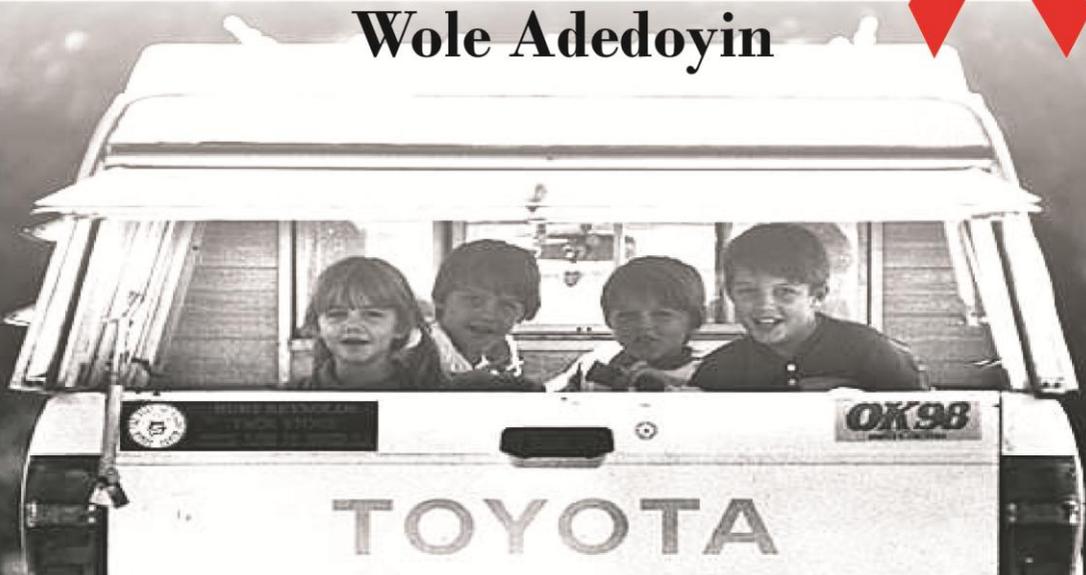
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**WRITERS AGAINST AIDS
AND
TOBACCO SMOKING**



Prepared by:

Wole Adedoyin



RYAN WHITE STDS/HIV-AIDS CORRESPONDENCE COURSE

The questions are written by recognized and dedicated HIV/AIDS educators. We have nearly ten to fifteen educators working on our questions. They are educators who have had years of practical experience and often they are people who have written recognized HIV/AIDS books for youths.

These HIV/AIDS educators not only prepare your questions of studies they also keep them constantly updated. Every year there are changes, both because of syllabus and text. It is vitally important that your courses are kept up to date. That is why this HIV/AIDS Correspondence Course insists on using the very best expertise available in preparing and updating your course of studies.

Secondly, these expertly prepared questions are available for you to study at your own pace, in your own time, in your own home.

At the end of the day you can relax by your fireside and read through your studies. No turning out at night and traveling to evening classes. No taking notes from lectures, everything is written down for you to study at will and revise as often as you like.

No being held back because of slower students in the class. No being rushed too quickly ahead because a lecturer has to keep up with a time-table.

You don't have to take a chance on how good you are. You can rest assured that your interests are in our interest and we make the best talent available to you to achieve your aim.

How to Enroll

This Letter of Introduction is normally accompanied by an enrolment form. If you require further copies of these documents, please contact the following addresses.

Interested applicants should contact the below listed addresses for registration form or call Wole Adedoyin - +2348072673852 or +2348142693764 or send your e-

mail to: olaase10@yahoo.com

**RYAN WHITE HIV/AIDS CORRESPONDENCE
COURSE BY E-MAIL OR POSTAL MAIL**

AIMS AND OBJECTIVES

1. To put a stop to the spread of HIV/AIDS in the country
2. To promote HIV/AIDS Education
3. To encourage HIV/AIDS victims and HIV/Educators
4. To give recognition, reward and award (RRA) to deserving HIV/AIDS educators to serve as role models
5. To highlight the roles of HIV/AIDS education in the education

COURSE ONE

1. Mention and explain 4 different ways by which HIV/AIDS is spread?
 - b. Mention 7 different ways by which HIV/AIDS is not spread?
 - c. Gonorrhoea is caused by Bacteria – Yes or No
2. Write out 2 causes, 3 symptoms and 2 havoocs caused by the following STDs when entered into the body
 - i. Syphilis
 - ii. HIV/AIDS
 - iii. Genital Warts
 - iv. Vaginitis
 - v. Chlamydia
- b. List 8 signs and symptoms of HIV/AIDS infection

3. In a 3 paragraphs, write down the brief history of HIV/AIDS, how it was

Discovered and when it was discovered.

b. How can you tell if someone has the virus HIV/AIDS?

4. Mention 5 different ways to protect yourself from HIV/AIDS?

b. Differentiate between diseases and infections

5. Mention 5 different ways to cope with an HIV/AIDS victim?

COURSE TWO

1. What is PMTCT?

b. How does the pregnant woman become HIV infected?

2. What are the benefits of testing pregnant woman for HIV?

- b. How can mother-to-child transmission of HIV can be prevented?
- 3. How does the baby get HIV from the infected mother?
 - b. What conditions increase the chances of a baby getting HIV infection from the mother?
- 4. What is the consequence of babies acquiring HIV?
 - b. How will a pregnant woman know if she has HIV?
- 5. For women who turn out to be HIV positive, what are the appropriate measures that could reduce or eliminate the chances of passing HIV to the baby?

COURSE THREE

- 1. What is the full meaning of STD?
 - b. Mention 8 STDs that you know

- c. Which out of the 8 TSDs is the deadliest disease?
2. Mention 8 sense organs of your body
 - b. Expatriate fully the functions of each organ
 - c. What is Sexual Relationship?
3. What is a Drug?
 - b. Differentiate between drug addiction and drug addicts
 - c. What type of people could become addicts?
4. Write out the full meaning of the followings
 - i. STI
 - ii. HIV
 - iii. AIDS
 - iv. PID
 - v. NGU

b. Differentiate between HIV/AIDS

c. Write short notes on the followings and how they can be contacted?

i. Virus

ii. Bacteria

iii. Fungus

5. Out of the above mentioned STDs which one has no cure?

b. Write short note on the following terms

i. miscarriage

ii. Burning Sensation

iii. Cervix

iv. Sterility

COURSE FOUR

1. Who is a potential Drug Addict
 - b. What is a Hard Drug?
2. What type of people could become addict?
 - b. What is Drug Addiction?
3. What is Drug Abuse?
 - b. Why do young people turn to drugs?
4. What are the consequences of addiction?
5. Is it possible for an addict to withdraw?
 - b. What role can you play to discourage or to terminate Drug addiction in spreading among youth?

COURSE FIVE

1. What is Youth Friendly Clinic?
 - b. Why Youth Friendly Clinic?

2. Why should you encourage your brother/sister to use Youth friendly clinic?
 - b. What types of services are provided?
3. What type of staff do you find at the Youth Friendly Clinic?
 - b. What are the social and reproductive health problems of young people?
4. What is teenage pregnancy?
 - b. What is an unwanted pregnancy?
5. What is child trafficking and child labor?