

HATiP

HIV & AIDS Treatment in Practice

Issue 129 | 29 January 2009



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Caring for the caregivers in the face of HIV and TB: a clinical review (part two)

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This clinical review was kindly supported by the Diana Princess of Wales Memorial Fund. Previous clinical reviews [can be found here](#).

We would like to thank the following people who contributed to or reviewed this article: Dr Linda Gail-Bekker, The Desmond Tutu HIV Centre, Cape Town, South Africa; Dr Liz Corbett, London School of Hygiene and Tropical Medicine, Harare, Zimbabwe; Dr Halima Dawood, Greys Hospital, Pietermaritzburg, South Africa; Dr Riitta Dlodlo, IUALTD, Zimbabwe; Dr Krista Dong, i-Teach, Edendale Hospital, Pietermaritzburg, South Africa; Dr Haileyesus Getahun, Stop TB Department, WHO; Dr Reuben Granich, WHO; Chris Green, Spiritia Foundation, Jakarta, Indonesia; Dr Kerrigan McCarthy, Reproductive Health and HIV Research Unit, South Africa; Professor Emmerentia du Plessis, North-West University, Potchefstroom Campus, South Africa; Dr Fabio Scano, Stop TB Department, South Africa; Dr Doug Wilson, Edendale Hospital, Pietermaritzburg, South Africa; Professor Alta Van Dyk, UNISA, Pretoria, South Africa.

Interventions

In its original report, Treat, Train and Retain (TTR - WHO's plan for AIDS and the health workforce) recommended, as part of the "Treat" component,

- the development of a package of HIV treatment, prevention, care and support services for health workers in countries affected by HIV, and
- occupational health and safety and other measures to improve the workplace to enable health systems to 'retain' workers.

But the two really go hand in hand.

Protecting and caring for healthcare workers will require concerted action on several fronts, at the facility level, department of health, medical training facilities, as well as at national and global policy level.

- A cross-cutting task is to improve the quality of training (pre- and in-service) and support and supervision - strengthening elements designed to help healthcare workers protect themselves. This would include how to manage stress, and to protect themselves in the workplace, from occupational and community exposure to HIV and other infections
- Measures should be implemented to improve workplace safety at the facility level and system-wide to reach nurses at primary health clinics, community outreach workers and home-based providers, especially for those who are HIV-infected
- Introduce measures to improve stress management support for the staff at health facilities
- Introduce systemic measures to improve the living and working conditions of health workers
- HIV services: provide HIV testing/care/ART in a way that is accessible and acceptable to the healthcare staff. Several models of delivery have been proposed and a few have reported on their experience (see below)
- Making these things happen may require new legislation, legal action and activism.

Note: similar services should also be put in place for teachers - which we hope to address in a future article.

Improving workplace safety

It's easy to come up with a laundry list of services that should be offered at the facility level (see the box below for a basic list used by the TTR survey to review participating facilities). But even though it may not be possible to eliminate risk entirely, every caregiver has a right to expect a safer workplace through the implementation of universal precautions (a simple set of measures to protect health from a wide range of infections including blood-borne viruses) with essential supplies and protective equipment, ready access to post-exposure prophylaxis (PEP), immunisation against hepatitis B, HIV/TB screening services, IPT and TB infection control.

Again, these are just basic interventions which healthcare services should offer. It may be necessary to take political or legal action to get health departments and hospital administrators to do so (see end).

Universal precautions:

Unsafe injections can spread HIV and blood-borne pathogens (such as hepatitis B and C virus, Ebola and Lassa virus and malaria).¹ The risk of exposure to HIV and other infections can be significantly lowered by good adherence to universal precautions:

- Routine hand washing after direct contact with patients
- No needle recapping
- Safe collection and disposal of needles and other sharp instruments
- Use of gloves for contact with body fluids, non-intact skin and mucous membranes
- Wearing a mask, eye protection and a protective gown if blood or other body fluids might splash
- Covering cuts and abrasions
- Cleaning up spills of blood and other body fluids
- A safe system for hospital waste management and disposal

And yet, in the University of South Africa (UNISA) study, described in [last week's HATIP](#), some participants complained that their workplaces did not inform employees about proper universal precautions, and that some did not have procedures in place to cope with needlestick injuries.²

Healthcare staff need: clear instructions about each facility's procedures; ongoing training in universal precautions, especially for those with less formal medical education (community-based caregivers, etc); ongoing supervision and mentoring from senior staff; and systems to monitor adherence to good practice.

Supplies:

"Protective clothing is not available in the labour ward where I work. Every night when I go to bed I think: Maybe tomorrow I will become infected by mistake", said one participant in the UNISA study.³

In order to practise universal precautions and safe injecting processes, facilities need to maintain stock of essential supplies: gloves, disposal containers for sharps, and soap and have running water.

In the TTR survey, supplies were reported to be well below what is required for safe working practices, with only 31.7% of participants reporting adequate availability of all four items (23.6% from randomly-selected and 41.9% best practice facilities, respectively, $p < 0.001$).⁴

Safety-engineered sharp devices:

New devices (sharps and needles) have been designed with protective features such as mechanisms to shield, blunt, or retract the needle in order to protect the user's hands during disposal.⁵ These have come into wide use in the US, after the Needlestick Safety and Prevention Act of 2000.

UNICEF and WHO recommend that donors fund safe (single-use) injection equipment bundled with medicines that must be administered by injection (such as immunisations). But there are many other applications, and single-use devices such as retractable needles have shown a high degree of safety especially when used for vascular access and drawing blood.

At the International AIDS Conference in Mexico City, Dr Jorge Mancillas of Population Services International (PSI) described his organisation's work to improve worker safety, including a Safe Devices Campaign to speed the adoption of retractable syringes, which are not only safe for healthcare workers, and safe for waste collectors, but also safe for patients because they cannot be reused.

"The barrier, for the widespread use of retractable syringes is the current price differential. But this is not explained by anything in the design or materials used in retractable syringes. The price differential is due to the size of the market. So WHO has recommended the creation of consumer demand for new single-use injection equipment. But decision makers - governments or employers - have by and large not taken the necessary steps to implement this policy," he said.

PSI's goal is to encourage a widespread shift to safe devices by building economies of scale, country by country to eliminate the price differential, to change national and international policy and find finance sources to help the developing countries who would like to make the transition (see [Health workers in DRC successfully lobby for safer injections](#)).

Hepatitis B immunisation:

Hepatitis B virus is the most common blood-borne pathogen to which healthcare workers are exposed - with an estimated two million exposures a year.⁶

However, a relatively inexpensive (less than US \$0.50 per dose) vaccine can prevent hepatitis B virus infection. But in the survey at one Johannesburg Hospital less than half of the healthcare workers had been vaccinated.⁷

WHO recommends that healthcare workers be immunised early in their career. Pre-vaccination serological tests are unnecessary but could save resources if feasible where prevalence of immunity is high.

Post-exposure prophylaxis (PEP):

The timely administration of a four-week prophylactic course of antiretroviral drugs after occupational exposure (needlestick injuries) can prevent HIV infection. The exact regimen varies by country.

Time is of the essence for PEP. It is generally recommended that post-exposure prophylaxis commences within 24 to 36 hours of injury, and preferably within a few hours of exposure. However, that means that supplies of the PEP regimen need to be on hand.

Not only should there be clear workplace policies around PEP, there should be emotional support and counselling available to help healthcare workers in their decisions to go for HIV testing, access PEP or disclose their status to significant others if necessary.⁸

Isoniazid Preventive Therapy (IPT)/TB Screening:

Likewise, IPT should be used to prevent TB in healthcare workers with HIV who have been exposed to TB, and who do not show signs of active disease. Concerns about mistreating sub-clinical disease can be minimised by only treating the well. A simple symptom checklist (for cough, fever, severe weight loss, etc.) can be used to exclude anyone with signs of active disease, who should receive a further diagnostic work-up for TB (see our past articles on IPT [here](#) and [here](#), and TB screening [here](#) and [here](#)).

Only a few countries have adopted this as policy, and even fewer implement it - however, as with other interventions described in this article, healthcare workers need to demand it as a right.

Note that, as part of TB prevention, healthcare staff should also be aware of their HIV status, since being HIV-positive puts them at much greater risk of TB disease. HIV testing is discussed in more detail below.

TB infection control:

Healthcare workers need to be trained in good TB infection control practice, which is not only for the patient, but to protect themselves as well. (See our recent articles: [Our health facilities are still unsafe: why we all need to do something about TB infection control](#) and [Expert views on TB infection control measures](#).)

"If you get TB, it's an occupational disease," said Dr Thomas at the South African TB Conference.

Many facilities are investing in expensive engineering interventions for infection control, such as UV lights or ventilation systems. But this may be a problem if many staff mistakenly believe it means they are safe and no longer need to worry about basic TB infection control practices, such as teaching patients about cough hygiene.

The problem is compounded by the fact that programmes, facilities and healthcare workers aren't sure which infection control interventions are the most critical to implement. According to recent systematic reviews of the available evidence, presented by Dr Fabio Scano of WHO's Stop TB department at the 39th Union World Conference on Lung Health, data on the efficacy of some of the TB infection control interventions are conflicting or of low quality and, in other cases, there are no data.⁹

For instance, triage and cohorting - attending to coughing patients first and separating them from other patients for diagnosis and care - is widely recommended to reduce the risk of TB transmission within the healthcare facility. Yet, in the literature review, out of two thousand papers, only 12 contained any real data on this. One study from a low or middle-income country showed little impact from the practices,¹⁰ but in two others, triage and cohorting affected a significant reduction in TB transmission.^{11,12} Most studies showed that implementing infection-control measures including triage and cohorting is associated with a decline in nosocomial transmission but the practice is "always part of a package of intervention [of administrative controls]," said Dr Scano. "However, there is strong theoretical benefit to implement these interventions."

"Likewise, the review didn't find any direct evidence showing that good cough hygiene prevents TB transmission, though there is theoretical rationale to support it," said Dr Scano.

There are nine papers with usable data on ventilation - with good ventilation clearly reducing TST conversions and transmission of drug-resistant cases. But when it comes to using UV lights and respirators, "there is a discordance in the data between modelling/lab experiments and epidemiological data," he said.

Some epidemiological studies have shown respirators are not as effective as modelling studies suggest that they should be. But it is

difficult to assess the effectiveness of respirators when healthcare workers given masks don't use them consistently, or when they haven't made sure that they fit properly.

These reviews were commissioned to inform the development of a new WHO policy on TB infection control. Dr Scano told HATIP the policy is being finalised, and should be posted online around the end of February 2009. Even so, as Harries et al. wrote in one key study highlighting the disconnect between guidance and practice, "The introduction of guidelines for the control of TB infection is an important intervention for reducing nosocomial transmission of the disease, but rigorous monitoring and follow-up are needed in order to ensure that they are implemented."¹³

"It's something that has to be a permanent institution at the hospital, to have ongoing education, ongoing infection control audits," said Dr Thomas. "Otherwise nothing changes." "After our clinic sister got MDR, I fought to get N95 masks and I taught the nursing sisters, I taught the other doctors, I taught the counsellors and we had a dietician and a social worker as well and everyone got a mask. And I taught them how to use it and told them about storage, how long they could use it and told them to open the windows in their offices. And everyone did it for sort of the first week. By the next week there was only one other doctor wearing the mask and all the windows were closed. So unless you've got 'infection control policemen' - that are going to go around the clinic or hospital all the time and shout at people - it's very difficult to get change of practice."

Seven key aspects of service provision for staff and their families and minimum criteria for a facility to be given a "fair" rating in the TTR survey

(copied from the full report)¹⁴

Service	Minimum criteria (all required)
<ul style="list-style-type: none"> Occupational HIV prevention 	<ul style="list-style-type: none"> Written PEP policy/guideline Responsible person/committee for infection control Refresher training on safe injection technique Gloves, sharps bins, soap & running water at visit No unsafe sharps disposal evident on tour No unsafe injection technique evident on tour
<ul style="list-style-type: none"> Sexually transmitted HIV prevention 	<ul style="list-style-type: none"> Written facility policy/guideline Ongoing education on safe sex Condoms available in both male and female toilets
<ul style="list-style-type: none"> Promotion of HIV testing of staff 	<ul style="list-style-type: none"> Written facility policy/guideline on HIV testing of staff and what is available for those testing HIV positive Ongoing education/promotion of benefits of knowing one's HIV status Facilitated access for staff wanting testing either at own facility or by arrangement with another facility/provider

<ul style="list-style-type: none"> Access to ART for staff 	<ul style="list-style-type: none"> Written facility policy/guideline Ongoing education/promotion of benefits of knowing one's HIV status Facilitated access to free HIV for staff either at own facility or by arrangement with another provider
<ul style="list-style-type: none"> Access to ART for family of staff 	<ul style="list-style-type: none"> Written facility policy/guideline Access to HIV testing for family members of staff Facilitated access to free ART for family of staff either at this facility or by arrangement with another provider
<ul style="list-style-type: none"> TB infection control 	<ul style="list-style-type: none"> Written facility policy/guideline Responsible person/committee for infection control Refresher training and monitoring of control practices Essential interventions in place <ol style="list-style-type: none"> Education on cough hygiene TB suspected in anyone with prolonged cough TB patients/suspects separated from non-suspects TB diagnosed and treated promptly
<ul style="list-style-type: none"> Prevention of TB in HIV-positive staff 	<ul style="list-style-type: none"> Written facility policy/guideline/manual/material concerning TB as an occupational health risk Refresher education/training of staff on HIV/TB Essential interventions in place <ol style="list-style-type: none"> Policy for moving HIV-positive health workers away from high exposure jobs on request Promotion of HIV testing of staff with high exposure to TB patients

Note, no facility (routine or best practice) achieved a rating of better than "poor" on all seven assessed services.

Helping healthcare workers deal with stress and prevent burn-out

Helping healthcare workers deal with occupational stress may actually improve the uptake of workplace safety measures and TB infection control.

"There is high burn-out and because of this, you'll find that the chances of you taking universal precautions significantly decreases," said Chisomo Zileni, a nurse from Malawi, speaking at the International AIDS Conference in Mexico City. "This puts the young nurses at risk of contracting HIV and tuberculosis."

But there are ways to manage stress. In the UNISA study, caregivers who were supported by their organisations or employers produced significantly lower scores on the HIV/AIDS-related stress-factor scale.¹⁵ There was a significant correlation between the number of different support services offered by an organisation or employer and lower scores on the HIV/AIDS-related stress-factor scale ($r_s = -0.152, p = 0.030$).

Healthcare systems need to prepare new healthcare workers for the demands of the HIV/AIDS (and TB) epidemics by integrating stress management components into pre-service training. "Caregivers should be trained not only in how to manage HIV disease, but equipped with extra skills and a broader understanding of the effects of HIV on individuals, their community and society," said Professor Van Dyk of UNISA.

In addition she proposed increasing professional supervision and mentoring and providing access to emotional support and therapeutic counselling, stress-reduction and coping skills, ongoing training and a supportive working environment.

In another paper, Prof. Van Dyk emphasised that stress reduction and coping techniques tend to be culture-specific. She conducted another survey with 137 black Zulu-speaking and 142 white English-speaking health workers and reported that the black participants tended to deal with stress through group activities, such as singing, dancing and mutual discussion of their problems in a way that allows emotion to be expressed, while white participants related mental wellbeing to individuality, independence and self-sufficiency and chose more private ways of handling stress.¹⁶

A needs assessment in Zambia also identified the need for training and support among nurses and midwives infected with or affected by HIV. Afterwards, the Zambian Nurses' Association and the Norwegian Nurses' Organization partnered to launch a Caring for the Caregivers project - which has set up a network of over 87 support groups.¹⁷ The groups provide a range of services across the country (caring for ill and retired nurses and orphans; training activities etc.). But one interesting aspect of the programme was that, after the provision of a little seed funding, the support groups are supposed to be financially self-sustaining through income-generating projects. While not all the projects have been financially successful, they have given each group something to work together on, in addition to HIV care and support. In fact, some complain that income-generating activities take up too much time.

Again, one of the best ways to improve the mental health of healthcare workers is to empower them to do something about HIV/AIDS and TB - by equipping them with the essential tools and resources to make a difference in their patients' lives. But since an HIV-positive patient on ART is in chronic care and may have a variable course of illness, so Prof. Van Dyk recommends finding other ways of rewarding healthcare staff for job performance and for providing high quality palliative care.

Examples of other strategies from AIDS care programmes to help caregivers deal with the strains on those caring for people with HIV/AIDS, can be found in [Caring for carers: Managing stress in those who care for people with HIV and AIDS](#), part of the UNAIDS Best Practice Collection.

Systemic measures to improve the living and working conditions of health workers

To address occupational stress and retain staff, healthcare workers need to earn a living wage, have decent housing and work in a safe environment.

Systemic measures must be put in place to improve workplace conditions, with enforcement mechanisms to make certain that policy disseminates down to the facility level.

Better pay and bonuses for performance would be ideal. But recognising that resources are constrained and that extra funds are not always available, with health worker input, health systems should consider developing and implementing additional incentive schemes such as more training opportunities, housing, transport

support, childcare facilities, food rations, free health care, flexible working arrangements or other benefits. (see [Guidelines: Incentives For Health Professionals](#).)

HIV testing and services - and models of delivery

As already mentioned, stigma and confidentiality issues potentially limit uptake of HIV programme services by healthcare staff, who may fear discrimination at work if they access HIV services at their own facility.

Testing:

The first and greatest hurdle may be accessing HIV testing services. While these must be made available on site for staff, as the TTR survey demonstrated, most do not make use of their onsite services.¹⁸

However, "in individual interviews we found the idea of annual HIV testing surprisingly acceptable. 75% say they would be very willing to have annual HIV testing, even if this was not linked to any extra HIV care. And only 5% here say they would not be at all willing, regardless of extra care provided," said Dr Corbett. But in focus-group discussions, there was "a lot of concern about the need for absolute confidence that could not be provided by your own workplace colleagues."

When given a choice about *how* they would like to be tested each year, almost half said that a self-testing option (either making self-testing available in private or at home for all staff) would be either their most or second most preferred option. Hiring an independent VCT provider to visit and provide testing each year was the next preferred option, though a high percentage also say they would prefer an HIV test to be part of their routine health check.

This final observation is especially worth noting because of field reports described below, that show uptake of testing increases when it is provided within the context of comprehensive care at staff clinics.

The TTR survey noted that many healthcare workers had secretly tested themselves - and this was something that some members of our advisory panel remarked upon.

"Health care providers (and other hospital/clinic employees) are stealing HIV rapid tests from the workplace to enable self-testing. This has become such common practice, that institutions have taken to locking up HIV tests so they cannot even be obtained easily by doctors who want to test their patients! This rather than recognising that healthcare workers, like patients, do not want to utilise the available VCT services due to stigma and fears of lack of confidentiality, and identifying an alternative," Dr Krista Dong told HATIP.

One alternative is to buy finger prick HIV test kits from private pharmacies. In some settings, these are widely available at a cost ranging from US \$2 to \$10 per test. However, the process of asking for the kit may be a disincentive to some healthcare workers, and there is a clear need to provide more support and counselling to healthcare workers who chose this option. Other alternatives are needed to make HIV testing more widely available, and linked to services for healthcare workers.

ART and HIV care:

The TTR survey also investigated how participants thought they might prefer to receive ART and other HIV treatment services - with somewhat counter-intuitive results.

Several models of HIV service delivery were considered, and participants ranked them in the following order:

- 1 Priority service at their own ART facility
- 2 From a staff clinic providing ART within the context of comprehensive care
- 3 Free medical insurance (and presumably making their own arrangements for care)
- 4 Priority access to another nearby ART clinic
- 5 A free arrangement with a private doctor
- 6 Separate 'Wellness' clinics for health workers in larger cities
- 7 Mobile clinics
- 8 Consultation by phone (with drugs sent to them)

According to the full report, "Secrecy about one's status does not appear to be problematic by the stage of seeking ART, and focus groups support a preference for being cared for by people who know you and so will give good service. There was little evidence of stigmatization of co-workers attending ART clinics, with supportive opinions more commonly expressed."

But these results have to be interpreted with caution because the majority of participants in the study are presumably not HIV-positive themselves. In addition, there are several other reasons to be somewhat circumspect about the findings. One is that when participants were asked to rate what qualities would be important to them in an ART service, the highest percentage chose "confidentiality" as the most or second most important feature to them - which would seem difficult if they were receiving treatment along with other patients at their own ART clinic. Another problem is that it is difficult to judge the uptake of ART services at these facilities in the survey since the HIV prevalence of the cohort is unknown - but as Dr Corbett said, it seems rather low at the facilities in the survey.

So it may be better to look at these findings in light of the evidence coming from practice in the field, keeping in mind that there are no comparative data. Some of the field evidence suggests that the findings are not entirely off the mark - but what may actually be needed is a range of options for accessing care - though the uptake of services clearly seem to be enhanced when provided in the context of comprehensive health services rather than at a dedicated ART clinic.^{19,20}

Uebel et al. report on three programmes in southern Africa:²¹

McCord Hospital

in Durban provides health care for staff free of charge at the staff clinic. All aspects of HIV care (including testing, CD4 monitoring and ART) are integrated with other comprehensive services provided at the staff clinic, including acute conditions and chronic conditions, such as TB. It is confidential for staff because it is separate from the general ART clinic.

Before institution of the programme, few staff (6 to 11 per year) were accessing VCT, but increasing numbers of staff have been accessing VCT every year since the programme started. There has been a great improvement in the morale and some staff members on ART have now disclosed their status to encourage others to undergo testing or start receiving treatment.

The programme also provides support groups for nurses to cope with the burden of providing care for dying patients, particularly adolescents and children.

Mseleni

Hospital, a government-supported facility in a remote rural part of KwaZulu-Natal, also provides care, including HIV care and ART, for staff through the staff clinic, though some staff have chosen to obtain medical care through local private practitioners. Here, as well, staff have become increasingly willing to disclose their status

to colleagues. However, uptake among non-caregiving staff (groundkeepers etc.) is still limited.

Tshedisa Institute

in Gaborone, Botswana is a privately-funded 'Wellness' clinic offering comprehensive holistic care to healthcare providers that is within walking distance of the Princess Marina Hospital. Tshedisa means "to rejuvenate or give life" in Setswana. The programme focuses on healthcare workers with HIV as well as those who are affected by caring for people with HIV and who are experiencing stress, compassion fatigue, and burn-out. It "offers holistic health services, including one-on-one counselling, support groups, creative arts therapy (e.g. dance, yoga, visual arts, poetry, and creative writing), comprehensive HIV/AIDS testing and treatment, general medical check-ups, and a quiet garden for staff to enjoy," according to Uebel et al. They also offer courses on stress management and cognitive behavioural therapy. Group counselling is also available for healthcare workers.

In a little over a year since opening, 204 healthcare workers have come in for HIV testing, 12% were found to be HIV-positive and 17 have started receiving ART.

Other wellness centres

have been set up in Swaziland, Lesotho, Zambia (linked to the support groups mentioned earlier) and now Malawi. According to Tesfamicael Ghebrehwet, of the International Council of Nurses, speaking at a session in Mexico City, these have been established in order to provide dedicated health services including HIV, TB, prevention, treatment and care; PEP; stress management; occupational safety training; capacity building; for healthcare workers and their families - all within the context of comprehensive care.

In Lesotho, these opened in November 2007 and have already reached more than 1300 healthcare workers with services and training. Training includes courses in stress management, behaviour change, PEP, WHO's Integrated Management of Adolescent and Adult Illnesses and so on. They also provide ART, nurse counselling and wellness checks.

In Swaziland,

a wellness clinic was set up in 2006 in the city of Manzini. According to presentations at the International AIDS Conference in Mexico, it focuses on offering healthcare providers comprehensive health services with counselling, HIV testing and other laboratory services, ART, TB and malaria clinics. Other services include skills building training, stress management, care and support programmes and recreation.

According to Ghebrehwet, 6225 healthcare workers have been reached (77% of the total health workforce) and HIV testing and counselling has increased among health workers.

Wellness Centres have been heavily promoted, however, in a more recent report, researchers from the Swaziland Nursing Association and the Southern African Human Capacity Development Coalition conducted a survey that suggested that Wellness Centres may not meet every healthcare worker's needs.²² The survey included 35 nurses, 50% of whom said that if they knew a colleague who was HIV-positive, they would advise her to go to another public or private facility for care. Twenty-five percent of them suggested that they get care at their own clinic, while only 20% of them recommended the Wellness Centre.

"Many said that there would be very few places where she would not know some of the health workers. This was echoed by many of

those who advised her to stay at her local clinic, as there was really no place she could go for complete anonymity. This perceived lack of privacy was a pervasive theme, in part due to the fact that Swazi health workers are members of a small community with shared training and work environments in a small country," the researchers noted.

The Wellness Centres may still be stigmatised, especially if the "well" never use them. Notably, participants in the survey felt that HIV services should be offered within the context of comprehensive services, and said that services were also needed for diabetes, hypertension and safe motherhood, along with counselling about HIV and stress.

These findings were shared with key stakeholders, and since that time 12 additional 'Wellness Corners' have been set up in facilities in the country, serviced by mobile services from the Manzini clinic.

The paper identified five key lessons learned:

- 1 More needs to be done to address the unique aspects of HIV stigma among healthcare staff.
- 2 "A range of services needs to be provided, as no single facility or programme will be acceptable to all health workers. In Swaziland, the stand-alone Comprehensive Wellness Center should continue but should work with other providers to harmonize marketing and identify gaps in services. Health workers need a range of options in order to feel comfortable seeking HIV care."
- 3 Peer support groups should be considered to address the emotional and financial stresses health workers face.
- 4 In order to be utilised and acceptable, services for health workers must be comprehensive and accessible.
- 5 Data on health workers' service use from all of these programmes should be monitored regularly (preserving confidentiality) to help to identify unmet needs.

While there may not be one 'right' way for health systems to begin to offer HIV services to their healthcare workers, it is important that programmes begin to be put in place. According to Uebel et al., formal policies must be put in place regarding the management of HIV/AIDS among staff in the workplace.²³ The authors note that TB management continues to be a challenge, because treatment is generally only provided by separate TB clinics. However, health systems can reduce the burden of TB among their staff by offering IPT, improving TB infection control, and TB screening and diagnostic services. "Programmes to provide HIV care and treatment for healthcare workers are an urgent necessity," Uebel et al. wrote. They recommend that health departments and hospitals perform anonymous surveys to assess the needs for care and treatment among their own staff, and then put in place a programme that is "convenient, holistic and integrated into one clinic".

Political action

These interventions require commitment from governments, employers and managers, which is often lacking. But healthcare workers are beginning to learn how to be activists.

In Mexico City, the Health Action AIDS Campaign of Physicians for Human Rights and the Association of Nurses in AIDS Care released a global call to action (see *Resources*), calling attention to the need for workplace health and safety assurances for all nurses and healthcare workers. Most important, it calls for commitment by government, funders and partners to adopt basic provisions of health and safety for health workers and incorporate them in the

implementation of their programmes, (supporting) the delivery of HIV prevention, care and treatment services.

"It is a requirement for any government in any country to avail nurses with accessible, confidential and affordable healthcare services," said Christine Mutati of the Zambia Union of Nurses Organization. "It is prudent for any government and other stakeholders to formulate and implement policies that will promote equitable distribution of care and support to all healthcare workers."

Others took it a step further.

"At times, we have to overcome professional politeness. Sometimes when the policy makers or employers will not make sound policy decisions, then we have to use our muscle," said Dr Mancillas at the conclusion of the symposia in Mexico City. "In South Africa, Democratic Nurses Association last year achieved great gains which not only impacted the income and working conditions of nurses in South Africa but also improved, going to strengthen the health system in their country through industrial action - they went on strike! Not because they wanted to, but because after months of trying to persuade and negotiate with the government, they took up the only action that they felt, and which subsequent events proved, to be effective."

"We also have a responsibility to our patients and to the health systems to be assertive when necessary. We have two tools: One when we negotiate with our employers - our collective bargain agreements, which can, should and do often cover issues that go beyond salaries, terms of employment and working conditions. And secondly, the other tool is through legislation to implement changes at a national level - achieved through our ability to lobby in different countries."

Resources

- [UNAIDS, universal precautions and blood safety](#)
- [CDC Materials on preventing the transmission of infectious diseases](#)
- [WHO's resources on injection safety and injections](#)
- [Safe Injection Global Network internet forum at \[sign@who.int\]\(mailto:sign@who.int\).](#)
- [ANAC - Association of nurses in AIDS care](#)
- [ACRN - HIV/AIDS Nursing Certification Board](#)
- [Health Action AIDS Campaign, Physicians for Human Rights \(PHR\)](#)
- [PHR Statement On The Rights Of Nurses To Health And Safety](#)
- [International Council of Nurses](#)
- [Public Services International](#)
- [Global Health Workforce Alliance, WHO](#)
- [The Stephen Lewis Foundation](#)
- [Swaziland Wellness Centre Innovative and Effective Response to Healthcare Worker Crisis - press release, 23 April 2008](#)
- [Center for Global Development - International Monetary Fund Programs and Health Spending](#)
- [Where HIV/AIDS and Africa's Health Worker Shortage Meet](#)

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A regular electronic newsletter for health care workers and community-based organisations on HIV treatment in resource-limited settings.

The newsletter is edited by Theo Smart (Cape Town) and Keith Alcorn, NAM's Senior Editor (London).

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