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HIV/AIDS and health care personnel: policies and practices

Sixth Consultation with
Leading Medical Practitioners
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Division of Human Resources Development
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Executive summary

Though the HIV/AIDS pandemic has stabilized in some areas, there have been sharp rises in HIV/AIDS prevalence in eastern Europe, southern Africa and Asia. In addition to the risk of acquiring HIV through the same high-risk behaviours as other members of the community, health care workers face the additional risk of becoming infected through occupational exposure. The Sixth Consultation with Leading Medical Practitioners brought together some 25 experts from around the world to discuss "HIV/AIDS and health care personnel: policies and practices" at the headquarters of the World Health Organization, in Geneva, 4-6 November 1997. The group noted that early in the HIV pandemic, guidelines were developed to prevent occupational exposure of health care providers. In order to apply such guidelines, however, it is necessary to identify and describe local opportunities and constraints. A better understanding of the number, nature and causes of injuries (such as needlesticks) that present a risk of HIV transmission is required as well. Professional associations must play a major role in formulating and dynamically updating standards from generic guidelines and in promoting adherence to such standards. Compliance can be enhanced through changes in organizational structure and culture and through ensuring that protective equipment and supplies are available and are used safely. New partnerships should be forged with all those responsible for formulating and implementing universal precautions and safety guidelines and standards. A number of measures will benefit HIV-positive health care providers: promotion of access to voluntary and confidential testing and counseling tailored to their needs; continuous care and support, including prevention of exposure to tuberculosis; promotion of access to prophylactic therapy; and ensuring retention of employment. Education, both pre-service and continuing, is essential to inculcate appropriate attitudes, skills and behaviour so that health care providers can provide care safely for their patients and themselves, and enable health care providers to train others.

Welcome and opening statement by the Director-General

The consultation was opened by the Director-General of the World Health Organization, Dr Hiroshi Nakajima, who welcomed the participants to Geneva (the list of participants appears in Annex 1). In his opening statement (Annex 2), the Director-General noted that WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have estimated that in 1996, 3.1 million persons had been newly infected and 1.5 million persons had died of AIDS. Data on HIV prevalence in health care providers are not available for most countries, but informal reports suggest that as a rule their rate of HIV prevalence reflects that of similar age groups in the population at large; in some areas, however, this could be as high as 40%. In some heavily affected areas, crude mortality among health care providers has increased twentyfold over the last ten years, almost certainly due to HIV.

The global upsurge in tuberculosis fuelled by the HIV pandemic is a real occupational hazard to health care providers worldwide, in particular to HIV-infected staff. Surgeons and nurses probably have the highest rate of occupational HIV infection of all health care providers.

Early in the HIV pandemic, guidelines were developed to strengthen universal precautions and prevent occupational exposure of health care providers, such as physicians, dentists and nurses. It is necessary to see how widely accessible such guidelines have been, and how successfully they have been implemented. Recent successes with antiretroviral treatment, the availability of which has been limited, have raised ethical and economic issues concerning how best to ensure the active contribution of health care providers in caring for persons living with HIV/AIDS and protect them from exposure to HIV.

Many health care providers, especially in developing countries, are overworked and face severe stress and depression – “burnout” – from dealing with disease and death under often extremely

trying conditions. Those health care providers who themselves are HIV-infected are often afraid to disclose their HIV status because of lack of support in their working environment.

One challenge of this meeting was to identify where improvements could be made to protect the health of health care providers and support their work. It was hoped that participants could also identify areas in which the professional groups they represent can collaborate more closely in sharing experiences, successful approaches and documentation.

Adoption of agenda, introductions, designation of chairman and rapporteur

The agenda was adopted as proposed (Annex 3). In introducing themselves, the participants stated their principal concerns, summarized as follows:

- improved comprehensiveness and integrity of data on HIV/AIDS
- guidance on formulating and implementing practical, constructive policies, both for governments and for health care providers, on how to improve the prevention and control of nosocomial HIV transmission
- improved education on HIV/AIDS
- looking after the interests of HIV-positive health care providers, including their right to information, confidentiality, counselling and treatment, and their right to practise
- infection control and surveillance systems, not only for HIV/AIDS but also for other bloodborne diseases, such as hepatitis B and hepatitis C, and for tuberculosis.

Dr Nakajima designated Dr A. Krishna Moorthy as chairman of the consultation and Dr 'Wole Atoyebi as rapporteur.

Global HIV/AIDS epidemiology

In presenting an overview of the epidemiology of HIV/AIDS worldwide, Dr Eric Van Praag, WHO Office of HIV/AIDS and Sexually Transmitted Diseases (ASD), noted that WHO/UNAIDS estimates that as of December 1996, 22.6 million persons are living with HIV/AIDS; since the beginning of the global epidemic, some 8.4 million persons had developed AIDS. Of the persons infected with HIV or living with AIDS, as many as 90% are in sub-Saharan Africa.

Recently the pandemic has stabilized in some areas, such as parts of Thailand and Uganda, but there have been sharp rises in HIV/AIDS prevalence elsewhere, such as in eastern Europe, southern Africa and Asia – notably in Cambodia, China and India. For example, there has been a steep increase in seroprevalence among pregnant women at sentinel sites in southern Africa during the 1990s, such that in some areas more than half of all pregnant women are HIV-seropositive. There appears to be a low and constant level of prevalence in such countries as Indonesia and the Philippines.

More than three-quarters of the persons who have developed full-blown AIDS are living in Africa, but Asia is rapidly catching up. In urban areas of some countries, up to 90% of all hospital beds in medical wards are occupied by persons with HIV/AIDS. There has been a reduction in the morbidity and mortality related to HIV in North America and Europe, due in part to treatment with antiretroviral drugs. However, a worldwide resurgence of tuberculosis has been driven by HIV; HIV-infected persons are particularly vulnerable to infection, and can then transmit tuberculosis to others.

As members of the general community, health care providers are at risk of acquiring HIV through high-risk behaviours, such as unprotected sexual activities and, to a lesser extent, through sharing needles in the course of nonmedical injection of drugs. Occupational exposure presents an additional risk of infection.

This is of special concern in very high-prevalence areas, particularly where the facilities and supplies to protect oneself may not be adequate to implement universal precautions. The impact of the epidemic was shown in two district hospitals in Zambia, where the rate of mortality in female nurses increased more than tenfold between 1980 and 1991 (from 2.0 per thousand to 26.7 per thousand) and similar increases were seen among factory staff during the same period, reflecting the mainly sexual spread of infection.

Because the attitudes of health care providers influence those of the rest of the community, destigmatization and protection of rights is the principal priority in ensuring that prevention and care can work. When a condition or disease is associated with a stigma, a vicious circle can develop that can deter prevention and care: a conspiracy of silence arises within the health and support system; this leads to fear and neglect in the hospital and community; health care providers are reluctant to give test results when a stigmatized disease is present; this means that one's serostatus may not be known or accepted, and not revealed to others - and further transmission can occur. In addition, as has been said: "If doctors will not operate on HIV-positive patients and nurses will not care for them, it becomes difficult to convince the public to work, eat or play with them."

HIV/AIDS creates opportunities to strengthen the health care system, through actions such as the following:

- Reviving primary health care through community-based and home care programmes.
- Strengthening tuberculosis management (prevention, case findings, case holding) through community-based HIV/AIDS care.
- Introducing HIV and sexually-transmitted disease (STD) prevention during any contact with patients or their relatives in the hospital, clinical and reproductive health setting.

- Stimulating syndromic approaches in STDs at all levels of the health system concerning persons who are potentially sexually active.
- Sustaining the dignity of persons living with HIV/AIDS by strengthening communication about diseases and risks and enabling coping through counselling of HIV/AIDS patients.

Occupationally acquired HIV infection among health care personnel

Worldwide there were 263 cases of occupationally acquired HIV infection reported in the scientific literature by mid-1997. Although these published reports almost certainly underestimate the true extent of the problem, it is likely that occupational acquisition of HIV is a rare event.

Exposure to the blood of an HIV-infected patient through a percutaneous injury, usually a needlestick, is the principal way health care workers have acquired HIV in the course of their work. Out of 70 documented HIV seroconversions in health care workers following a specific exposure in the workplace, 62 (89%) were the result of percutaneous injuries. Pooling data from many studies shows the rate of HIV transmission after a single percutaneous exposure to HIV-infected blood to be 1 in 316 (0.32%).

In countries and places where the prevalence of HIV infection is high, many needlestick accidents will involve HIV-infected blood and the rate of occupationally acquired HIV infection is likely to be higher than elsewhere. Efforts to minimize the occupational risk of HIV infection should be focused upon reducing the rate of needlestick injuries to health care workers.

Potential occupational risks

There was general agreement that no health care environment can be made entirely risk-free. Some risks that are hard to eliminate are as follows:

- airborne infections, including tuberculosis
- invasive contact with blood from patients of unknown HIV status or risk, and close contact with other body fluids
- accidents, in particular when staff are fatigued
- rare events such as deliberate spread of HIV.

Voluntary pre-intervention counselling and testing of patients may be of value in situations where the patient indicates having been at risk and where the test results may help indicate appropriate care (administering immunosuppressants might do serious harm to patients with tuberculosis or HIV/AIDS, for example), but HIV should not be singled out from other communicable diseases.

Coping with risks and fears

The following are ways in which health care providers can cope with risks that are hard to eliminate:

- Minimize the risks: for example, by establishing systems of incentives and disincentives to reduce risks or by modifying the working environment.
- Live with the risks, by being aware of them.
- Be innovative: for example, thimbles can be worn under gloves as protection from needlesticks. Such techniques can be useful as long as feasibility and effectiveness are carefully monitored.

The degree of risk that health care providers must endure depends in part on what is practical and affordable, but what

does it cost *not* to take preventive measures? Health care providers are expensive to train, and therefore expensive to lose.

There is ever-greater need for local resources for health care services, which increasingly means reduced resources for supplies, including gloves. If financial resources continue to decline, this will certainly have a negative impact on safety procedures.

Practices can be modified to increase safety: midwives can reduce the number of episiotomies; surgeons can reduce the number and length of operations, thus leaving more time for proper sterilization of equipment, though this may be resisted because it may reduce their income; blood transfusions can be more strictly limited. The performance appraisal system could be used to evaluate practices as well as theoretical knowledge.

In China, testing for hepatitis B and C is now routine in the course of medical treatment; HIV testing may soon become routine. The belief is that it is right and necessary to protect medical personnel by mandatory testing of patients.

WHO and UNAIDS do not favour mandatory testing – for example, of pregnant women and surgical patients – as a means to prevent transmission to health care providers. They regard such testing as undependable, given the “window period” of uncertain length between infection with HIV and seroconversion – when tests could yield false negatives – and unethical in the absence of a cure and without the explicit and voluntary consent of the patient. Furthermore, as a consequence of stigmatization of HIV/AIDS, people are reluctant to seek care and support from institutions known to have a policy of mandatory testing.

But as for mass screening, there is no evidence that it diminished risks. It is none the less true that presurgical screening still occurs, principally to protect physicians rather than patients, despite the Hippocratic Oath. It was pointed out that laboratory technicians, for example, want good reasons for testing, in order to avoid wasting money and providing a false sense of security.

Needlestick accident surveillance is vital to reducing occupational risk. It was agreed that the preconditions to surveillance are the existence of an infection control committee in the health care facility whose function is to stimulate surveillance and to train and sensitize health care providers, and stimulate easy access to voluntary counselling and HIV testing for health care providers in a confidential manner. In primary care settings, an appropriate person or group should be named to look after infection control.

Education is the key to change in knowledge, attitudes and behaviour. Education about HIV/AIDS must be improved so as to reduce gaps between policies and their grassroots implementation, so that health care providers can protect themselves (particularly when resources – such as gloves – are lacking), provide care without transmitting HIV and help educate the community.

It is necessary to inculcate safe occupational practices at the earliest opportunity and to continually reinforce this teaching. The educational process may take varied forms – memorization of basic concepts as well as problem-solving, for example, and learning individually as well as in groups. To enhance retention, safety messages should be presented in memorable, visually lively ways.

For most health care providers as for the population at large, the greatest period of HIV risk occurs during young adulthood (usually ages 18 to 28) and is related to sexual behaviour. This indicates that empowerment and reduction of behavioural risks must be emphasized during training.

Given the important role of family members as caregivers, it is important to provide them with training also, in order to prevent their becoming infected and to reassure them as to how HIV is *not* transmitted. In some locales it is necessary for rural health care providers to educate traditional birth attendants as well as the general public, despite the lower rate of HIV sero-

prevalence in rural areas, since many women return to their rural home villages to deliver.

Coping with lack of drugs and other resources required for HIV-infected patients

It was emphasized that a person or group responsible for infection control should be designated in each health care facility, and that access to voluntary counselling and testing should be made readily available. The following techniques were suggested as ways to provide care safely to HIV-infected patients in the face of a shortage or lack of drugs and protective supplies and equipment.

- Audit the facility's safety record: document and review commonly occurring injuries.
- Classify procedures as high-, medium- and low-risk in order to guide use of protective equipment.
- Set priorities, standards and protocols, including adherence to universal precautions to the greatest extent possible.
- Foster an institutional culture of safety, and provide recognition for excellence of care without risk.
- Properly orient and supervise health care providers.
- Adopt safe practices and techniques, e.g. dispose of sharps in special containers without capping them.
- Eliminate unnecessary procedures and tests.
- Negotiate physician prescribing behaviour.
- Use oral medications where feasible.
- Implement measures to prevent and reduce burnout: rotate health care providers to less stressful assignments; provide peer support; ensure an appropriate workload.
- Find out what is available from the government and other sources (e.g. what supplies are routinely provided by patients).
- Determine the quality of the available supplies.
- Assess protective equipment for risk and safety

- Consider involving medical equipment suppliers in designing safer devices.
- Develop or improve a system of ordering, transport and storage of equipment and supplies.
- Improve management and use of equipment and supplies (e.g. wearing gloves for bedmaking is wasteful).
- Substitute less expensive items for more expensive ones: explore alternatives and low-cost items; observe the distinction between cost-effectiveness and simple cost containment.

HIV-positive health care personnel: prevention and care

Health care providers include physicians, nurses, midwives, paramedics and home caregivers. For many of these, the change from care provider to care recipient is very difficult. The main barriers to care are fear and shame, and lack of a system of care and support specifically for health care providers.

Some HIV-positive health care providers react by going into hiding, seeking care elsewhere anonymously, or joining an AIDS-care organization.

Their colleagues may react by shunning, silence, gossip, excessive support, and denial of benefits. The news media and the public have been known to react by insisting that all patients of the HIV-positive health care provider be contacted and tested.

Stigmatization occurs because HIV/AIDS is viewed by many as a consequence of a negatively sanctioned lifestyle. If a cure existed, HIV/AIDS might be dealt with like tuberculosis: with a cure, it is likely that fear and stigmatization would be reduced.

Health care providers are a hard-to-reach group: their training in sexuality is limited; they are assumed to know it all (though facts learnt academically are harder to apply in practice: they must be personalized, and doubts that arise must be dealt with) and they

may find it hard to be told what to do; they have little or no opportunity for counselling, and they may fear the implications of confidentiality issues. But as can be seen from reduced smoking among health care providers, behaviour can be changed.

The principle of universal precautions calls for behaving as if all patients are carriers of bloodborne diseases. This is the case in Sweden, where extra precautions are applied when there is reason to believe there is special risk. Though there is little experience with occupationally infected health care providers, counselling is available. This is also true of Japan, where a telephone "warm line" is available to offer information and support.

Peer support is needed and should begin to be inculcated during training. In the Nigerian Medical Association, the Nigerian Counselling Committee for Sick Doctors has been set up to avert possible stigmatization.

In balancing patients' right to know against the health care provider's right to confidentiality, it is necessary to weigh the possibility of causing unnecessary alarm against the right to know of potential risk. Participants who are HIV-positive reported that disclosure of their HIV status had resulted in medical support and in social support from patients and others. The ruling consideration should always be that patients must not be placed at risk; if one's mode of work involves potential risk to patients, the way of working must be modified.

Policies, management issues and guidelines

Many guidelines and sets of precautions exist, but the challenge is to improve compliance with these safe practices. This could be achieved by observing what health care providers actually do in daily practice, and asking them why they do what they do. Such operational research should be directed towards site-specific solutions to the problem of non-compliance. It would also be

useful to study differential rates of occupational exposure; this could be a collaborative study by different professional associations.

The keys to good practice are education, incentives – both moral and economic – and enforcement. One approach is to do as follows:

- achieve universal agreement as to routes of infection and risks
- identify and endorse protective mechanisms and procedures – preferably those that use practical, low-technology equipment and supplies
- follow up to monitor effectiveness.

These steps should be pursued through the health care professional associations and schools. This approach could be packaged as an identifiable campaign that potential donors might be interested in financing..

What is also needed is a process to adapt existing guidelines and related materials to local situations and to capture new knowledge, since specific local circumstances make compliance with universal guidelines difficult and universal guidelines take time to formulate. WHO could contribute by stimulating this process and fostering development of norms and standards that could then be adapted locally. It must be remembered that efforts to improve compliance with safe practices should focus not only on the secondary and tertiary levels of care, but also on the primary care level, including home care.

Management of accidental exposure

To improve the management of accidental exposure, it is necessary to identify an appropriate national standard of post-exposure care and promote adherence to it, and to encourage dynamic standard-setting.

Use of antiretroviral drugs for post-exposure prophylaxis

Benefits of the use of antiretroviral drugs are as follows:

- decreased risk of transmission
- prevention of immune deficiency.

Potential disadvantages of antiretroviral drugs for post-exposure prophylaxis include the following:

- strict and complex regimen of tablet-taking, which may interfere with performance of normal tasks
- raising false hopes of successful prevention in a proportion of persons who either will not respond or will not tolerate the therapies
- early development of drug resistance and cross-resistance when antiretrovirals are not effective, limiting the number of available therapeutic options in the future and increasing the risk of transmission of resistant strains.

Guiding principles proposed for the use of antiretrovirals might be stated as follows:

Health professionals must have ready access to voluntary counselling and testing; those at risk should be encouraged to use such services on a regular basis. Antiretroviral treatments must be supported by a functioning clinical and laboratory system that ensures a relevant testing strategy and adequate diagnosis and treatment of opportunistic infections, appropriate pain management, and correct use of and adherence to an antiretroviral drug regimen to avoid the emer-

gence of drug resistance and transmission of resistant strains of HIV.*

The minimum requirements for use of antiretroviral drugs for post-exposure prophylaxis may be stated as follows:

- reliable and inexpensive HIV tests
- access to voluntary and confidential counselling and testing for health care workers
- training for physicians and nurses
- joint decision-making between physician and affected health care provider on antiretroviral treatment
- a reliable, long-term and regular supply of drugs for palliative care and opportunistic infections, as well as for antiretroviral treatment
- functional laboratories to monitor adverse reactions to antiretroviral drugs
- a functional social support network to improve adherence to the treatment regimen.

Strengthening the care of HIV-positive health care providers

With respect to strengthening care of HIV-positive health care providers, it is the obligation of employers to provide a safe work environment, which includes ensuring all feasible means to prevent exposure. To provide for HIV-positive health care providers, it is necessary to promote access to voluntary and confidential testing and counselling and continuous care and support, and to identify an appropriate national standard of post-

*WHO consultation on the implications of ARV treatments, April 1997. Geneva, World Health Organization, 1997 (unpublished document WHO/ASD/97.2; available on request from Office of HIV/AIDS and Sexually Transmitted Diseases, World Health Organization, 1211 Geneva 27, Switzerland).

exposure care and promote adherence to it, so as to ensure avoidance of exposure to opportunistic infections, including tuberculosis, and promote access to prophylactic therapy.

It is also necessary to emphasize rights and responsibilities by making sure health care providers on completion of training are aware of lifestyle risks and occupational risks alike; to ensure retention of employment, with possible change of responsibilities; and to provide guidance on the rights and responsibilities of patients. The possibility of insurance for occupational exposure to HIV/AIDS of health care providers and students should be explored; this already exists in some countries. Innovative, flexible compensation mechanisms for HIV-positive health care providers should be developed.

Presentation and discussion of recommendations/Adoption of recommendations

The welfare of patients is the fundamental concern of health care providers; it motivates, permeates and determines their actions. These recommendations are intended to help ensure provision of care safely for patients and health care providers alike. In the interest of ensuring the best possible health care, it is necessary to train and recruit qualified health care providers and retain them in the workforce. Work in health care should be as free from hazards as possible, so that those interested in health care careers can provide care safely and not be hindered by fear for themselves and their families. Although these recommendations refer specifically to the Human Immunodeficiency Virus, they are intended also to be applied to other bloodborne diseases, such as hepatitis B and C, and to tuberculosis.

With respect to reducing the occupational risk of exposure to HIV, all the professions represented at this consultation were aware of the availability of guidelines on universal precautions to prevent occupational exposure of health care providers to HIV. In order to apply such guidelines, however, it is necessary to

identify and describe local conditions and constraints and the number, nature and causes of injuries. It is also necessary to establish a system to disseminate and update guidelines and best practices in light of rapid changes in knowledge and technology. Professional associations should play a major role in formulating and dynamically updating standards from generic guidelines, and in promoting adherence to such standards.

It is necessary to ensure adherence to safe-practice guidelines and standards. This is a universal problem due to continued practise of unsafe procedures. The situation can, however, be improved by identifying best practices, such as innovations that are sound and feasible in the local context. It would also help to establish a continuous, participatory, performance audit system that ensures high quality in practice and includes observation of routine practices and examines why gaps in compliance occur.

Adherence to safe practices can be improved by emphasizing incentives for safe practices (such as remaining HIV-negative and being sure of providing safe care) and instituting disincentives for unsafe practices (such as withholding the license or certificate of a practitioner or institution that persists in unsafe practices), and motivating staff through sharing of personal experience, thus reinforcing the impact of objective facts with real-life examples.

Compliance with safe practices could be enhanced through structural means, such as giving priority in resource allocation to the availability of protective equipment and supplies; and giving enhanced attention to planning, design and use of physical facilities, equipment and supplies, so that safer equipment and supplies are physically accessible and used safely.

Management issues also play a role in improving compliance with safe practices: accountability at senior levels should be expressed in organizational structure and financial commitment to safety; an infection control committee should be mandatory, multidisciplinary, structural, outcome-oriented and have full authority to facilitate adherence to standards of performance and

to impose meaningful sanctions for non-adherence. Human relations, even in the context of professional hierarchy, should be based on mutual understanding, respect and commitment to excellence in health care.

New partnerships should be forged with all those responsible for formulating and implementing safety guidelines and standards, including professional associations, government agencies and intergovernmental and nongovernmental organizations, and: policy-makers (such as the ministry of health and legislators, so that worker health and safety legislation is enforced, and, if necessary, strengthened); research institutes, for support in local research and evaluation; additional sources of financial, material or other support, to supplement resources regularly allocated; the private and commercial sector, including, for example, insurance providers, for their data and expertise, and manufacturers, to design safe and affordable equipment, supplies, packaging, etc., at an appropriate level of technology; and educational institutions and student organizations, to reinforce their learning and for their perspective as prospective health care providers.

Medical, paramedical and nursing education, both pre-service and continuing, is essential to inculcate appropriate attitudes and behaviour so that health care providers can provide care safely for their patients and themselves, and enable health care providers to train others. Consideration must be given to content: not only technical considerations, but also ethical and psychosocial considerations; and methodology to facilitate full assimilation and behaviour-shaping (e.g. problem-solving, interactive, possibly interdisciplinary methods, using real-life examples, personification of lifestyle risks and current telecommunications technology).

The recommendations are summarized in the following table.

Summary of recommendations

Those principally responsible	Reducing risk of occupational exposure	Strengthening care of HIV+ HCPs
Health care providers	<p>Exercise both rights and responsibilities</p> <p>Practise safe personal behaviour</p> <p>Adhere to safe professional practices</p> <p>Access to voluntary counselling and testing</p> <p>Report accidents</p>	<p>Exercise both rights and responsibilities</p>
Professional associations	<p>Provide education: content and methodology</p> <p>Develop and disseminate standards for safe practice</p>	<p>Provide education: content and methodology</p>
Employers	<p>Provide vaccinations</p> <p>Provide a safe work environment: protective equipment and supplies; planning, design and use of physical facilities, equipment and supplies</p> <p>Conduct accident surveillance</p>	<p>Provide access to voluntary, confidential testing and counselling, and continuous care and support</p> <p>Ensure avoidance of exposure to opportunistic infections</p> <p>Retain HIV + HCPs, modifying their duties if and as necessary</p> <p>Provide compensation</p>

Those principally responsible	Reducing risk of occupational exposure	Strengthening care of HIV+ HCPs
Other partners	<p>Educational institutions: Education: content and methodology</p> <p>Peers: Human relations should be based on mutual understanding, respect and commitment to safe care</p> <p>Manufacturers: Equipment and supplies should be designed for safety</p> <p>Legislators: Promulgation and enforcement of worker health and safety legislation</p> <p>Research institutes: Local research and evaluation</p> <p>Insurance providers: for data and expertise</p> <p>Funding sources: supplemental resources</p> <p>Student organizations: to reinforce their learning and profit from their perspective</p>	

Those principally responsible	Reducing risk of occupational exposure	Strengthening care of HIV+ HCPs
Shared responsibilities	<p>Ensuring the continuous availability of trained personnel</p> <p>Education: content and methodology</p> <p>Policy-makers at government and institutional level: priority in resource allocation should be given to availability of protective equipment and supplies</p> <p>At institutional level: structural arrangements, such as establishment of infection control committee</p>	<p>Identifying an appropriate national standard of post-exposure care and promoting adherence to it</p> <p>Developing insurance systems and innovative, flexible compensation mechanisms for HIV + HCPs</p>

Closure of consultation

At the close of the consultation the participants thanked the Director-General for organizing the meeting and urged that consultations of this nature continue to be held.



WORLD HEALTH ORGANIZATION

**Sixth Consultation with Leading Medical Practitioners
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"HIV/AIDS and health care personnel: policies and practices"

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**SIXTH CONSULTATION
WITH LEADING MEDICAL PRACTITIONERS
on
HIV/AIDS and health care personnel: policies and practices**

Introductory remarks by
Dr Hiroshi Nakajima
Director-General, World Health Organization
Geneva, 4 November 1997

Mr Chairman,
Distinguished participants,
Ladies and gentlemen,

Welcome to Geneva and to this Sixth Consultation we are holding with leading medical practitioners. I am pleased to meet again those of you who have been regular participants in these consultations, and I extend special greetings to the additional participants who have joined us to deal with the important issue of HIV/AIDS and health care personnel, policies and practices.

In many countries, data on HIV prevalence among health care workers are not available, but informal reports suggest that the rate reflects the overall rate of infection for their age group in the countries concerned. In some places the prevalence rate can be as high as 40%, and, in countries and areas heavily affected by HIV/AIDS, mortality among health care providers has increased as much as twentyfold over the last ten years. Though the infection rate directly linked to occupational exposure is low, estimated at 0.3% in contrast with 10% to 30% for hepatitis, HIV/AIDS has created an atmosphere of fear and insecurity. In some situations, it has resulted in the attrition of staff and neglect of patient care.

Fuelled by the HIV pandemic, a global upsurge of tuberculosis has occurred which, in some cases, is multidrug-resistant. This has made

tuberculosis a real occupational hazard for health workers worldwide. Not surprisingly, the greatest risk of nosocomial TB transmission is to HIV-infected staff. Nurses were the first occupational group found to be at particular risk for tuberculosis, and they show what may well be the highest rate of infection and disease among health care providers.

In the earlier days of the HIV pandemic, guidelines for the prevention of occupational exposure were developed for certain categories of health professionals, such as dentists and nurses. Some years later, taking into account the facts and observations I have just mentioned, it appears that these guidelines now need to be reviewed, assessed and revised in the light of field experience.

As importantly, the apparent effectiveness of newly available antiretroviral treatment is raising a whole new set of difficult questions which are both economic and ethical. How do we provide for the safety and care of the health care workers who may be exposed to or affected by HIV? How do we ensure that the considerable resource they represent for their countries and health services is protected and sustained?

Health care workers are themselves confronted with more personal difficulties. For those who may be infected with HIV, there is often little support in their own institutional environment. As a consequence they are afraid of disclosing their HIV status. How can we respond to this and provide them with the support they desperately need but are unwilling to seek or unable to obtain?

Another problem is burnout, which occurs among health workers in many health care settings, particularly in developing countries and where HIV prevalence is high. These workers bear a heavy professional and psychological burden as people and communities affected by HIV/AIDS turn to them for help. How can we give health workers the effective personal and material support they need before burnout occurs?

With your help, over the next two-and-a-half days, we hope we can define the ways in which improvements can be made to support health care providers in carrying out their tasks. With this in view, you

will also want to propose areas in which the different groups represented here can most usefully share information and ideas. We look forward to your contribution to these discussions and to benefiting from the knowledge you have gained from your personal experience of working in communities living with HIV/AIDS.

With these few words of introduction, I want to thank you all very sincerely for taking the time to come here and take part in this consultation. I wish you a fruitful meeting and a pleasant stay in Geneva.



WORLD HEALTH ORGANIZATION

**SIXTH CONSULTATION WITH
LEADING MEDICAL PRACTITIONERS**

Geneva, 4-6 November 1997

Salle "C" (5th floor)

"HIV/AIDS and health care personnel: policies and practices"

Agenda

Tuesday, 4 November 1997

- | | | |
|-------------|----|---|
| 09.30-09.45 | 1. | Welcome and Opening statement by the Director-General |
| 09.45-10.30 | 2. | Introductions/Adoption of Agenda/Designation of Chairman and Rapporteur/General announcements Moderator and Rapporteur |
| 10.30-11.00 | | <i>Coffee/tea break</i> |
| 11.00-11.30 | 3. | Problem Overview I (presentations) <ul style="list-style-type: none"> 3.1. Global HIV/AIDS epidemiology 3.2. HIV prevalence among health care personnel |
| 11.30-12.30 | 4. | Problem Overview II (presentations and discussion) |

- 4.1. Policy statements related to occupational exposure to HIV (examples)
- 4.2. Care and prevention programmes for health care personnel (examples)

12.30-14.00

Lunch

14.00-17.00

5.

Managing occupational hazards for health care personnel (presentations and discussion)

(incl. coffee/tea break)

- 5.1. Reported data and incidents
- 5.2. Potential risks (modelling)
- 5.3. Policies, management issues and guidelines (examples)
- 5.4. Use of ARV drugs for post-exposure prophylaxis

17.30-19.00

Director-General's reception

Wednesday, 5 November

09.00-10.30

6.

Reducing the impact on health care personnel

- 6.1. Coping with risks and fears
- 6.2. Coping with lack of drugs and other resources required for HIV-infected patients
- 6.3. Living with HIV as a health care worker

10.30-11.00

Coffee/tea break

11.00-12.30

7.

Implementing policies and services related to prevention and counselling as well as to care and support of HIV-infected health care personnel

- 7.1. Prevention of non-occupational HIV exposure: health care personnel as a 'hard-to-reach' group
- 7.2. Voluntary counselling and testing
- 7.3. Who cares for the carers?

12.30-14.00

Lunch

14.00-14.30

- 8. Recapitulation (Rapporteur)

14.30-17.00

- 9. Group work for development of recommendations related to topics 5., 6. And 7.

(incl. coffee/tea break)

Thursday, 6 November

09.30-10.30

- 10. Presentation and discussion of recommendations (in plenary)

10.30-11.00

Coffee/tea break

11.00-11.15

- 11. Adoption of recommendations

11.15-11.30

- 12. Closure of Consultation.
