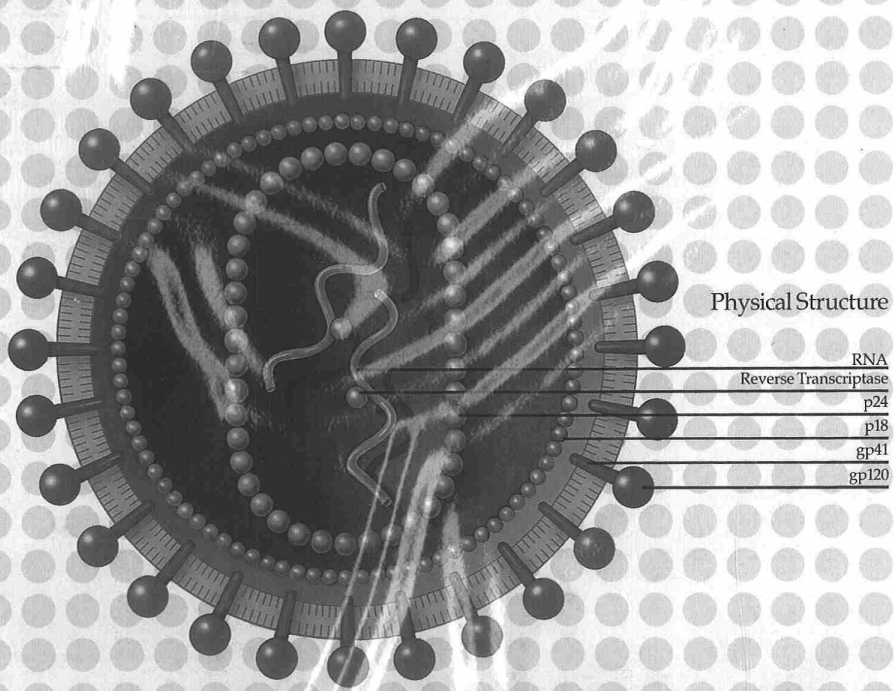
HIV: HUMAN IMMUNODEFICIENCY VIRUS

&

AIDS: ACQUIRED IMMUNE DEFICIENCY SYNDROME



HEALTH AUTHORITY STRATEGY

Wolverhampton
Health Authority

HIV & AIDS HEALTH AUTHORITY STRATEGY

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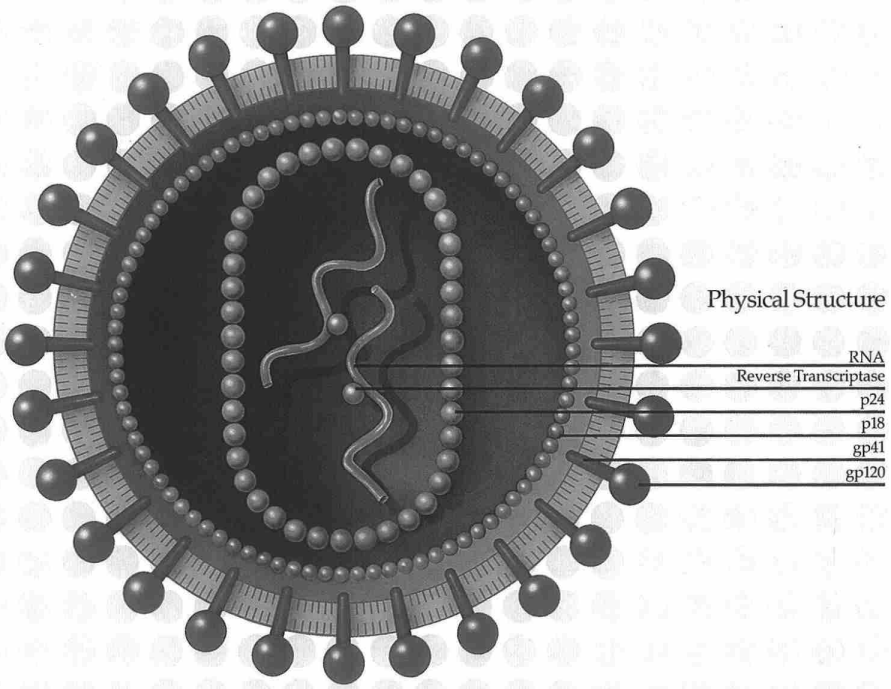

HEALTH AUTHORITY STRATEGY

Wolverhampton
Health Authority

HIV/AIDS HEALTH AUTHORITY STRATEGY

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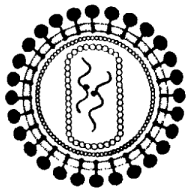
[August, 1992]

'Against AIDS we have set our common course - the global AIDS strategy 2000'.

Jonathon Mann, World Health Organisation.



HIV

'Fortune favours the prepared mind'

Sir Alexander Fleming

1. PREFACE

1.1 INTRODUCTION

This strategy represents Wolverhampton Health Authority's consistent and co-ordinated response to the challenge of HIV infection. It is produced in consultation with the Community Health Council, the Family Health Services Authority and the Local Authority, and will, in conjunction with policies being developed within the departments of Wolverhampton Metropolitan Borough Council, form the healthcare component of a district-wide strategy. The Health Authority and the Local Authority have already issued a joint statement outlining their responsibilities towards people infected with HIV, both as patients/clients, and as employees.

The document has as its aim a comprehensive plan for prevention and care, and will serve as a focus for action in Wolverhampton. Most people with HIV will have full and active lives for a number of years, and services will endeavour to maintain individuals within their own communities, restricting institutional or hospital care to those occasions when it is essential.

Since the recognition in 1982 of the first known case of Acquired Immune Deficiency Syndrome [AIDS] in the United Kingdom, it has become apparent that infection with the Human Immunodeficiency Virus [HIV] will have profound implications for individuals, the health service and other caring agencies. In order to promote the prevention of HIV infection and to optimise the levels of care given to people with HIV, it is essential that health care workers and others involved in providing care and support have a basic understanding of the disease and its modes of transmission.

Ignorance of the disease can lead to a lack of competence and compassion in caring for patients and inadequate or inappropriate procedures for the prevention of cross-infection; it reinforces a mythology which obstructs the development of a realistic approach to HIV prevention, and the delivery of a service sensitive to the needs of patients and their carers.

1.2 HUMAN IMMUNODEFICIENCY VIRUS [HIV]

AIDS is caused by the Human Immunodeficiency Virus [HIV]. It is a fragile virus which is passed from one person to another only in certain circumstances.

The three identifiable routes of transmission are:-

- Penetrative sexual intercourse with a person who has the virus, whether male or female, and whether symptomatic or not;
- Inoculation with infected blood, predominantly through the sharing of contaminated syringes and needles.
- Transfer of the virus from mother to child either during pregnancy or at the time of birth, and possibly during breast feeding.

There is no evidence that HIV is transmitted by normal social behaviour, kissing, contact with crockery, toilet seats, dust or insect bites.

Once HIV has entered the body, it attacks cells [lymphocytes] in the immune system, which are the body's main defence against infection. The virus slowly affects more and more lymphocytes and renders the immune system progressively less effective at fighting infection. The majority of individuals continue to feel well for many months or years after acquiring the virus and are generally unaware that they are infected.

HIV causes a spectrum of illness ranging from very mild non-specific symptoms to AIDS, which is a condition characterised by severe infections and certain cancers. Episodes of illness can include symptoms such as fever, weight loss, swollen lymph glands, severe diarrhoea, fungal infections, and dementia. Between episodes of illness people can look and feel well for long periods of time. AIDS is the most severe form of the illness and once it has developed there is an 80% chance of dying within three years.

Once acquired, HIV infection is lifelong. Treatment may slow the course of the illness and ameliorate symptoms but there is no cure at present. It is not yet known if everyone who becomes infected with HIV will develop AIDS but probably at least 30% will do so within six years of being infected, and a further 40% within seven to eight years.

1.3 PREVALENCE *[Statistics are closely rounded for clarity]*

1.3.1 Global Overview

By the end of November 1990, 150 countries had reported over 300,000 cases of AIDS to the World Health Organisation [WHO], half of which were in the United States. The numbers doubled between September 1988 and November 1991. The global estimate is 1.8 million people with AIDS and 8-10 million with HIV infection.

Actual numbers of AIDS cases world-wide are certainly much higher than reported numbers, because of a lack of diagnostic and reporting facilities, particularly in the continents of Africa and Asia where prevalence is highest. The extent of HIV infection internationally,[which is predominantly through heterosexual intercourse], is even more difficult to estimate, for several reasons:-

- the HIV antibody test is not universally available.
- a negative antibody test is not conclusive owing to a latent period.[see 1.5]
- testing is voluntary and not everyone is tested.
- the majority of infected individuals will be unaware of their infection for several years of the asymptomatic phase and will not present for testing.
- many in the third world die from the disease without ever being diagnosed.
- individuals are dying from other causes before HIV infection is detected.
- delay in notification of test results to central authorities by testing agencies.

1.3.2 National Profile

In the United Kingdom 5000 cases of AIDS were diagnosed and reported between 1982 and 1991, of whom 3000 have died; A quarter of all cases appeared during 1990, indicating a recent rapid increase in incidence of the disease.

The actual level of HIV infection in the U.K. is uncertain, but to date 16,000 individuals have tested HIV positive, with 70% of cases being notified by the four Thames Regions. Official estimates put the total number infected [which includes those untested] at around 55,000.

The anonymous screening survey conducted throughout 1990 revealed:-

1 in 90 heterosexual, and 1 in 5 homosexual male attenders at Genito-urinary clinics in London tested HIV positive, compared to 1 in 600 and 1 in 25, respectively, outside London.

1 in 500 pregnant women tested HIV positive across inner London [with one district recording a level of 1 in 200], compared to 1 in 1,400 across the other Thames regions.

Levels of HIV infection amongst injecting drug users were 50% in Edinburgh, and varied between 2% and 10% elsewhere.

Approximately half the people known to have been infected since 1982 acquired the virus through sexual intercourse between men, but this proportion is decreasing, indicating that other modes of transmission are becoming more significant. The number of reported infections due to sexual intercourse between men and women in 1990 was 60% greater than in 1989. Overall, a third of known HIV-infected adults can be described as heterosexual. This indicates that the potential for heterosexual transmission is increasing and HIV is therefore a health problem for the whole community.

1.3.3 HIV and AIDS in the West Midlands

Between 1982 and 31 December 1990, 91 cases of AIDS were diagnosed in the West Midlands Regional Health Authority of whom 53 have died. A third of all cases of AIDS in the West Midlands since 1982 were diagnosed during 1990.

495 HIV antibody positive tests were reported in the West Midlands between 1985 and the end of 1990, and over 100 [20%] of these were reported during 1990. This represents an acceleration in the spread of HIV infection in the West Midlands, which has the third highest incidence after the Thames Regions and Scotland.

Distribution of reported HIV infections by exposure category, 1982-1990:

Sexual intercourse between men	43%
Receipt of blood products [prior to 1985]*	32%
Other/undetermined [including mother-child transmission]	11%
Sexual intercourse between men and women	9%
Injecting drug use	5%

*HIV transmission through blood transfusion has been virtually eliminated since action was taken in 1985 to screen donations, and treat blood products for HIV infection.

A pregnant woman infected with HIV is estimated to have a 10-20% probability of infecting her unborn child.

Whilst 'reported' HIV infections due to sexual intercourse between men have been predominant, it should be recognised that this group is more likely to see itself as being at risk of infection and thus to seek advice and be tested.

1.4 THE IMPACT OF HIV AND AIDS

Most, but by no means all individuals infected with HIV or developing AIDS are young, and face the prospect of a long-standing illness for which there is no cure. For them and their families, infection with HIV is a tragedy, accompanied by the additional anguish of persecution, discrimination and rejection by people who do not understand the disease.

The scale of the pandemic will have far reaching consequences both nationally and internationally. For those countries where HIV is spread predominantly through heterosexual intercourse, numerous children are already being orphaned, and the impact of large numbers of deaths of young adults may have considerable economic and social implications. Whilst the U.K. has not experienced such dramatic levels of population infection, a concerted effort is required to avoid the worst case scenario.

1.5 TESTING FOR HIV

The standard test used to identify HIV infection does not detect the virus itself but the antibody to the virus. Antibodies are the immune system's response to the presence of HIV within the body, in a vain attempt to destroy the virus.

HIV antibody appears in the blood normally 1 - 3 months after the virus enters the body. There is a delay between infection with HIV and the appearance of the antibody in the blood, thus it is possible for someone to have recently contracted HIV infection but still to have a negative antibody test and be capable of passing on the virus to other people. Owing to this "window period" between infection and the appearance of antibody it is important that anyone tested for HIV antibody is counselled before and after the test about the significance of the results. It may be necessary to repeat the test three months after an initial test to ensure a conclusive result.

People whose blood contains antibody to HIV may be described as "sero positive" or "HIV positive". Those people who have been tested and whose blood does not contain antibody to HIV may be described as "sero-negative" or "HIV negative". Further confirmatory tests are now available which detect the virus itself [the "antigen"].

Studies have shown that large amounts of virus may be present in the blood during the early stages of infection, and later when AIDS is about to develop. Levels of virus may be very low or undetectable between these stages, suggesting that HIV positive individuals are more likely to pass on the virus during the early months of infection and again in the later stages of the illness.

It is important to stress that a majority of individuals who are infected with HIV will not present for testing for a variety of reasons; the principal one being that at any point in time most individuals will be asymptomatic and unaware that they may have been infected. Other factors include ignorance of what constitutes high-risk behaviour, fear of facing the implications and consequences of a positive test result, and avoidance of the stigma associated with testing.

Latest official estimates assume that there are actually three to four times as many people infected as those confirmed by HIV testing.

HIV antibody testing should only be undertaken with informed consent [other than in certain exceptional circumstances] and in the context of appropriate pre-test and post-test counselling, and according to established guidelines on confidentiality.

2. SERVICE PROVISION

2.1 ACUTE CARE

2.1.1 Introduction

The needs of HIV antibody positive individuals are wide-ranging. Early in the natural history of infection, patients are often physically well, but require considerable emotional support following the psychological shock of the knowledge that HIV infection is present. Individuals face the prospect of an uncertain future punctuated by illness and early death. After a number of years of good general health the patient's physical health deteriorates, resulting in more frequent hospital visits, the occurrence of life-threatening illnesses, and in some cases considerable physical dependency. The challenge facing the caring services is therefore immense. They must help sustain the physical and mental well-being of those affected through a long and often unpleasant experience that is likely to end in early death, whilst reducing as far as possible the social and economic consequences of the infection for the sufferers, their family and friends. By its very nature, the care of such patients is multi-disciplinary, requiring close co-operation between the community health, social, and hospital services. The aims of care and support should be:

- To provide all known HIV antibody positive persons with information, advice, and understanding when needed, from the point of diagnosis onwards;
- To provide a closely co-ordinated system of medical, nursing and social care which is responsive to the patient's needs, and which sustains normal life as far as possible.
- To help HIV antibody positive persons avoid behaviour that might lead to further spread of infection
- To provide support for the families and carers of infected persons.

2.1.2 Characteristics of People Affected by HIV

The type of people affected and the nature of their personal circumstances have an important influence on their requirements. As a general rule, people are relatively easy to assist if they have stable home circumstances and high levels of support from friends and relatives. In contrast, those who do not have this stability and support present special problems.

2.1.3 The Overall Model of Care

The overall model of care should include provision for those who are HIV antibody positive, both well and unwell, and those who have developed AIDS. This model must integrate hospital and community care services, and should be applied with sufficient flexibility, acknowledging that some people will not be diagnosed at an early stage.

2.1.4 Pre-and Post-Test Counselling

It is recommended that no one should have an HIV antibody test or be told that he or she is HIV antibody positive without a skilled counsellor being on hand who is able to discuss the implications of the result and respond sensitively to questions and worries. Testing without consent will not be carried out except in certain specified circumstances [ie critically ill patients who are confused or comatose].

Currently, within the Health Authority there are five trained counsellors dedicated to the Genito-urinary Medicine Clinic, which include 1 Doctor, 2 Nurses, and 2 Health Advisers who work closely with the Social Services Department. There are four trained counsellors attached to the local drug agency [Drug Care]. In addition 1 Occupational Health Physician, an Occupational Health Nurse, and the Infection Control Nurse, have all received formal training in HIV counselling. The Acute Unit has a Consultant Physician with experience in the counselling of HIV antibody positive and AIDS patients.

In view of the long term psychological effects of diagnosis, post test counselling must be seen as a first option to provide the advice, reassurance and support that is likely to be needed at various stages throughout the rest of an infected person's life. Counselling may be provided by health professionals or social workers in the hospital unit which the HIV antibody positive person attends. Groups such as Body Positive, Barnados, and the Terrence Higgins Trust, most of whose members are HIV antibody positive, have contacts within the Wolverhampton area. These organisations can play a vital role in sustaining the morale of their members. It is important that groups established for people with HIV infection should be given support by the statutory agencies in Wolverhampton.

2.1.5 Referral to an HIV Specialist

Given the serious and often highly complex nature of the effects of HIV infection, all HIV antibody positive persons should be offered referral to a Consultant with special training and experience of HIV infection and AIDS. From the patient's point of view it is clearly desirable that referral is to a hospital as close to home as possible.

2.1.6 The Out-Patient Clinic

It is essential that HIV antibody positive patients be reviewed regularly on an out-patient basis. During the first months, or even years following diagnosis, most people with HIV infection remain in good physical health, but for much of a patient's life the out-patient visits may be the main link with the caring services. The out-patient clinic should play a pivotal role in the care of HIV antibody positive persons and provide an environment where they feel increasingly secure with staff they can trust. With the limited number of known HIV antibody positive people within the Wolverhampton area at the present time, centralisation of such care would provide essential experience to the staff involved. The out-patient clinic should be able to offer the HIV antibody positive person not only the opportunity to have his or her physical health monitored but also access to information and advice about the many other consequences of HIV infection, including worries about disclosure, transmission, employment, and financial matters.

2.1.7 HIV Antibody Positive and Unwell

In order that continuity of care is maintained, patients who require hospitalisation should be admitted to a ward designated as having appropriate facilities for care. Specific policies regarding the community and in-patient care of HIV antibody positive individuals are available [see Control of Infection Committee Policies]. The medical care of HIV infected patients is often multi-disciplinary, because of the serious and complex nature of the effects of HIV infection. On admission to hospital with a specific condition related to HIV, the advice of the designated AIDS Physician should be sought, and as a general rule patients should be transferred to his care.

2.1.8 Care in the Community

In order to ensure that an individual's quality of life at home is acceptable and hospital admissions are minimised, it is essential that a high standard of community care is available. Close liaison should exist between hospital based staff and the primary care team. Where possible, patients should be nursed at home and this will require a range of home care services, including home helps, night nurses, occupational therapists, physiotherapists, meals on wheels and laundry. As well as being appropriately trained, staff will need to be adequately equipped and well supported to cope with attendant emotional strains.

2.1.9 Accommodation

Community care aims to support the person in his or her own home and this can only be achieved in satisfactory accommodation. However, this may not always be feasible, and longer term shared accommodation for those capable of living co-operatively will be needed. Many patients will become debilitated, and whilst not requiring acute hospitalisation, will be in need of prolonged hospice care, which is not available at the moment.

2.1.10 Respite Care

There is no respite care provision in Wolverhampton to support and relieve individuals, their families, or carers, but this issue is under consideration.

2.1.11 Recommendations

- It is recommended that following diagnosis, all HIV antibody positive persons should be offered referral to a Consultant with special training and experience of HIV infection and AIDS for treatment and monitoring.

- Training in good practice and infection control needs to be undertaken if the health of staff and patients is to be ensured. The Control of Infection Team should be closely involved in nurse training/education.

- The Health Authority should, in conjunction with other agencies, work to develop respite care in Wolverhampton for people with HIV/AIDS.

- The Health Authority should, in conjunction with other agencies, work to develop hospice care for people with HIV/AIDS.

- The Health Authority should work in conjunction with other agencies to develop appropriate support networks and services for people with HIV/AIDS and their carers Professional staff and key individuals in the community should share this responsibility.

- The Health Authority should work closely with housing agencies to ensure the provision of adequate accommodation.

- All staff should be trained in the issues surrounding HIV and AIDS. This should be incorporated into basic training, and is a priority for in-service programmes.

2.2 CARE OF CHILDREN WITH HIV

In the past, most children who became HIV antibody positive were haemophiliac boys infected through blood products given by intravenous injection for their clotting disorder. Present and future haemophiliac boys should not become infected by this route, since the screening of donors, testing of blood, and heat treatment of blood products was introduced in 1985.

There will be new cases of 'vertically' transmitted HIV, [an infected mother passing on the virus during pregnancy and delivery]. It may be possible for babies to become infected during breast feeding, and this is therefore not usually advised. [As there are other proven advantages to breast milk a determined mother should not be dissuaded]. Such babies may come to medical attention because of the mother being identified as HIV antibody positive. These children will require close supervision in a hospital clinic and will be monitored by a Consultant Paediatrician [including routine immunisations]. Initial symptoms may be varied and non-specific making diagnosis difficult. The prognosis of HIV antibody positive babies is unknown, but is perhaps better than was first feared.

It is anticipated that the numbers of infected babies will increase as heterosexual transmission becomes more common.

Children with HIV and their families will be afforded the monitoring and support provided for children through existing services. The special needs of these children will be met through the sensitive response of the caring agencies, and if necessary, the development of new services. The Local Education Department has developed policy and guidance on HIV infection and AIDS for schools. Further information is available from the Education Department at the Civic Centre, Wolverhampton.

Recommendations

- People who care for children with HIV/AIDS should receive adequate training.
- Agencies working with children should develop policies and guidelines to ensure an appropriate response to children with HIV/AIDS.
- Due to the special needs of children, they should be treated in a childrens' unit and not in an adult HIV/AIDS facility.

2.3 COMMUNITY DENTAL SERVICES

Clinical procedures to prevent cross infection are to be applied to all patients. All members of the dental team are subject to the rules of confidentiality.

Adults who are diagnosed as HIV antibody positive and who are unable to obtain dental care from the general dental services can obtain appropriate care from the Community Dental Services. Advice regarding oral hygiene in relation to HIV is also available.

For patients with AIDS, primary treatment is restricted to the management of dental pain and infection. A large number of conditions arise in the mouth as a result of HIV infection, and this category of patient with oral complications requiring treatment should be referred to a specialist or oral medicine department. Oral manifestations of the disease should be treated subject to the patient's consent, after conferring with the patient's physician.

Although these conditions in the mouth are not life-threatening, they do cause considerable distress and are important clinical markers for determining the individual's immune status. As a number of these conditions are easily overlooked, it is important that regular examination of the mouth is carried out on all patients known to be HIV infected.

N.B. The Community Dental Services are available to all children irrespective of their HIV status.

Further information can be obtained from the Community Dental Services, Leasowes, 10 Tettenhall Road, Wolverhampton WV1 4TG [Tel: 310641].

Recommendation

- The Community Dental Services should ensure that appropriate information is available to professionals and the public to enable people with HIV/AIDS to receive advice and treatment.

2.4 GENITO-URINARY MEDICINE

Genito-Urinary Medicine Departments are the first line of contact for many patients with HIV/AIDS. Throughout the years the department has developed a special relationship with its client group. The Genito-Urinary Medicine Department is well equipped with a team of trained Health Advisors and medical staff to offer pre-and post-test counselling on request.

All patients requesting an HIV test are offered testing after counselling. Patients are encouraged to inform their General Practitioner of the results. Medical colleagues are informed on a 'need to know' basis with the patient's consent. Although there is much concern about notification, confidentiality is maintained by staff directly involved in caring for patients.

The department offers continuing counselling and treatment where necessary. With the anti-viral treatments that are now available, careful monitoring is important.

The preventive role of Genito-Urinary Medicine is crucial in respect of the vulnerable client group it serves.

Recommendation

- The HIV/AIDS service provided by the department of Genito-Urinary Medicine should be the subject of Medical Audit. This should identify any need for additional resources arising from potential increased demands on the service, and facilitate further development of the service.

- The appointment of the HIV-AIDS Community Liaison Nurse should provide continuity of counselling and support for clients in the community.

2.5 COMMUNITY NURSING

The impact of AIDS and HIV infection on the local Community Nursing Service has been minimal and has not yet reached the level of demand on the health care delivery systems being experienced elsewhere.

As essential components of the information and communication network, Community Nurses have a responsibility to become and remain fully and accurately informed, and to help create a supportive social environment. An agreed number of community nurses should undertake ENB Course 934 and become expert resource nurses to their colleagues within an agreed training programme.

Provision of continuing care and support for families whose children may be HIV antibody positive should be provided by existing community staff to avoid confusion and duplication.

Discharge of people with HIV infection should be planned with the appropriate Community Nursing Service. Referrals should be early and contain adequate detail of the individual patient's condition and the nursing care provision required.

Confidentiality surrounding a person's antibody status should be maintained, requiring an emphasis on good Standards of Practice at all times.

The post-basic training of Community Nurses which places great emphasis on prevention, and acquired experience in the provision of home care support for people with chronic and life-threatening conditions, enables them to provide a range of expertise, including counselling, and to promote collaboration between statutory and voluntary agencies.

Recommendations

- An agreed number of community nurses should undertake ENB Course 934 and become expert resource nurses to their colleagues within an agreed training programme.
- The Health Authority should, in conjunction with other agencies, work to develop respite care in Wolverhampton for people with HIV/AIDS.
- The Health Authority should, in conjunction with other agencies, work to develop hospice care in Wolverhampton for people with HIV/AIDS.
- The Health Authority should work in conjunction with other agencies to develop appropriate support networks and services for people with HIV/AIDS and for those who care for them. Professional staff and key individuals in the community should share this responsibility.
- The Health Authority should work closely with housing agencies to ensure the provision of adequate and appropriate accommodation.
- The newly appointed HIV-AIDS Community Liaison Nurse should be the central point of reference and referral for activity surrounding HIV and AIDS.

2.6 PRIMARY HEALTH CARE

Within a four year period 90% of the population attend their general practitioner's surgery, it is therefore inevitable that staff will come into contact with people with HIV infection at some time.

Patients will be seen by a variety of staff such as the general practitioner, nurse [practice and district], and receptionist, and it is important that all healthcare personnel maintain confidentiality and good standards of practice.

Of the 126 Wolverhampton general practitioners, 60 are registered to undertake minor surgery on their premises. This represents a cross infection risk area and all general practitioners should be aware of aseptic techniques and Control of Infection precautions.

All practice staff should be aware of the surgery's cross infection policy, the facilities for treatment and counselling within the District, and the national document on sterilising procedures in General Practice - RCGP. They should also keep abreast of available local statutory and voluntary HIV/AIDS services.

Recommendations

- General Practitioners and practice staff should be trained in the issues surrounding HIV/AIDS.
- General Practitioners and practice nurses should be trained in good practice for control of infection.
- General Practitioners and their staff should offer advice on health promotion and HIV prevention.

2.7 OBSTETRICS, MIDWIFERY AND GYNAECOLOGY

2.7.1 Obstetrics and Midwifery

Expectant mothers are not routinely tested for HIV infection. However requests for testing are performed after the mother has received appropriate counselling. It is anticipated that the number of requests for testing will increase as the risk of heterosexual transmission of the virus becomes increasingly widely appreciated.

In cases where the mother is shown to be antibody positive, medical and midwifery staff who will be involved with the mother during her ante-natal care and delivery are made aware of the diagnosis with the consent of the mother. Contact is made with the appropriate support agencies. Close liaison is maintained with the Neonatal Paediatricians because of the risk of vertical transmission of the virus.

2.7.2 Gynaecology

Requests for testing are rarely received from gynaecological patients in the Out Patient Department. This is probably because most women who are concerned about infection probably self refer themselves to the Department of Genito-Urinary Medicine. However, when requests are received they are usually dealt with in conjunction with the Department of Genito-Urinary Medicine.

2.7.3 Recommendations

- It is recommended that an appropriate policy is developed which ensures that practice within the unit is such that all patients are treated so that cross infection cannot occur, whether or not the HIV status of the woman is known.

- Information should be made available to all women attending the maternity unit to enable them to make an informed decision on whether HIV testing is appropriate.

- Pre-and post-test counselling requires trained counsellors. It is recommended that an appropriate number of staff receive training in pre-and post-test counselling and offer support and advice to women within the unit.

- It is recommended that requests for HIV testing are dealt with within the service rather than by referral.

- Policy guidelines for Maternity and Gynaecology are currently at the stage of consultation and it is anticipated that these will be implemented by the time of publication of this corporate strategy.

2.8 MENTAL HEALTH SERVICES

The psychological and psychiatric implications of HIV infection make it likely that in the years ahead increasing numbers of individuals suffering from HIV disease will come into contact with the mental health services. The extent of the problem nationally and its likely proliferation calls for an effective local strategy to be implemented.

The psychiatric needs of increasing numbers of young people with AIDS will have significant consequences for the already overstretched community-based psychiatric services.

In the absence of either a cure or vaccine for this disease, the respective contributions of both clinical psychology and psychiatry, in terms of diagnosis, counselling, therapy, and care, are especially important in managing the trauma attending this disease - which is arguably as significant to quality of life as the physical effects of HIV infection.

By virtue of its exploitation of human sexuality for its predominant transmission and its association with drug misuse, HIV and AIDS have a social dimension which can only be properly addressed by the application of the psychosocial sciences.

The majority of AIDS patients with chronic organic brain syndrome will also be suffering from serious physical disorders resulting from HIV infection and will require access to expert medical care for diagnosis, treatment and prevention of other complications. Most of these patients will require a medical bed on a periodic basis, and liaison psychiatrists should play an important role in their care while they are in hospital and also in planning their aftercare; other patients will be in the terminal stage of their illness and may be more appropriately nursed either at home [provided the necessary home-care support is available] or in a hospice. It is estimated that about 10% of AIDS patients will suffer from dementia in late stage of the disease and will require treatment appropriate to this condition.

Guidelines are being developed for the Mental Health Services based upon the following recommendations:

2.8.1 All patients should have access to appropriate care for their disorder, and counselling and support services should be extended to the families and carers of people with HIV and AIDS.

2.8.2 The mental health services should have a G.P. orientated primary health care focus and be closely integrated with the community health services to provide a seamless and holistic regime of patient care.

2.8.3 Psychiatrists and Clinical Psychologists should act as professional mentors to staff caring for the psychosocial aspects of HIV infection, such as HIV Counsellors, Health Advisors, and the HIV/AIDS Community Liaison Nurse.

2.8.4 AIDS patients referred by acute specialties require combined management of their inter-related physical and psychosocial problems and an enhanced level of collaboration between professionals.

2.8.5 All patients, regardless of HIV status should be regarded as potentially at risk of transmitting or acquiring HIV infection, thus avoiding the need to operate a two-tier service which would be discriminatory.

3. SPECIAL RISK PROVISION

3.1 CARE AND TREATMENT OF INJECTING DRUG USERS

Drug Care which was established in January 1985, provides a comprehensive service for all types of drug users. The doctors are able to prescribe oral methadone and one of the strategies is to persuade injecting drug users to move to oral medication.

The appointment of 2 outreach workers has considerably extended the scope of Drug Care and hopefully will encourage drug users to attend for treatment and rehabilitation. Their work will also raise awareness of HIV and AIDS amongst drug users.

In conjunction with the Health Education Programme and information given through Drug Care those attending should be advised about the importance of "Safer Sex". Clients are supplied with free condoms on request.

3.1.1 The Provision of Clean Syringes and Needles

Drug Care operates a syringe and needle exchange for current injectors.

The presence of a local injecting population means that there is a risk of spreading HIV and Hepatitis B. The drugs most commonly injected are amphetamines and opiates.

Thus, priority should be given to:

- Encouraging and enabling all current injectors never to share equipment.
- Encouraging and enabling all injectors to stop injecting.
- Discouraging other adolescents and young adults from starting to inject.

A number of local injecting drug users continue to purchase syringes and needles through pharmacists. Pharmacists are being urged to provide a collection point within their premises so that syringes and needles can be safely handed in and disposed of.

3.1.2 Care of Drug Users With HIV Infection

Considerable support and counselling will be provided by the Drug Care Team for drug users who have HIV infection. These drug users will also need to be linked into the wider care services in the home, hospital, or hostel. Drug Care is located at 23 Temple Street, Wolverhampton WV2 4AN [Telephone 222821].

3.1.3 Recommendations

- Pharmacists are recommended to provide a collection point for the safe disposal of syringes and needles.
- The provision of hospital services for injecting drug users should be seen as a priority for the Health Authority in view of the risk of HIV in this group.

3.2 FAMILY PLANNING CLINICS

3.2.1 Current Provision

At present Family Planning Clinics are held in twelve different clinic locations with sessions in the mornings, lunchtimes, afternoons and evenings, and also Saturday mornings. 15 sessions per week are provided. A full range of family planning methods are available at all of these clinics, including intra-uterine devices and the morning after pill and condoms. Free supplies of condoms are also available at the clinics for patients attending their GP for contraceptive services.

Supplies of the condom are available at all twelve family planning clinics where sessions are held. Every month, 5000 to 8000 sheaths are issued. The correct use of a condom [conforming to British Standards] reduces the risk of sexually transmitted infections including HIV. However, it is advisable to use a more effective method of contraception to prevent unwanted pregnancy. Since neither the pill nor the IUD [coil] provide any protection against HIV, effective birth control and protection against HIV infection require the combined use of the pill or coil, and the condom.[This message is currently being promoted in the clinics]

While men are welcome at clinics, and can be issued with sheaths with the minimum of formality, very few have taken up this service, [only 25 to 40 each month. The service has been extended to a few non-clinic locations, eg a bail hostel, but this has only involved small number of clients.

A current initiative seeks to attract men and young people to clinics, and to promote HIV awareness and safer sexual practice. Because of the "embarrassment factor" for men attending a clinic primarily catering for women, arrangements have been made to publicize times when men can come along to use the service and collect condoms outside the regular family planning sessions.

3.2.2 Recommendations

- Family Planning staff should receive further training to enable them to meet their responsibilities with regard to HIV/AIDS.
- The role of Family Planning Clinics in health education for HIV prevention needs to be developed.
- Further initiatives are required to promote family planning services for men
- There is a need to develop services and advice specifically for young people.

3.3 ASPECTS OF SEXUAL BEHAVIOUR

Within Wolverhampton both men and women are working as prostitutes. There are also other men and women whose sexual behaviour puts them at risk of infection with HIV. It is possible to have unsafe sex with only one sexual partner and become infected with the virus. However, a person who has unsafe sex with more than one partner, either concurrently or consecutively, puts themself at an increased risk of being infected with HIV.

There is a current outreach project aimed at promoting sexual health amongst women. However, work with men is on a limited informal basis. Likewise, there is no formal programme for prostitutes.

Recommendations

- The Health Authority should work with other agencies and groups to develop a programme promoting sexual health and HIV prevention amongst prostitutes and their clients.

- More sexual health promotion work should be undertaken with men, both heterosexual and homosexual, in conjunction with other agencies.

4. LABORATORY SERVICES

The Microbiology and Public Health Laboratory at New Cross Hospital offers the following tests, either in-house or via the reference laboratory network, for patients infected with HIV:

- HIV antibody detection
- Markers of the progression of HIV infection
  - HIV antigen
  - Antibody to HIV core
  - Alpha-interferon detection

Tests for opportunistic infections such as atypical mycobacteria, pneumocystis, cytomegalovirus.

The standard full range of medical microbiological tests.

The Consultant Microbiologists offer clinical advice regarding the laboratory diagnosis and microbiological management of HIV infected individuals. This advice is available to medical practitioners in the hospital and in the community.

It is recommended that patients found to be infected with HIV are regularly tested every 2-3 months for the markers of infection listed above. In HIV antibody-positive patients the usual findings are that HIV antigen and alpha-interferon are negative and core-antibody is positive. One or more of these tests alters as the disease progresses. There is evidence that these markers change before the onset of clinical symptoms and can predict impending deterioration. This may allow anti-viral therapies to be used optimally.

Recommendations

- The increasing demand on laboratory services should be taken into account in the review of resource allocation.

5. INFECTION CONTROL

It is essential that hospital staff consistently follow good working practices that are sufficient to prevent the transmission of any infection, whether or not the patient is known to be infected. The Wolverhampton District Hospital Control of Infection Team has produced a policy for the hospital care of patients known to be infected with Human Immunodeficiency Virus [HIV]. The policy is designed to prevent the spread of infection, protecting patients and staff.

5.1 VENEPUNCTURE AND BLOOD TESTS

It is recommended that staff follow the standard instructions before taking blood samples, and all equipment, together with a 'sharps' box should be made available. Investigations of patients who are or may be infected with HIV are restricted to those essential for medical management. If laboratory tests are required, the Consultant or deputy in charge of the laboratory is informed.

5.1.1 It is District policy that venepuncture for HIV antibody tests is undertaken only by medical staff. In certain departments, eg GUM Clinic, Registered Nurses holding the certificate under the Authority's Extended Role Policy may undertake venepuncture if authorised by the Consultant in charge. The phlebotomist must not be asked to take blood for HIV antibody tests.

5.1.2 Disposable gloves, plastic apron and eye protection must be worn. A sheet of disposable plastic, eg another apron, must be placed under the patient's arm to contain any spillage.

5.1.3 Before discharging the specimen into a container, the needle must be removed from the syringe without re-sheathing, and put immediately into a 'sharps' container.

5.1.4 The specimen must be discharged gently into the bottle taking great care not to contaminate the outside of the specimen container. The empty syringe is placed in the 'sharps' container.

5.1.5 Gloves, aprons and disposable equipment used in obtaining the specimen must be placed in a yellow plastic bag for incineration.

5.1.6 Spillage of blood must be dealt with as described below.

5.1.7 Extreme care must be taken to avoid contact with the patient's blood. Accidental puncture wounds must be treated immediately by encouraging bleeding and liberal washing with soap and water. Contamination of broken skin, mouth and eyes must be washed with plenty of water. Accidents must be reported to the Occupational Health Department.

5.2 TRANSPORT OF SPECIMENS

Specimen containers are placed individually in leak-proof biohazard bags which are normally combined with the request form. Request forms must be fully completed and bear the biohazard sticker. For patient confidentiality, the forms should not be labelled 'HIV antibody positive' or 'AIDS'.

6. HEALTH AND SAFETY

6.1 OCCUPATIONAL HEALTH

6.1.1 Protection of Staff from Infection

To keep staff well informed about HIV, Occupational Health will participate in training sessions and the development of local policies and guidelines. Staff should report all sharps injuries to Occupational Health. Any member of staff who has been injured by a bloody needle will be offered counselling and blood sampling for future testing. Post-test counselling will also be offered.

6.1.2 Cross Infection Risks to Staff at Work

These include Sharps injuries and contact with blood on broken skin, cuts, eczema or other rashes, mucous membrane - nose, ears, eyes, mouth etc.

6.1.3 Staff who have HIV Infection

Staff who have HIV infection will be given confidential support and counselling by trained staff in the Occupational Health Department. Arrangements will be made for help from outside agencies with the employee's written consent.

Staff who are infected with HIV require counselling in cross infection precautions. They need prompt treatment for opportunistic infections, and should not nurse patients with infectious diseases. When symptomatic, they should avoid working with pregnant or immuno-suppressed colleagues or patients.

Staff with weeping eczema or similar skin conditions are not permitted to care for these patients but should seek the advice of the Occupational Health Department. Cuts and abrasions on hands and forearms must be covered with waterproof dressings. Pregnant and immuno suppressed staff should not care for patients with opportunistic infections.

6.1.4 'Sharps' Disposal and 'Needlestick' Injuries

The prevention of 'needlestick' injury by the safe handling and disposal of 'sharps' is the single most important safety measure. The policy recommends that extreme care is taken to ensure that needles, IV cannulae and other sharp instruments are handled safely to prevent inoculation accidents. Needles must be discarded into a 'sharps' box.

It is recommended that, in the event of an inoculation accident, bleeding is encouraged and the site of injury is washed with soap and water. Splashes of blood into the eyes or mouth must be irrigated with water or saline. The policy states that after any accident, hospital staff must attend the Occupational Health Department as soon as possible for advice and follow up. A blood test may be offered after counselling, if requested by the member of staff. District Health Authority employees must complete an Accident Form noting the name of the patient, and return it to their Head of Department.

6.2 GENERAL NURSING PROCEDURES

The Wolverhampton Hospitals' Control of Infection Committee has prepared a detailed policy for the care of patients infected with HIV.

6.2.1 Confidentiality

All hospital staff maintain the confidentiality of details of a patient's diagnosis. If they are in doubt as to where their duty of confidentiality lies, staff are requested to seek the advice of the ward sister or the consultant caring for the patient. Medical staff follow the guidelines of the General Medical Council.

6.2.2 Blood Spillage

Spillage of blood must be dealt with immediately, wearing gloves, plastic apron and eye protection. Strong hypochlorite solution [see section 6.7] is poured onto paper towels placed over the spill, before being mopped up with absorbent paper. The towels, gloves and apron are placed in yellow bags for incineration.

6.2.3 Isolation

In general, patients infected with HIV do not require single room isolation for infection control purposes. However, source isolation procedures are required when the patient has uncontrolled bleeding, diarrhoea or opportunistic infections. In cases requiring source isolation, protective clothing, gloves and plastic aprons are worn. In addition, a mask and eye protection are worn when there is a significant risk of contamination by blood, tissue fluids, or secretions; eg venepuncture; attending to the patient's sanitary needs; oral hygiene, and tracheal suction.

HIV infected patients who develop immune deficiency may require protective isolation. Staff who have an infection should not attend these patients.

6.2.4 Nursing

The patient can use the general ward toilet unless isolated in a single room. It is not necessary to put disinfectants down the toilet. If the patient uses a bed-pan, it is discarded immediately after use in the macerator with the lid closed for one minute after the cycle stops, to allow aerosols to settle. Suitable disinfectants are hypochlorite or glutaraldehyde as described in section 6.7.

Patients infected with HIV can use normal hospital crockery and cutlery since routine hot washing is adequate to disinfect it.

6.2.5 Hospital Linen

Disposable sheets and pillow-cases are used only when there is bleeding or leakage of tissue fluids or where there are difficulties in maintaining standards of hygiene, such as profuse diarrhoea or faecal incontinence. After use, these are incinerated as infected waste.

Ordinary hospital linen is used by most patients infected with HIV. Hospital linen is safely handled and washed in accordance with the District Linen Policy under which grossly soiled

or blood-stained linen is incinerated as infected waste. Used unsoiled linen is sealed in an alginate bag before being placed in a red laundry bag for washing at high temperatures. An 'infected linen' label, stating ward and date, is attached to the bag, and the Laundry Services Manager is informed prior to infected linen being sent to the laundry.

6.3 LAST OFFICES [Laying Out Bodies]

The body of a patient infected with HIV is handled following the District procedure 'Last Offices: Care and Removal of Infected Bodies'. An impermeable plastic cadaver bag is used and the body labelled with a biohazard label.

6.4 SURGICAL OPERATIONS AND MATERNAL DELIVERY

The Consultant in charge of the patient is responsible for informing all members of the surgical team of the infection hazards and measures to be taken. The Hospital Control of Infection Team has prepared detailed policies covering the procedures in theatres and delivery suites.

6.5 SERVICING OF EQUIPMENT

To protect service engineers, equipment used in the treatment of a patient infected with HIV must be suitably decontaminated before being sent for servicing. A Certificate of Decontamination will accompany the equipment.

6.6 WASTE DISPOSAL

All 'Sharps', such as needles or scalpel blades are placed in an approved 'sharps' container. Infected waste is placed in a yellow bag, sealed and put in a second yellow bag overprinted 'infected' in large red letters. Waste is incinerated in accordance with the current District Waste Disposal Policy.

6.7 CLEANING AND TERMINAL DISINFECTION

The Domestic Supervisor is informed to ensure that cleaning and terminal disinfection is carried out according to the District Policy: ' Procedure for Cleaning Rooms of Patients requiring Standard Source of Protective Isolation'.

DISINFECTANTS

HYPOCHLORITE

This can be prepared using Milton[R] or 2.5 gram Presept[R] tablets which are available from Pharmacy:

TYPE	Available Chlorine	Milton[R] Dilution	Presept[R] Tablets [2.5 gram]
STRONG solution	10,000 ppm	Neat	1 tablet in 140 ml 4 tablets in 1 pint
STANDARD Solution	1,000 ppm	1 in 10	1 tablet in 1.4 litres 3 tablets in 1 gallon

GLUTARALDEHYDE

2% freshly activated glutaraldehyde.

7. EMPLOYMENT ISSUES

7.1 INTRODUCTION

There has been much ill-informed speculation about the implications of HIV/AIDS for employment. This paper sets out the Authority's policy in relation to its employees who may be infected with HIV or have AIDS.

The policy embodies the following important principles:-

7.1.1 The Authority is committed to caring for the carers and seeks to create an environment conducive to promoting the health of all its employees.

7.1.2 The Authority is committed to equality of opportunity in both employment and service delivery. All patients/clients and staff are entitled to be treated with dignity and with freedom from discrimination.

7.1.3 Persons who are HIV positive or who have AIDS require understanding and appropriate care. Employees who are HIV positive or who have AIDS will not be treated differently from any other employee who has contracted a serious or potentially serious illness.

7.1.4 The Authority in its HIV/AIDS strategy has recognised that it has a responsibility to promote a general awareness about HIV and AIDS, to provide protective material for its employees, and to promote safe working practices and procedures.

The policy has been drafted in the light of currently available information. This is a rapidly developing subject and it will be necessary to keep the issues under review and to revise the advice as necessary.

7.2 BACKGROUND - HEALTH CARE WORKERS WITH HIV INFECTION OR AIDS

The Department of Health Expert Advisory Group on AIDS reported in March 1988 on AIDS: HIV-Infected Health Care Workers, and issued updated guidelines in December 1991. The following points from the report help to set the Authority's policy in context:-

7.2.1 No country has reported infection of a patient by an HIV-infected health care worker.

7.2.2 The cumulative epidemiological data indicate that the transmissibility of HIV in the health care setting is extremely low. However, as for other blood borne pathogens, there is a theoretical possibility of transmission of infection by health care workers to patients as a result of inoculation of blood by injection or through breaks in the skin. It is therefore advisable to act prudently.

7.2.3 If normal hygienic practice is followed (eg the wearing of gloves or waterproof dressings over cuts or sores), any risk to patients from infected staff is confined to those cases where during surgical invasive procedures the operator has an accidental injury.

7.2.4 The overall risk of infection during surgical invasive procedures is probably very low indeed, however, the Health and Safety Executive in its publication 'Health and Safety News Bulletin' in January 1991 reported that a dentist in Florida had transmitted HIV infection to four patients during invasive procedures.

For many of the Authority's employees there will be no risk of infection whilst at work. Those employees including students and trainees, whose activities involve contact with the blood or other body fluids of patients, may be exposed to the risk of infection. However, almost all possibility of blood to tissue contact between health care workers and patients (other than from unforeseeable accidents) can be eliminated by meticulous attention to personal hygiene and to well established safe working practices. It is vital therefore that employees strictly observe the Authority's established control of infection policies and procedures.

In areas of work where there may be a greater level of risk or hazard, e.g. dental surgeries, Accident and Emergency Departments etc, it is imperative that local policies, procedures and practices are adhered to by staff.

7.3 RECRUITMENT AND SELECTION

In keeping with the Authority's policy on Equal Opportunities and its Guidance on Recruitment and Selection, managers are expected to ensure that no applicant receives less favourable treatment than any other on grounds of sex, marital status, race, religion, creed, colour, ethnic origin, disability, sexual orientation, or age, unless this is directly related to a genuine requirement of the post.

Applicants will undergo selection procedures including pre-employment medical screening by the Authority's Occupational Health Department. However, this will <u>not</u> include screening for HIV/AIDS either by direct methods (HIV antibody testing) or by indirect methods (assessment of risk behaviour), or by reference to tests already taken.

Should it become known through self disclosure during the course of medical screening that an applicant is HIV antibody positive or has AIDS, this will be confidential to the Occupational Health Department. The only information to be made available to the manager will be the applicant's 'medical fitness' to undertake the duties of the post.

An applicant who is deemed to be medically fit to undertake the duties of a post at the time of interview will not be discriminated against because he/she is HIV antibody positive or has AIDS.

7.4 EMPLOYEES: GENERAL STRATEGY

Most people with HIV/AIDS want to continue in work which enhances their physical and mental well being, and subject to the guidance in section 7.5, they should be entitled to do so.

Employees with HIV infection who are healthy should be treated the same as any other employee. Employees with HIV related illness including AIDS should be treated the same as any other employee with an illness, in accordance with the guidance set out in the Personnel Policy 'Absence of staff from duty owing to sickness - Action Guide for Managers'. This will be subject to the provisions of points of guidance in section 7.5.

Persons in employment will not be asked to undergo HIV/AIDS screening whether by direct or indirect methods, or questioned about tests already taken. The only exception to this will be the offer of an HIV antibody test following a sharp's injury.

7.5 MEDICAL AND DENTAL STAFF

Medical and Dental staff will be expected to observe the ethical guidelines of the General Medical Council and General Dental Council. The General Medical Council has stated that:-

> *'It is imperative, both in the public interest and on ethical grounds that any doctors who consider that they may have been infected with HIV should seek appropriate diagnostic testing and counselling, and if found to be infected, should have regular medical supervision. They should also seek specialist advice on the extent to which they should limit their professional practice in order to protect their patients. They must act upon that advice, which in some circumstances would include a requirement not to practice or to limit their practice in certain ways. No doctors should continue in clinical practice merely on the basis of their own assessment of the risk to patients'.*

The General Dental Council has stated:-

> *'It is the ethical responsibility of dentists who believe that they may have been infected with HIV to obtain medical advice and, if found to be infected, to submit to regular medical supervision. Their medical supervision will include counselling, in particular in respect of any changes to their practice which might be considered appropriate in the best interests of protecting their patients.'*

> *'It is the duty of such dentists to act upon the medical advice they have been given, which may include the necessity to cease the practice of dentistry altogether or to modify their practice in some way. By failing to obtain appropriate medical advice or to act upon the advice that has been given them, dentists who know that they are, or believe that they may be, HIV positive and might jeopardise the wellbeing of their patients, are behaving unethically and contrary to their obligations to patients'.*

The Regional Health Authority's Occupational Health Service is available for staff whose contracts are held with the RHA. As with any other illness, it may be necessary for the Occupational Health Service, as appropriate, to deal with any implications for the individual's ability and safety in carrying out the duties of their post.

7.6 OTHER STAFF

Other staff, who consider, on the basis of the known means of transmission, that they may have been infected with HIV, should seek immediate counselling, and if appropriate, diagnostic HIV antibody testing. Staff have a responsibility to carry out their duties in a safe and responsible manner. If they are found to be infected and their duties involve performing or assisting in surgical invasive procedures, they must seek advice from their personal physician. They must act upon the advice on any modifications or limitations to their duties at work which may be necessary for the protection of patients.

Medical and other staff should be aware that if it becomes apparent that a health care worker is failing to follow advice on modifying his/her work practices, there will be a duty on the doctor who had counselled the health care worker to modify his or her professional practice, to inform the employing Authority that the health care worker's fitness for duties may be seriously impaired.

Where an employee has been advised to modify or limit his/her duties, he/she should inform the Authority's Occupational Health Adviser. The Occupational Health Adviser will advise the manager that the employee is unfit to carry on undertaking the full range of duties and will recommend any modifications or limitations to duties.

The manager will discuss with the employee a range of options, and these will include modification to duties, alternative employment, extension of sick pay, or retirement on grounds of ill-health.

Where these options have been exhausted and medical advice indicates that a return to work is unlikely, it may be necessary to consider ill health retirement or dismissal.

7.7 CONFIDENTIALITY AND DISCRIMINATION

It is vital that confidentiality should be assured. This is the greatest safeguard for patients, for without it there is the possibility that employees may not seek advice. Deliberate breaches of confidence or discrimination concerning HIV infection or AIDS will result in disciplinary action.

7.8 COUNSELLING

An employee who has been infected with HIV or has AIDS may suffer particular personal hardship and distress, and wherever possible, full counselling support via the Occupational Health Service should be provided, together with access to information and other support agencies. Confidential advice is also available from the Authority's designated Physician for HIV/AIDS and from the GU Medicine Department.

Employees who are required to provide care for patients/clients who have been infected with HIV or have AIDS may also be subject to stress, and it is recommended that counselling and staff support groups are available.

7.9 TRAINING

The Authority will continue to support the training of employees to undertake pre-and post-test counselling.

Employees will be provided with continuing education and training in the relevant aspects of safe working practices and control of infection procedures.

The District Health Promotion Officer will continue to provide a comprehensive HIV/AIDS prevention, training, and awareness programme for the Authority's employees, the general public, schools and colleges.

HEALTH PROMOTION

8.1 AIMS

8.1.1 To prevent the spread of HIV/AIDS through comprehensive public education programmes.

8.1.2 To prepare the caring services and the community of Wolverhampton to deal sensitively and appropriately with HIV/AIDS through a programme of education and training.

8.2 OBJECTIVES

8.2.1 To educate the public about HIV/AIDS using local networks, public awareness initiatives and local media, and provide clear, accurate, up to date and non-discriminatory information.

8.2.2 To develop educational initiatives for particular groups in the community, provide specific information on risks associated with particular behaviour, and support clients who want to change behaviour to reduce risk.

8.2.3 To develop training programmes, preparing statutory and voluntary agencies to respond appropriately to people with HIV/AIDS and those who care for them.

8.2.4 To encourage and assist with the development of policies to prevent the spread of HIV infection and protect the rights of people with HIV.

8.3 DETAIL

Health promotion relating to HIV /AIDS has been undertaken over the past few years. This work includes:

8.3.1 Developing public awareness materials: a theatre production for pubs and clubs; display material; local leaflets, and a local directory of services for people with HIV and their carers.

8.3.2 Holding public awareness events; World AIDS Days, and sexual health weeks.

8.3.3 Developing basic training packages for professional and community workers.

8.3.4 Disseminating educational material to young people through training.

8.3.5 Ensuring HIV/AIDS is covered in general education and training programmes.

The work done so far has been carefully planned to meet the local situation; This involves multi-agency working which has laid the foundation for future work

8.4 PRIORITIES

To meet the challenge of HIV/AIDS for the future requires commitment and co-ordination in all areas, including health promotion. There is a need to set priorities and work systematically, to share information and to evaluate. The priorities for the next three years for health promotion are as follows:-

8.4.1 To continue general public education.

8.4.2 To develop education programmes, targeting the following specific sections of the community:-

GUM Clinic attenders
Young People
Men who have sex with men
Injecting drug users
Women
People with learning difficulties
Ethnic minorities

The education programmes developed will involve:-

- providing accurate up-to-date information
- exploring feelings and attitudes towards issues such as sexuality, sexual orientation, lifestyle, bereavement, personal and social responsibility etc.
- developing appropriate skills eg communication, assertiveness.
- promoting a change of behaviour to prevent the spread of HIV/AIDS through harm reduction applied to sexual activity and drug use.
- encouraging and facilitating the development of appropriate support networks and disseminating information about these activities.

8.4.3 To further develop training and education for professional staff and community workers. All staff within statutory agencies should undertake basic HIV/AIDS awareness training to enable them to:-

- respond appropriately to people with HIV/AIDS
- develop good practice, thus protecting themselves against infection.
- act as health educators
- dispel myths and fears associated with HIV/AIDS

There is also a need for some key workers within the statutory and non statutory agencies to receive specialised training to enable them to:-

- provide care and treatment for people with HIV/AIDS
- offer psychological and social support to people with HIV/AIDS and those who care for them.
- promote a healthy lifestyle amongst people with HIV infection to reduce the impact of HIV/AIDS on the individual and to limit transmission within the community.

Specialised training must meet the specific needs of participants according to their role. It is important that those coming forward for specialist work must have undertaken basic training and worked through issues such as sexuality, drug use, bereavement etc. It is also important that specialists gain experience of a specific AIDS Unit through placement arrangements.

8.4.4 In order that agencies are clear about how to respond to HIV/AIDS in the community it is important that comprehensive policies are developed. This should be done in consultation with all involved in the service. It should address the issues which concern agency staff and should consider the agency's response to the people it serves. Advice and support on policy development can be obtained from the Health Promotion Department, the District HIV Prevention Co-ordinator, and the District AIDS Action Group.

8.5 RECOMMENDATIONS

Wolverhampton Health Authority should:

8.5.1 ensure that all staff receive basic training on HIV/AIDS and related issues and arrange for an adequate number of staff to receive appropriate specialised training.

8.5.2 ensure that all departments with responsibility and opportunity for HIV/AIDS education fulfil their responsibilities. Specialist advice regarding education can be obtained from the Health Promotion Team.

8.5.3 build strong partnerships with other statutory and non-statutory agencies with the aim of developing effective public education initiatives.

8.5.4 work with other agencies to establish appropriate care and support networks for people with HIV/AIDS and their carers.

8.5.5 ensure that due consideration is given to the impact of HIV/AIDS in policy development.

9. DISTRICT AIDS ACTION GROUP

When the Wolverhampton Health Authority District AIDS Action Group was formed in 1985, its membership comprised a small number of doctors with an interest in control of infection within the Health Authority.

Initially, the Group was convened to develop policies and procedures for the prevention of cross-infection with HIV in the health service setting. Since then the Group has extended both its role and composition. It now has a diverse membership from the Health Services, Wolverhampton Metropolitan Borough Council, General Practice,the Family Health Services Authority, the Probation Service, the Community Health Council, and Voluntary Agencies.

The District AIDS Action Group now acts as a focus for HIV/AIDS prevention and health promotion activities within the Health Authority in conjunction with other agencies, and in the community. The Group has initiated HIV/AIDS information services for Health Authority staff and for Voluntary Sector personnel, and is the body responsible for advising on the use of funds for HIV/AIDS prevention projects in Wolverhampton.

The District AIDS Action Group has until recently occupied a free-standing position within the Health Authority. This has not empowered the Group in its role in securing funding, however the establishment of the District Control of Communicable Disease Committee [DCCDC] has offered the Group the opportunity to become part of the recognised Health Authority advisory structure. The District AIDS Action Group is now a sub-committee of the DCCDC.

The District AIDS Action Group will be responsible for reviewing the Strategy Document annually.

Membership:

Dr. J. Spencer [Chairman]	- Consultant in Communicable Disease Control
Dr. D. Bose	- General Practitioner
Mrs V. Burke	- District Dental Services
Dr. I. Dass	- Senior Registrar: Microbiology, New Cross Hospital
Mrs V. Gough	- Probation Service
Mr. B. Hadley	- Hospital Social Worker
Mr. B. Hales	- Environmental Health Dept., Local Authority
Mr. P. Jones	- District HIV Prevention Coordinator
Dr. J. Mann	- Consultant Chest Physician, New Cross Hospital
Miss. R. Middleton	- Health Promotion Officer
Mr. J. O'Brien	- Family Health Services Authority
Miss. M. O'Dwyer	- District Health Promotion Manager
Mr. A. Pentecost	- Education Department, Local Authority
Mrs H. Price	- Senior Nurse, Occupational Health Dept.
Ms S. Pritchard	- Health Liaison Officer, Local Authority
Mr. K. Rogers	- Aids Community Church Trust
Mrs F. Smith	- Control of Infection Nurse, New Cross Hospital
Dr. R. Thompson	- Consultant Microbiologist, New Cross Hospital
Mr. J. Urwin	- Chairman, Community Health Council
Dr. T. Wanas	- G.U.M. Consultant, Royal Hospital
Dr. J. Wardle	- Consultant Microbiologist, New Cross Hospital
Dr. J. Wright	- Consultant in Public Health Medicine

10. RECOMMENDATIONS

10.1 It is recommended that following diagnosis, all HIV antibody positive persons should be offered referral for treatment and monitoring to a consultant with special training and experience in HIV infection and AIDS.

10.2 Training in good practice and measures to avoid cross infection need to be implemented if the health of staff and patients are to be ensured. The Control of Infection Team should be closely involved in nurse training/education.

10.3 The Health Authority should, in conjunction with other agencies, work to develop respite care in Wolverhampton for people with HIV/AIDS.

10.4 The Health Authority should, in conjunction with other agencies, work to develop hospice care for people with HIV/AIDS.

10.5 The Health Authority should work in conjunction with other agencies to develop appropriate support networks and services for people with HIV/AIDS and for those who care for them. Professional staff should share this responsibility with others in the community.

10.6 The Health Authority should work closely with housing agencies to ensure the provision of adequate accommodation.

10.7 All staff should be trained in the issues surrounding HIV and AIDS. This should be incorporated into basic training and made a priority for in-service programmes.

10.8 People who care for children with HIV/AIDS should receive adequate training.

10.9 Agencies working with children should develop policies and guidelines to ensure an appropriate response to children with HIV/AIDS.

10.10 Due to the special needs of children, they should be treated in a children's unit and not in an adult HIV/AIDS facility.

10.11 The Community Dental Services should ensure that appropriate information is available to professionals and the public so that people with HIV/AIDS receive advice and treatment.

10.12 The service provided by the Genito-Urinary Medicine department related to HIV/AIDS should be the subject of Medical Audit in order to identify the need for additional resources arising from potential increased demands on the service.

10.13 An agreed number of community nurses should undertake ENB Course 934 and become expert resource nurses to their colleagues within an agreed training programme.

10.14 General Practitioners and practice staff should be trained in the issues surrounding HIV/AIDS.

10.15 General Practitioners and practice nurses should be trained in good practice for the control of infection.

10.16 General Practitioners and their staff should offer advice on health promotion and prevention.

10.17 An appropriate policy should be developed to ensure that practice within the maternity unit precludes the possibility of cross infection, whether or not the HIV status of the woman is known.

10.18 Information should be made available to all women attending the maternity unit to enable them to make an informed decision on whether HIV testing is appropriate.

10.19 Pre-and post-test counselling requires trained counsellors. It is recommended that an appropriate number of staff receive training in pre- and post-test counselling and offer support and advice to women within the maternity unit.

10.20 Requests for HIV testing should be dealt with by the department which the patient is attending and not referred elsewhere.

10.21 The Mental Health Services should be pro-active in extending services to people with HIV/AIDS and should develop appropriate policies and services to fulfil a role to people experiencing post HIV diagnosis, mental trauma, and suffering from the neurological consequences of AIDS.

10.22 The Mental Health Services should develop services to support the families and carers of people with HIV/AIDS.

10.23 Psychiatrists and Clinical Psychologists should act as professional mentors to staff caring for the psychosocial aspects of HIV infection; such as HIV Counsellors, Health Advisers, and the HIV/AIDS Community Liaison Nurse.

10.24 The mental health services should have a G.P. orientated primary health care focus and be closely integrated with the community health services to provide a seamless and holistic regime of patient care.

10.25 Aids patients referred by acute specialties require combined management of their inter-related physical and psychosocial problems and an enhanced level of collaboration between professionals.

10.26 Pharmacists are recommended to provide a collection point for the safe disposal of syringes and needles.

10.27 The provision of hospital services for injecting drug users should be seen as a priority for the Health Authority in view of the risk of HIV infection in this group.

10.28 Family Planning staff should receive further training to enable them to meet their responsibilities with regard to HIV/AIDS.

10.29 The role of Family Planning Clinics in HIV prevention through health education needs to be developed.

10.30 Further initiatives are required to promote family planning services for men.

10.31 There is a need to further develop services and advice through family planning clinics specifically for young people.

10.32 The Health Authority should work with other agencies and groups to develop a programme promoting sexual health and HIV prevention amongst prostitutes and their clients.

10.33 More sexual health promotion work should be undertaken with men, both heterosexual and homosexual, in conjunction with other agencies.

10.34 The increasing demand on laboratory services should be taken into account in the review of resource allocation.

10.35 Wolverhampton Health Authority and other key agencies should ensure that all staff receive basic training in HIV/AIDS and related issues, and that an adequate number of staff receive appropriate specialised training.

10.36 Wolverhampton Health Authority should ensure that all departments with responsibility and opportunity for HIV/AIDS education fulfil these responsibilities, Specialist advice regarding education can be obtained from the Health Promotion team.

10.37 Wolverhampton Health Authority should build strong partnerships with other statutory and non-statutory agencies with a view to developing effective public education initiatives.

10.38 Wolverhampton Health Authority should work with other agencies to ensure that appropriate care and support networks for people with HIV and those who care for them are established.

10.39 Wolverhampton Health Authority should ensure that consideration be given to the impact of HIV when developing policies.

10.40 All patients regardless of HIV status should be regarded as potentially at risk of transmitting or acquiring HIV infection, thus avoiding wherever possible the need to offer a discriminatory two-tier service.

11. CONTACTS LIST

Wolverhampton	[0902]
G.U.M. Clinic Health Adviser: [Female Patients]	644898
G.U.M. Clinic Health Adviser: [Male Patients]	644896
AIDS Line Wolverhampton	644894
Family Planning Clinic, Red Hill Street	312123
Well Women's Advice And Information Centre	29217
Mrs. P. Smith, HIV-AIDS Community Liaison Nurse	GRO-C
Dr. J.S. Mann, Consultant Physician	GRO-C
Dr. J.K. Wardle, Consultant Microbiologist	GRO-C
Dr. T.M. Wanas. Consultant Physician	GRO-C
Dr. J. V. Spencer, Consultant Communicable Disease	GRO-C
Health Promotion Centre, The Royal Hospital	644853
District HIV Prevention Co-ordinator	310641
Drug Care, Temple Street	22282
Community Dental Services	310641

Birmingham Regional Services]	[021]
AIDS Line West Midlands	622 1511
National AIDS Counselling Training Unit	766 6611
AIDS Life Line and Counselling Centre	235 3535
Barnados	633 3522
Body Positive	212 3636
Lesbian and Gay Switchboard	622 6589
Friends West Midlands	622 7351
Rape Crisis Centre	622 2465

London	
National AIDS Helpline	0800 567123
National AIDS Trust	071 338 1188
Terrence Higgins Trust	071 242 1010
Body Positive	071 373 9124
Lesbian and Gay Switchboard	071 837 7324
Mainliners	071 737 3141
Blackliners	071 738 5274
Positively Women	071 490 5515
Bisexual Phoneline	031 569 7500
Asian Helpline	0800 282445
Minicom Deafline	0800 521361
Haemophilia Society	071 928 2020
Cruise Bereavement Counselling	081 332 7227