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# HIV and its impact on health workers

In countries with high HIV rates, health workers, auxiliary staff and managers are all under pressure to cope with the impact of HIV.

HIV has led to more patients requiring treatment and care, but often with lower budgets and staff shortages due to HIV-related illness. HIV creates its own emotional stresses for health sector staff - the sadness of seeing people die, the fear of getting HIV, and the stigma attached to HIV. Patients often have expectations that health workers cannot meet. As one health worker said: 'Sometimes there is uncontrollable pain, yet a patient is sure that I am able to help'. It is not surprising that health workers sometimes feel exhausted and helpless.

However, steps can be taken to improve the situation, even where resources are scarce. This special joint issue of *AIDS Action* and *Health Action* aims to help health sector staff responsible for providing HIV treatment and care to identify key problems and find ways to overcome them. It contains examples of how staff have got together to discuss their concerns and seek solutions. It includes guidelines on reducing occupational risk of HIV transmission, and a section for district health managers on how to plan the most effective use of existing resources.

Several key points emerge. Most important is the need for good support to health workers and carers, including training and supervision, and access to confidential counselling. Support from other sectors and the community is also very important. AIDS affects all areas of life - it is not the responsibility of the health sector alone.

Demand for care and treatment of people with HIV will continue to rise, especially in areas where people have HIV but are not yet sick. Resources will continue to be in short supply, and dealing with HIV will never be easy. But by following the strategies outlined in this issue, some of the worst problems can be alleviated, and health workers will be better placed to cope.

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**IN THIS ISSUE**



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# Making a Difference: New Roles for Health Workers

*by Waranya Teokul*

*Waranya Teokul is an economist working with the National Economic and Social Development Board. The Office has been a lead partner in managing the HIV/AIDS problem in Thailand.*

Some time back one of my friends, a nurse working in maternal and child health, shared with me her problems with her work. She was in charge of a health centre in one of the districts in Chiangmai province, which has a high HIV prevalence rate. This friend had found that much of her work had evolved, to include more and more counselling and dissemination of AIDS information.

It was not just a matter of having counselling skills. She found that she had to do more home visits since counselling and education were best done in such settings. With her pleasant and cheerful personality, she found herself even being invited by villagers to come to their homes, even if they had no sick relatives.

At the end of the day, after doing these home visits, she would return to a hospital and find a number of patients waiting there as well, so she ended up having to work extra hours each day.

These are just some of the challenges that the AIDS epidemic has posed for Thai health workers. These are challenges for which health workers were probably not trained for when they were still in school. Counselling, for example, is not just a matter of health education. Our health workers now find themselves having to help people with their grief and sorrow with losing a relative to AIDS, or with providing support to those dying of AIDS.

In some cases, AIDS has challenged existing health procedures. I had another friend working in a "Baby-Friendly" hospital that was supposed to be promoting breastfeeding. But because of the AIDS epidemic, my friend now has to provide bottle-feeding for infants born to HIV-positive mothers. Some of her patients have become confused over the apparent contradictions between the hospital's official policy of breastfeeding and this switch to bottle-feeding for HIV-positive mothers. This means my friend has to take time to explain what is going on.

Besides the medical work, let's look at some other examples.

Health workers in Teang District, Chiangrai province, learned about certain medicinal plants that grow well only in their areas. Some of these plants were useful for some of the illnesses of people living with HIV/AIDS (PLWHAs). Others were used as health tonics. The Teang Community Hospital collaborated with the Faculty of Pharmacy at Chiangmai to grow the plants in their hospital backyard and to process them into capsules.

What happened then was that hospital workers now found themselves becoming herbalists and pharmacists. Word spread about the availability of the plants at the Teang District hospital so the health workers at both the hospital and health centres took on still another role: organizing groups of PLWHAs to grow the plants in their own backyards.

The AIDS epidemic means that health workers have to acquire a variety of managerial skills. They often have to enter into community development programmes with income-generating schemes. Health workers are learning to work with other people involved in community development, agricultural extension, and animal husbandry.

In the northern Thai provinces, groups of PLWHAs now raise fish and chickens; produce mulberry paper; grow palm trees; produce handicrafts. Health workers therefore find themselves playing pivotal roles helping the PLWHAs with accounting, with accessing credit facilities, and in marketing the products.

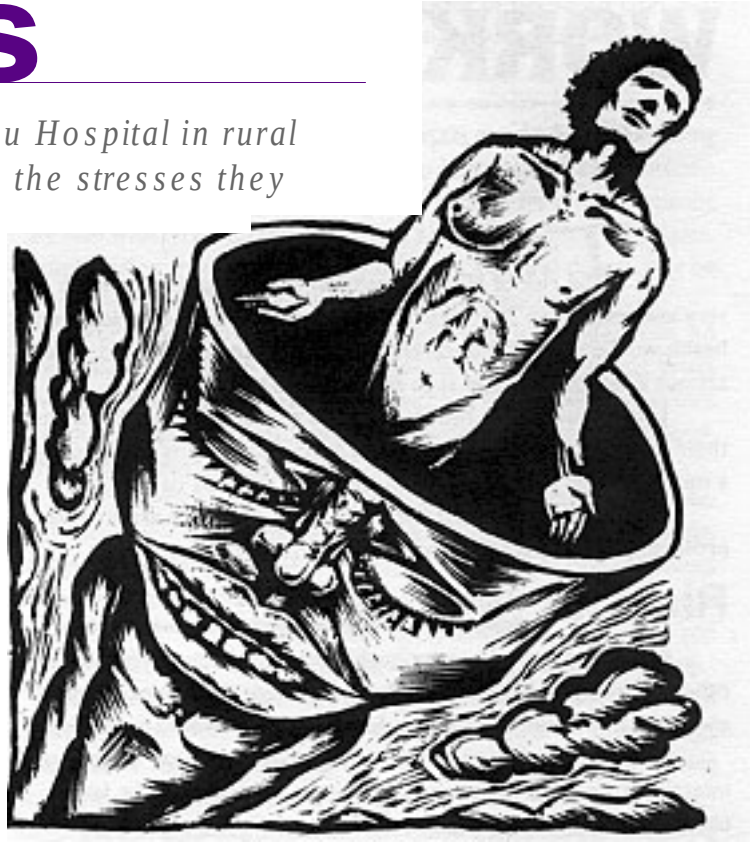
I asked one health worker involved in these activities about how she mobilised people. Her response: constant contact and communication, letting information flow so that the processes are truly participatory. All this sounds easy but is actually a time-intensive process, almost an art. What happens, too, is that people end up building AIDS management teams.

The challenges occur at all administrative levels. The Thai central government is now grappling with the cost of anti-HIV drugs. Even if only one drug - AZT - were given, the cost could run up to 40,000 baht (US$1000) per patient per year. Right now, only about 6500 Thais, less than one percent of the projected total number of PLWHAs, have access to this drug. The Thai government finds itself in a dilemma: how does one justify a subsidy for AZT when the school lunch programme in public primary schools has an allocation of only 1,000 baht (US$25) per student per year?

Thai health workers are becoming multi-task managers, often beyond their original terms of reference. This means creative thinking, a spirit of cooperation, and a great deal of personal sacrifice. Maybe in the process, health workers will find themselves moving away from treating a "disease" and going back to the original focus of healing: the person.

# Getting together to talk about stress

*Hospital staff and outreach workers at Kitovu Hospital in rural Uganda worked with a facilitator to analyse the stresses they faced and how to improve the situation.*



*About 80-90 percent of people in adult medical wards have an HIV-related disease. Staff felt stressed because:*

***We cannot cure HIV***—Some people feel that without a cure for AIDS, little can be done to help. Stigma leads to some of our patients being neglected at home.

***The pain experienced by AIDS patients***—"I feel touched when I counsel a client in pain. Sometimes there is uncontrollable pain, yet a patient is sure that I am able to help."

***Heavy workload and burn-out***—"I have to talk to many people with HIV with limited time. Sometimes I am hungry, tired and anxious. By the end of the day I may be burnt out. The death of someone to whom I have been close leads to frustration."

***Fears of having HIV***—"Sometimes I feel sad and tired, thinking that one day I may be like one of the patients."

***Behaviour change is slow***—We have to educate people about preventing HIV and positive living and care. Change can take a long time, or does not happen.

Some staff felt that they were drinking or smoking too much, over-reacting to patients, developing nagging behaviour and keeping away from friends.

*Managers felt stressed by staff illnesses:*

***Being fair***—Staff who are sick with HIV fear losing their salary, so they continue to work, even when they are too ill. It is problematic to be compassionate to them, fair to other staff and fair to the hospital.

***Planning work***—It is hard to plan work because staff are often off due to illness, burials or other family needs.

***Losing skills***—We want to train staff to improve their skills, but we know that many staff who are being trained are likely to become ill.

***Personal issues***—Staff have problems at home which are the same as those they see in hospital, so there is no place for them to relax. Bringing their emotional burdens to work affects their performance.

***Low morale***—Staff have a sense of helplessness in situations that do not seem to resolve themselves. It is hard to motivate them or get them to take initiative.

*All staff noticed the stresses on the hospital:*

***Other health problems***—These seem to be getting worse. For example, there was a measles outbreak, despite local immunisation campaigns.

***Expensive care***—People are attending hospital when their illness is already at an advanced stage. If the illness is HIV-related, it often takes a long time for the patients to recover.

## ACTION PLAN

After we had identified our concerns, the facilitator helped us to make recommendations. Some needs could be met through incentives, salaries or performance appraisal, but these are expensive. We came up with other ideas. As carers we need:

***Time*** for reflection and recreation to refuel ourselves.

***Training,*** updating and supervision.

***Confidential counselling*** to discuss our fears about HIV and help us cope with demoralising work. Many nurses said that their training had not prepared them for coping, so frequently, with young people with HIV and with dying patients.

***Group support*** among patients and carers to make expectations more realistic, make sure that patients can air their grievances about staff, and help staff feel appreciated.

***A holistic approach*** to healing, incorporating spiritual and emotional issues into our training programmes.

***Recognition from managers*** that staff are affected and may be infected. They may be experiencing the same problems as patients.

***Information*** on how to protect ourselves against HIV/AIDS and more knowledge about the infection.

We realised that health workers shouldn't take on the responsibility of others, just because the challenge is there. We need to start working with others who can do this better than we can.

*Mrs Robina Ssentongo, Programme Manager, Kitovu Hospital, PO Box 413, Masaka, Uganda.*

# Steps to making the WORKPLACE SAFER

*AIDS Action explains how to reduce the risk of spreading HIV at work and what to do if an accident occurs.*

The risk of HIV transmission during health care work is very low. Fewer than 200 cases have been proved worldwide. However, health workers (and other carers) can be exposed to HIV and other serious infectious diseases such as hepatitis B and C, and TB.

Like anyone else, health workers can also be at risk from their own or their partner's sexual behaviour. This is likely to be a much greater risk, yet is often the most difficult to accept.

Health workers need to know what the risks are in their professional and personal lives and how to minimise them.

## Risks at work

HIV is present in large enough amounts to cause infection to others in blood and some body fluids: lymphatic fluid, semen, vaginal and cervical secretions, colostrum, breastmilk and cerebro-spinal fluid.

HIV is not present in large enough amounts to cause infection to others in saliva, sweat, tears, vomit, urine or faeces, unless blood is visibly present.

- Splashes of HIV-infected blood or body fluid on intact skin present **almost no risk** of HIV transmission.
- HIV-infected blood or body fluid on cuts or grazes, or in the eye, presents a **possible risk** if much blood or fluid is in contact with the cut, graze or eye for a significant length of time.
- Needlestick injuries involving HIV-infected blood, where the skin is punctured by a sharp (needle, scalpel or other sharp instrument), present a **higher risk**, especially if the injury is caused by a hollow needle.

## Preventing accidents

Accidents normally happen during emergencies, when health workers are stressed. Poor working conditions, such as bad lighting or long working hours, also make accidents more likely.

Both individual health workers and managers have responsibility for preventing accidents at work.

### *HEALTH WORKERS*

☑ Take care to prevent injuries when handling sharps. Hollow needles are the most risky.

☒ Do not recap used needles. Do not remove them from syringes by hand. Do not bend or break them by hand.

☑ Handle sharps carefully, especially in emergencies. Dispose of them carefully with thought for others. Place used sharps in puncture-resistant containers with lids (sharps boxes). Keep these as close to the place of use as possible. Sharps boxes can be made from large drug tins, tablet bottles or buckets with a lid.

☑ Use protective barriers such as gloves to prevent contact with blood and other body fluids. If necessary, re-use gloves carefully after rinsing in water (not alcohol or disinfectant) and leaving to dry out of direct sunlight.

☒ Avoid unnecessary injections, episiotomies (cutting the perineum during labour) or laboratory tests.

☒ Avoid direct contact with patients' blood or body fluids if you have an open cut or sore.

☑ Cover broken skin, sores or cuts with a waterproof dressing.

### *MANAGERS*

☑ Try to ensure reasonable working conditions.

☒ Do not let inexperienced staff carry out difficult or stressful procedures.

☑ Assess where the greatest risk is - injecting rooms, operating theatres, delivery rooms, laboratories, clean-up departments and mortuaries - and ensure that infection control procedures are followed in these areas.

☑ If resources are limited, use them rationally. For example, keep gloves for activities with the greatest risk of exposure, such as delivery.

☑ Promote a 'safety ethos'. If no one seems to care about safety, everyone is at increased risk. If health workers believe that infection at work is unavoidable, they may take unnecessary risks, both at work and in their private lives. Some health facilities have set up infection control committees with authority to take action, or developed a procedure for reporting and monitoring accidents. These have reduced the number of accidents. They can help to maintain morale by showing that staff health is taken seriously.

## Hepatitis and TB

**Hepatitis B and C**, which are also transmitted via blood, are much more infectious than HIV. They can cause chronic disease and death.

Hepatitis can be transmitted the same way as HIV. The risk of acquiring hepatitis B at work is up to 100 times greater than HIV.

Health workers should follow the same infection control procedures for hepatitis B and C as for HIV. There is a vaccination against hepatitis B.

**Tuberculosis (TB)** is infectious. It is transmitted by air-borne particles from TB bacilli in the lungs. TB stops being infectious two weeks after the start of treatment.

*To minimise the risk of TB:*

- Isolate people suspected of, or diagnosed with TB, from other patients, and, during the early stage of treatment, from people with HIV.
- Ventilate rooms - keep windows to the outside open and uncurtained, if possible. Keep doors closed.
- Encourage infectious patients with uncontrolled cough to wear masks or a clean cloth over their nose and mouth.

**Midwives, birth attendants and surgical staff** may be at higher risk than other health workers because of the large amount of blood present after delivery and during operations. They should be provided with gloves and cover any open wounds, sores and cuts on their hands and arms.

**Health workers making home visits** need to take special care because of the stresses involved. Poor housing often means that they have to see patients in dark rooms with little fresh air. They are at increased risk of getting TB. They also have additional responsibilities, such as training family members to care for someone with HIV while protecting themselves.

## After an accident

Despite following precautions, most health workers will have an accident at some time in their work. Health workers need to know what to do after an accident and where to go for confidential counselling. It may be useful to have a poster on the wall of the clinic or ward outlining the procedures.

*1)* If infectious body fluids have been spilled, clean them up immediately using soap and water, or a chemical disinfectant if available.

*2)* If eyes or skin have been splashed with blood or body fluid, wash them as soon as possible with water (for eyes) and soap (for skin). Do not scrub skin or use disinfectant chemicals, as this may cause cuts or grazes.

*3)* If skin has been cut or pricked, let the wound bleed for two minutes. Then clean with alcohol disinfectant if available (which will burn) for 3-4 minutes. Try to assess the risk of transmission. Unless a lot of blood is involved, such as with a hollow needle, there is no need to do any more.

*4)* Report the accident to the manager, so that steps can be taken to avoid similar exposures in the future. Policies vary about what to do if a health worker has been exposed to a significant amount of blood from a patient. The World Health Organization advises that the patient and health worker be tested soon after exposure, and the health worker tested again six months later.

However, HIV antibodies cannot be detected until three months after infection, so a blood test soon after exposure might not confirm that a person had HIV.

Health workers who have possibly been exposed to HIV need time to think about the implications of having an HIV test. They need access to trained, confidential counselling and support in making decisions.

Antiviral treatment after exposure to HIV (post-exposure prophylaxis or PEP) can reduce the risk of infection. PEP using zidovudine alone has been proved to reduce HIV transmission from an average of three in 1,000 injuries that involve puncturing the skin with HIV-infected blood, by 79 percent; but it is expensive. Combination therapy (using two or three antiviral drugs) may be even more effective, but it is even more expensive.

PEP needs to be guided by local policy and depends on availability of drugs. If available, a combination of antiviral drugs should be taken as soon as possible within 24 hours after exposure for four weeks. However, there is still a risk of infection, and long-term side-effects are unknown.

PEP needs to be carried out by trained health workers who can assess the risk of possible transmission; provide counselling, including assessing the risk of HIV transmission from previous activities if the health worker's HIV status is unknown; diagnose HIV in the patient and health worker quickly and accurately; and ensure a month's supply of antiviral drugs, starting immediately.

In most countries, antiviral drugs are not accessible to health workers. However, it is important for managers to know about them, as it may be possible to purchase them privately. Taking antiviral drugs incorrectly is dangerous.

Health planners also need to realise that, although the costs of PEP are very high, they are much lower than training a new health worker. They can also help to maintain health workers' morale by showing that health workers' health is important.

*WHO, Preventing HIV transmission in health facilities, 1995.*

*Provisional Public Health Services Recommendations for Chemoprophylaxis After Occupational Exposure to HIV, Morbidity and Mortality Weekly Report, Vol. 45, No 42. 1996.*

*Take care to prevent injuries when handling sharps. Hollow needles are the most risky.*

*Place used sharps in puncture-resistant containers.*

*Use protective barriers such as gloves to prevent contact with blood and other body fluids.*

*Cover broken skin, sores or cuts with a waterproof dressing.*

# Our fears about HIV

*Many health workers are worried about the risk of HIV at work. Health workers in Zambia discussed their fears.*

HIV affects every aspect of life in Zambia. The majority of adult medical hospital admissions are HIV-related. We set up small group discussions with nurses, midwives, hospital porters, cleaners, laundry workers, mortuary attendants and medical students to see how HIV affected hospital staff.

Most staff were worried about getting HIV from needlestick injuries. Some nurses also worried that they might transmit HIV to patients this way. 'When you are giving injections, you can infect yourself or the patient. Sometimes the needle pricks you, but you still treat the patient. You can get infected.'

Almost all nurses said that they had had a needlestick injury. They often did not have clear guidelines on what to do when this happened. They often did not report needlestick injuries, as they felt that little could be done. They were usually told to squeeze the wound and then wash it and apply white spirit. Antiviral treatment is not routinely available in Zambia to medical staff after exposure to HIV.

Some people were confused about how HIV could be transmitted. For example, they wondered if they could get HIV by washing cloths from the mortuary.

## What can we do?

Staff felt that they were very likely to have HIV because of repeated occupational exposure, but that there was nothing they could do about it.

'We do have a little fear. On the other hand, this is just work. If we are infected, there is nothing we can do.'

About one in three sexually active adults in Lusaka is HIV-positive, so it is likely that many hospital workers have become HIV-positive through unprotected sex. Even though HIV is common, there is fear and stigma attached to it. Few people are open about their HIV status. This may explain why the nurses we talked to were reluctant to have an HIV test following occupational exposure.

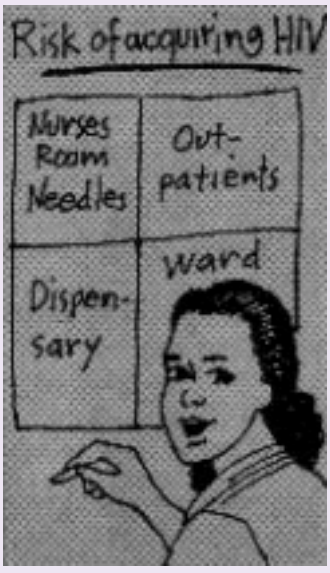
'It is better not to know because it's very depressing. There is also the stigma. People will be pointing at me. Who is going to believe that you got HIV from a patient?'

These discussions show how important it is for health workers to have access to accurate information, and how efforts need to be made to reduce the stigma around HIV.

*With thanks to Rachel Baggaley and Zachariah Kasongo, Zambast Project, c/o ASD, WHO, CH-1211 Geneva 27, Switzerland.*

ACTIVITY

## ACCIDENT ZONES




*This activity allows hospital and health centre staff, traditional birth attendants and others to discuss the risks of HIV infection at work. All staff must be represented, including doctors, nurses, auxiliaries, and laundry and cleaning staff.*

*In small groups, ask participants to draw a map of their workplace - wards, operating rooms and kitchens in hospitals, or homes and local services for community-based staff. Then ask them to mark areas where they may face a risk of acquiring HIV.*

*Ask the groups to feed back to the large group why they think that there is a risk. Make sure that any inaccurate information is corrected.*

*Then ask the group to identify ways to reduce the risks. It may be useful to list these in order, starting with those that can be implemented immediately at no cost.*

*With thanks to CAFOD AIDS team, 2 Romero Close, Stockwell Road, London SW9 9TY, UK.*

ACTIVITY

## Twenty-four hour clock

*This activity encourages health workers to consider their risk of acquiring HIV both at work and outside work. It may be best done in single-sex groups. It is important that the facilitator can discuss issues such as sex sensitively.*

*In small groups, ask participants to write down what they usually do each hour of the day, both at work and out of work. In the large group, ask the groups to compare their 'twenty-four hour clocks'. Ask them to discuss the main points that relate to HIV risk. These may involve out-of-work activities and also risks at work, such as working for a long time without a break.*

# Health workers need support

*It is important that health workers with HIV can continue to work while they are healthy.*

Many health workers know that they are HIV-positive. Others suspect that they might be. Managers need to provide appropriate support.

**Confidentiality** Many health workers may not want an HIV test if they know the people who will be testing or counselling. They need access to confidential counselling. No health worker should be forced to disclose their HIV status at the request of patients or other staff.

**Health and safety at work** HIV-positive health workers should be allowed to continue their work as long as possible. They (and all other workers) must take precautions to protect themselves against HIV transmission. If possible, managers should enable health workers with HIV to avoid infections such as TB, for example, by ensuring that they do not work in TB wards.

**Fears for the future** Health workers need to know that they will be able to work as long as they are healthy, without discrimination from colleagues. Managers have a key role in providing information to employers, colleagues, and patients and their families.

viewpoint

## Positive about my work

*A health worker in Uganda talks about fears and hopes connected with being HIV-positive.*

*My partner died six years ago. Before he died we talked, and he agreed, on my suggestion, to have an HIV test. We both took the test and were both diagnosed positive. Hell broke loose, but we got counselling and accepted the situation.*

*I have since faced problems as a human being and as a health worker. Ill-health may lead to me losing my job, which is a major worry. I see patients suffering and it is an indication of what I may face in the future. I always think about what people may say about me.*

*However, knowing about HIV and AIDS does help me practise positive living.*

viewpoint

## Having HIV makes me less afraid

*Francois Lanteigne, a Canadian nurse who has been living with AIDS for nine years, outlines advantages and disadvantages of being an HIV-positive health worker.*

- *I can give advice based on my own experiences. That means I emphasise the importance of sleep, nutrition, exercise and emotions. I want patients to understand the importance of informing their families about their health condition. It is amazing how many people wait until the last minute. With few exceptions, the reaction of patients to learning about my condition is good.*
- *I can clearly understand the physical and psychological problems, such as fatigue, experienced by patients.*
- *I have a good understanding of potential problems; I can easily recognise the signs of opportunistic infections.*
- *I give patients a feeling of security by giving them a lot of information.*
- *I do not judge the disease. I am convinced that there are still people who say, 'If only he were not gay... a drug addict... a delinquent...'*
- *I learn to become less afraid of death through listening to patients and talking with my friends and family.*

*Where there are advantages, there are also disadvantages:*

- *I run the risk of getting infectious illnesses.*
- *Working with people with AIDS requires a lot of energy, and my energy level is not always at its best.*
- *There is always the fear of going public - to admit to being HIV positive in front of patients - or the pain of hiding it.*
- *It is difficult to be present and to comfort patients and my friends during the terminal phase.*

*These are my recommendations to all care givers working with AIDS:*

- *Dissociate work from your private life. Have fun after work.*
- *Be strong in your mind, because you must expect to regularly come into contact with death.*
- *Take steps to prevent burn-out. Don't do too much. Make time to enjoy life.*
- *Be professional. Keep an interest in the subject - be curious, scientific, and organised.*
- *Be aware of the benefits. This can be an enriching experience.*

*Extract from a speech at the International Conference on AIDS, Canada, 1996. Source: Canadian Association of Nurses in AIDS Care.*

# ALLOCATING RESOURCES

*How should district health managers make the best use of existing resources? Assessing needs and coordinating with other sectors and the community are key strategies.*

Many district health managers fear that caring for patients with HIV-related illnesses will result in lower quality care for all patients. Few extra beds, staff or drugs are usually available for patients with HIV. Managers therefore need to find ways of allocating existing resources to benefit the most people. This means making choices about what services to provide and where to provide them.

Managers need to ask themselves the following questions:

- How can I coordinate efforts with other health care providers and other sectors?
- How can I assess needs, including those at community level?
- How can I use existing resources more efficiently?
- How can I strengthen links with the community?
- What essential drugs do I need?

## Coordination

Activities such as gathering data, supporting home care schemes and running community education programmes can be carried out more efficiently if hospitals coordinate their efforts with:

- other sectors, such as education, transport and agriculture
- other health care providers, such as religious organisations, private practitioners, pharmacists, and traditional healers
- local and national NGOs working with people with HIV/ AIDS
- local communities
- people with HIV/AIDS.

An example of coordination comes from Magu district, Tanzania. The district AIDS programme was originally set up under the primary health care committee, with representatives from a number of sectors. However, the committee turned out to be too large to meet regularly to plan an AIDS programme.

A smaller committee has now been established, called the District AIDS Action Team. Members include the district planning officer, heads of health, education and community development sectors, and representatives of NGOs. The district AIDS control coordinator acts as the committee secretary.

By sharing members' experiences, the committee tries to assess what is needed to deal with HIV, what resources are available, and what effect existing services and interventions have had. The aim is to ensure that resources are used effectively and that groups work together.

Some districts have problems when donors or international agencies wish to do AIDS-related work that does not fit in with district priorities. Some agencies may even do harm - providing drugs that are not otherwise available, or employing staff at higher salaries.

If this happens, managers have to explain their priorities and negotiate with agencies to ensure that these are taken into account. Managers are more likely to be successful if they can show that their programmes are based on sound research, good financial planning and efficient allocation of resources.

## Assessing needs

Before allocating resources, managers need to assess the need for them. One way to do this is by organising a workshop.

1) ***Invite people who provide support and services.*** These include representatives of health centres and tuberculosis (TB) services, NGOs of people living with HIV/ AIDS, other NGOs and people involved with home care.

2) ***Share experiences.*** Consider the particular problems in your area. Look especially at the range of care services from hospital to home. Where are the links weak and where are there bottlenecks? For example, drugs may be available in the district hospital but not in health centres. The aim is not to lay blame but to recognise strong points and acknowledge weaknesses.

3) ***Look for creative solutions.*** Find ways of shifting people and resources into weaker areas and unblocking bottlenecks. For example, improve drug supply to health centres or give more support as people are discharged from hospital. Again, the aim is not to lay blame or to increase already heavy workloads, but to find ways for people to work together.

4) ***Agree how each level can respond.*** Write down how people and organisations fit into the new arrangements. Agree on a trial period and process of monitoring. Remember to promote

joint activities. Try to link activities between 'formal' and 'informal' sectors - link home and community with clinic and hospital.

5) ***Arrange follow-up meetings*** to review progress, share solutions and successes, and consider problems.

## Hospital or home?

To allocate resources efficiently, managers need to compare the cost of hospital care (including the time that people are in hospital, drugs and other treatment, and the outcome of treatment) with other types of care. Hospital costs are usually high.

Home-based care schemes are often promoted as a way of saving hospital costs. However, home-based care has its own costs. Carers need basic information and training before a patient is discharged, and continuing support from trained health workers.

Home-based care cannot replace all health facility care. Health services have the main responsibility for diagnosing HIV-related illnesses, carrying out more complicated examinations, such as sputum and X-ray investigations, and treating complex illnesses, such as PCP (a common HIV-related pneumonia) or meningitis.

Some services, such as diagnosis or treatment of common conditions, can be done in health centres, provided that staff are trained in basic procedures and have essential drugs. Managers should find ways to allocate resources to health centres and provide training and supervision to staff.

People who are either terminally ill or recovering from illness may prefer to be at home. However, in some countries, legal requirements concerning death mean that carers prefer people with AIDS to die in hospital. Health managers should press for legal changes to make it easier for people stay at home.

Allocating resources away from hospital may be unpopular with some staff. Managers need to work with staff to convince them of longer-term benefits and help them to deal with any problems that result.

## Reaching Health Science Students and Teachers

A key link in building up HIV/AIDS services are the health science institutions that produce our future doctors, nurses, midwives and other health professionals.

Since 1991, Health Action Information Network (HAIN) has worked closely with these institutions to provide HIV/AIDS training. Between 1995 and 1997 alone, we trained more than 1000 students and faculty members from 96 institutions in 16 Philippine cities.

The training workshops are intensive with 2-1/2 days of lectures, role-play and discussions. "AIDS 101" - basic biomedical information about HIV/AIDS - is only one module. The workshop participants also get information on psychosocial aspects of HIV/AIDS as well as principles for effective health education and counselling. In the last two years, participants have also received additional lectures on reproductive tract infections to impress them with the need to incorporate reproductive and sexual health concerns into their HIV/AIDS work.

After participating in a workshop, the institutions are eligible to apply for seed grants to implement their own educational activities. This has led to many more workshops reaching several thousand people, including other academic units in their institutions, and communities with which the students and faculty work.

HAIN has emphasised reaching the institutions outside Metro Manila, many of which have little access to up-to-date information on reproductive and sexual health. After the workshops are over, we continue to send them lists of reading materials which they can obtain. A training manual and a set of teaching transparencies were also produced as part of the project, so that the institutions now have standardised information to use.

The impact of the workshops on participants is two-fold, addressing the health workers' risks both on the professional and personal levels. While the participants generally appreciate the biomedical training, the teaching modules with the greatest impact have been those on psychosocial needs. One nursing faculty member attending one of the role play sessions in our workshops actually wept afterwards. She remembered having a friend who had been infected with HIV and had gone to the hospital she worked in. Because she had no access to information on HIV, she had shunned this friend. After the workshop, she realised how her lack of access to information had driven her away from her roles both as a health professional and as a friend. The woman with HIV died before this nurse attended our workshop.

*Acknowledgements: These workshops were supported in an early phase by Aidscom (1991-1992) and later by the Australian Agency for International Development (AusAID, 1995-1997).*

# Caring for children

*For the past two years, the Thuthuzela Abantwana project in Cape Town, South Africa has been working with families of children with HIV.*

In the Khayelitsha squatter camp, eight percent of people are estimated to have HIV. Children with HIV have been treated at the children's hospital 25 kilometres away. Many have become ill again after being discharged, and have had to return to hospital. Most primary level doctors have not been trained to treat HIV-related illnesses in children, and there has been little support or training for home-based care.

We aim to build links between:

- medical advisers and health workers
- the hospital and primary level health workers
- project workers and families
- families and community agencies.

The project has an advisory committee consisting of representatives of the hospital, Red Cross Society home-based care staff, and NGOs working in HIV/AIDS and welfare.

We have four full-time community health workers who advise families on the management of childhood illnesses and HIV. Minor interventions, such as advice on nutrition and food preparation, can make a major difference to the health and wellbeing of children with HIV. Through regular visits, the project workers gain the confidence of carers and families.

Since the project began, we have supported 89 families, trained 30 community health workers, increased the knowledge of primary level doctors and established links with NGO agencies. However, there are huge problems in sustaining the project, including lack of resources, long distances, poor transport and lack of community support structures.

*Desirèe C Fransman, Project Coordinator, Thuthuzela Abantwana, c/o Child Health Unit, 46 Sawkins Road, Rondebosch, 7700 Cape Town, South Africa.*

# Support for HOME CARERS

*Links are being developed between hospital and home in Manipur state, north-east India, where HIV is spreading rapidly, mainly because of the large number of injecting drug users.*

We have been looking at practical ways of developing links between our hospital and people with HIV/AIDS, family members, NGOs and other community organisations, to ensure that patients with HIV continue to receive good care after being discharged. Initiatives include:

**A directory** listing local sources of support for health staff, families and patients. However, the directory is not as widely known about as it could be.

**A home care handbook** for home carers, in two languages. The handbook is popular and widely used.

**Voluntary community organisations** called 'community care groups'. Each group covers a local area. Members include local health workers, people with HIV/AIDS, families, drug user support groups and home care NGOs. The groups aim to ensure minimum standards of home care. A person can contact their community care group for support after being discharged from hospital.

Health workers give their knowledge and services to the groups, not as part of their work, but as members of the community. Their involvement has proved very useful. They also provide useful feedback to the hospital about community needs and activities. However, many areas still have no community care groups.

**Voluntary service cells,** which are groups of volunteers who visit hospital out-patients to give support and advice. The next step will be to establish protocols in the hospital to include the cells in discussions.

**Pre-discharge discussions** with patients and families, and with NGOs and volunteers, to consider the options for community care. These discussions are very useful, but do not always take place. We want to ensure that they become standard.

**Recognising nurses' role.** Nurses are the main link between the hospital and community-based carers, but are often left out of discharge planning, which is still mainly done by doctors. Managers need to allocate extra time to share information with nurses.

Many people are resistant to these new ways of working. Nurses who support new ways of working are trying to persuade other nurses through the All Manipur Nurses Association and by talking to managers and doctors.

*Mrs. Lhingneilam Kipgen, Health Studies Unit, Centre for Organization Research and Education, Yaiskul Police Line, Imphal 795 001, Manipur, India.*

# Drugs for dealing with HIV

*Managers need to know what drugs to stock for treating HIV-related infections.*

The drugs used for treating HIV-related infections are mainly those used for other illnesses. Managers should follow essential drugs policies when dealing with HIV.

The World Health Organization Essential Drug List (EDL) contains most of the drugs used for treating HIV/AIDS opportunistic infections and sexually transmitted infections (STIs), according to a survey carried out in 1997. In some African countries, the WHO list gives a wider choice than national treatment guidelines.

Often the major problem for district health services is ensuring that drugs reach health centres and dispensaries. HIV, STIs and tuberculosis (TB) are all public health problems, so it is particularly important that drugs for treating them are:

- available when needed
- available in areas of greatest need
- correctly prescribed
- used for their intended purpose.

Some drugs are supplied in ready-made kits, as part of an essential drugs programme or specific disease control programme. In either case, drugs arrive in standard quantities without taking local needs into account. District staff have to ensure that kits reach health facilities when needed and that they are used sensibly.

In some programmes, drugs are supplied according to their rate of use at individual health units. This has the advantage that supply is adjusted to actual needs. District staff have the additional tasks of monitoring consumption, supplying drugs as required, and ordering supplies as needed.

A major challenge for district staff is to get drugs from district headquarters to health units, particularly those in remote areas. This requires good communication, good planning, and sometimes creative solutions. However, even when supplies are at health centres, they may not reach the people in greatest need or be prescribed or used correctly.

More people are likely to request drugs in areas of high HIV prevalence than in lower prevalence areas. Requests should be monitored to:

- assess needs
- determine patterns of use and distribution
- consider alternative patterns of use and ways to improve distribution
- see whether there is a strong case for keeping more drugs.

Most HIV-related illnesses are treated with drugs that should be available at health centres. For example, HIV-related fevers are treated with aspirin. Very few drugs that are useful for treating HIV are not included in essential drugs lists. These vary from one area to another, depending on the national drugs policy and locally common HIV-related illnesses.

Drugs prescribed for HIV-related illnesses must be considered in relation to those used for other health problems, especially problems likely to occur because of HIV, such as tuberculosis (TB), other respiratory ailments and chronic diarrhoea.

For example, an HIV-positive patient who is receiving TB treatment should not be prescribed thiacetazone (a TB drug common in some countries), because this can cause a severe reaction in people with HIV.

Antiviral drugs (if available) may have reactions with other drugs. Pharmacists supplying patients who are taking antiviral drugs such as zidovudine or DDI should check that these drugs do not react with other drugs that patients are taking.

*With thanks to Robin Gray, DAP, WHO, CH-1211 Geneva 27, Switzerland and Mrs. E. Grace Allen-Young, Pharmaceutical Division, Ministry of Health, Jamaica.*

National AIDS Bulletin

## Antiviral drugs

Antiviral drugs aim to prevent the HIV virus from reproducing in the body. The hope is that they will help to keep people with HIV healthy for longer. They are expensive, and are not accessible to most people in developing countries. However, in all countries, some people are likely to be using them. Hospitals and pharmacies therefore need to know how they work.

Ideally, antiviral drugs should be used only where there are laboratories with enough equipment and trained staff to monitor their use. Otherwise it is difficult to monitor any side-effects or to see if the patient is developing resistance.

## Announcement

### New AIDS Prevention Law

The Philippines passed a new law which sets forth a legal framework for responding to the HIV/AIDS epidemic. The "National AIDS Prevention and Control Act" is the first significant legislation on HIV/AIDS in the Philippines. The law upholds basic rights such as non-discrimination, access to health information, access to health services, and medical confidentiality. The law also lays down basic policies, namely:

1. the responsibility of the State to promote public awareness on HIV/AIDS, and

2. the promotion of human rights and civil liberties of people known or suspected to be HIV positive.

The law provides for HIV/AIDS education in schools, health facilities, the workplace, and local communities. Furthermore, the law mandates that:

- Compulsory HIV testing is unlawful
- The right to privacy of individuals with HIV shall be guaranteed
- Basic health services shall be provided

The law also strengthens the government programme on HIV/AIDS, as well as the Philippine National AIDS Council, a national policy-making body.

A free copy of the law can be requested from HAIN. Please write to: 9 Cabanatuan Road, Philam Homes 1104 Quezon City, Philippines

An electronic file copy can be obtained by sending an e-mail message to: hain@mnl.sequel.net

## Resources

**Reducing the impact of HIV/AIDS on nursing/midwifery personnel** advises nurse and midwife planners on how to create a safe work environment to protect against HIV transmission and support HIV-positive nurses. Free in English, French or Spanish from International Council of Nurses, 3 Place Jean Marteau, CH-1201, Geneva, Switzerland.

**Practical guidelines for preventing infections transmitted by blood or air in health-care settings** provides guidelines for hospital, health centre and home-based carers on protecting against hepatitis, HIV and TB. Free to readers in developing countries and £5/US$10 elsewhere, from AHRTAG, Farringdon Point, 29-35 Farringdon Road, London EC1M 3JB, UK.

**Helping health workers learn** by D. Werner & B. Bower - a collection of methods, aids, and ideas written for village instructors and health workers who may have limited formal education. Focus is educational rather than medical. Available from The Hesperian Foundation, 1919 Addison St., Suite 304, Berkeley, CA 94704 USA.

**Where there is no doctor: a village health care handbook** by D. Werner - more than a book on first aid, covers a wide range of things that affect the health of the villagers. This new revised edition includes information about some additional health problems - AIDS, dengue, complications from abortion, drug addiction, and updated advice on topics covered in the first edition. Available from The Hesperian Foundation, 1919 Addison St., Suite 304, Berkeley, CA 94704 USA.

### DISABILITY UPDATE:

**Nothing about us without us: developing innovative technologies for, by and with disabled persons** by D. Werner with the Projimo team - explores the development of innovative aids and equipment that can be made at low cost at home or in a small community workshop. Yet it also considers how to achieve fuller integration of disabled people into society: ways to help communities look at disabled persons' strengths, not their weaknesses. Write to HealthWrights, PO Box 1344 Palo Alto, CA 94302, USA.

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