AIDS

Gwyneth Lewis, Joel Finlay, & Roy Widdus

AIDS programmes in transition

National AIDS programmes of industrialized countries are moving from rapid growth to consolidation. This transition should afford opportunities for strengthening the approaches to AIDS prevention.

During the late 1980s the health ministries of many industrialized nations created special units and/or coordinating centres to develop, manage and implement AIDS prevention and control programmes that often received support from a wide range of experts. This was an efficient way of marshalling financial and human resources for the development of coordinated plans of action. The approach was especially important when little was known about the prevention and treatment of HIV infection and AIDS and when there was sustained media attention. The efforts made at national level were mirrored by the establishment of the World Health Organization’s Global Programme on AIDS in 1987.

The experience and knowledge gained in the industrialized countries during the 1980s have led to a greater understanding of AIDS and its implications, as well as to new perspectives on HIV infection as a public health issue. These insights can be expected to shape the development of national AIDS prevention and control programmes during the 1990s.

New phase

HIV infection is expected to be a major public health issue for many years. National AIDS programmes in industrialized countries, which were instituted as task forces responding to an emergency, are now moving into a second phase that should build on existing policies, sustain and develop educational work, and ensure the...
continuing provision of high-quality care and counselling. They should also continue with efforts to maintain the dignity and rights of the individual, on the basis of the principles of privacy, confidentiality and equality of access to care, treatment and support.

National programmes should plan for sustained momentum and the introduction of new strategies while securing maximum benefit from resources.

National programmes should plan for sustained momentum and the introduction of new strategies while securing maximum benefit from resources. Methods devised in response to emergencies are not necessarily the best for maintaining longer-term policies and programmes.

Pressures on national AIDS programmes have frequently hindered critical evaluation of prevention and control strategies, and planning for the future has not always been systematic. Consequently the programmes are now faced with the problem of ensuring their continued development in unexpected political, financial and administrative adversity.

The demand for human and financial resources in prevention and control work, health care, and counselling can be expected to rise during the 1990s. WHO estimates that health care costs for HIV-related illnesses alone will be at least several billion US dollars annually in the industrialized countries. This means that consideration has to be given to financial planning for these costs within the broader context of health care planning.

HIV infection and AIDS have brought burn-out in their wake: many dedicated people involved with the epidemic have become emotionally exhausted. Not only health care workers and volunteers but also national and local administrators and planners have been affected as a result of working long hours. Even persons not directly involved with patient care may be working in an environment where they come constantly into contact with young people, possibly their own colleagues, who are ill or dying. The management of AIDS programmes in the coming decade will require recognition that this situation exists and it will be necessary to assist the affected individuals to reduce their levels of stress.

**Integrated approach**

Closer relationships should be encouraged with public health and social service networks so as to maximize resource use. However, it is important that questions related to HIV infection do not become marginalized at the national, local or individual levels. In industrialized countries the steady increase in the number of persons with AIDS, particularly among heterosexuals, suggests that issues surrounding HIV infection will form part of everyone’s life experience, through media exposure, educational initiatives, or personal contacts. It is to be expected that there will be parallel changes in programmes.

There are links between HIV infection and substance abuse, other sexually transmitted diseases, tuberculosis, sexual abuse, and, more broadly, low literacy, poverty, and group marginalization. In many societies it appears that people who are socially disadvantaged are more likely than others to engage in practices that increase the risk of HIV infection. It is therefore desirable that HIV infection programmes be developed to
work in concert with other public health and social service initiatives.

Governments should examine the functions and objectives of established central HIV/AIDS coordinating units. Eventually, their role may shift from programme delivery to the facilitation and strengthening of partnerships between the elements of public health, social service, education, and human rights programmes, including those of nongovernmental organizations. The objective should be to draw on these other elements so as to support and strengthen initiatives on HIV infection and AIDS.

Epidemiological considerations

Throughout the 1980s in the industrialized countries, HIV infection predominantly affected people who injected themselves with drugs and homosexual men. Transmission of HIV among older homosexual men appeared to level off during the late 1980s, in some places, reflecting changes in sexual behaviour. However, in some countries a rise in gonorrhoea among younger homosexual men and heterosexuals suggests that these groups do not perceive themselves to be at risk.

There are still large numbers of uninfected people who inject themselves with drugs; HIV infection could spread extensively among these individuals and their sexual partners if they continue with high-risk behaviour. Heterosexual transmission is expected to continue increasing, especially in populations where other sexually transmitted diseases and the injection of drugs occur at high frequency. HIV is expected to become a major, if not the leading, cause of death in persons aged 20–40 during the 1990s in certain industrialized countries. Perinatal transmission is increasing as the number of HIV-infected women grows. There is a clear need for sustained monitoring and surveillance of the future spread of the epidemic.

Education and prevention

It is necessary to strengthen work on AIDS education and prevention by further development of mutually beneficial links with broader programmes, including ones concerned with disease- or issue-specific strategies. Among the health education programmes of interest in this connection are those covering cervical cancer screening, sexuality, maternal and child health, and sexually transmitted disease. The linkage in industrialized countries between HIV infection and the required educational initiatives, life-styles, and drug abuse is of enormous importance.

Care, support and counselling

Medical services, support and counselling for persons with AIDS are already established to some extent in most industrialized countries within the health service infrastructure. This is not necessarily true for symptomless individuals and their sexual partners if they continue with high-risk behaviour. Heterosexual transmission is expected to continue increasing, especially in populations where other sexually transmitted diseases and the injection of drugs occur at high frequency. HIV is expected to become a major, if not the leading, cause of death in persons aged 20–40 during the 1990s in certain industrialized countries. Perinatal transmission is increasing as the number of HIV-infected women grows. There is a clear need for sustained monitoring and surveillance of the future spread of the epidemic.
community-based; in some countries day care, respite, and hospice care were provided by specialized teams. Many persons with AIDS have expressed a wish to die at home, for general practitioners needs to be strengthened so that the epidemic can be tackled in the context of public health and social service infrastructures.

Nongovernmental organizations

Since HIV first appeared in industrialized countries the response of community-based nongovernmental organizations has been very important. Mainly through their networks of volunteers, these bodies have been instrumental in providing care and support for infected people and their partners, families and friends. In some countries, established nongovernmental organizations took on this responsibility, whereas elsewhere new ones did so. As well as providing invaluable care and support, these organizations have developed innovative information and education programmes.

AIDS service organizations have become an integral part of the community-based, nongovernmental movement. This sector, with its history of involvement in social change, has worked to increase local control over the definition and delivery of community programmes and services. The principle of citizens’ participation or the involvement of people in defining their own health needs and assisting with the delivery of services is likely to remain an important element of HIV prevention, control, and treatment programmes for the foreseeable future. The AIDS service organizations should not take over the statutory or licensed functions of professional health care workers or governments but should continue as a valuable adjunct.

During the 1990s the AIDS service organizations will undoubtedly seek to strengthen their links with other groups in the nongovernmental sector which have a
strong role in the public health and social service infrastructure. Such collaboration should help to ensure that the best possible use is made of resources.

In order to try to meet requirements in the face of competition for voluntary services, cooperation and supportive partnerships in the nongovernmental sector will have to be strengthened.

* * *

The transitional stage in the national AIDS programmes of industrialized countries, which may last for up to 10 years, will have to be carefully agreed, planned and managed. Aspects of the programmes will undoubtedly move into the mainstream of public health and social services at varying times. The establishment of sustained programming requires continual discussion with national and local officials, key players in health care, education, the media, and the voluntary sector, and with affected individuals themselves. The transitional stage should afford opportunities for strengthening and making more comprehensive the approaches both to HIV/AIDS prevention and to public health and human rights in general.

---

Transmitution of HIV in health-care settings

Based on the information available, transmission of human immunodeficiency virus (HIV) can and does occur in health-care settings. No cases of such transmission have been reported from an infected health-care worker to a patient. Transmission of HIV from an infected patient to a health-care worker has been documented after parenteral or mucous-membrane exposure to blood. However, this risk is <1%, is limited to exposure to blood, and can be further minimized through adherence to routine infection control measures. Patient-to-patient transmission through invasive equipment or through HIV-infected blood, blood products, organs, tissues, or semen also occurs but can be prevented by proper sterilization of instruments and through donor-deferral, donor screening, and heat treatment of Factors VIII or IX to inactivate the HIV. In health-care settings, prevention of HIV transmission requires education of all health-care workers and ancillary staff, provision of necessary equipment, and strict adherence to general infection control practices.