Module 5: Counselling, Care and Treatment

Session 1: Overview of HIV and AIDS care and Treatment Services
Objectives:

1. Identify HIV and AIDS Care and Treatment services

2. Discuss the link between VCT and HIV and AIDS Care and Treatment
HIV/AIDS care and treatment services

HIV/AIDS care and treatment services are the services based on an active concern for the well being of people living with HIV and AIDS. People directly affected by HIV an AIDS need care and treatment services. These services are:

• Social economic support services (Micro credit, Nutrition support, orphan support, Home care)
• Medical care services (Treatment OIs, TB, prevention therapies, Palliation, ARVs)
• Human Rights & Legal Support services (PLHA involvement, Making will, Community sensitization)
• Psychological support services (VCT, Spiritual Support, Follow up counselling)
The link between VCT and HIV and AIDS care and treatment

VCT is not an end point but rather an entry point for HIV prevention, treatment and care:

- VCT is the entry point to all other services provides an opportunity to access accurate and comprehensive information on HIV/AIDS

- VCT enables a person to confidentially find out and understand his or her risk of HIV infection.

- It proposes a range of interventions
- It proposes a range of interventions

- It supports prevention by offering individuals, couple and groups risk – reduction counselling.

- It incorporate a range of different people, resources and services

- It promotes and sustains behaviour change and links with prevention MTCT, prevention and treatment of STIs, and other interventions.

- VCT facilitates early referral to comprehensive clinical and community – based services, including provision of ART, where available, and treatment of OIs
Module 5: Counselling, Care and Treatment

Session 2: Continuum of Care in HIV and AIDS

M5-2
Objectives:

1. Discuss components of continuum of care.

2. Discuss possible interventions used in the continuum of care.

3. Discuss the role of a Counsellor in the continuum of care.
Continuum of care is a mechanism of pooling together of medical and other services within the community to accommodate the needs of PLHA and their families, which goes beyond clinical care and treatment. Continuum of care starts right from the time someone is tested HIV positive until death.
Components of continuum of care

- Voluntary Counselling and Testing (VCT)
- Care, coping and social support
VCT as part of continuum of care can (VCT as an Entry point for HIV Prevention and Care)

- Planning for future orphan care will Making
- Acceptance of serostatus and coping
- Facilitates behavioural change and involvement of others
- Normalizes HIV/AIDS
- Facilitate access to Mother to Child Intervention
- Early Management of Opportunistic Infections and HIV (e.g. TB, etc.)
- Referral to Social and Peer Support
- Access to syphilis screening and treatment and other STIs
- Access to Preventive Therapy (TB and bacteraemia) and Contraceptive Advice
- Access to ARVs

Voluntary Counseling and Testing
Care, Coping and Social support as part of continuum of care can:

- Improve the quality of life of the infected and affected persons.
- Reduce HIV related morbidity and mortality
- Improve the survival of PLHA
Possible interventions used in the continuum of care

**Individual counseling:**
- Provides an opportunity for clients to express their feelings, and to talk about, prioritize and solve their problems.
- Provides an opportunity for others to express empathy and concern for the client.

**Family counseling:**
- Provides an opportunity in helping the family members of different personalities to cope with the situation and solve issues.
**Group counseling/support:**
Provides an opportunity for mutual support by individuals experiencing the same problem. Involvement of people living with HIV/AIDS is critical in provision of psychosocial care and such involvement should be part of care and support programmers.

**Spiritual counseling:**
Provides spiritual support through spiritual leaders.

**Medical support:**
Facilitates provision and access to relevant medical care.
Home and community – based care:
Home and community based care means any form of care given to PLHA in their own homes and community. It can be care activities that PLHA might do to care of themselves or the care given by their relatives, friends or health workers within their homes and communities.

Medical and Nursing care:
The care of an HIV positive patient is multifaceted and multidisciplinary. HIV positive clients who have been diagnosed in any stage of the HIV infection may eventually develop physical problems. These specific issues that patients will have to deal with include deteriorating health and treatment options.
Nutrition and HIV/AIDS:

• Health care for people with HIV/AIDS has concentrated almost entirely on treatment and management of infections while neglecting the nutritional status of PLHA.

• Food cannot cure HIV/AIDS, nor does it treat the virus, but it can certainly improve fitness and quality of life for PLHA. Eating enough and balanced diet helps one to maintain the body weight and muscles. Besides, suitable food helps to maintain and improve the performance of a person's immune system.
The role of a counselor in continuum of care (The HIV AIDS Continuum of care)

PLHIV

Voluntary Counselling and Testing

Primary Health Care
- Health posts
- Dispensaries
- Traditional healer
- Orphan care

Community Care
- NGO’s
- Churches
- Youth groups
- Volunteers

Home Care
- Palliative
- emotional and spiritual support
- Self Care

Secondary Health care
- District hospitals
- HIV clinics
- Social/legal support
- Hospice

Tertiary Health care
- Specialists and specialized care facilities

Peer Support

Entry Point
Module 5: Counselling, Care and Treatment

Session 3: The Role of a Counsellor in ART
Objectives:

1. Describe the goals of ARV therapy

2. Explain the classification of ARV

3. Describe the ARV combination regimen in Tanzania

4. Discuss the role of a Counsellor in ARV/ART Counselling
Goals of ARV therapy

Primary goals of antiretroviral therapy therefore are:
- Maximal and durable suppression of viral load
- Restoration and/or preservation of immunologic function
- Improvement of quality of life
- Reduction of HIV-related morbidity and mortality

Secondary goals are to decrease the incidence of HIV through:
- The increased uptake in voluntary testing and counseling with more people then knowing their status and practicing safer sex.
- The reduction of transmission in discordant couples
- Reducing the risks of HIV transmission from mother to child.
Classification of antiretroviral drugs

Nucleoside Reverse Transcriptase Inhibitors (NRTIs)
- The primary mechanism of action of this class is inhibition of viral RNA-dependent DNA polymerase (reverse transcriptase) enzyme.

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)
- This class of drugs act by disrupting the reverse transcription of viral RNA into DNA which is then incorporated in the cell’s nucleus.
- They are not directly incorporated into the viral DNA but instead inhibit replication directly by binding to the enzyme reverse transcriptase.
- Resistance to these drugs develops rapidly, especially when used alone.
Protease Inhibitors (PIs)

- PIs competitively inhibit the HIV protease enzyme whose activity is critical for the terminal maturation of infectious virions.
- This inhibition prevents the maturation of virions capable of infecting other cells.

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The ARV combination regimen in Tanzania

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The roles of a counselor in HAART counseling

- To give knowledge on ART services to clients
- Briefly to explain the process of initiating ARV
- To refer the client who are HIV positive to ART clinic
- To refer client with ARV complication to ART clinic
In order to perform these roles, a Counsellor needs to prepare the ground for engaging the client. The Counsellor needs to:

- Establish trust.
- Assurance of confidentiality
- A none judgmental attitude
- Mutual respect
- Clear communication of information

NB. The Counselor should conduct adherence counseling for 3 sessions prior use of ARV.
Module 5: Counselling, Care and Treatment

Session 4: Overview of TB/HIV Co-infections

M5-8
Objectives:

1. Describe the magnitude and distribution of TB globally and Tanzania.

2. Identify modes of TB transmission and risk factors.

3. Explain the relationship of HIV/TB infection.
Definition

What is Tuberculosis (TB)?
Tuberculosis is a chronic infectious disease caused mainly by Mycobacterium tuberculosis. These microorganisms are also known as Acid- Fast Bacilli (AFB). TB is an infectious disease that is spread from person to person through the air. TB usually affects the lungs, but can also affect other parts of the body, such as the brain or spine.
Transmission of TB

• The germs are expelled into the air when a person with TB of the lung coughs, or sneezes, thus it is easier to spread to other people who share the same breathing space such as family members, friends, co-workers, roommates, people in overcrowded situations such as public transport, prison cells and markets.

• Workers in certain occupations such as miners, textile workers, workers in the tobacco industry, and prisoners are prone to TB.
• People with chronic diseases such as diabetes and malnourished children are also at risk of contracting TB.

• Many people are infected for years with the germ that causes TB but do not show signs of the disease.

• But if a person’s immune system gets weak, the germ can be activated and cause TB disease.
Diagnosis of TB

General symptoms of TB may include:
• Weakness
• Feeling sick
• Weight loss
• Fever usually in the evening
• Night sweats
• Lymph node swelling

Common symptoms of TB of the lungs may include:
• Long term cough (3 weeks or more)
• Chest pain
• Coughing up blood
• Shortness of breath
• Fatigue
Module 5: Counselling, Care and Treatment

Session 5: TB/HIV related Counselling Including TB Screening Tool
Objectives:

1. Describe TB/HIV relationship

2. Explain the rationale for TB-HIV collaborative programmes.

3. Identify the role of a Counselor in TB control
TB/HIV relationship

- TB and HIV are overlapping epidemics. HIV and AIDS is fueling the TB epidemic in many parts of the world including Tanzania.

- On the other hand TB is the commonest opportunistic infection and leading cause of death among HIV/AIDS patients.

- Due to interaction between these two disease it is important to have joint efforts to reduce the burden of TB and HIV patient. HIV and TB interaction is bi-directional.
The Impact of HIV on TB

- HIV is the strongest risk factors for development of TB (Increases the progression from infection to TB disease) it increases the rate of recurrent TB

- HIV infected people are more susceptible to TB when they are exposed to M. tuberculosis

- TB increases the risk of progression from HIV to AIDS it is the commonest opportunistic infection among AIDS patients.
• TB is also the leading cause of HIV-related morbidity.

• TB is the leading cause of death among AIDS patients; one-third of all AIDS related deaths are due to TB.

• Increased TB cases in PLHA pose increased risk of TB transmission to general community

• high frequency of HIV(+) among TB cases

• high rates of TB in high HIV prevalence settings and

• high frequency of TB among HIV(+) patients
Rationale for TB HIV collaborative programmes

• About 50% of TB patients are infected with HIV (NTLP) and TB is the leading cause of death among PLHIV.

• HIV promotes progression to active TB in people with both recently acquired and latent M *tuberculosis* and HIV increases risk of recurrent TB.

• In order to control the dual infection, the Government of Tanzania has adopted the approach of “One patient, two diseases” So - Controlling TB and HIV should be the priority of HIV and AIDS and TB programmes: Thus the need for collaboration between the two program.

• This is because HIV has fuelled TB epidemic in many poor countries and therefore DOTS alone is not enough to control TB.
Collaborative Activities

Goal of TB/HIV Collaborative Services is to decrease the burden of TB and HIV in populations affected by both diseases with the following objectives:

- To establish mechanisms for collaboration between TB & HIV/AIDS programmes
- To decrease the burden of TB in PLHA
- To decrease the burden of HIV in TB patients
TB Screening Tool

1. Do you cough for two or more weeks?
2. Do you cough up blood stained sputum?
3. Have you had fever for two or more weeks?
4. Have you had noticeable weight loss or a three kilogram weight loss in a month?
5. Do you get excessive sweating at night for two or more weeks?

If the answer is “YES” to one or more questions refer client to TB clinic for further investigation
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Session 6: Overview of STIs/RTIs

M5-6
Objectives:

1. Define STIs/RTIs

2. Describe major types of STIs in Tanzania

3. Describe major signs and symptoms of common STIs

4. Explain the main modes of transmission of STIs

5. Explain STI preventive measures
Introduction

- STIs patients should be counselled about their increased risk of HIV transmission and should seek VCT services.

- Most STIs can be treated and cured and STI patients that receive prompt and effective treatment of an STIs can help prevent future HIV transmission.

- Clients should be aware of other STIs screening and assess for the signs and symptoms of all STIs
Definition of STI

Is the infections transmitted through unprotected sexual intercourse.
Major types of STI

- **Bacterial:**
  - Neisseria gonorrhoeae
  - Chlamydia trachomatis
  - Haemophilus ducreyi
  - Treponema pallidum

- **Viral:**
  - Herpes simplex virus,
  - Human papilloma virus,
  - Human Immuno Deficiency Virus

- **Fungal:**
  - Candida albicans

- **Protozoa:**
  - Trichomonas vaginalis

- **Parasitic:**
  - Phthirius pubis (pubic lice)
  - Sarcoptes scabiei
Three major groups of STI

1. **Those, which cause genital discharge**
   Such as: Gonorrhoea, Chlamydia, Trichomoniasis Vaginalis, Candidiasis.

2. **Those, which cause genital ulcers,**
   Such as: Syphilis, Chancroid, Herpes genitalis.

3. **Those, which cause pain**
   Pain Scrotal Syndrome (PSS) and Pelvic Inflammatory Disease (PID)
Major signs and symptoms of common STI

Men
- Burning or pain during passing urine
- Unusual pus/watery discharge from the penis
- Sores or blisters on the genitals
- A new growth in the genitalia (warts)
- Swollen glands in the groin
- Painful swollen testicles
- Painful inflamed foreskin /or whole penis.
Major signs and symptoms of common STI

Women
- Burning or pain during passing urine
- Unusual discharge from the vagina
- Sores or blisters around genitals
- Lump in the genital area (warts)
- Itching in the genital area
- Swollen glands in the groin
- Pain in the lower abdomen, sometimes with fever
- Pain during sexual intercourse
- Unusual bleeding (other than menstrual cycle).
Major signs and symptoms of common STI

Neonates

• Discharge from the eyes
• Red swollen eyes
• Pneumonia
Complications of STIs

- Infertility to both men and women
- Morbidity associated with STIs - extremely painful
- Miscarriage
- Stillbirths
- Eye infection to the newborn, which can result into blindness.
Major modes of STIs transmission

Unprotected penetrative sexual intercourse
Factors facilitating to STIs transmission

Risk sexual behaviors such as:

- Having multiple partners.
- Changing partners
- Having sexual contacts with casual partners/casual
- Sex workers.
- Not practicing safer sex (condoms are not used due to dislike, unavailability, un-affordability, cultural /religious believes, myths)
- Alcohol and drug abuse resulting to impaired wise decision making in sexual matters.
Social-economical:
- Occupation (profession that force person to be away
- The sexual partners for a long term.
- Exchanging sex for money, materials and favours.
- Lack of information on STIs and basic facts.
  (Those people who have sores discharge in STIs infection they have entry point for HIV viruses).

Cultural:
- Rituals such as cleansing widow inheritance
- Widow inheritance
- Women have no negotiation on sex issues.
Political:
• War and political instability create mobility and migration that adversely influence changing in sexual behaviour.
Prevention and control of STIs:

- Sensitisation and client education.
- Abstinence
- Fidelity
- Early screening and treatment of asymptomatic cases.
- Partner notification and treatment.
- Safer sex i.e. proper use of condom.
  - Treatment compliance and consistence in taking medications.
  - Reduce multiple partners.
Importance of referral

• Clients may require services, which you do not offer such as treatment for STIs, HIV, antenatal care, psychological counseling, or legal help.

• Type and number of referrals you make depends on the services you can offer and the range of local facilities to people in different economic groups.
Relationship between HIV and STIs

- HIV and AIDS and other STI’s share the major transmission route such as unprotected penetrative sex.

- Share the same risk behavior predispose to infection with HIV/AIDS and other STI’s.

- Having STI’s increases the risk of acquiring and transmitting HIV infection.

- Prevention measures used for STI’s are the same to those used to prevent HIV/AIDS.
Relationship between HIV and STIs

- Another relation HIV and AIDS belong to STI’s. The proper treatment of STI’s can mitigate to the transmission of HIV and AIDS. As STI’s cause genital ulcer, ulcer on anus and mouth they can cause early penetrating HIV virus.

- Vise Versa immune suppression due to HIV and make person to develop signs and symptom of STI’s. Lines showing relation between HIV and AIDS an STI’s.

- Someone living with HIV who also has an STI may have more HIV in their body because of STI infection.
Relationship between syphilis and HIV

☑️ It has been proven that all STIs including syphilis facilitate the transmission of HIV and vice versa.

☑️ It has also been found that there is high frequency of dual infection between syphilis and HIV.

☑️ Neuro-syphilis should be considered in the differential diagnosis of neurological disease in HIV infected individuals.

☑️ In case of congenital syphilis the mother should be encouraged to undergo testing for HIV.
Similarities of syphilis and HIV by mode of transmission

- The most common mode of transmission is through unprotected sexual intercourse with an infected person.

- Syphilis can also be transmitted from mother to child.

- Another possible mode of transmission of syphilis is through blood transfusion.

- It is also possible to be infected with syphilis by non-penetrative contact with ulcers and rashes of an infected person.
Signs and symptoms of syphilis vary according to the stage of the disease. There are three main stages of syphilis infection which are:

- Primary syphilis
- Secondary syphilis
- Tertiary syphilis
Primary syphilis

☑ Occurs in a week to three months period after infection and presents with a sore/ulcer on the genitalia called **chancre**. Usually the sore is **single, hard and painless**. But with the current advent of HIV it could be **multiple and painful**.

☑ In the females, the ulcer can occur on the cervix or vulva. Also extra genital ulcers can occur on the breast, fingers and the lips.

☑ Primary syphilis may not draw attention because it is painless, hidden from view and may heal without treatment.
Secondary syphilis

- Emerges three months up to two years as a result of untreated primary syphilis. It presents commonly with the following signs and symptoms.
  - General body rash and swollen lymph glands of the armpits and groin that is painless.
  - Localized eruptions of the skin on the palm, the palate, the lining of the mouth and genitalia.

- Other presentations include raised, flat, moist and soft lesions called condylomata lata which may occur around the mouth, vulva or anus of the patient.
Tertiary syphilis

- Occurs after 2 years to forty or more years after primary and secondary syphilis, which were not treated.

- Tertiary syphilis commonly affects the heart with its larger vessels and the brain, spinal cord and nerves.

- It can also affect the liver, eyes and kidneys.
Objectives:

1. Define opportunistic infection

2. Explain the common diseases in people living with HIV

3. Describe clinical management of common diseases in people living with HIV

4. Describe nursing care of common diseases in people living with HIV
Introduction

• It is a fact that currently no drugs for the cure of HIV infection, but there is treatment for some opportunistic infections resulting from HIV induced immune deficiency.

• It should be always recognized that treatment and cure is for the associated diseases and symptoms and not HIV itself.

• In treating these opportunistic infections length and quality of life of the HIV infected patient can be substantially improved.
Definition of opportunistic infection

- Opportunistic infections are diseases/infections, which arise due to compromised or suppressed immune system as a result of HIV Infection.

- A person with a healthy immune system and normal T-cell count would not, or not as easily, experience an opportunistic infection.
Common types of opportunistic infections

Tuberculosis (TB)
- TB is a bacterial infection that is spread by droplets through coughing or sneezing by infected

Pneumocystis pneumonia (PCP)
- Pneumocystis Carinii Pneumonia is a protozoal infection of the lungs that can cause severe pneumonia and is characterized by difficulty in breathing, fever and dry cough.
Candidiasis

- Candidiasis is a fungal infection commonly known as thrush. It appears as white patches curd-like and sometimes painful.
- There is ulcers in the mouth as well that make it difficult to swallow.
- The fungal infection can also affect the vagina causing vaginal candidiasis with curd-like vaginal discharge.
- The vaginal wall becomes red and results in painful intercourse.

Herpes zoster (Varicella-zoster virus: Herpes zoster or shingles)

- It is a viral infection characterised by severe pain (radicular) and fever, followed 2-4 days later by vesicular rash over involved dermatomes.
- Herpes zoster in HIV infected individuals may be more severe, with more recurrences and may involve more dermatomes than other forms.
**Oxoplasmosis (Toxoplasma encephalitis)**
- It manifests with focal paralysis or motor weakness depending on area affected.
- Also other feature may include neuro-psychiatric manifestation corresponding to the affected area in the brain and altered mental status (e.g. forgetfulness)

**Cryptococcus neoformans (Cryptococcal meningitis)**
- Major cause of meningitis in HIV infected persons and disseminated disease may occur. Contrary to bacterial meningitis, fever may be absent in these cases.
Treatment of Opportunistic Infections

All efforts should be made to deal with all treatable conditions in people with HIV and AIDS. These conditions will be managed at various levels of care from dispensaries to national level health care facilities, requiring early detection, treatment and referral accordingly.
Fungal infections

Fungal infections commonly found in association with HIV and AIDS include: Cryptococcus neoformans, Pneumocystis pneumonia, Candida species, Histoplasma capsulatum and several others.
Module 5: Counselling, Care and Treatment

Session 8: Nutrition in the Context of HIV and AIDS
Objectives:

1. Define nutrition and food

2. Explain importance of good nutrition to PLHIV

3. Describe the relationship between HIV and nutrition

4. Describe conditions that contribute to malnutrition
Introduction

◆ Any immune impairment as a result of HIV and AIDS can contribute to malnutrition.

◆ Malnutrition leads to immune impairment, worsens the effects of HIV, and contributes to a more rapid progression of the disease.

◆ Thus, malnutrition both contributes and is a result of HIV disease progression.
Definitions

**Nutrition** is the science of utilization of nutrients by the body

**Nutrients:** Are substances found in foods that provide energy, enhance growth, help repair body tissues and regulate body functions

**Malnutrition:** Is a condition caused by excessive or deficiency of one or more nutrient in the body, common malnutrition are kwashiorkor and marasmus.

**Balanced meal:** Food put together in a form that can be consumed and that, when eaten together, provides an individual with adequate amount and required nutrients to maintain good health
Importance of good nutrition to PLHIV

Good nutrition strengthens the Immune system enabling the body to fight against HIV and other infections. Good nutrition:

- Plays a big role in building the body immune system in the fight against infections
- Prevents muscle wasting
- Delays the progression of HIV infection to AIDS
- Replenishes the body with lost nutrients
- Improves effectiveness and tolerance to drug treatments
The relationship between HIV and Nutrition

- The relationship between HIV and nutrition is complicated by the fact that the virus directly attacks and destroys the cells of the immune system:

- Nutritional deficiencies affect immune functions that may influence viral expression and replication, further affecting HIV disease

- HIV affects the production of hormones which are involved in the metabolism of carbohydrates, proteins and fats
Infections affect nutritional status by reducing dietary intake and nutrient absorption, and by increasing the utilization and excretion of protein and micronutrients as the body responds to invading pathogens.

Anorexia, fever, and catabolism of muscle tissue frequently accompany the acute phase response.

Even mild infectious diseases influence nutritional status.

Almost any nutrient deficiency, if severe, will impair resistance to disease.
Conditions that contribute to malnutrition

There are causes of Poor Nutritional Status in HIV/AIDS

- Depressed appetite, poor food intake, and limited food availability
- Chronic infection, mal-absorption, metabolic disturbances, and muscle and tissue catabolism
- Fever, nausea, vomiting, and diarrhea
- Depression
- Side effects from drugs used to treat HIV-related infections
Illnesses commonly caused by HIV infection leading to malnutrition

**Anorexia:** Anorexia as a loss of appetite may occur as a side effect of medications. It leads to general weight loss and is common when individuals are depressed.

**Diarrhoea:** There are several causes of diarrhoea including bacterial and viral infections, parasites, diarrhoea also reduces appetite and leads to poor nutrient absorption. Severe malnutrition can occur following a prolonged period of diarrhoea.

**Fever:** Fever is common in PLHA and does not necessarily indicate serious illness.
Nausea and Frequent Vomiting: These can result from the drugs used to treat HIV and AIDS or from opportunistic infections.

Thrush: Thrush is common in HIV infected people. These can result in difficulty eating foods, loss of appetite.

Anemia: This can result from poor food intake or caused by HIV itself
Module 5: Counselling, Care and Treatment

Session 9 Counselling for Nutrition in the Context of HIV and AIDS
Objectives:

1. Discuss balanced meals from locally available foods.

2. Describe dietary management of the different conditions, which may occur for PLHIV.

3. Identify the main food groups.

4. Define the balanced meal.
Introduction

- Good dietary practices play an important role in maintaining a healthy lifestyle and healthy body.

- An HIV infected person already has a weakened immune system.

- A nutritious diet can help maintain the proper functioning of the immune system and provides needed energy, protein, and micronutrients during all stages of the HIV infection.

- This can be obtained through a balanced meal.
Balanced Meal:
• Balanced meal is food put together in a form that can be consumed and that, when eaten together, provides an individual with adequate amount and required nutrients to maintain good health.

• There is no single food that contains all the nutrients that the body needs, except breast milk for infants up to six months of age.
Balanced meals locally available

• **Cereals,**
  roots, tubers, bananas, these are mainly staples. They include maize, millet, rice, sorghum, cassava, yams, potatoes and bananas.

• **Pulses,**
  nuts and foods of animal origin, foods in this group include groundnuts, cashew nuts, meat, fish, milk, eggs, insects e.g. senene, kumbikumbi, and caterpillars, beans, peas.

• **Fruits,**
  this group includes all types of fruits such as mangoes, oranges, guava, tangerines, bananas, ubuyu, ukwaju, mabungo.
Vegetables,
this group includes all types of vegetables such as sweet potato leaves, pumpkin leaves, tomatoes, amaranth, okra, carrots, pumpkins, mlenda, figiri, mnavu.

Sugar and fats,
these are needed in moderation, they include ghee, lard, butter, margarine, coconut oil, oil seeds such as sunflower and groundnuts, sugars like honey.

Water; although water is not food group it is important for life and is necessary everyday. Water aids digestion, absorption and transportation of nutrients in the body.
Nutrient requirements for PLHIV

• Energy: HIV infected adult Increased by 10% asymptomatic stage and 20-30% during symptomatic HIV

• Protein: No evidence of extra requirement due to HIV

• Micronutrients: Micronutrient intake is best achieved through adequate food intake.

• However when an individual have micronutrient deficiency, supplements may be necessary
• There is evidence that some micronutrient supplements e.g. Vit. A, Zn and Fe, can produce adverse outcomes in HIV-infected populations. Intakes should not exceed RDA.

• Iron-folate supplementation: similar as for pregnant women: 400µg folate and 60 mg iron daily
Improving the quality of diet

• Mashing or grinding food:
facilitates swallowing, digestion and absorption of nutrients

• Use of high nutrient dense foods:
Such as grounded nuts, milk, fats and oils, honey, coconut milk and eggs will enrich the meals especially starchy foods.

• Use of fermented foods:
Fermented foods e.g. - sour milk (yoghurt) and togwa. Can be easily digested and absorbed in larger quantities. Facilitates digestion and absorption of other foods as well.
Healthy eating and life style

• Eating at least 2-3 balanced meals in a day (in adequate amounts) is key to maintaining good nutritional status

• Eating a **variety of foods** together aids absorption of nutrients (e.g. vit. C enhances Iron bio-availability, fat for fat soluble vitamins, etc.)
  - Foods complement each other (e.g. amino acids)

• Water- (clean and safe) is an important part of a meal; (8 glasses or more per day)

• Fruits and vegetables are the most forgotten; they should be promoted.
• Use of indigenous foods should be promoted

• Use foods from each of the 5 food groups to promote balanced meals.

• Be physically active: Everyday activities such as walking, cleaning, working in the field and collecting firewood and water might provide enough exercise. Avoid smoking and alcohol

• Practice safe sex
Dietary practices and nutrition for AIDS related symptoms

This is the strategy of using food and dietary practices to alleviate the effects of AIDS-related symptoms on food intake and nutrient absorption.

- Ensure adequate food intake by adding more flavour, encouraging PLHA to take small but frequent quantities of meals; and by presenting foods with a texture that can be easily eaten by PLHA.

- Ensure comfort while eating.

- Provide more nutrient dense foods to compensate for nutrient losses.

- Prevent dehydration that occurs due to diarrhoea and fever.
Complement medical treatment, including the provision of ARVs

Reduce the severity of symptoms by providing specific nutrient needs

Increase intake of foods that may contribute to strengthening the immune system

Manage specific symptoms (e.g., nausea, vomiting, diarrhoea and constipation).
Management of poor appetite

• Try alternative foods & eat foods you like most.

• Use spices (garlic, cinnamon & ginger) to stimulate appetite, improve flavour and assist digestion.

• Add sugar to some foods to decrease bitterness

• Eat foods that provide energy

• Take plenty of fluids in between meals
• Eat with others as this makes food more enjoyable.

• Avoid alcohol as it reduces appetite and weakens the body.

• Rinse your mouth and brush your teeth regularly.

• Exercise frequently to stimulate appetite.
Nutrition counseling

1) What does the client know about balanced diet
2) The importance of balanced diet
3) What food groups are available in our society
4) The function of each food group
5) Among the foods discussed, what is available in the clients environment
6) Discuss different foods a client can take to form a balanced meal
Nutrition Education

- Can address a big group of people
- May not meet individual needs
- Gives a lot of information
- Many people can be reached
- Less man-power, space and time
Places to Promote Nutrition
for PLHIV

Part of VCT programs

PMCT programme

During counselling for clinical problems

With self-help and support groups

Nutrition education

Places to promote nutrition for PLHIV

ART Clinic

During in-patient care

Home care visits
Module 5: Counselling, Care and Treatment

Session 10: Stigma and Discrimination in HIV and AIDS Context - 1
Objectives:

1. Define the terms stigma, discrimination and denial.

2. Explain social stigma and related reactions.

3. Identify stigmatised groups and their characteristics.

4. Identify sources of stigma in different settings.

5. Describe stigma in different settings.
Definitions

**Stigma** is the act of identifying, labelling or attributing undesirable qualities targeted towards those who are perceived to be “shamefully different” and deviant from the social norms.

**Stigma** can also be feeling of disapprove that people have to particular illness.

**Discrimination** is the practice of treating a particular group or individual in the society less fairly than others.

**Denial** is a refusal of the truth and disownment of responsibility or disassociation from the truth.
Social stigma and related reactions

**Enacted or perceived stigma:**
It is experienced by the stigmatized through different behaviors and actions by members of society.

**Societal stigma:**
This can be recognized through the different expressions and actions being done by the society. e.g. Denying access to a certain services or rights

**Self Stigma:**
Almost same as perceived or felt stigma. The individuals with drawn from normal activities or from companions due to strong societal stigma.

**Symbolic or verbal stigma (acted stigma):**
There are labels or words from the stigmatising group. The expressions or deeds which are discriminatory in nature can also be heard by a stigmatised group.
Stigmatized groups and their characteristics

- People affected with chronic diseases such as TB, Cancer, Leprosy
- People with disabilities such as Deaf, blind, albino, physically hand caps
- Sex workers
- Barmaids
- Orphans and other vulnerable children
- Men who have sex with men
- The poor
Sources of stigma in different settings

**Sexuality:** Differences in sexual expressions and sexual actions in many societies are the main cause of stigma.

**Race:** Stigma across skin colour differences in common in mixed societies.

**Ethnicity:** As in racial stigma, different ethnic groups experience stigma in many ethnic mixture groups.

**Religion:** The religious institutions want to maintain high moral standards and condemns all immoral acts including
Gender: Women and men often suffer discrimination as a result of their indulgence into sexual acts.

Poverty: HIV/AIDS is a disease of the poor people in many societies and are denied of many basic requirements like.
Disease and Dying from AIDS

- Death has become a common slogan. Everyone fears death and death from AIDS in particular is feared most.
- Fear of stigmatisation
- Fear of withdraw and discrimination
- Fear of rejection or dismissal from various affiliations like at home, school, occupation. etc.
- Fear of shortening ones life and fear of lack of support
- Perceived lack of immediate profit from being tested, as there are no vaccines, drugs or cure for HIV and AIDS.
Stigma in different settings

In Health care setting:
• Labelling them; Denying services
• Early discharge; Isolating them
• Attended by supportive staffs
• Subject to HIV testing without consent.
• Disclosure of one’s HIV test results without their consent
**Work place:**

- Transferring near their homes.
- Denied certain job benefit e.g. promotion or participation in certain functions e.g. workshops, travelling.
- Terminating employment for those who are HIV positive
- Denying employment to PLHIVs
- Discrimination of PLHIVs in use of facilities
The Media:
• The media has played a major role in maximizing stigma in the society. HIV and AIDS reporting is often negative, fear arousing, discrediting and victimizing.
• Reporting in a stigmatising manner such as AIDS sufferers, victims or associating them with promiscuity all provoke attitudes of stigma among people.
Education system:

- Teachers/ other employees living with HIV and AIDS are suffering the same stigmatisation as in other settings.
- Pupils with HIV infected parents marked
- Fear is significant among pupils in schools where infected pupils are.
At home:
• Infected people are denied of basic services e.g. food, sharing rooms, eating utensils, toilets. Etc.
• Some left to die alone – leading to committing suicide or running away from home.
• Absence of open and honest communication about HIV and AIDS makes disclosure within the family difficult.
In community:

- Many suicidal attempts for PLHIVs are a resulting of community or domestic based stigma and discrimination.
- By recognizing the pain of stigma PLHIVs often isolates themselves, become withdrawn and denied.
In religious setting:
• Negative response to issues of HIV and AIDS e.g. condom uses.
• They are judgmental in contrast to principles of morality.
• Denial of spiritual services to PLHIVs
• Sermon services not provided when they die.
• Requirements for pre-marital testing by religious leaders ends up to segregation, discrimination and denial of certain rights and services
Module 5: Counselling, Care and Treatment

Session 11: Stigma and Discrimination in HIV and AIDS Context - 2

M5-20
Objectives:

1. Describe effects of stigma.

2. Identify strategies for minimizing stigma and discrimination.

3. Describe reasons for HIV and AIDS stigmatisation.
Stigma experiences and their effect on individuals

- Feeling of shame and guilt – leads PLHIVs to be stressed all the time blaming themselves as source of the problem in the family and rapid health deterioration.
- Isolation – leading to extreme feelings of isolation and loneliness.
- Can do things that harm others
- Suicide
- Stigmatized individuals experience physical and social isolation and are subject to gossip, rumor and name-calling.
The stigma associated with HIV can lead those who are infected to develop feelings of guilt, inferiority, self-blame and despair.

Those living or working with HIV-infected people, such as healthcare workers, may also be stigmatised by association.

Women can experience violence, loss of shelter and economic support from their family and community leading women to keep their HIV status a secret.

Loss of fundamental human rights, social status and decision making power in the household.
Reasons for HIV and AIDS stigmatization

- HIV and AIDS have all characteristics associated with heavily stigmatized medical conditions.
- They are associated with socially improper forms of sex and injecting drug use, socially censured behaviors that are viewed as the responsibility of the individual.
- AIDS is incurable, degenerative, often disfiguring and associated with an undesirable death.
- It is often incorrectly thought to be highly contagious and a threat to the community at large.
☑ The general population, and sometimes-medical personnel are not well informed and lack a deep understanding of HIV and AIDS.
☑ Many people living with HIV and AIDS are members of groups that are already socially marginalized, such as sex workers, homosexuals and the poor. This type of individuals with HIV and AIDS experience multiple stigma, with HIV stigma compounding pre-existing stigma.
☑ Those most likely to experience HIV related stigma, commonly have the fewest resources to cope with and resist it, adding to the difficulty in fighting stigma.
☑ HIV related stigma is also complicated to tackle because it is dynamic. It changes both as an individual progresses from HIV to AIDS, and as the HIV epidemic evolves in a given community.
☑ The main modes of HIV transmission are associated with promiscuity
Strategies for minimizing stigma and discrimination

- Awareness campaign
- Good quality education in and out of school
- Ensuring treatment, prevention, care and support services
- Leadership and commitment on the part of politicians, church leaders, sports personalities, movie stars and others
- Involving PLHIVs fully in response towards the epidemic.
- Monitoring human rights violations
- Training for health care workers and other institutions on effects of stigma
- Action from grass root organized by PLHIVs and affected by HIV and AIDS.
Responsibility of PLHI in stigma reduction

• Participate in advocacy for prevention of HIV and stigma reduction

• Participate in the development and implementation of their individual treatment or service plan to the extent that he/she is able.

• Provide their providers, to the best of their knowledge, accurate and complete information about their current and past health and illness, medications and other treatment and services they are receiving, since all of these may affect their care. Communicate promptly in the future any changes or new developments.

• Communicate to their provider whenever they do not understand any information they are given.
Responsibility of PLHI in stigma reduction (cont.)

• Follow the treatment plan they have agreed to and/or accepting the consequences of failing the recommended course of treatment or of using other treatments.

• Keep their appointments and commitments or inform promptly if they cannot do so.

• Keep their provider or main contact informed about how to reach them confidentially by phone, mail, or other means.

• Be considerate of their providers and fellow clients/patients and treat them with the respect they themselves expect.
Strategies to reduce social stigma

- Being open about HIV status is one of the most powerful ways to reduce HIV social stigma. It has other benefits like encouraging partners to be tested for HIV and prevent the spread of HIV by allowing those infected to openly take appropriate prevention steps. Disclosure also allows individuals to receive support from partners, family and friends.
Module 5: Counselling, Care and Treatment

Session 12: Legal and Human Rights Issues

M5-21
Objectives:

1. Define the terms: Legal issues; Human rights; and Will

2. Describe human rights issues related to HIV and AIDS both for client and Counsellor

3. Describe features of a valid Will
Introduction

• All human beings are equal, deserve basic rights and freedom equally. Principally, human rights are for everybody and therefore should be known by all people.

• The Government and non-governmental institutions have the responsibility of adhering to them; safeguard them and advocate them for the benefit of all people.

• People living with HIV and AIDS are human beings, and therefore deserve to have these basic human rights without being discriminated.
Definitions

• **Legal** – Something based or concerned with the law.

• **Human rights** – Are basic and essential requirements for people that cannot be violated in any means. These are inborn rights and are more than regulations that safeguard interests of people. These rights need to be respected regardless of sex, colour, religion, tribe or sero-status of an individual.

• **A Will** - denotes the sum of what the Testator (a person who makes a Will) wishes or “wills” to happen on his death. It also denotes the document or documents in which the intention is expressed.
Basic human rights issues related to HIV and AIDS

For PLHIVs:
In general PLHIV may experience the following problems related to break of human rights.
• Termination of employment
• Denied to get married
• Denied to the right to worship
• Legal support and help
• Denied access to write a “Will”
• Access medical treatment
• Access to education
• Denied to participate in community development activities
• Denied the right to have information concerning his/her life, HIV and AIDS.
Rights of PLHIV

• PLHIV has all human rights as any other person without regard to the status of their health

• PLHIV has the right to live. Remember that infirmity is not death, so it is to deal with such a person in a way that will cause death like denying them treatment, food and harassing them

• Everyone has the right to work and earn a living. Testing for HIV as condition for employment is against human rights. Testing for HIV is voluntary
Rights of PLHIV (continued)

• Clause 13 of the Constitution of the United Republic of Tanzania states categorically on equal rights to the law and security without discrimination.

• Everyone has the right to marry and start a family according to the UN convention for human rights. For this reason even PLHIV have the right to marry on condition that their relationship does not affect the health of the partner.

• The government and religious bodies encourage premarital partners to test for HIV.
Rights of PLHIV (continued)

- Everyone has the right to good life
- Government and the community have the right to ensure that the health of PLHIV is maintained especially during the AIDS stage
- According to the Tanzania AIDS Policy and the Convention for Africa on Human Rights, which Tanzania has ratified, everyone has the right to treatment to ensure the wellbeing of physical and mental health.
Rights of PLHIV (continued)

• Education is a right for all. Therefore PLHIV have the right to education without discrimination.
• Everyone has the right to getting correct information. PLHIV have the right to receive correct information about HIV and AIDS from relevant institutions.
• Everyone, including PLHIV, has the right to participate and benefit from economic development, and social issues of the community.
The counselor:
When a Counsellor does the following acts, he/she breaks human rights of the client:
• Counsellors not obtaining clients’ consent to engage them in testing process.
• Confidentiality not upheld by counsellors leading to clients’ information and test results given away without their permission
• Client’s records not identifiable to the individual client
• Counsellors not respecting clients
• Counsellor being judgemental
Features of a valid will

Through a “Will” the testator makes a disposition of his/her property, the manner of disposition of his/her body, the appointment of executors and guardians of his/her children.
Basic requirements for a valid will

• It must be in writing
• It must be signed by the testator or by some other person in his/her presence and direction.
• The signature of the testator must be witnessed by two or more persons present at the same time, and each witness attests and signs the Will.
• The Will must be in permanent ink or preferably typed or printed
• The date of writing the Will must be clearly shown in the Will
• If the testator knows how to read and write, only two witnesses are required
• Testator does not know how to read and write, the number of witnesses required is four, and the Testator should affix his/her right hand thumbprint on the Will.
The validity of the will relies on

- The Testator must have testamentary intention.
- The testator must be aware and intend to make a Will accordance with the law.
- The testamentary intentions must be manifested in writing and must be duly executed in accordance with law.
Objectives:

1. Define minor in the context of counselling and testing.

2. Describe how to deal with minors in a VCT set up.

3. Identify support services for minors who receive VCT services.

4. Demonstrate the filling of parent/guardian consent form for testing minor and clients with communication disabilities.
Introduction

• In Tanzania, the legal age for adults is 18 years; that is, any one from 18 and above is regarded as an adult and is capable of providing informed consent.

• For young people below 18, however VCT services can be provided if the counsellor determines the young person has sufficient maturity to understand the testing procedure and results.
Dealing with minors in a VCT set-up

• When minors are brought to a VCT site for testing, the counsellor talks to the minor or meets with parents/guardians to determine the reasons for testing.

• Counselling minors shall be carried out only when the counsellor has determined and is satisfied that it is in the best interest of the minor and should involve parents and guardians who sign the consent.

• Before a minor is tested, he/she must be involved in the dialogue and the parent or guardian must approve the testing.
• In giving test results to a minor, the counsellor will counsel both the minor and his/her parent/guardian before the results are communicated.

• First, the counsellor talks to parent/guardian separately, and then to the minor alone and later with parent/guardian and minor together.
Support services for minors who receive VCT services

- Involvement in sports activities.
- Joining youth centres
- Joining youth activities in religious institutions, community and clubs
Session 14 Universal Precautions and Infection Prevention Control
Objectives

1. Define standard precautions, infection prevention control (IPC) and injection safety (IS)
2. Discuss the importance of IPC
3. Describe medical waste disposal management process
4. Describe appropriate actions following accidental exposure to potentially infectious specimen
5. Describe the steps for Post-Exposure Prophylaxis (PEP) as stated in the IPC Guidelines
Universal Precautions (UP)

• Originally devised by Centers for Disease Control (CDC) in 1985
• It entails use of simple and standard infection control practices in the care of all patients and in all situations
• It aims to minimise risk of blood borne pathogens and possible HIV transmission
• It places emphasis on applying blood and body-fluid precautions universally to all persons regardless of their presumed infectious status
Universal Precautions (cont.)

Consists of:
- Careful handling and disposal of sharps (needles or other sharp objects)
- Hand washing before and after a procedure
- Use of protective barriers such as gloves, gowns and masks – for direct contact with blood or other body fluids
- Safe disposal of waste contaminated with body fluids and blood
- Proper disinfection of instruments and other contaminated equipment
- Proper handling of soiled linen
Infection Prevention and Control

- Infection prevention and control (IPC) are strategies to ensure safe and effective health care practices
- These protect health workers, patients, and the community from acquiring nosocomial infections
- Also serve to protect the environment from pollution
Why Is IPC Important?

- Coming into contact with human blood or blood products is potentially hazardous.
- Infection prevention and control involve taking precautions to protect:
  - Yourself
  - Your colleagues
  - Your clients
  - Other people who may come in contact with body fluids and contaminated instruments.
Standard Precautions

• Refers to guidelines that enable health care providers to:
  – use protective barriers when caring for patients regardless of their diagnosis
  – protect patients from nosocomial infections
Minimum Standard Precautions

- A source of clean water
- Routine hand washing before and after any contact with a patient
- Use of protective barriers such as bandages, masks, and gloves
- Safe handling and disposal of sharps, instruments and equipment, including needles and syringes, use “sharps box” at every ward
When Do You Need to Wash Your Hands?

• Before and after patient contact
• When preparing food or serving food
• After removing gloves
• When hands are visibly dirty for any reason
• After using the toilet
• Before and after eating
• After contact with blood or body fluids
  – Taking specimens to the lab, but also after sneezing, coughing or blowing one’s nose
Routine Hand Washing

- Hand washing helps to stop the spread of germs between patients and between staff and patients.
- It protects both the patients and the caregivers.
- The most important precaution for the prevention of infections.
- Washing hands with soap and water eliminates microorganisms from the skin and hands.
Barrier Protection

• Wear disposable gloves to:
  – empty bedpans or urinals
  – clean up spills of blood, vomit, urine, or faecal materials, and
  – perform any invasive procedure such as drawing blood or starting an IV line

• Cover cuts, scrapes, hangnails, and rashes with band-aids or bandages

• Wear goggles, masks, gown or apron when there is a risk of splashing
Principles of Handling Sharps

• User is responsible for disposal of sharps
• Must place sharps in sharps boxes
• Do not drop sharps on the floor or in the office waste bin
• Place sharps container near your workspace
• Seal and remove when box is $\frac{3}{4}$ full
• Incinerate all waste
Handling and Disposal of Sharps

- Disposable needles and syringes should be used only once
- Needles should not be removed from the syringes
- Do not recap needles after use
Dispose of Sharp Instruments Safely

• Discard the used disposable needle and syringe in a puncture-resistant container labelled “sharps box”

• Burn the container in an incinerator or pit for burning
Dos and Don’ts: Sharps and Waste Containers

- Do not break, bend, re-sheath/re-cap or reuse lancets, needles or syringes
- Do not shake sharps containers to create space

Source: CDC, 2005
Never Place Needles or Sharps in Office Waste Containers

Source: Tanzania MOHSW
Source: Tanzania MOHSW
Sharps Containers Must Be:

- Placed near workspace
- Closed when not in use
- Sealed when ¾ full

Source: CDC, 2005
Incineration of Waste

• Incineration is burning contaminated waste to destroy and kill micro-organisms

• Incineration:
  – Is effective against potential re-use
  – Protects the environment
  – Must be supervised
Disinfect Reusable Equipment and Instruments

- Soak the instruments in 0.5% chlorine for 10 minutes
- Thoroughly wash with clean water while putting on protective barriers
- Let them air dry ready for sterilization or high level disinfection (0.5% chlorine for 20 minutes)
Disinfect Work Areas with Bleach

• Disinfection:
  – Kills germs and pathogens
  – Keeps work surface clean
  – Prevents cross-contamination
  – Reduces risks of infection
In Case of a Spill or Splash

• Wear clean disposable gloves when cleaning up
• Immediately and thoroughly wash any skin splashed with blood
• Large spills:
  – Cover with paper towels and soak with 10% household bleach and allow to stand for at least 5 minutes
• Small spill:
  – Wipe with paper towel soaked in 10% bleach
• Discard contaminated towels in infectious waste containers
• Never leave spills unattended
Needle stick/sharps injuries

What is a Needle stick injury?

• A needle stick injury is a puncture of the skin caused by a needle (solid or hollow).

What are Sharps injury?

• A sharps injury is a puncture of the skin by a sharp object/instrument (surgical blades, prickers, forceps, broken glass) including needles
Categories at-risk for needle stick injuries

Who are at risk for needle stick and other sharps injuries?

- Nurses,
- Physicians,
- Medical Laboratory technologists,
- Housekeeping staff,
- Laundry workers,
- Waste collection personnel,
- Patient/clients and community
Low & high risk exposures

Low risk exposure
- Low volume of blood from symptomatic HIV patient with low viral load (titre)
- Injury with a solid needle
- Superficial injury or muco-cutaneous exposure

High risk injury
- Large volume of blood or other potentially infectious fluid
- Blood from a patient with high viral titre
- Injury with a hollow needle
- Deep and extensive injuries
- Confirmed drug resistance in source patient
Post-Exposure Prophylaxis (PEP)

- **Post** - after…

- **Exposure** – someone has been exposed to a disease or infection…

- **Prophylaxis** – the means by which that person may still be able to prevent disease
Importance of PEP

• Contact with blood and other body fluids is one of the most common sources of infection in health facilities and community

• PEP is an intervention taken to prevent infection after exposure to infected source
In Case of an Accident…

• Check exposed person for HIV
• Check exposed person’s record for Hepatitis B infection
• Contact the supervisor on duty immediately
• Record using Occurrence Report form
Management of Occupational Blood Exposure

• **Immediate care:** wash wounds with soap and running water; flush mucous membranes with water

• **Risk assessment:** Type of fluid and type of exposure

• **Evaluate source:** Counsel and test source for HIV serology using rapid HIV test

• **Exposed person:** Test and counsel person and initiate PEP as quickly as possible
Management of Occupational Blood Exposure

- Follow-up: HIV exposure (source positive HIV serology or acute HIV with positive HIV RNA)
- HIV serology to the exposed individual at baseline, 6, 12 weeks and 6 months
- Re-evaluate and adjust regimen within 72 hours (depending on the availability of results), if taking PEP
- Pregnancy test should be done for all exposed females in reproductive age if their pregnancy status is unknown
- Monitor for drug toxicity
PEP Protocol for Occupational Exposure

Health Worker exposed to HIV – contaminated material (occupational)

Preferably less than 24 hrs, not more than 72 hours: Counsel and recommend test

Consent denied: test NOT done

No PEP*

HIV negative: counsel how to stay negative

Consent given:

TEST PERFORMED

HIV Negative

PEP

Perform follow up HIV test after 3 months

HIV negative: counsel how to stay negative

HIV positive

Refer for regular HIV management

HIV positive

More than 72 hours: no PEP offer support and counselling
Non-Occupational Blood Exposure

• For example, in the case of rape
• When deciding whether to offer PEP, consider if any of the following factors were present during the assault:
  – Presence of blood
  – Survivor or assailant with a sexually transmitted disease with inflammation
  – Significant trauma to survivor
  – Evidence of ejaculation by assailant
  – Multiple assailants or multiple penetrations by assailant(s)
Administering PEP on a HIV+ individual could lead to resistance development.

Patient allegedly sexually assaulted

- Perform medical examination and key tests (STI and pregnancy) and counsel patient on trauma
- Determine period when assault occurred

Less than 72 hours

Counsel and recommend HIV test for individual

- Consent denied; test NOT done
  - NO PEP*
- Consent given; test performed
  - HIV negative
    - PEP
    - Perform follow up HIV test after 3 months
    - HIV negative
      - counsel on how to stay negative
    - HIV positive
  - HIV positive
    - Refer patient for regular HIV management

More than 72 hours

- NO PEP
PEP Administration

- Administer Prophylactic ARV treatment as soon as possible, within 36 hours of exposure
  - AZT 300mg bd + 3TC 150 mg bd for 4 weeks
  - Consider additional 3rd drug (EFZ) if:
    - Source individual is symptomatic
    - The exposure is considered very high risk
    - In case of rape with multiple perpetrators, anal penetration, or obvious trauma [bleeding]
  - Prophylaxis should be continued for 4 weeks if tolerated
PEP Administration (cont.)

• Exposed person should be re-evaluated within 72 hours as additional information about the source is obtained, including:
  – serologic status
  – viral load
  – current treatment
  – any resistance test results
  – or information about factors that would modify recommendations

• If available:
  – HIV antibody test should be administered at baseline and at 6 weeks, 3 months, and 6 months post exposure to monitor for seroconversion
  – VL tests for screening are not recommended in the exposed person unless there is an illness compatible with acute retroviral syndrome
PEP

• If PEP is given, monitor exposed person for drug toxicity at 2 weeks with Full Blood Picture and hepatic function tests (at baseline and at 2 weeks)

• HCWs should be asked to commit to behavioural measures (sexual abstinence or condom use for several weeks to two months)

• The greatest risk of transmission to a partner is during the first 6 to 12 weeks post exposure
PEP (cont.)

- Females should be advised for Family Planning
- Females with known or possible pregnancy should be treated as anyone else, except for selection of drugs, which should involve a discussion of benefits and risks between the HCW and her care provider
- EFV and the combination d4T and ddl should be avoided