HIV/AIDS: A Commonwealth emergency; the challenge to medical education

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The conference, held on 13 October 2000, was organised by the Royal College of Physicians (RCP), Commonwealth Secretariat, Commonwealth Medical Association (CMA) and Association of Commonwealth Universities (ACU). The delegates included academics, health professionals, the voluntary sector and civil servants from the Commonwealth countries. There was much audience participation and debate.

"In view of the grave threat posed by HIV, history will judge us harshly if we do not do something now."
Baroness Amos, Department for International Development (DIFID)

The scale of the epidemic

Between 33 and 35 million people are infected with HIV worldwide. Nine of the most heavily infected countries are in the Commonwealth, with other countries in the Caribbean and Asia following suit.

The heads of state are at last showing a growing awareness of the problem. At the Durban AIDS conference the Commonwealth states issued a joint statement expressing grave concern at the devastating socio-economic impact of HIV/AIDS, and pledged individually to support the development of a vaccine, affordable drugs and access to health care. The G8, the UN Security Council and the European Committee have all expressed their commitment to tackling this epidemic.

The particular challenge to medical education is twofold:

1. The effect of the epidemic on an already overstretched health care system
2. The effect of losing health care workers and teachers to the epidemic.

UNAIDS was created in 1996 to coordinate advocacy, country driven actions and resource mobilisation against AIDS. There is a dynamic relationship between poverty and HIV; stigma and denial fuel the epidemic; prevention is inextricably tied to care; vulnerability reduction programmes and respect for human rights are important; all this needs effective partnerships.

In the discussion that followed, conference themes began to take shape: access to care rather than the traditional model of treatment, resource mobilisation (debt relief, good governance and prevention of capital flight), vulnerability, and partnerships (public, private, religious, communities).

HIV/AIDS: consequences for health care delivery

Poverty, poor education, violence and migration helps the spread of HIV. Fragile health systems are overwhelmed: half the hospital beds are occupied by AIDS cases, health care workers are dying and HIV is perpetuating a TB epidemic. A continuum of care: voluntary counselling and testing (VCT), home based care, primary and secondary health care, and community care, all require resource allocation and infrastructure development.

In Zimbabwe 80% of hospital admissions, 80% of TB patients and >30% of pregnant women are infected with HIV. The staff have to cope with a heavy workload, low morale, and low pay. The risk of occupational exposure is very real. The limited resources are running out. Pressure on hospital beds leads to early discharge and the load on the unsupported home based care increases the demand for

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Conference programme

- **Lower risks and better lives – focusing on priorities in AIDS prevention and care**
  Baroness Amos, Department for International Development, UK
- **HIV/AIDS and the international response**
  Dr Awa-Marie Coll-Seck, Director, Department of Policy, Strategy and Research, UNAIDS
- **HIV/AIDS – consequences for healthcare delivery**
  Professor Alan McGregor, Association of Commonwealth Universities
- **HIV/AIDS – consequences for medical education**
  Marianne Haslegrave, Commonwealth Medical Association
- **The way forward**
  Professor Michael Adler, Royal Free and University College Medical School and Royal College of Physicians, London

hospital admissions. Savings are being drained by basic health care needs and the spiral of poverty continues.

In South and Southeast Asia the epidemic is spreading but health services remain unprepared. There are 300–400 new cases per month and the burden of care falls on the public sector. There is little expertise or knowledge and therefore 80% of patients present with AIDS. The cost of care is exacerbating the rich-poor divide. It is estimated that <1% of Thai people has money left over from daily expenses to purchase dual nucleoside therapy.

Five large pharmaceutical companies (Glaxo Wellcome, Roche, Bristol-Myers Squibb, Merck, Boehringer) have reduced the price of the antiretrovirals AZT/3TC by 85%, but even these prices are unaffordable by the worst hit countries and would have to be subsidised. To be considered for this price reduction governments will need to be politically committed, provide an appropriate infrastructure and consider solutions such as public/private initiatives to treat skilled workers. The cost of creating an effective infrastructure is 3–4 billion dollars. Some members of the audience expressed concern that such initiatives may create a gulf between the skilled and unskilled work force, and the vulnerable groups, particularly women, could be left out all together.

Consequences for medical education

In training and assessing medical students in the UK, HIV can be used to teach the principles of general medicine and to explore the role of the multidisciplinary team, the continuum of care, confidentiality, informed consent, ethical issues, death and palliative care, pharmacology, and most of all the holistic approach and empathy. Medical students need to know how to protect themselves from occupational, sexual, and intravenous drug exposure to HIV. All members of the multidisciplinary team are involved in training and assessment.

In stark contrast, in countries with the twin burdens of the epidemic and poverty the lack of resources has created a situation of helplessness and despair and makes such a Western education model difficult to implement. This is exacerbated by the loss of staff to the epidemic.

In a country, such as Jamaica, coming to terms with the epidemic, the goals of a curriculum in HIV are to create a group of health professionals equipped to care and counsel whilst remaining HIV free, and working within a team. Different team members may be the teachers, in particular the people living with HIV/AIDS.

Participants in the lively discussion were concerned about the provision of continuing medical education and dialogue with practitioners isolated in their private practices, and the alternative care givers. Some felt that other health care workers had been neglected. Others explored means of developing a training programme based on a multidisciplinary model, involving all aspects of care, especially skills in palliative care.

There was concern that interventions during further education are too late to protect health care workers. Should the medical profession advocate HIV prevention in schools; should the profile of adolescent and sexual health be raised in the medical curriculum? Should training equip health professionals to engage with an extended role in the world of politics, economics, law and ethics? Several people reminded the conference of the excellent training resources available from the voluntary sector, as well as governmental and international organisations.

There was a general feeling that the policy of discouraging UK students from doing their electives in the worst hit countries contravened the spirit of sharing educational resources and learning from each other.

Summary

Some general goals of medical education at an undergraduate and postgraduate level were defined:

- The ability and skills to give care and counsel
- Empowering students to be free from HIV
- A multidisciplinary team approach to caring and training
- Recognition of HIV as a development and poverty issue

The barriers were apparent at every junction: inadequate resources, helplessness, crowded curriculum, poor coordination, excessive workload, and too little time.

The future

The UK has an important role in Commonwealth medical training and the potential for strengthening this relationship, through twinning, continuing medical education and exchange programmes. Medical professionals can influence policy makers. The Commonwealth universities (ACU) and medical associations (CMA) should lead the debate, set the standard of good practice, and eventually adopt prototype HIV policies which could be adapted for use by other structures and institutions.

Health care workers bear the brunt of this epidemic but are currently not equipped to deal with it. The next generation, through a changing curriculum, can be trained to take on their multifaceted role within a multifaceted team.