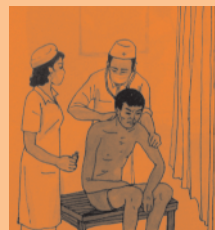


Safe & Friendly Health Facility

Trainer's guide

Institute for Social & Development Studies (ISDS)
International Center for Research on Women (ICRW)
The Horizons Program/Population Council



Safe & Friendly Health Facility

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Khuat Thi Hai Oanh

Pham Duc Muc

Ross Kidd



This guide was made possible by the President's Emergency Plan for AIDS Relief and the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. HRN-A-00-97-00012-00. The contents are the responsibility of the Horizons Program and do not necessarily reflect the views of USAID or the United States Government.

Published in February 2008.

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Acknowledgement

THE TRAINER'S GUIDE FOR THE SAFE AND FRIENDLY HOSPITAL PROJECT was produced for use in the project "Reducing HIV Stigma and Discrimination in the Health Care Setting in Vietnam". This project was jointly run by the Institute of Social Development Studies (ISDS), International Center for Research on Women (ICRW), and the Horizons Program/Population Council.

The guide was used to train health workers on HIV/AIDS, HIV stigma and discrimination, and universal precautions – and guide the process of developing new policy guidelines on these issues.

After being used in more than 20 trainings, the guide was revised and updated to incorporate what was learned from the trainings.

The team express our sincere thank to the extraordinary commitment of many people who have contributed to the development of this guide, especially:

- Staff from Quang Ninh TB and Pulmonary hospital, Hai Phong TB and Pulmonary hospital, Can Tho city hospital and Thot Not district hospital, Can Tho.
- A number of PLWH from Hai Phong, Quang Ninh, Can Tho, Ha Noi and Ho Chi Minh city.
- Can Tho AIDS Prevention and Control Center.
- Project staff: Pham Duc Cuong, Vu Manh Tri; consultants and co-facilitators: To Thi Dien, Hoang Nong, Pham Ngoc Cuong, Nguyen Quang Trung, Dinh The Manh.

The project is grateful for their sincere contribution and commitment throughout all the trainings, all in very hot weather.

Graphics used in the training and to illustrate this guide are drawn from the manual, "Understanding and Challenging HIV-related Stigma – Toolkit for Action", published by the Institute of Social Development Studies.

Some graphics in this guide are taken from the above-mentioned toolkit. The rest were developed by Nguyen Phong Chau. Pictures presented here were taken by project staff and consultants.

This Trainer's Guide is part of a package of training materials, named "Safe and Friendly Health Facility – Experience and Tools", which aims at helping to reduce HIV-related stigma and discrimination in the health care setting.

Other publications in the package include:

- Improving hospital-based quality of care in Vietnam by reducing HIV-related stigma and discrimination.
- Safe and Friendly Health Worker Handbook.
- Set of pictures used for training the health workers.

Institute for Social Development Studies (ISDS)

Vimeco Building – Suite 19.1
Pham Hung Road - Ha Noi - Vietnam
Email: isdsvn@isds.org.vn
Website: www.isds.org.vn

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anteretroviral Therapy
ARV	Anteretroviral
ICRW	International Center for Research on Women
ISDS	Institute for Social Development Studies
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
PLHIV	People Living with HIV and AIDS
PP	Power Point
UP	Universal Precautions
VCT	Voluntary Counselling and Testing

Introduction

Overview

Welcome to the TRAINER'S GUIDE for the SAFE & FRIENDLY HEALTH FACILITY TRAINING. The guide is written for you, the facilitators of the training workshops. It will tell you all you need to know to plan and implement your own training program for staff of health facilities. This course will help the staff transform their hospital into a "safe and friendly health facility".



The Trainer's Guide is divided into FIVE chapters:

The first chapter is an introduction to the Trainer's Guide. It will explain the overall framework for the training, the participants (and how they are organised), the overall goals of the training, and some of the overall strategies used in the training.

CHAPTER A looks at HIV AND AIDS KNOWLEDGE and its link to FEAR BASED STIGMA. Its aim is to strengthen health workers' understanding on HIV transmission, treatment issues, continuum of care, and testing and counselling; and at the same time help them reflect on their own fears about HIV and how this produces stigma.

CHAPTER B introduces the concept and principles of UNIVERSAL PRECAUTIONS and then looks at each of the practical aspects of implementing Universal Precautions – handwashing, protective barriers, safe injections and sharps disposal, equipment and linen processing,

hospital hygiene, waste management, and handling occupational exposure.

CHAPTER C introduces HIV STIGMA AND DISCRIMINATION – what stigma means, different forms of stigma in different contexts (including the hospital), how stigma affects people living with HIV and their families, and its effect on the epidemic.

CHAPTER D describes the process of developing a new hospital policy to apply the new ideas on Stigma and Universal Precautions.

This Trainer's Guide is accompanied by the Safe and Friendly Health Worker Handbook, which provides basic knowledge on HIV and AIDS, Universal Precautions, as well as legal stipulations relating to HIV/AIDS, and directory of self-help groups of people living with HIV, to whom health facilities can collaborate for more comprehensive and effective care for patients, or refer their patients for support.

Background

AIDS related stigma and discrimination continues to be a pervasive problem worldwide, particularly in health care settings. People living with HIV often discover their status in these settings and this discovery is often accompanied by forms of stigma and discrimination which block them from getting effective treatment and care, and prevent them from adopting HIV preventive behaviors.

In Vietnam HIV stigma and discrimination has been recognized as an important issue and the government has taken a number of steps to confront widespread stigma:

- The Vietnamese National Strategy on HIV/AIDS to 2010 with vision to 2020 includes a target of providing “appropriate” care to 90 percent of people living with HIV and ARV medications to 70 percent of patients that need them;
- In April 2005, government issued Decree 45-2005/ND-CP which stipulates concrete punitive sanctions against institutional stigma and discrimination, such as denying someone health care due to their HIV status;
- In June 2006, the National Assembly passed an HIV/AIDS Law, which outlaws HIV-related stigma and discrimination, and recognizes all rights of people living with HIV, including the right to confidential and voluntary HIV counseling and testing.

Numerous efforts have been made in Vietnam to reduce stigma and discrimination against PLWH in Vietnam. However, there has not been a systematic approach to address these issues in health care settings in Vietnam. Institute for Social Development Studies (ISDS), International Center for Research on Women (ICRW), and the Horizons Program/Population Council have initiated a project to support and document change within the health care setting. The project draws on Horizons' experience in training hospital workers and developing codes of practice in hospitals in India, and the experience of ISDS and ICRW in conducting stigma research and implementing stigma reduction in Vietnam.

The baseline study for the project identified the following

forms of stigma and discrimination in the two pilot hospitals:

- Segregation or isolation of HIV positive patients in special wards
- Labeling of files and clothing to distinguish HIV positive patients from other patients;
- Excessive use of barrier protection methods including gloves and masks;
- Gossip/negative words by hospital staff towards and about patients living with HIV;
- Compulsory HIV testing without counseling and informed consent;
- HIV patients not being given the results of HIV testing;
- Breaches of confidentiality through sharing test results with staff and family members.

HIV stigma is often rooted in hospital workers' fears about getting HIV through casual contact, which is partly based on lack of full understanding of HIV transmission and partly related to the fear spread about HIV. According to the baseline survey, many hospital workers had fears about touching the skin or sweat of people living with HIV, serving food to people living with HIV, or changing the clothes of people living with HIV. Some hospital workers think that HIV is highly contagious and spreads through casual contact, when in fact HIV does not transmit easily and does not survive outside of the body.

Despite knowledge, fear about casual transmission leads to hospital workers trying to **“protect” themselves** by identifying which patients are HIV positive in the hospital and then minimizing contact with them. Many feel it is their right to be told who is HIV positive so they can protect themselves. Some health workers believe that not knowing who has HIV puts them at risk. Mechanisms for identifying who has HIV include: compulsory testing, putting patients living with HIV into separate rooms, marking the files of patients living with HIV, marking clothing of patients living with HIV, etc. These mechanisms are viewed as legitimate ways to protect health workers, but in fact there is no medical justification for these forms of protection. These mechanisms are forms of discrimination toward HIV positive patients – separating them from

other patients, inducing fear on the part of everyone, and causing those with HIV to be stigmatized..

The intervention project was built around two primary causes of stigma:

- fear of contagion and infection through casual contact, and
- social stigma manifested in blame, value judgments, and shame.

The project involves:

- Active involvement of hospital managers and staff in planning the whole project;
- Practical training for hospital workers on stigma and universal precautions;
- Active involvement of people living with HIV in delivering the training;

- Active involvement of hospital staff in drafting and then using Safe and Friendly Hospital Code of Practice.
- Regular monitoring of the implementation of the Safe and Friendly Hospital Code of Practice.

The project's endline study and post-intervention follow-up yielded encouraging results:

- Remarkable reduction of both fear-based and value-based stigma in all hospitals involved;
- Considerable reduction in various stigmatizing behaviors and hospital practices; and
- Changes in hospital workers' attitudes and behaviors, which contributed to improving the quality of care and treatment for HIV+ patients.



Goals, Objectives, and Approach

Overall Goals of the Training Course

- Create a safe and friendly hospital environment, one in which health workers and patients feel physically safe and psychologically safe;
- Build more respect, caring and support for people living with HIV;
- Develop the practical skills to implement Universal Precautions in a systematic way;
- Develop a code of practice for implementing stigma free practices and Universal Precautions.

Specific Objectives

- Review and update knowledge on HIV and AIDS, especially HIV transmission;
- Address fears and misconceptions about getting HIV through casual contact, and what it means to live with HIV;
- Update and expand knowledge about ART, PMTCT, PEP, etc;
- Develop practical skills to adopt Universal Precautions eg handwashing;

- Develop a deeper understanding about HIV stigma – its forms, effects and causes;
- Instill a greater understanding of HIV related issues, how stigma affects people living with HIV, and a commitment to stopping stigma

Indirect Approach of “Naming the Problem”

The training program does not “name the problem” of stigma in a challenging or criticizing way, or use the language of “stigma” at the start. A direct, confrontational approach would produce a defensive reaction on the part of health workers and block any change in attitudes. Instead the program uses an indirect approach. The overall theme for the training is introduced as “building a safe and friendly environment” for health workers and patients with HIV. Health workers are then invited to identify stigma as one of the barriers to creating a safe and friendly environment. In this way stigma is introduced indirectly – health workers don’t feel defensive and they begin to name the problem of stigma themselves and accept some responsibility for solving it. By the end of the process the health workers themselves have adopted the language of “stigma” and used it to assess their own behaviour.

Avoid Blaming Health Workers

The testimonials given by people living with HIV and discussion on stigma should avoid blaming or criticizing the health workers, or making them feel defensive about their work in the hospital. Vietnamese culture is not a culture of blaming each other – people find it very difficult to be publicly criticized. There should be no blaming – it is important to create the view that “everyone can make mistakes”. Don’t tell them they are doing “bad things” – help them analyse their practices without being judgmental.

The testimonials should use a neutral approach without saying who should be blamed, i.e. saying who was stigmatizing. Patients living with HIV should describe what happened to them - the stigma they have faced, its effect on them (e.g. feeling sad and hurt), and their views about why they are being stigmatized (e.g. “they are scared that I will give them HIV through casual contact, etc”)

Participants



PARTICIPANTS

Training should be provided for ALL staff – doctors, nurses and administrative and support staff. Hospital workers at all levels have fears about HIV and may stigmatize patients living with HIV, consciously or unconsciously. Involving everyone in training will help to build common knowledge, understanding and values, creating consensus throughout the hospital, which in its turn will make changes happen faster and more effectively.

In health facilities which have a relatively large number of staff, and need to provide services round the clock, it is necessary to divide staff into different groups for training. There are two ways for grouping.

- Integrating the different levels of staff within the training – e.g. doctors learning and sharing ideas with ward cleaners - was originally proposed as a way of breaking through hospital hierarchies and getting staff with diverse roles and responsibilities within the hospital talking together. With this form of grouping, the trainers should take care of differences in knowledge and learning capacity among participants, and make sure that everyone has a chance to participate actively. Ensure that doctors and managers do not dominate the discussions.

- Grouping the trainees according to their different professions. Using homogeneous groupings it was felt would allow the training to suit the different roles and knowledge bases of the different categories of hospital staff. This, however, doesn't help to improve the relationships and understanding between staff of different roles.

In stigma reduction projects in Tanzania and India stigma training for health facility staff was organized on a mixed basis. Each group of trainees included doctors, nurses, and support staff (including cleaners). The pilot project in Vietnam applied the other way of grouping – arranging hospital staff into training according to the type of cadre and level of exposure to HIV patients. Participants were organized into 3 groups:

- Doctors and nurses
- Auxiliary nurses (ward staff)
- Administration and support staff

Depending on the number of staff and the arrangement with the facility, the size of each training group can vary, but there should be no more than 40 participants.

People Living with HIV in the training team

Roles of PLWH in the training

The positive trainers' personal and practical experience of living with HIV and AIDS helped the health workers get a better understanding of the issues – one which was no longer theoretical, but based on practical and personal examples. For most if not all health workers it was the first time for them to relate to people living with HIV as peers and as HIV experts, rather than as patients under their care. The HIV positive trainers' knowledge and experience, skills in communication and facilitation, plus their modest attitudes and professional manner helped to make a big change in the view of health workers toward PLWH in general.

The HIV positive trainers can contribute in the following ways to the training:

- Serve as a resource person on HIV knowledge and what it is like to live with HIV;
- Serve as a resource person on the experience of HIV stigma and discrimination;
- Be a source of inspiration – as role models, as people who are getting on with their own lives and encouraging others;

In particular, PLWH can play the following roles:

- Co-trainer/facilitator;
- Trainer assistant;
- Providing testimonials.

Positive co-trainers

Criteria to select positive co-trainers:

- Members of a local support group for people living with HIV;
- Have comprehensive knowledge on HIV transmission, prevention, treatment and care, - it would be best if they have experience as a HIV counselor or caregiver;
- Have intimate understanding of the local HIV situation and lives of PLWH;
- Have skills and experience in running educational sessions on HIV/AIDS;
- Open to training participants about their HIV positive status and confident and comfortable to talk about their own situation without being overly self-conscious

Preparation for positive co-trainers:

HIV positive co-trainers should be prepared as any other members of the training team.

- They should be briefed carefully about objectives, agenda, content, method, and organization of the training;
- They should participate in detailed discussion and rehearsal of sessions in which they will take part, and help to set the objectives, steps and task assignment for each member of the training team. They should also have a copy of the detailed trainer's guide for each session;
- They should participate in the training from the start – the introduction – to establish rapport with and get to know the participants - their background knowledge and concerns – so that during the training they can address issues of concern to hospital workers.

At the start of the pilot training the assigned role of the two positive co-trainers was limited to giving testimonials. Once the workshop started, however, the two positive co-trainers made such a useful contribution to all sessions (not only the testimonial session) that their role was upgraded to full participation as co-facilitators throughout the training. The participation of these co-trainers had a huge impact on the change in attitudes on the part of the health workers and were overwhelmingly appreciated by participants. Through more than 20 trainings conducted, positive trainers have proven their unique role in the training.

Testimonial:

The positive co-trainer can share their personal experience of living with HIV. However, the testimonial on stigma in health care settings should be given by another PLWH, to keep the positive co-trainer in a neutral and objective position in his/her relationship with health worker trainees.

Number of PLWH in the training team:

For each training, it is best to have 2 PLWH in the training team: one to do some presentation, and one to be a training assistant. Both should help with facilitating the discussion and serving as resource persons. Ideally, the pair should include one man and one woman. If possible, there are more than one or two co-trainers for a training series, so that participants see that the co-trainers they work with are not the exceptional positive example of PLWH.

Fee/Honoraria:

The positive co-trainers should be paid the fee/honoraria corresponding to their contribution, as other members of the training team.

PLWH provide testimonials

Selection criteria:

- PLWH who have experience of using health facilities as a patient with HIV;
- The PLWH has a “story” to tell, whether positive or negative regarding the attitude and behaviors of health workers;
- Able to appear in front of a group and speak clearly;
- Willing to disclose their HIV status in front of the participants.

Preparation:

- Brief PLWH on the objectives of the training, and specific objectives of the testimonial.
- Ask the PLWH to focus on the event, and their own feeling, not to criticize or blame health workers.
- Ask them to rehearse their story so that the facilitator may be able to get some more details, or suggest where to spend more time or cut short.

Honoraria:

It is necessary that the training cover the costs for their transportation and food/drink as they participate in the training.

Testimonials (Stories describing their experience as people living with HIV):

The HIV positive co-trainers will give two testimonials during the training – one on “Living with HIV” during the one-day session on HIV, and one on “Stigma in the Hospital” during the half-day session on stigma. Both of these testimonials will in fact cover the issue of stigma since stigma is such a big part of the experience of living with HIV i.e. living with HIV equals living with stigma.

Encourage the HIV positive co-trainers to give their testimonials in an objective way, for example explaining their experience of being stigmatized within the hospital and how it made them feel, but without blaming, naming, or criticizing hospital staff. The aim is to avoid a situation where hospital staff feel attacked and become defensive, rather than listening carefully to the story.

One HIV positive co-trainer told a story of going to the lab for a blood test. At the lab the lab technician told her, “We don’t want to test for people like you, but we have to do it because it is our job.” After telling this story, she broke into tears. Everyone was silent – the hospital workers felt ashamed. But she did not blame the hospital staff, so they were open to reassessing how they deal with patients living with HIV who come for services, rather than being defensive.

Provide a detailed briefing for the HIV positive co-trainers before the training starts – e.g. the project objectives, details on implementation, the training agenda and content, etc. This will make it easier for them to contribute fully during the training.

Steps in Planning and Organising Training

We recommend the following steps in setting up and organizing the training program:

Step One: Introduction of the Safe and Friendly Health Facility model to the administration

If the training initiative doesn't come from the facility's administration the training organizer should meet with them to discuss their own experiences of working with HIV positive patients and the challenges they face. Introduce the idea of the "Safe and Friendly health facility" model as a strategy to overcome challenges that health facilities are facing in the era of HIV. This model was developed based on the fact that health workers usually do not feel comfortable and confident in interacting with HIV patients. On one hand the model provides necessary knowledge on HIV and patients with HIV, on the other hand it provides essential knowledge and skills to adopt universal precautions – the key approach applied globally to prevent blood-borne diseases. The training is the first step to adopt the model.

One important factor to ensure the success of the implementation is the active involvement of the administration in planning and organizing health workers to attend trainings, as well as monitoring the implementation after the training.

Step Two: Form a Steering Committee

Ask the hospital to set up a Steering Committee for the adoption of Safe and Friendly Health Facility model. This might have members drawn from the directors of the hospital, head of nursing, head of planning, head of outreach, etc. This group would help with planning and managing the training program, and monitoring the implementation of the Safe and Friendly Health Facility Code of Practice after the training.

Step Three: Conduct a Formative Study

Conduct a baseline study to assess current practices of the hospital – their feelings towards and the way they treat HIV positive patients and how they implement Universal Precautions. This study is very important because it helps the hospital begin to recognise some of the limitations in their current practices – and this is a useful motivation for the whole training program. This information will also be useful to you as trainers, because it will help you focus the training on the specific hospital practices that need improvement.

An example of information need to be collected during the formative study is on the following page.

Step Four: Present and Discuss the Results of the Formative Study

Explain the results of the baseline study to the Steering Committee. This will help them become more aware of hospital practices which are stigmatizing or infection control practices which actually put themselves or others at risk.

Step Five: Agree on the Arrangements for the Training

Meet with the Steering Committee to plan the training program – what is to be covered, the duration and schedule of the program, and how to divide up hospital staff for the trainings.

Step Six: Identify and Orient HIV Positive people who will assist with the training

Meet with support groups in the same town as the hospital and identify co-trainers, training assistants and people who provide testimonials and prepare them for the training. (See session above People with HIV in the training team).

The model is described in detail in the report "Improving quality of care in Vietnam hospital through reducing HIV-related stigma and discrimination", enclosed in the same package with this manual.

Step Seven: Conduct the Training Program and Development of New Code of Practice

Conduct the training program, including the sessions to develop a new code of practice.

Step Eight: Support the Steering Committee on Implementing and Monitoring the Implementation of the Code of Practice

- Encourage the Steering Committee to lead the implementation of the Safe and Friendly Health Facility Code of Practice.
- Introduce them to the Monitoring Checklist, revise the checklist to fit the real situation (if necessary) and train them in using the checklist for monitoring the implementation.



Training Sections and Modules

The training program is divided into the following sections, which correspond to the four chapters. Within each section there are a number of modules:

SECTION A: HIV AND AIDS BASIC KNOWLEDGE

Duration: half a day

Modules:

- Personal experience with HIV/AIDS
- Who are infected?
- Basic Knowledge on HIV and AIDS
- Living with HIV and AIDS – Testimonials

SECTION B: UNIVERSAL PRECAUTIONS

Duration: one day

Modules:

- Hospital infection and Principles of Universal Precautions
- Handwashing
- Protective Barriers
- Safe usage and disposal of sharps
- Equipment Processing
- Linen Processing

- Hospital Hygiene
- Safe Medical Waste Disposal

SECTION C: HIV STIGMA AND DISCRIMINATION

Duration: half a day

Modules:

- Naming Stigma Through Pictures
- What is the Meaning of Stigma
- Overview of Stigma in the Health Care Setting
- Naming Stigma in the Hospital – Forms and Causes
- How It Feels to be Stigmatised – Testimonials

SECTION D: POLICY DEVELOPMENT

Modules: one day

PART 1: GROUP WORK: half a day

- Introduction of Law on HIV/AIDS Control and Prevention
- Policy Development – Group Work

PART 2: ASSEMBLY: half a day

- Policy Development – Hospital Meeting
- Finalization of Code of Conduct



How to Use the Modules

The Trainer’s Guide consists of a number of training modules or session plans - detailed, step by step descriptions of how to run each session in a workshop. Each module consists of the following components -

OBJECTIVES	What trainees will KNOW or be able to DO by end of the session
TIME	Estimated amount of time needed for the training session
MATERIALS	Case studies, pictures, exercises, etc which are used during the training session
STEPS	Detailed description of the learning activities and training methods listed step-by-step, along with the training content.

“STEPS” are a detailed description of how to conduct each learning activity, one “step” at a time. “Steps” includes information on:

SUB-TOPICS	The sub-topics covered within the session
METHODS	Discussion, brainstorming, cardstorming, demonstration, practical exercises, role playing, case studies, picture discussion, etc
GROUPS	Buzz or small groups – suggestions on group size and tasks
QUESTIONS	Specific questions used to guide discussion – presented in italics
RESPONSES	Examples of responses to the questions – presented in boxes. These are only examples – they are not the required output.
REPORT BACK	Suggestions on how to organise “report backs” after discussion
SUMMARIES	Points to be emphasized in a summary at the end of the session

Participatory Learning

As a trainer we have to remember that:

Participants remember
 only 20% of what they **hear**,
 50% of what they **hear & see**,
 but 90% of what they **DO!**

The Vietnamese say: “Hundred times of hearing is not as effective as one watching” and “Hundreds times of watching is not as effective as one... touching”.

Health workers are not used to participatory learning –

- The norm for training is the lecture – one way communication. This is what is expected. Health workers are used to a teaching approach where a lecturer tells them what to do and they sit back and listen. They look to trainers for answers to problems, rather than trying to find solutions themselves.
- Their main experience of learning is the formal education system which uses one-way information delivery, rather than challenging people to think critically.
- Their own work context is a top-down system with senior people (doctors) telling others below them what to do, rather than two way dialogue/discussion.
- Some may come thinking that all they need is infor-

mation on the problem, rather than hands-on grappling with the issues.

- It is painful to push them into participatory learning, but if you don't push they will sit there passively and simply wait for you to tell them what to do – what is right or wrong.

At the start of the training program explain the importance of a participatory process – the need for health workers to understand the issues through a practical, hands-on process of sharing ideas with other health workers, discussing and analyzing issues, and doing joint planning. We are looking for an active form of learning in which participants learn not only through lectures but also through discussion. The aim is to develop a new set of attitudes and procedures to create a safe and friendly hospital – and everyone's views are needed to agree on how to do this. This is why the training process emphasizes active participation of everyone.

Explain that making the hospital safe and friendly is not just a matter of digesting facts. There are also feelings and attitudes involved. This is why we need a participatory approach which helps people talk openly about their feelings and attitudes, and understand how it feels to be stigmatized.



Participatory Training Methods

Here are some ways to make your training more participatory and fun!

DISCUSSION is the most important method. All of the sessions will be built around discussion. Discussion gets trainees to learn actively through talking and sharing ideas with others, and interacting with the trainer.

PRESENTATIONS should be short, clear, and interesting. Trainees should be able to hear and understand what you say. Look at your audience, speak clearly, avoid too much technical jargon, and relate what you say to participants' own experience. Include questions to keep people involved.

SMALL GROUPS get everyone involved. Some trainees feel shy in a large group but in a small group they find it easier to talk. Small groups make it easier for people to share ideas and learn from each other.

BUZZ GROUPS - 2 people sitting beside each other - are a trainer's secret weapon! They generate instant participation. It is hard to remain silent in a group of 2 people.

CASE STUDIES and ROLE PLAYS will be used to present the real situation in the hospital as a focus for analysis and problem solving.

PICTURES will also be used to show the stigma faced by people living with HIV. This helps participants begin to recognise stigma in the family, community, and hospital

TESTIMONIALS are real stories given by people living with HIV about their own lives. This helps participants get an understanding of the real issues they face, including stigma.

QUIZ is a set of questions assigned to individuals or groups of participants. The questions spark interest in a new topic and assess what participants know already about the topic.

PRACTICE SESSIONS will give trainees a chance to try out the skills eg how to do effective handwashing, how to interact effectively with patients living with HIV, etc.

ROTATIONAL BRAINSTORMING This method generates ideas quickly and helps to maximize participation. Divide into small groups and give each group a starting topic. Each group records points on its topic on flipchart - and after 3 minutes moves to a new topic and adds points. During the exercise groups contribute ideas to all topics.

CARD-STORMING This is another technique to get out ideas quickly and get everyone involved. Participants divide into pairs or trios and are given cards. They write single points on each card and tape the cards on the wall. Once everyone is finished, the cards are organised into categories and discussed.

Power Point Presentations, and Health Worker Handbook

POWER POINT PRESENTATIONS

The toolkit also includes power point presentations on a number of the topics. This will help you with your presentations. These include key points to explain things or trigger discussion.

SAFE AND FRIENDLY HEALTH WORKER HANDBOOK

All health workers will receive a “Safe and Friendly Health Worker Handbook”. This booklet is written in simple language and provides basic information on HIV, prevention and treatment, universal precautions and AIDS law. It provides additional reading material to supplement what health workers have learned from the workshops.





Tips for Participatory Trainers

BE WELL PREPARED

- ❑ Plan each of the sessions before the training so you are well prepared.
- ❑ Bring all materials – training manual, flipchart paper, markers, cards, etc.
- ❑ Arrive early so you are ready to welcome participants when they arrive.

PREPARE THE ROOM

- ❑ Remove tables to make room for 'doing' and make training more informal.
- ❑ Set up the meeting space in a semi-circle - check that all can see the flipchart.
- ❑ Put up flipchart paper on the front wall for recording discussions.
- ❑ Prepare some tables ready for group work.
- ❑ Set up a separate table for markers, masking tape, cards, etc.

MAKE TRAINEES FEEL COMFORTABLE

- ❑ Break the ice and put participants at ease at the start of the workshop.
- ❑ Learn their names, be informal, use games, or buzz groups.

FIND OUT WHAT TRAINEES REALLY NEED TO LEARN

- ❑ What may catch their attention?
- ❑ What do they really need to know or do? What skills are they weak in?
- ❑ What new knowledge or skills would really make a difference to their work?
- ❑ What are some of the problems they are facing in their work?

ASK QUESTIONS AND LEAD DISCUSSION

- ❑ Ask simple, open questions that allow people to give their opinions.
- ❑ Fish for contributions - use your hands and body to encourage participants.
- ❑ Wait for responses. Give people time to think and come up with an answer.
- ❑ Encourage everyone to talk. Buzz groups get everyone talking.
- ❑ Keep asking questions - "Who would like to add to that?"
- ❑ If there is no response, rephrase the questions.
- ❑ Show that you are listening and are interested.
- ❑ Praise responses to encourage participation.
- ❑ Rephrase responses to check you understand.
- ❑ Redirect to involve others - "He said..... What do others think?"
- ❑ Summarize and check agreement before moving to the next question/topic.

USE SMALL GROUPS TO BUILD PARTICIPATION

- ❑ Give a clear explanation of the group task, time, and reporting method.
- ❑ If the task is difficult, write the task on flipchart so that everyone is clear.
- ❑ Keep changing the groups so trainees work with different people.
- ❑ When trainees move into groups, go around to check they understand the task.
- ❑ Use "Round Robin" to make report backs more interesting and efficient.

KEEP PRESENTATIONS SHORT AND SIMPLE!

- ❑ Speak slowly, clearly, and loud enough.
- ❑ Look at people and use your hands and body to emphasize points.
- ❑ Keep it short and simple - no more than 15 minutes. Only explain the basics.

DEMONSTRATE NEW SKILLS AND LET EVERYONE PRACTICE

- ❑ Demonstrate one step or skill at a time. Describe what you are doing.
- ❑ Go slowly and check that everyone can see and hear what is happening.
- ❑ After the demonstration allow enough time for trainees to practice the new skill.
- ❑ Use small groups for practice sessions. Organise feedback in each group.

KEEP CHANGING YOUR METHODS

- ❑ Use different methods for different topics to keep things interesting.
- ❑ Use different sizes of groups - don't "buzz" in pairs all the time - try trios or 4s.
- ❑ Change the space – use different spaces in the room

CHECK THE ENERGY LEVEL

- ❑ Observe body language. Do they look bored? sleepy?
- ❑ Ask "How are you feeling? Is it time for a break?"
- ❑ Change the topic, take a break, or do a wake-up game.

WATCH THE TIMING AND PACING

- ❑ Be time conscious. Decide how much time you need for each session.

- ❑ Remember - small group work takes more time than you expect. You will also need to allocate time for report backs.
- ❑ Don't go too fast. Let the group help you set an appropriate pace.
- ❑ Give groups enough time to do their work. Don't rush them.
- ❑ Do small group work in the afternoon when the energy level drops.
- ❑ Don't forget to take breaks to relax, get drinks, and talk informally.
- ❑ Close on time! Don't drag things on forever at the end of the day.

EVALUATE THROUGHOUT WORKSHOP

- ❑ Evaluate as an ongoing activity - not just at the end of the workshop.
- ❑ Organise a short evaluation at the end of each day - or on the following morning get participants to review what was learned.
- ❑ Assess a) what was learned and b) how the learning was done.

TEAM FACILITATION

- ❑ Plan and conduct the workshop together and debrief it afterwards.
- ❑ Take turns in the lead facilitation role and as the flipchart recorder.
- ❑ Support each other. If one runs into trouble, help him/her out.

Chapter A

Basic HIV and AIDS Knowledge

Introduction

A limited understanding about how HIV is transmitted can lead to fears about getting HIV through casual contact. According to the baseline survey, many hospital workers had fears about touching the skin or sweat of HIV positive patients, serving food to HIV positive patients, or changing their clothes. Some hospital workers think that HIV is highly contagious and spreads through casual contact, when in fact HIV does not transmit easily and does not survive outside the body for long.

Fear about casual transmission leads to hospital workers trying to “protect” themselves by identifying which patients are living with HIV and then minimizing contact with them. They feel it is their right to be told which patients are HIV positive so they can protect themselves; and many think that not knowing which patients have HIV puts them at risk. Mechanisms which health workers have put into place to identify who has HIV include: compulsory testing, putting patients with HIV into separate rooms, marking the files or clothing of HIV positive patients, etc. These mechanisms are viewed as legitimate ways to protect themselves, but in fact there is no medical justification for these practices. These practices are a form of discrimination towards people living with HIV – separating them from other patients and inducing fear on the part of everyone.

This section of the training program will help health workers understand that they don’t need to take these extra precautions – and it will help to reduce their fear.

The actual likelihood of transmission through casual contact or even through occupational exposure is very low. For example in Vietnam as of the end of 2006 there had been no recorded cases of HIV transmission through occupational exposure to infected blood or bodily fluids.

Survey data from the four pilot hospitals indicates that some health care workers have a limited understanding about what happens to a person after they become infected. Some assume that those with HIV will die quickly and don’t fully

understand that they can lead a long life if they take care of themselves and get proper treatment and support.

Fear of transmission in the health care setting comes from the fear in the population in general, that AIDS is not curable. However, HIV/AIDS nowadays has become a chronic health problem, which is manageable, and it is possible to live a normal life, for many years. As such, from a medical perspective, HIV/AIDS is similar to other chronic health problems such as diabetes or hypertension – that patients have to take medicine for the rest of their lives, but they can still live healthy and productive lives.

On the other hand, there is an assumption among health care workers and the general population that people infected with HIV are bad – that they are drug users or sex workers or promiscuous. In fact, the majority of new HIV infections in Vietnam over the last few years are no longer belonging to drug users or sex workers.

This chapter includes a set of basic modules, which:

- a) help to personalise and internalise the issue of HIV and AIDS
- b) help health workers understand that HIV is now a generalised epidemic affecting the whole population (and no longer restricted to high risk groups)
- c) provide factual information on HIV transmission to help respond to their fears
- d) help them understand how it feels to be living with HIV – through testimonials

Modules

BASIC MODULES

- A1. Personal Experience of HIV and AIDS**
- A2. Who Gets HIV?**
- A3. Basic HIV and AIDS Knowledge**
- A4. Living with HIV and AIDS – Testimonials by People Living with HIV**

A1. Personal Experience of HIV and AIDS

Facilitator's Notes: This is an optional exercise to help participants talk about their own personal experience of HIV and AIDS. The aim is to help health workers look at how HIV and AIDS affects them personally – how they feel about people living with HIV and how they feel about the idea of being infected themselves. This is also an opportunity for participants to discuss with their colleagues about their experiences and feelings.

It requires a lot of trust and openness within the group. Usually after one person has started to share, other people will feel more at ease. If this module is successful, then it will be easier to conduct other modules because a trustful atmosphere has been created. One way to get participants started is by the facilitators sharing their own experiences and feelings first.

Sharing one's experience is voluntary. No one should be forced to give their stories. Encourage group members to listen carefully to each other's stories.

Set an intimate and private atmosphere. Try to minimize outside interference (big noises from outside, people watching...).

The exercise can be very emotional for some participants. Participants are being asked to think and talk about strong feelings. You should be ready to deal with the emotions raised.

Objectives: By the end of this session, participants will have:

- a) Explored their feelings and attitudes about how HIV and AIDS has affected them personally and professionally
- b) Developed empathy for people living with HIV by imagining how they would feel if they were infected
- c) Examined how fears about HIV and AIDS can affect the quality of care for patients

Time: 45 minutes

Materials: List of questions on flipchart

Steps:

REFLECTION AND SHARING IN SMALL GROUP. Divide into groups of three people. Ask participants to form groups of people who know each other very well and are comfortable with each other because the sharing is very personal. Read out the questions below – one by one. After each question ask participants to reflect on their own for 1-2 minutes – and then share feelings within their groups. Emphasize that no one has to share his or her thoughts unless he or she feels comfortable.

Question 1: How did you feel when you first saw or treated a person living with HIV?

Probes: When did you first see or have contact with a person living with HIV? In which circumstance? What did you think about that particular person? How did you treat him/her?

Question 2: How do you treat HIV positive patients in your hospital?

Probes: How different from other patients? Why?

Question 3: How would you feel if you discover that you are infected with HIV?

Probes: What would be your reaction? How would you like people in your family, your community, your colleagues, friends, and other health workers to treat you?

SHARING IN BIG GROUP. When the small groups have finished sharing, invite a few participants to share their experiences in the large group – but this is voluntary.



Examples from training workshops in July 2006 and March 2007

How did you feel when you first saw or treated a person living with HIV?

Frightened. Shocked. Confused.

Most of them have promiscuous behaviors or lifestyles. Some are victims.

About 10 years ago people living in my street spread a rumour that one neighbour was HIV positive. He was very thin and sick. I felt very sorry for him because he had been a handsome, healthy man. Everybody tried to avoid him. I told my kids not to play in front of his house. I was afraid that they could upset him and he might intentionally infect them.

In 1995 we had a patient who had pneumonia and was very thin. We treated her for few days, but there was no improvement. Then the police came and asked for her. Soon after the police arrived, she disappeared. The police told us that she was infected with HIV. Everybody in my department was shaking because we had all treated or cared for her. I could not sleep for many days. I was afraid that I could be infected because I examined her many times without wearing any gloves.

At the Obstetric Department, we had our first HIV patient in 1998. Everybody panicked and tried to hide, so they could avoid delivering the woman's baby.

A close friend of mine found he was HIV positive a few years ago. I tried to avoid him. If we happened to be in the same table in a party, I would find an excuse to leave the party earlier than him. I was afraid that if he touches me and his skin has cuts and there are cuts on my skin, that he might give me HIV. One time, after we both drank a bit, he put his hand on my shoulder while we were walking. I was so afraid. I pretended that my shoelaces needed to be tightened so I could bend down and he had to let go his hand.

I remember the first time we had an HIV patient here. He was very sick. But his family abandoned him. He was by himself. Everybody was afraid of him. When he asked other patients to give him water to drink, nobody came to help him.

How do you treat HIV positive patients in your hospital?

Very careful. I am afraid, alert, and cautious. I am nervous but I try to behave normally.

I feel sorry, but I don't sympathize. I feel sorry for those in the last phase of the HIV illness. I try to isolate the patient.

I avoid direct contact. I put on more gloves, wear goggles, mask.

I share with them what I know about HIV/AIDS. I treat them like other patients.

How would you feel if you are found to be infected with HIV?

Horrified. Shocked. Cannot imagine it. Fear of being stigmatised. Fear of death.

If I get HIV due to occupational exposure, I would like it to be announced on the radio and TV so that my family will not be stigmatised. If I get HIV through other routes, I will keep it a top secret. It is not only to protect myself – it is also to protect my family.

I was preparing for a surgery last year and I knew they were going to test me for HIV. I was afraid I might be positive

so I went for a test beforehand. If the results were positive, then only I would know the result, instead of the whole hospital knowing. After my blood was taken, I sat in a café near the testing centre. I sat so still that I could count 147 drops of coffee coming out of the filter. As those drops fell into the cup, I increasingly thought myself stupid for going to the testing center. I asked myself - What would happen if I am positive? My reputation would be ruined. My daughter could not get married. No patient would want to see me any more. Colleagues would try to avoid me.

Summary

- HIV and AIDS is an emotional issue because HIV and AIDS are associated with death, sex, and other taboos. Health workers do have feelings as any ordinary person. It is therefore understandable that health workers feel worried, confused or do not sympathize with persons living with HIV.
- It is a health worker's right to be protected and to be safe while providing care to patients.
- Fears about getting HIV through accidents in the workplace and feelings toward patients can increase health

workers' stress levels and affect their performance, if not addressed adequately. Health workers should be aware of this because patient's health and even life is in our hands. It is important to address our personal feelings, reactions and attitudes.

- On the other hand, it is our professional duty to ensure that our personal feelings, thoughts, and attitudes do not affect the quality of care we provide to patients.

This module is borrowed and adapted from: **Reducing HIV Stigma and Discrimination: Training for Health Care Providers (Engender Health, 2004)**

A2. Who Gets HIV?

Facilitator's Note: Many people in Vietnam, including health workers, still think that HIV only affects high risk groups such as injecting drug users and sex workers. This module helps participants understand that HIV has moved beyond this stage – it now affects the general population, not just high risk groups who, at present make up only one third of those living with HIV. So health workers should no longer assume that anyone with HIV is a drug user or sex worker – and stop stigmatizing HIV positive patients as “socially evil”.

Objectives: By the end of this session participants will be able to:

- a) Recognise that it is not only drug users and sex workers who get HIV but the majority of people who are living with HIV are “normal people”.
- b) Give the number of people infected with HIV in the world, Vietnam, and their own province, and the proportions who are IDUs, sex workers, and others.

Time: 45 minutes

Materials: Powerpoint presentation on demographic characteristics of HIV epidemic.

Steps:

1. Full Group Discussion: Ask -

- a) *Who are the people living with HIV that you come into contact with through your work in the hospital?*
- b) *Which group accounts for the majority of people living with HIV as you see them?*

Record responses on flipchart. Encourage everyone to respond by asking, “*What is your experience? Have you met the same type of people living with HIV?*”



Who are the people living with HIV that you have come into contact with?

Drug users. Wives of drug users. Beautiful women. Women who worked in Cambodia as sex workers. Children of drug users. Mobile construction workers. Policemen. Soldiers.

Who are the majority of people living with HIV?

Drug users. Women who get HIV from their husbands. Sex workers who have returned from Cambodia

Summarize: Read out the lists on the flipchart and then say –

“You have made a list of people living with HIV whom you have seen as patients in your hospital, or in some cases in the community. Do you think all people living with HIV are the same type of people as those you have just described?”

Then say (whatever the response): *“We will now look at the actual numbers of people infected with HIV in this province, in Vietnam and in the world to see if you have fully described the types of people living with HIV”.*

2. Group Discussion: Divide into three groups and assign each group one question. Ask each group to discuss the question and prepare a short presentation on flipchart (10 minutes).

Group A: *Approximately how many people are living with HIV in the world?*

Which groups in the population account for the majority of them?

Group B: *Approximately how many people are living with HIV in Vietnam?*

Which groups in the population account for the majority of them?

Group C: *Approximately how many people are living with HIV in this province? Which groups in the population account for the majority of them?*

Report back – flipchart presentations by each group. After each group presents, leave 2-3 minutes for reactions from other participants.



How many people have HIV and who gets HIV?

(Participants' responses – Training, March 2007)

Group A - The World

- 33 million people. Sex workers - 50%, drug users - 30%, health workers - 10%, others - 10%
- Some millions. Most are injecting drug users, homosexuals, sex workers, and a few victims.
- Some ten millions. The majority are long distance truck drivers.
- 13 million. Drug users - 40%, sex workers - 20%, others - 40%
- Over 800.000. Sex workers - 50%, drug users - 30%, others - 20%
- Promiscuous people - 50%
- Over 100 million.

Group B - Vietnam

- 283.000. Drug users - 70%; sex workers - 20%; health workers - 10%
- Around 120.000. Sex workers, clients of sex workers, occupational exposure e.g. health workers and policemen, trash collectors, drug users, and mobile workers.
- 200.000. Sex workers - 40%, drug users - 40%, others - 20%
- Don't know the statistics. Probably many. Sex workers - 30%, drug users - 30%, others - 40%
- Drug users - 60%, sex workers - 30%, promiscuous - 10%

Group C - Can Tho Province

- 5.000 - 6.000
- 3.000. Sex workers - 40%; drug users - 30%; others - 30%
- 1,500 – 2,000. Drug users, sex workers, and others.
- 160 – 170. Sex workers, drug users, wives infected by husbands, soldiers.
- 90 – 95% are drug users and sex workers.

3. Powerpoint presentation and plenary discussion

A 10 minute presentation on the HIV situation in the world, Vietnam and the host province, followed by 10 minutes discussion help to clarify points through discussion.

Powerpoint presentation:

Part 1. HIV in the world

Slide 1: Number of PLHIV in the world. Present the graph showing the number of PLHIV throughout the years. In 2007, there were about 33,2 million PLHIV in the world. In that year, 2,5 million people got infected, 6,800 people every day.

Slide 2: Number of people who die of AIDS throughout

the years. Present the graph. In 2007, an estimated 2.1 million people died of AIDS – or 5,700 people every day. This is equivalent to the total deaths during 20 years of war in Vietnam which involved the USA.

Slide 3: HIV infection and AIDS deaths in South and South East Asia. In 2007 there were about 4 million PLHIV in the region, 340,000 were newly infected and 270,000 people lost their lives from AIDS. The epidemic is being curbed in some countries but is still rapidly spreading in Vietnam.

Slide 4: The most affected group: This varies by region and country. In many countries of Eastern Europe and South East Asia, IDUs account for the majority of PLHIV. In sub-Saharan, the majority of PLHIV are “normal” heterosexual people and more likely to be women. In North

and South America gay men are the largest group of PLHIV.

References: HIV Epidemic Updates. UNAIDS. This can be found on UNAIDS website in the link below or at your country's UNAIDS office. In the web link below, you can also find ready-made powerpoint slides on the global epidemic.

<http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2007/default.asp>

Part 2: HIV in Vietnam

Slide 5: Number of PLHIV in Vietnam throughout the years. Present the graph. It is estimated that there were around 293,000 PLHIV in Vietnam in 2007. Around 100 people got infected every day – or one person every 15 minutes. Vietnam is one of the countries in Asia where the epidemic is rapidly spreading.

The number of people who had been tested and found positive in Vietnam by the end of August 2007 were over 132,000.

Note: The presenter should explain to participants that there are two kinds of data on HIV: the reported and estimated and projected data: Reported data only counts those who were actually tested. There are large numbers of people who are HIV positive but have not tested. The numbers presented on the media are usually reported data.

Slide 6: Estimated deaths for AIDS in Vietnam. Present the graph of deaths for AIDS throughout the years. It is estimated that in 2005, about 14,000 people died of AIDS, 40 persons every day. In 2004 and 2005, AIDS was the second major cause of deaths in hospitals.

Slide 7: HIV infection in the general population. Show the table estimating prevalence in different regions. The national prevalence is about 0,53% and the epidemic in the country as a whole is a concentrated one (concentrating on some vulnerable populations such as injecting drug users) but in some provinces, such as Quang Ninh, Hai Phong and Ho Chi Minh city, the prevalence has already reached over 1% - the level of a generalized epidemic.

Slide 8: Who are infected in Vietnam? The injecting drug

population is the most severely affected – almost 1/3 are living with HIV. However, the share of IDUs among total PLHIV is changing. Among the new infection cases, the majority of those infected are due to sexual transmission. Most of the people who are newly infected are not injecting drugs or selling sex. By the end of 2006, no health worker had been found infected with HIV due to occupational exposure.

References:

HIV/AIDS estimates and projection 2005 – 2010. Ministry of Health. Available online at

http://unaids.org.vn/resource/topic/epidemiology/e%20&%20p_english_final.pdf

Health Statistics Yearbook 2004, 2005. Ministry of Health. Summary of the HIV epidemic in Vietnam. September 2006. UN in Vietnam. Available online at http://unaids.org.vn/facts/docs/key_messages_sep_2006_e.pdf

Part 3: HIV in the province

Note: Try to collect both reported and estimated and projected data.

Slide 9: HIV infection in the province. Present a graph or table estimating the number of PLHIV in the province.

Describe the trend and highlight the new infections.

Slide 10: In the province, who are infected? Present and analyse a table or graph of PLHIV by population.

Questions to stimulate reaction:

- What do you think about these data? Do they surprise you? In which way?*
- Do they reflect the situation as you see it in your own daily life and work in this health care facility?*

When participants raise questions, encourage other participants to respond first, and then add your own information.

Summary:

Most people think that only drug users and sex workers get HIV. This is partly due to the fact that at the beginning

of the epidemic, almost 20 years ago, these two groups were the most heavily affected by the epidemic. It is also partly due to the IEC campaigns which in the past have focused heavily on these two groups.

However, the impression that IDUs and sex workers are the only groups at risk of getting HIV gives people a false sense

of immunity, making them think that they are not at risk. The truth is that HIV has spread beyond the groups we called “high-risk”. Now the majority of people living with HIV (roughly two thirds of the Vietnamese population) are neither drug users nor sex workers. As health facility workers, we will see more and more of these people – people who have no involvement in drugs or sex work.

Examples of Common Statements by Participants - and How to Respond

We always hear that it is drug users and sex workers who get HIV.

Explanation: Sex workers and drug users, due to particular behaviors associated with their lifestyle, are truly at higher risk of being infected. At the beginning of the epidemic in Vietnam, it was true that drug users accounted for the majority of infections. However, as the epidemic grows, it is no longer the case. Although the prevalence among drug users and sex workers is higher than the general population, the size of their population is small compared to the size of the “general population”. Therefore, once the epidemic starts to spread to the general population, the number of people infected among the general population can be higher than the number of those who inject or sell sex.

Almost all people known to be living with HIV in hospitals and in the community are drug users or their wives and children.

Explanation: Ask: *“If you know that you have HIV, will you go to a hospital in this town to get medical care?”* Participants’ response - *“No, I am afraid that other people will know and will stigmatize me.”*

Then ask, *“Who come for services in this hospital? Who cannot hide their HIV from the community?”*. Participants’ response: *“Drug users and their families because it is difficult to hide when someone is addicted, and they are heavily stigmatized already.”* *“They are poor and don’t have money to go anywhere other than the nearest hospital”*.

If they are not IDUs or sex workers, they must be promiscuous men who are infected by sex workers so they are bad anyway.

Explanation: Ask, *“Were sex workers born with HIV? From whom did they get HIV?”*. Participants’ response: *“From clients”*.

Ask - *“Among a group of 10 men, how many have had sex with someone other than their wives?”*. Response: *“All”, “9”, “9.5”*.

Then ask, *“Is it possible that all men are bad?”*

I have a friend who is a company director and he is infected with HIV. He is a very good person, very kind, very responsible. But he is so afraid of being stigmatized that he doesn’t dare tell anybody, even his family. He told his wife that he has too much work and no interest in sex any more to avoid having sex with her because he is afraid that he will infect her. I thought he is a rare case”.

(Training, March 2007).

A3. Basic HIV/AIDS Knowledge

Objectives: By the end of this session, participants will be able to:

- a) Explain in detail the conditions under which HIV is transmitted
- b) Deepen their understanding on HIV and AIDS

Time: 90 minutes

Materials:

Write down the questions below on small pieces of paper, ideally using different colors, one question per piece. Prepare enough pieces for each participant.
Powerpoint presentation.

Steps

1. Opening quiz:

Ask each participant to select one piece of paper with a question and think about the response. Clarify the question to those who need it.

Quiz:

- 1) What are the conditions for a person to be infected with HIV? For the same exposure why are some people infected, and some are not?
- 2) How could we know if a person is HIV positive or not? If a person tests negative, does it mean he does not have HIV? Why?
- 3) How does HIV affect the body? How does HIV cause AIDS?
- 4) For how long can an HIV positive person live? Is it possible to live a normal life once infected with HIV?
How to treat HIV and AIDS?
- 5) How is HIV transmitted in health facilities? How can we prevent HIV transmission in health facilities?

Ask participants who have the same question to get together and discuss the response for about 10 minutes.

2. Report back:

Write all 5 questions on a flipchart, put it up and read out loud all the questions. It is important to ensure that all participants understand all five questions before groups share their response. It helps to engage their interest in the whole subject, not just the question their group is dealing with.

Allow each group 2-3 minutes to report back. After each group's presentation, invite participants to ask questions or make comments. Facilitators should clarify any misconceptions or inaccurate information, but save their main presentation to the powerpoint presentation.

Participants' responses – Training in March 2007

How is HIV transmitted in health facilities?

Through blood transfusion or injection. Through patient's fluids such as vomit, urine.
Because health workers don't wear gloves or gloves are punctured.

How to prevent HIV transmission in health facilities

Screen patients for HIV. Always wear gloves and other protective barriers such as goggles and mask. Avoid contact with patient's fluids.

Reactions of the facilitator:

The facilitators recognized that three points needed to be discussed: a) bodily fluids that can transmit HIV, b) screening patients for HIV, and c) the use of protective barriers. Facilitators invited comments on the group's presentation, focusing on these three points. Discussion led to common correct knowledge and consensus among participants.

Powerpoint presentation

The presentation covers many aspects of HIV knowledge. However, the facilitator should present only those slides which are needed to respond to gaps in participants' knowledge. Some slides can be skipped while some issues will need to be elaborated and discussed.

Some points may deserve attention

“Window period”: the person has already been infected with HIV but the test result turns negative. This period is very important in term of transmission as the viral load is significantly higher than the asymptomatic period, the person is completely healthy and the test result is negative. In this period, the person is very infectious.

HIV screening of patients in order to “protect health workers” – a practice used by many hospitals, will lead to carelessness towards patients who test negative, some of whom may be in the “window period” and very infectious. The most effective strategy to prevent HIV transmission in health facilities is to practice universal precautions – being cautious with blood and bodily fluids of all patients as if all of them have HIV.

“Essential and sufficient conditions” for HIV transmission. Explain the three conditions, and emphasize that only when all three conditions are met will transmission occur. Prevention of HIV is to prevent each of these conditions. It is like “breaking the link”.

Contents of the powerpoint slides

Note: The following is a description of each slide. However, trainers should only present the key points and avoid putting too many words in a slide, which may distract participants as they would try to read the slide and not listen to the trainer.

1. Basics about HIV and AIDS

Slide 1: What is HIV?

Human Immunodeficiency Virus. HIV is a

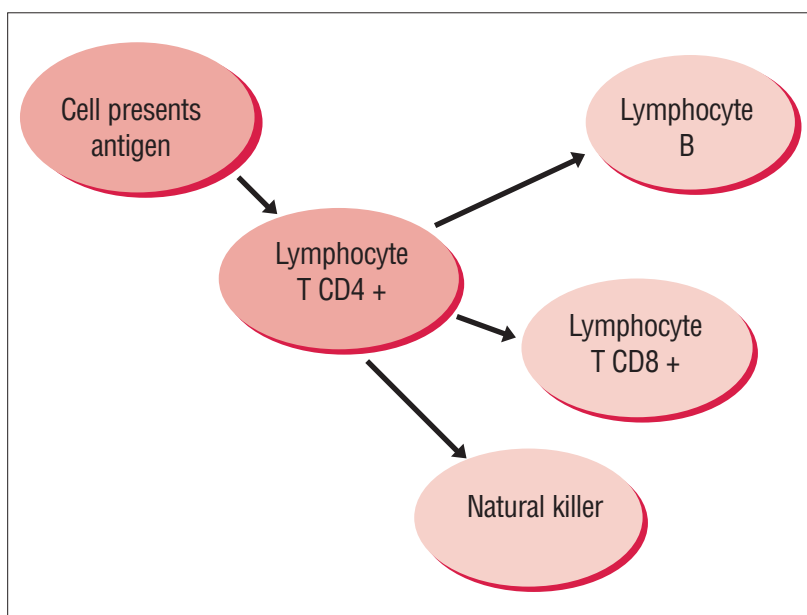
retrovirus: this means having a reverse transcriptase to produce RNA from DNA, i.e. having to use the host cell's machinery to reproduce

Slide 2: What is AIDS? Acquired Immune Deficiency Syndrome, caused by HIV. The last phase of HIV infection. A PLHIV is said “to have AIDS” when s/he starts to get some specific opportunistic infection (e.g. TB), or the CD4 count in blood is below 200 cells/mm³.

Slide 3: CD4 and immune system. Present the following diagram. When a germ enters the body, the immune system will analyze it. The antigen producing cells will form a lympho T cell, named CD4 around the construct of the germ. The CD4 will mobilize an appropriate immune response to fight against the germ. For that, CD4 is called “the chief orchestra of the immune system”.

2) Natural progression of HIV

Slide 4: How does HIV harm the body? Because a CD4 cell has a receptor for HIV, HIV can infuse into the cell. HIV uses the CD4 machinery to reproduce and eventually destroy the cells. Therefore, the amount of CD4 cells in the human body decreases with the progression of the infection. Without CD4 cells, the body's immune cells are not coordi-



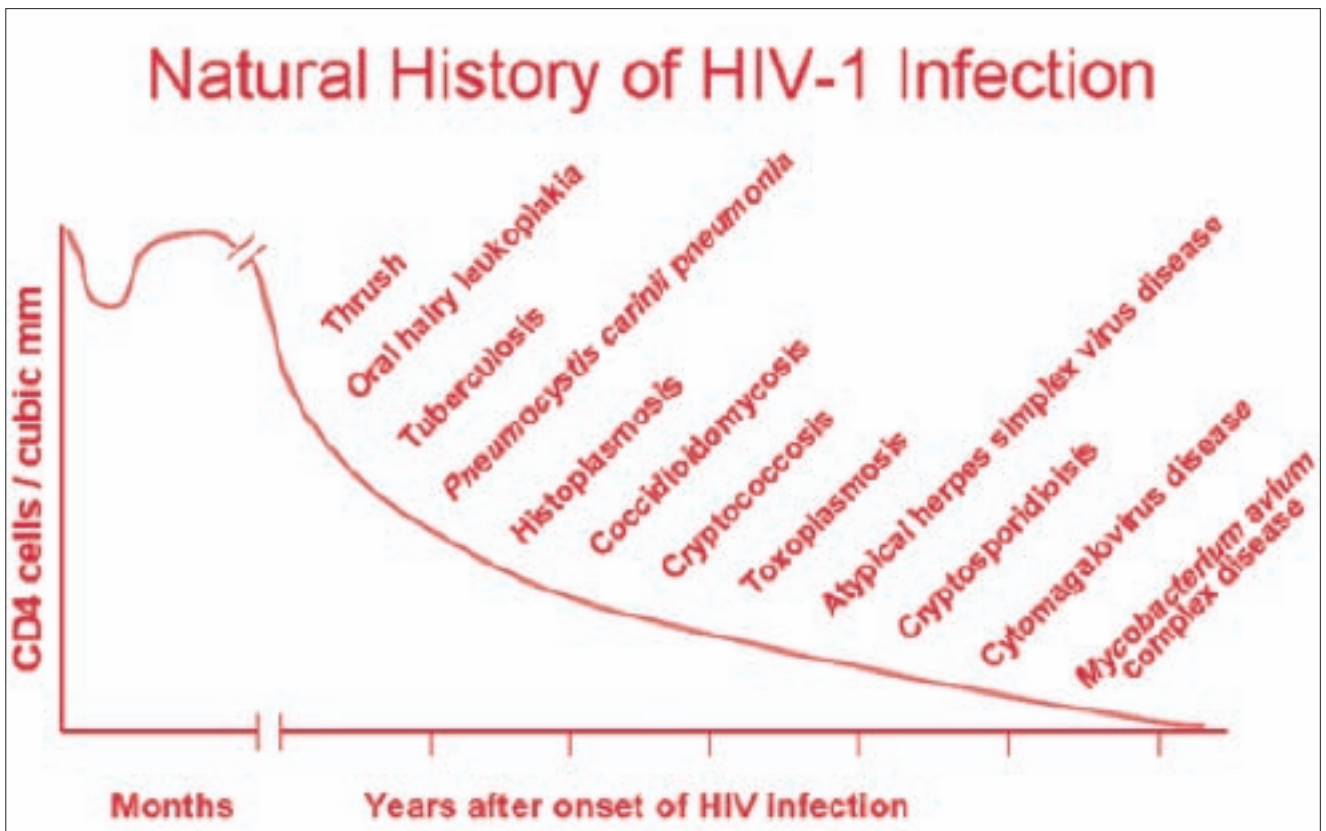


nated to kill germs and they become easily infected. Some micro-organisms, which do not usually make people with normal immune systems sick, take the advantage of lacking CD4 to cause infections. These infections are therefore called opportunistic infections. The body then enters the AIDS phase. CD4 accounts for up to 90% of body cells infected with HIV. Other cells which can be infected are in the brain, intestine membranes, etc, causing symptoms such as headache, diarrhea, etc.

Slide 5: HIV progression. There are four phases of HIV infection: acute infection, asymptomatic, mild and moderate symptoms, and AIDS. Progression to AIDS takes more than 5 years for about 70% of PLHIV.

Slide 6: Correlation between CD4 count and clinical symptoms. Introduce the following diagram – Natural History of HIV-1 Infection. Discuss some of the following points:

- PLHIV can be symptomatic for many years.
- Once the CD4 count falls below 350/mm³, different opportunistic infections may emerge. TB and candida are among the first opportunistic infections.
- For each level of the CD4 count, PLHIV are likely to have certain kinds of opportunistic infections.
- Note that, the figure, however, doesn't represent every case.



3) HIV transmission

Slide 7: Survival of HIV Outside Body

- The higher the temperature, the more likely that HIV will be killed.
- HIV can be killed easily by common detergent, bleach and decontamination solutions.
- Eg HIV can be killed by boiling or immersing in bleach solution for 20 minutes.
- However, HIV can survive in dry blood or in very low temperatures (7 to 10 days at 40°C, months in -70°C).

Comment: in medical services, if the worker has no physical exposure to blood or bodily fluid then s/he has no risk of being infected. Use of heat or chemicals to clean blood and bodily fluids will ensure the safety of workers and other patients.

Slide 8: HIV concentration in different bodily fluids.

Potentially infectious: Blood +++ ; Sexual fluids (cervical, vaginal, semen) ++; Breast-milk +; Liquid surrounding the body's organs (heart, lung, joints, amniotic...) + ; Biological liquid which has blood +

Non-infectious: Sweat; Urine; Stool; Tears; Saliva; Vomit.

Slide 9: Essential and Sufficient Conditions for HIV Transmission

Present the three conditions as shown in columns of the table below: a) sufficient amount of virus; b) having an entry route; c) the conditions favorable for HIV to survive. These are the three essential and adequate conditions for HIV transmission to occur.

The trainer can take an example of an act where HIV transmission probability is not 100% - such as sexual intercourse without a condom. If the PLHIV is in the window period or AIDS phase, the virus concentration is high and the amount of virus can be sufficient for the transmission to occur. Or if the PLHIV has an STD, then HIV concentration in his/her genital secretion is higher. Non-HIV sexual partners having an STD offer a better entry to the body for HIV. HIV in genital secretion can survive for some time.

With the same exposure, some people get infected, some don't because everyone's HIV concentration, receptivity and genetic profile are different. For example:

- HIV concentration in each phase of HIV infection in one person varies – it is the highest in the window period, low in the asymptomatic and very low if the body responds to ARV treatment.
- People who have STDs have a higher concentration of HIV in their genital secretion, and they are more receptive to HIV.
- Some people have certain genes which make their body more receptive while others have genes that make HIV difficult to enter.
- Men who have penile circumcision are less likely to be infected than those who haven't been circumcised.

Slide 10: Transmission Routes and Probability of Transmission

Intact skin: none recorded. Skin-puncture: 0.32%. Sharing contaminated syringe: 0.67% (variable).

Having sex with a HIV+ person: Recipient of anal sex: 0.5 to 3.2%; Vaginal sex (woman): 0.05 to 0.15%; Vaginal or anal sex (risk to the one who inserts): 0.03 to 0.09%; Oral sex: lower risk.

Mother to child transmission: With no prophylactic treatment: about 30%; with prophylactic treatment at labor: 10-15%; with prophylactic treatment from the second trimester: 2-5%.

4) HIV Testing

Testing is the only way to know if a person has HIV or not. There are three types of tests: antibody, antigen and viral load.

The common test is the antibody test. An infected person can still test negative, for being in the "window" period or having severe immune deficiency in which the body has not yet, or is not able to produce antibodies.

During the window period, the body has not yet produced or does not have sufficient antibodies to be tested positive. This is a very critical period because the viral concentration is very high, transmission probability is very high

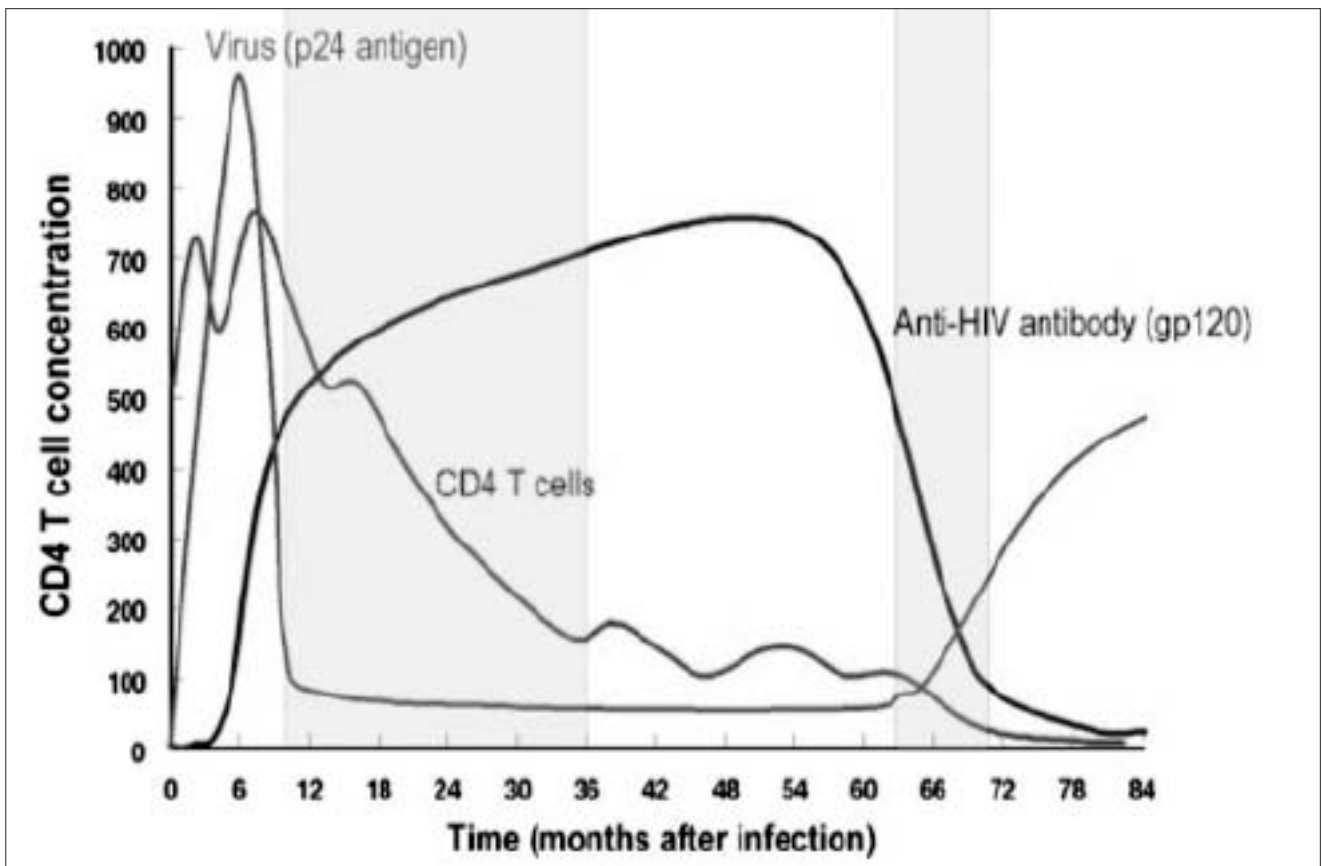


Eg

	Sufficient amount	Having an entry route	Physical condition permits HIV survival
Blood transfusion	+++	+++	+++
Kiss	-	-	-
Taking blood pressure	-	-	-

while the person can look completely healthy, having no symptoms, so is normally sexually active, and often careless. This period lasts from 4 to 12 weeks. People who have been exposed to HIV and tested negative should be re-tested.

Present the following graph. Show participants the line representing HIV concentration in the blood. Emphasize that the window period is the one when viral concentration is many times higher than the others, therefore infectivity is very high.



5) Prevention of Transmission

Slide 12: Strategy to Prevent HIV Transmission

To avoid HIV transmission, prevention of the three essential and sufficient conditions is crucial. The trainer may want to remind participants about the three conditions and encourage participants to introduce prevention strategy, then summarize and supplement. For example:

- Do not have direct contact with blood and bodily fluids that have high HIV concentration such as genital secretion, fluids that surround body's organs... (Wear gloves if you have to handle these fluids).
- Reduce HIV concentration in PLHIV by ARV treatment.
- Block the entry route: do not share injecting equipment, use a condom for sexual intercourse, cover wounds and cuts, get circumcision, etc.
- Eliminate conditions for the survival of HIV: pour bleach on stains of blood and bodily fluids on surfaces, soak contaminated equipments and linens, study microbicides, etc.

Slide 13: Prevention of HIV Transmission in Health Care Setting:

Encourage participants to discuss principles for preventing transmission in health care settings. Ask, "Does HIV screening help to identify correctly ALL HIV-infected patients?" The correct response would be "NO – because HIV-infected people in the "window period" may have a negative test result while this is the most infectious period". Facilitate the discussion on the first principle: **Treat all patients as if they all have HIV.**

Then ask, "If we treat all patients as if they all have HIV, what should health workers do to prevent infection for themselves and other patients?" Facilitate discussion on the second principle: **avoid direct contact with blood and bodily fluids that may have a high concentration of HIV, for all patients.**

Discuss the use of protective measures and come to an agreement that goggles should be used if there is a risk of blood or bodily fluids splashing on the eyes such as dur-

ing a delivery, an operation, or bodily fluids aspiration. Gloves should only be used when there is a risk of contact with blood or bodily fluids, such as while putting IV transfusion, giving IV injection, caring for wounds, operating a surgery, assisting a delivery, etc. For procedures such as taking blood pressure, hearing the lungs and heart while there is no cut, no bleeding or wound on the patient's skin, gloves are not necessary. It is not necessary to use a mask with an HIV+ patient because HIV does not transmit through the air.

However, there are cases where health workers are exposed to patient's blood or bodily fluid due to occupational accidents (needle stick injuries, cut by operating knife, etc). In these circumstances, post-exposure prophylaxis is considered.

Explain to participants that the above points are principles of the Universal Precaution strategy, which is recommended by the World Health Organization to prevent transmission of HIV and other blood-borne diseases in health care settings. One part of the training will be devoted to this.

6) Treatment for PLHIV

Slide 14: **Treatment for PLHIV.** Introduce treatment options for people with HIV and AIDS: prophylactic treatment of opportunistic infections. Treatment of opportunistic infections. Treatment with ARV for people who have come to the AIDS phase. Prevention of mother to child by treating HIV-infected pregnant women and their newborn with prophylactic ARV regimens. ARV treatment could restrain the development of HIV, to the point that viral loads can be reduced from tens or hundreds of thousands of copies to less than 50 copies per mm³ of blood.

Slide 15: **Conclusion.** If time permits, the trainer can encourage participants to summarize the key points presented and discussed in the session. Some points to be stressed are: HIV does not transmit through casual contact. In health care settings, universal precaution is the most effective strategy to prevent transmission to health workers and patients. HIV infection is a chronic health problem and can be managed.

A4. Living with HIV and AIDS - Testimonials

Facilitator’s Note: This session is the first of two sessions using testimonials in the whole training. In this session, testimonials are given by HIV-positive members of the training team. These trainers tell stories of their lives since they discovered their HIV status in an objective and descriptive way, not focusing on stigma.

Objectives: By the end of this session, participants will be able to:

- a) Name some of the challenges facing people living with HIV
- b) Identify with the lives and struggles of PLHIV
- c) Understand that HIV is a chronic health problem, which can be managed so that people can live healthy and productive lives.

Time: 45 minutes

Preparation: Invite the HIV positive co-trainers to give their testimonials. Ideally those selected to give the testimonials should be currently on ARVs and feel comfortable talking in front of a group. Ask the trainers to talk about all the things that have happened to them after getting HIV:

- a) *Health related things* eg getting sick, getting tested, treatment for Opportunistic Infections, going to the hospital, CD4 count tests, taking ARVs, adherence, side effects, etc
- b) *Social things* eg disclosure to partners and family, relationships with family, friends, co-workers, sexual partners, and different aspects of life such as sex, work, income, etc

Steps

1. **Myths about living with HIV (Brainstorm):** Ask – “What are all the things you have heard about the lives of people living with HIV after they have learned they are positive?” Record these ideas on the flipchart.
2. **Testimonial:** Ask the HIV positive trainers to give

their testimonials. Stop them at points to ask questions to get more detail and encourage participants to ask questions. Keep the testimonials focused on the experience of “living with HIV”.

After each testimony, **ask** the other participants – “What did you learn? How are their lives different from what you imagined?”

3. Summarize

- ▶ Many people think that getting HIV is an immediate death sentence – that the person with HIV will get sick and die quickly. Believing this, they give up on those who are HIV positive and treat them as people who are no longer productive and a drain on the family. This is stigma – being told you are no longer part of the living. It hurts and demoralises those to whom it is directed, and if not stopped, produces the expected result – people give up and die, not because of the virus but because of loss of hope.
- ▶ Living with HIV is difficult – not only because of HIV, but because of stigma.
- ▶ People living with HIV face many forms of stigma – isolation, gossip, blame and shame, and discrimination in the family, the community, and health facilities.
- ▶ Stigma hurts people living with HIV and their families – and makes them want to hide their status, sometimes in negative ways.
- ▶ Getting HIV does not mean the end of one’s life. Life goes on and those living with HIV have the right to live a normal life – to have friends, love, sex, children, and work.
- ▶ PLHIV can still contribute to the family, the community and the workplace.
- ▶ A PLHIV can lead a normal and productive life in many years, as long as they are supported psychologically and get ARV treatment.
- ▶ Most opportunistic infections can be treated and cured – as with other people who have infections.

Sample Testimonial – Living with HIV and AIDS

I am 35 years old. I started to use drugs when I was 19. My parents tried everything to stop me, but the “white death” was too strong for me, and I couldn't stop. I could see how my parents were suffering but the drugs took over my life. I had tried detox many many times but no matter how hard I tried, I couldn't break the habit. I started by inhaling, and ended up injecting.

When I was 25 year old, my parents decided to send me to Russia with my elder brother, to separate me from the environment and drug friends, hoping that I could finally kick the habit. And it is true, being in a completely new place, with no friends, where I didn't speak the language made it impossible for me to find drugs although I did crave them sometimes. I helped my brother in his business and the past was gradually put behind me. Four years later, I married a woman who also came from Vietnam to help an elder brother. Unfortunately, a few months after the marriage, I fell sick. I coughed, had difficulty breathing and had constant fever. No matter how much medicine I took, I saw no improvement. Then my brother took me to a hospital. There, they found that I was HIV positive. When my brother broke the news to me, I was shocked. While still using drugs, sometimes I thought I might be infected because I did share drugs with other users. But I didn't expect to be positive after being able to get rid of drugs for so many years. I deeply regret it, but it is too late. My wife quietly left me, returning to her brother's place, and her brother blamed me. I couldn't do anything other than send her a message to apologize and let her have her freedom. I managed though to recover after a month or so. However, my elder brother and my sister in law were still afraid that I would not live for long, so they sent me back to Vietnam.

Everyone in my family was afraid that I would transmit the virus to them so they arranged a floor on the top of the house for me to live. I lived in isolation there. I had my own things, even utensils, to be used by me only. Before meal, I brought a bowl to take food from the kitchen and ate up there.

Although my parents almost kicked me out of the house, neighbours and people in my clan also knew about me being HIV-infected. As a result people stopped visiting my family. One time a visitor saw me, and refused to drink when my mother offered him a cup of tea. From that day on, whenever there was a visitor, I was sent up there, so that nobody would see me.

Everybody in the family thought I would die soon but on the contrary, I was healthy. I only felt sad and hopeless for being treated like a ghost. In my mind there were so many dark thoughts of being dead. However, one day my mother was invited to the Empathy Club for family members of PLHIV where she got some materials tha helped her understand that HIV doesn't mean an immediate death sentence, and that it doesn't transmit through casual contact. Since then, I was allowed to eat with the family and my family started to think about finding a job for me. My family owns some shops and my parents gave me a job in accounting.

Three years before, I had fever and coughing for weeks and lost weight. My family brought me to the hospital where I met some other PLHIV. They introduced me to a self-help group of PLHIV. After being discharged from the hospital, I participated in group meetings and found out about my CD4 count. My CD4 count was only 127 then. After a few week waiting, I was given ARVs. When I started taking the drugs, I suffered because of side effects. My body was full of rashes and itching, and I was very uncomfortable for almost 2 weeks. I had headache and fatigue. But friends in the group were very very supportive. They tried to comfort me and encouraged me to take the medicine on a timely basis. After a month, I felt totally normal. Since then, I have been healthy. I have even put on weight. I met a woman who shares my suffering. We decided to live together. My parents were very happy. They gave us a small



flat. We have a daughter. She is 19 month old now. And she has tested negative. My wife got prophylactic treatment during her pregnancy.

I feel as if I have returned from the dead. Very often I think that if my mother had not joined that Empathy Club, I would have died of loneliness and depression. Therefore, I want people to understand that HIV doesn't mean instant death. I have been infected for more than 10 years but I am still alive, healthy, and even have children. I also wish that many more PLHIV can get access to treatment so they can lead healthy and happy lives like me.



Chapter B

Universal Precautions

Introduction

This chapter introduces concepts, procedures and skills on implementation of Universal Precaution in health facilities, based on World Health Organization's guidelines on Universal Precautions and Ministry of Health's Guidelines on Infection Control.

Health workers nowadays face the risk of occupational exposure with HIV and other blood-borne agents, or they carry pathogenic agents from one patient to the others, or transmit micro-organisms from themselves to the patients. Health workers, fortunately, can minimize these risks by adhering to the principles and procedures of Universal Precautions.

Universal Precautions is a set of preventive measures to minimize exposure to blood and bodily fluids by health workers and patients. Universal Precautions is based on the principle that all human blood and bodily fluids have a potential of transmitting Hepatitis B, Hepatitis C, HIV and other blood-borne pathogens.

Universal Precautions help health workers actively protect themselves, their patients and communities. Discriminatory practices such as HIV testing without the patient's consent, isolating patients with HIV, marking their clothes or files and other discriminatory practices out of great fear of getting HIV have been proven to be unnecessary. These measures don't help to protect health workers, simply because HIV is not transmitted through casual contact. On the contrary, the above behaviours may lead to violation of the law, because the Law on Prevention and Control of HIV/AIDS stipulates that HIV testing should be voluntary, patients should receive pre- and post-test counselling, and efforts should be made to prevent stigma and discrimination against PLHIV. In addition the categorization of patients into positive and negative can be counterproductive. Health workers may be more cautious with HIV positive patients and less cautious with HIV negative ones, even though some of the negative patients may be in the window period, which is the most infectious.

Universal Precautions is the best strategy to protect health

workers and patients. Its principle is as simple as its name – always be cautious and protect oneself from human blood and bodily fluids, no matter whose it is

During our research we recorded the following inappropriate practices used by health workers:

- Inappropriate use of gloves. Many health workers use a single pair of gloves to care for many patients and perform different tasks one after another (eg. giving intramuscular and intravenous injection, taking notes, dispensing drugs, pushing the stroller, opening doors, etc). This incorrect way of using gloves increases the risk of spreading pathogenic agents – the health



worker transports the agents from one patient to other patients, to health workers and to others present in the health facility through surfaces touched by contaminated gloves.

- Infrequent hand-washing. This is a common phenomenon. One of the causes is that health workers wear gloves all the time as described above. With the pair of gloves on, they feel safe so they don't wash their hands. Their gloves become the vehicle for transporting pathogens. This practice can be dangerous not only for patients but also for other health workers, because they may touch the infected surfaces that have been touched by the contaminated gloves.
- Separating linen used by HIV patients. In many

health facilities, linens used by HIV+ patients are collected separately and soaked in decontamination solution before washing, or they are washed in a separate washing machine, even when these linens are dry and without any stains. This practice wastes chemicals, time and energy of the workers, and creates stigma and discrimination against patients with HIV.

- HIV screening for all patients. Some health facilities use this practice, believing that once health workers know which patients have HIV, they will be more careful, and this will protect them from getting HIV. This can lead to violation of the HIV testing clauses in the HIV/AIDS prevention and control law. It can also make health workers careless in handling patients whose test results are negative. Dividing patients into positive and negative patients will also lead to stigma and discrimination against patients with HIV. Finally if health workers focus all their attention on the patient's HIV status, they will ignore other blood-borne pathogens, some of which can be much more infectious than HIV (eg. Hepatitis B and C).
- Isolating patients with HIV. Some health facilities isolate HIV patients by placing them in a separate place - last beds in a room, a designated room, or an HIV/AIDS department. This arrangement causes stress for health workers who are assigned to provide care to these patients, and creates stigma and discrimination against

patients with HIV. Some hospitals put patients with HIV in the same rooms with patients of infectious diseases such as TB, etc, and this increases the risk for HIV patients of getting opportunistic infections.

- Health workers wear excessive protective barriers while providing services for patients with HIV. Many health workers apply these practices out of the fear of being infected. This practice is unnecessary and wasteful, makes patients feel stigmatized, and at the same time creates a stigmatizing atmosphere in the health facility.

Modules

B1. Introduction of universal precautions

B2. Cleaning health worker's hands

B3. Use of protective barriers

B4. Safe use and discard of sharps

B5. Disinfection – sterilization

B6. Linen processing

B7. Health facility hygiene

B8. Safe handling of medical waste

Duration of training is different for different groups of health facility workers:

One day for physicians, nurses and auxiliary nurses/cleaners.

Half a day for administrative and support staff.

B1. Introduction of Universal Precautions

Objectives: By the end of this module, participants will be able to:

- a) Explain the significance of universal precaution practices in health facilities,
- b) State the general principle of universal precautions,
- c) List seven procedures for universal precautions.

Time: 60 minutes

Materials:

- Questionnaire on risk clarification regarding HIV, Hepatitis B, Hepatitis C
- Powerpoint slides to introduce Universal Precautions
- 3 case studies, each printed on a sheet of paper.

Steps

1. Potential risks in health facilities for patients and health workers

Brainstorming. Ask, “In your opinion, is a health facility a safe place for patients and health workers?” Participants will have different opinions. Ask participants to explain their opinions and record their responses on flipchart. If necessary, ask additional probing questions – a) Can patients be exposed to infection in a hospital? B) Can health workers be exposed to infection in the hospital?

Then summarize the discussion, emphasizing two main

problems: hospital infection and occupational exposure. Then introduce the powerpoint slides, which will provide more knowledge on these issues.

Powerpoint slide. Use the following slides to provide information on these issues.

Slide 1. Definition of hospital infection.

Hospital infection is a generalized or localized pathogenic condition resulting from being infected by microorganisms or being attacked by microorganism's toxin, since the patient had no clinical symptoms or was not in incubation period by the time of admission. This usually occurs 48 hours or more after the admission.

Slide 2: An example of hospital infection.

Nguyen Thi T., 34 year old, admitted on 16/02/2005. Diagnosis: nhuoc co. At the admission: no sign of infection. Procedures performed after the admission: intubation, respirator, urethral catheter insertion. Sputum culture on Feb 24: Paeruginosa, Staphylococos aureus. Urine culture on Feb 25: Candida albicans

Slide 3. Situation of hospital infection.

Other countries: 3,5 to 10% patients admitted to hospitals get hospital infection. Viet Nam: estimated 5 – 7%.

Viet Nam: a survey in 2005 found that the most common bacterial hospital infections were hospital pneumonia, infection of surgical sites, urine tract infections, infection of digestive system, of skin, soft tissues and sepsis.

Slide 4: Health worker's risk of occupational exposure.

Health workers have a risk of exposure to different pathogens. The biggest concerns are blood-borne agents such as Hepatitis B, Hepatitis C and HIV.

WHO estimates that annually around 3 million health workers worldwide are exposed to blood due to sharps, causing 70,000 Hepatitis B, 15,000 Hepatitis C and 500 HIV.

A study in the US found that 16% of health workers tested positive with Hepatitis B, in comparison to 5% among voluntary blood donors (Dienstag et al).

According to different studies, the percentages of health

workers who ever had a sharp injury were:

- 35 – 54% - Institute of Occupational Health and Department of Therapy, in many hospitals (2004)
- 60%: Tran Chi Liem et al, in health facilities at various levels (2006).

Slide 5: Types of occupational exposure.

There are three main types of occupational exposure:

- 1) Injuries due to contaminated needles and sharps;
- (2) Splashing of blood or bodily fluids from a patient to a worker's eyes, nose or mouth during a procedure;



- (3) Direct contact of worker's non-intact skin with contaminated blood or bodily fluids.

Slide 6: Risk of getting blood-borne infection due to occupational exposure.

Studies found that the risk of a health worker getting a blood-borne infection after an occupational sharp injury is: HIV: 0,%; Hepatitis B: 6 – 30% and Hepatitis C: 1.8% (Beltrami EM et al, 2000) Risks of HIV infection: splash of blood to mucous membranes: 0.09%; splash of blood to non-intact skin: 0.01%.

2. Causes of infection in health facilities

Brainstorming. Ask: “What are the causes of hospital

infections and occupational exposure?" Note the responses on flipchart.

Powerpoint slides. You may want to use the following slides to explain the causes.

Slide 7: Hospital infection circle.

Present the following picture:

Slide 8: Causes of hospital infections.

- Invasive procedures;
- Surgeries;
- Pathogenic microorganisms existing in the environment of the health facility, as well as those which exist on patients' skin and natural holes;
- Medical equipments;
- Hospital arrangement, especially the overcrowded situation, a bed is shared among 2 or more patients;
- Health worker's hand hygiene;

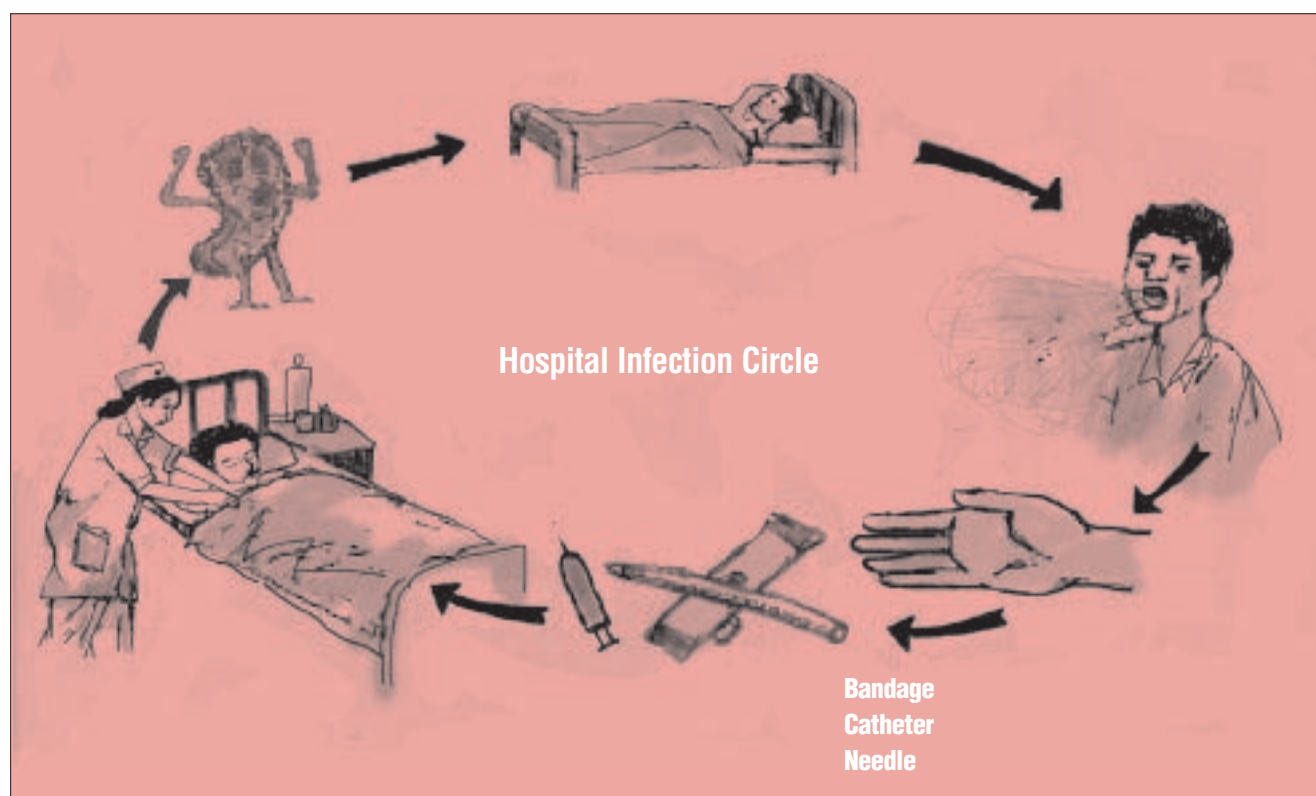
Example. Causes of hospital infections.
Training, July 2006 and March 2007.

Because we don't do infection control very well. Some patients have weak immune systems. Due to the polluted environment. Due to health workers carrying the germs. There are bacteria on health workers' hands.

Patients have immuno deficiency. Due to invasive procedures (intubation for respiratory, insertion of urethral catheter). Due to improper processing of instruments. Due to unsafe handling of medical waste.

- Patients having chronic problems, long tem use of antibiotic, weak immunity...

Hospital Infection Circle





Slide 9: Causes of occupational exposure.

80% cases of occupational exposures are due to needles and other sharps.

Leading causes are: to recap needle with two hands, to unsafely collect and discard sharps (WHO).

Strategy to increase safety of patients and health workers. Trainer can start this section by explaining that different measures need to be taken at different levels to ensure patient’s and health worker’s safety. At the level of every health worker, the practical and feasible strategy is adherence to universal precautions.

Powerpoint slides.

Slide 10: Definition of Universal Precautions

Universal Precautions is a set of prevention measures based on the principle that blood and body fluids of every patient is a potential source of transmission of HBV, HCV, HIV and other blood-borne pathogens, regardless of their diagnosis and infectious status. Therefore, all health care workers when in possible contact with blood or body fluids at work should apply the appropriate precautions.

Before moving to the other slides, ask participants to share their understanding of universal precautions and list the contents of universal precautions as they see it.

Slide 11: Guiding Principle of Universal Precautions.

Treat all human blood and bodily fluids as if they have the potential to transmit Hep B, Hep C, HIV and other blood-borne pathogens.

Health workers while performing procedures that splash or are in direct contact with blood or bodily fluids, should use appropriate preventive measures.

Preventive measures should be used in all health facilities, by all health workers, every time they are at risk of contacting human blood or bodily fluids.

Exercise. Ask participants to make a list of bodily fluids that need and do not need to apply Universal Precautions. Note the results on a flipchart which has 2 columns: 1. UP applied, 2. UP not applied. Discuss then come to the conclusion as in the following table:

Slide 12: Application of Universal Precautions to blood and bodily fluids

UP applied	UP not applied
- Blood and all blood products	- Tears
- All secretions containing visible blood	- Sweat
- Vaginal secretion	- Faeces
- Semen	- Urine
- Pleural fluid	- Nasal secretions
- Pericardial fluid	- Sputum
- Cerebrospinal fluid	- Vomit
- Peritoneal fluid	- Saliva
- Synovial fluid	
- Amniotic fluid	
- Breast milk	

Slide 13: Contents of Universal Precautions

Universal Precautions are applied to three areas: 1) Health worker's skills; 2) Appropriate use of protection; 3) Safe and clean health facility environment.

Seven procedures:

- 1) Cleaning health worker's hands (hand washing);
- 2) Use of personal protective barriers;
- 3) Disinfection and sterilization of medical instruments;
- 4) Health facility hygiene;
- 5) Handling medical waste, including sharps;
- 6) Processing contaminated linen;
- 7) Prevention and handling of occupational exposures.

Exercise on risk clarification. Hand out the risk clarification questionnaire below, and ask participants to complete the questionnaire, working with their neighbour. The objective of this exercise is to check participant's understanding of UP principles and how to apply them in their work practices.

Risk clarification questionnaire

Please tick (x) in the appropriate column your response to the following statements

Code: 1 = Strongly agree; 2 = Agree; 3 = Don't agree; 4 = Strongly disagree

	Statement	1	2	3	4
1	Patients who are HIV positive should be placed in a separate room.				
2	The linens of HIV positive patients should be separated from the linens of other patients and washed separately.				
3	All patients prior to surgery should be given an HIV test.				
4	Extra protective barriers are needed when coming into contact with the blood of HIV positive patients.				
5	Special care should be taken in cleaning up the blood spills of HIV positive patients				
6	After giving an injection to HIV+ patients, the needle should be separated and treated differently than the needles used with others.				
7	Gloves must be used at all times when touching HIV+ patients.				
8	Coming into contact with HIV positive patients is the biggest occupational risk facing health workers.				
9	Health workers should treat the blood of all patients as having the potential of transmitting HIV, HBV and HCV				
10	The main goal of Universal Precautions is to protect health workers				

After participants have completed the questionnaire, facilitate a discussion on each item of the questionnaire in order to ensure that participants have common knowledge and understanding of UP. It is important to come to an agreement that: 1) There is no need to isolate HIV patients in a separate room because HIV is not transmitted through respiratory tract or casual contacts; 2) Linen used by patients with HIV doesn't need to be treated separately; linens that have blood or bodily fluid stains regardless of the patient's HIV status need to be decontaminated before washing; 3) There is no need to test all patients prior to a surgery because surgeons and their teams should be cautious with all blood and bodily fluids, and consider those fluids as potential sources of HIV and other blood-borne pathogens; 4) and 5) Health workers should always wear

appropriate protective barriers whenever they come into contact with blood or bodily fluids of any patient; 6) Health workers should be cautious with any sharp; all used needles have to be discarded as instructed; 7) When coming into contact with the skin of a patient with HIV, a health worker needs to wear gloves only if the patient's or health worker's skin is not intact; 8) HIV cannot be transmitted through casual contact; among all patients in Vietnam, HIV prevalence is much lower than prevalence of Hep B or Hep C while the probability of transmission is much higher for Hep B and Hep C, therefore coming into contact with HIV patients can not be considered the biggest occupational exposure; 9) Health workers should regard the blood of every patient as a potential source for transmission of Hep B, Hep C and HIV because it is impossible to test every

patient; and even if it can be done, a negative test result doesn't guarantee the HIV-free status of the patient (some patients may be in the window period); 10) UP's goal is to protect patients and health workers.

Summary:

- ▶ Health facility environment can become unsafe for patients and health workers.
- ▶ Different types of infections can occur in health care settings and not only HIV. Eg. the risk of getting Hepatitis B is a thousand times higher than the risk of getting HIV.
- ▶ Health workers have the right to safety and not getting infected due to occupational exposure. Patients have the right to safety and not getting hospital infection.

- ▶ Many factors cause infection risk in health care settings. Universal Precautions is an effective prevention strategy, which can be used by any health worker.



B2. Cleaning Health Worker's Hands

Note to trainer: This module is very important because many health workers are not aware of the importance of proper hand-washing.

This module is based on demonstration and practice of a standardised approach to hand-washing – using six steps. Prepare all the materials beforehand – running water, soap or disinfectant solution, and towels. You should give a clear, step by step demonstration which everyone can see and hear, and then allow participants to practice these skills with feedback, so they can become good at it. Make the practice sessions fun. Participants can learn and have fun at the same time!

Some hospitals have no running water in the wards. It would have been too complicated for staff to go back to wash in a central place where water was located. The solution was to introduce disinfectant solutions – commercial products sold in small plastic bottles or a home-made alcohol-base solution (eg. a mixture of 1% glycerin in a 70% alcohol solution) contained in small dispensers. The training should include demonstrations using this kind of disinfectant to clean hands.

Objectives: By the end of this session, participants will be able to:

- Explain situations where handwashing is required
- Demonstrate how to wash their hands correctly, using water and soap, and how to clean their hands using alcohol-based solutions.

Time: 45 minutes

Preparation:

- Lavatories with running water or four water containers with taps on stools, with bucket for waste water;
- Soap, disposable hand towels, and basket for used towels



- c) 8 bottles of alcohol-based hand disinfectant
- d) Handwashing checklist
- e) Poster showing routine handwashing technique
- f) Powerpoint slides on handwashing.

1. Introduction

Ask:

- a) How many times do you wash your hands per day in the hospital?
- b) When do you wash your hands?

Note the responses on flipcharts.

Steps

Example – Training in March 2007

How many times do you wash your hands?

Twice: After the ward tour and before going home. Twice: before starting to give injections to patients and after finishing all injections. Twice or thrice. Many times. Four or five times. Some days I don't wash my hands at all because I don't do anything (no procedure).

When do you wash your hands?

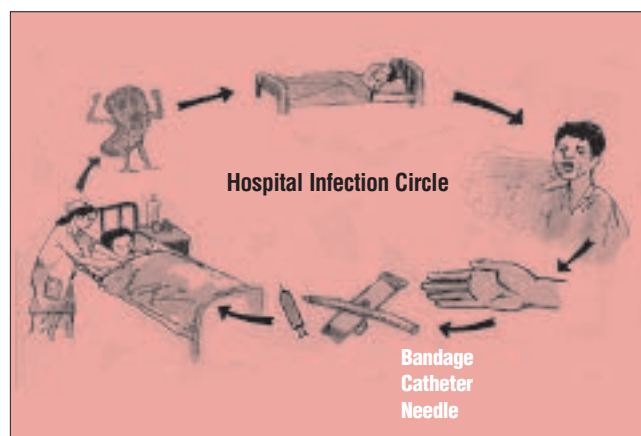
Before we do something we wash our hands. Before meals and after using the toilet. Before and after contacting patients, and when performing invasive procedures. Before we examine patients and after we have examined 3 or 4 patients. With HIV patients, we wash our hands right after examining each patient. I am in charge of many wards so I only wash hands after a number of patients. I examine 50 patients every day, so I cannot wash hands very often. After each patient, we should wash our hands once, if water is not available, I use alcohol, to avoid infecting other patients. If I have no time then I cannot wash continuously because of having too many patients, I try to clean my hands with alcohol.

2. The importance of clean hands

Powerpoint presentation

Slide 1: Health worker's hands are the vectors through which infections are transmitted in health facilities. Reintroduce the picture on the Hospital Infection Circle. Emphasize: most procedures performed on patients or through instruments involve health workers' hands, thus health workers' hands play a very important role in hospital infection.

Slide 2: Health workers' hands often come into contact with skin, blood and bodily fluids of patients, therefore carrying many pathogens. A study in Cho Ray hospital (Vietnam) revealed that there were on average almost 270,000 clusters of bacteria grown from 1cm² skin of a health worker's hands, 26 times higher than a required amount to cause an infection. By cadre: physicians' hands contain 275,000, nurses: 127,000 and auxiliary nurse/cleaners: 480,000 bacteria per cm².



Slide 3: The hands shown incorrectly wearing gloves are not clean hands. Invite participants to comment on the picture of a nurse holding the rail of the trolley. Make it clear that when health workers touch surfaces/instruments with their gloved hands, which have provided services to patients, they redistribute pathogenic agents from patients to other patients, to other health workers



and to themselves. Besides, some studies show that patients' bacteria were found on around 30% of health workers' hands, even when gloves were worn.

Slide 4: How to have clean hands?

“Hand-washing is the oldest but most effective measure in hospital infection prevention” (WHO).

However, water and soap are not easily available for hand-washing in many health facilities. An alternative for routine hand-washing is cleaning hands with an alcohol-based solution.

“Hand-disinfection with an alcohol-based solution is a strategy to increase compliance to hand-washing, and a quick and effective hand-washing technique”. Asia Regional Association of Hospital Infection Control. 2007.

3. Demonstration

Give a demonstration on how to wash hands with water and soap, then with an alcohol-based solution – and get participants to copy each step individually while you are doing it.

Tips:

- Put up the hand-washing poster or show it on LCD screen;
- Explain the significance of each move and how to do it properly;
- Ensure that everyone can see what you are doing;
- Demonstrate one step at a time – describe the step and then do it;



- After each step ask trainees to copy the action with their own hands and call out what you are doing – eg “wetting hands and rubbing hands together”;
- Go slowly, explain clearly - make sure everyone understands;
- When you finish all seven steps, repeat the seven steps with the whole group copying your actions and calling out what you are doing at each step. The aim is to help participants remember the six steps as an enjoyable ritual.



Routine hand washing procedure



Step 1: Wet hands, take soap, rub hands to spread the soap.



Step 2: Palm on the back of the other and rub.



Step 3: Palm to palm, fingers interlaid, rub.



Step 4: Interlock the fingers of 2 hands. Rub the back of the fingers



Step 5: Clasp and rub thumb of the other by rotational motions



Step 6: Rub all finger tips of one hand in the palm of the other.

Note: The routine hand washing takes a minimum of 30 seconds.

4. Practice with feedback (small practice groups)

Introduce 3 checklists for hand-washing practice: 1) Hand-washing facility; 2) Procedures for hand-washing with water and soap; 3) Procedures for cleaning hands with alcohol-based solution (checklists are available at the end of this module).



- Ask the others to watch carefully to identify things to improve.
- Encourage participants who practice, even if they have not done it correctly, but make sure to correct any mistake in front of the whole group.
- Go around the groups to check on the quality of the practice sessions.



Divide into four groups to practice the steps. Ask each group to stand in a circle. Handout the 3 checklists for each participant.

“Dry” Practice (Whole Group): Ask the members of each group to do the six steps, all at the same time (without water) while looking at the checklist.

“Wet” Practice (Individual Practice – with water and soap): Then ask each group to take a water container, soap and other materials as prepared in advance. In each group participants take turns doing the six steps using water and soap, while the others watch and give feedback on how well each person does.

Practice on Quick Hand Disinfection (Individual Practice – with alcohol based solution): Give each group one bottle of alcohol based hand disinfectant – and ask individuals to practice the same six steps while the others watch and give feedback on how well each person does.

Tips on organising the practice sessions:

- Put up the hand-washing picture on the LCD screen.

5. When do you need to wash your hands? (Whole group)

Get all participants together, spend 2-3 minutes for reflection and clarification of the practice session.

Indications for hand washing

- Before putting gloves.
- Before touching a patient.
- Before preparing instruments, medications.
- Before performing an invasive procedure.
- Before preparing or distributing food.
- Before eating.
- After contacting patient’s blood or fluid .
- After examining, giving care to one patient.
- After completing procedures in an infected zone and moving to a clean zone on the same patient .
- After touching objects around patients.
- After removing gloves.

Then put up the flipchart that recorded participants' responses at the beginning of the module on when they should wash their hands, ask them to add points, and correct them.

Show on the screen indications for hand-washing and explain each indication.

Finally, refer participants to pages in the Safe and Friendly Health-Worker Handbook on hand-washing and hand-washing checklists.

Summary

- ▶ Health workers' hands are the most important instruments to provide services for patients but they can also be a source of infection to patients and health workers themselves, if their hands are not clean.
- ▶ Hand-washing with clean water and soap or with alcohol-based solution is the most important procedure to prevent hospital infection.
- ▶ Even when gloved, health worker's hands can still carry pathogenic agents and should be washed before and after gloving.

Checklist - hand - washing facility

Srl	Items	Yes	No
1	There is lavatory that meets the requirement		
2	Taps have a lever that can be opened with the elbow		
3	There is a holder for soap		
4	There is a box for clean towels or disposable napkins		
5	There is a box for used towels/napkins		
6	There is clean water or alcohol-based solution in designated positions		
7	There is a hand-washing station in all rooms for exam, procedure, instrument preparation, intensive care and administrative offices.		

Checklist - hand - washing with clean water and soap

Srl	Steps	Yes	No
1	Step 1: Wet hands, apply 3-5ml of liquid soap and lather, rub palms and back of the hands and make the soap spread		
2	Step 2: Put fingers and palm of one hand on the back of the other hand and rub the back of the hand and the external areas between fingers and lateral side (each side)		
3	Step 3: Put the palm of one hand to the palm of the other hand, the fingers interlaid. Rub thoroughly the palms and the internal areas between the fingers		
4	Step 4: Interlock the fingers of both hands. Rub the back of the fingers.		
5	Step 5: Use the palm of one hand to clasp and rub the thumb of the other hand by rotational motions.		
6	Step 6: With the fingers of one hand held together, rub the tops of the fingers in the palm of the other hand. Rinse hands under running water, then dry them with a clean towel/napkin or leave hands to dry themselves.		



Checklist - hand - cleaning with alcohol - based solution

Srl	Steps	Yes	No
1	Step 1: Wet hands, apply 3-5ml of alcohol-based solution, rub palms and back of the hands and make the solution spread.		
2	Step 2: Put fingers and the palm of one hand on the back of the other hand and rub the back of the hand and the external areas between fingers and lateral side (each side).		
3	Step 3: Put the palm of one hand to the palm of the other hand, the fingers interlaid. Rub thoroughly the palms and the internal areas between fingers.		
4	Step 4: Interlock the fingers of both hands. Rub the back of the fingers.		
5	Step 5: Use the palm of one hand to clasp and rub the thumb of the other hand with rotational motions.		
6	Step 6: With the fingers of one hand held together, rub the tops of the fingers in the palm of the other hand. Leave hands to dry themselves.		

B3. Protective apparels

Note to trainer: In this module, you should not focus on the techniques to wear and remove protective apparels but aims and indication of each device. One of the key findings of the pilot project’s baseline study was the wide-spread misuse and excessive use of protective apparels. Health workers wore the same pair of gloves for long time – up to a half day, to serve many patients and perform different tasks. Some staff always wear mask and gloves when come in contact with a patient with HIV although the patient has no skin problem or any sign of a respiratory infection.

Another common practice is that health facility workers always wear reusable cloth mask while providing care for patients and at the reception. Studies found that only special masks (N95, N99, N100) are able to prevent bacteria and some kinds of virus entering respiratory tract. Cloth masks, if not decontaminated and washed regularly, can be the environment where microorganisms develop.

Objectives: By the end of this session, participants will be able to:

- a) Explain aims and indications of common protective apparels;
- b) Use protective apparels appropriately and correctly;



- c) Discard or process for reuse of protective apparel properly.

Time: 45 minutes

Materials:

- a) Slides of pictures on using protective apparels in their own facility – to show current practices
- b) Samples of protective apparels:
 - Gloves – different types: utility, non-sterile gloves,

- sterile gloves in pack: 4 pairs each.
 - Masks – different types: surgical, reusable cloth, N-95 masks: 4 each.
 - Goggles: 4 pairs.
 - Face shield: 4 pieces.
 - Shoes covers: 4 pairs.
 - Apron: 4 pieces.
- c) Powerpoint slides.
d) Case studies.

Steps

1. Introduction

Invite participants to list commonly used protective apparels. Note on flipchart. Add items on the list if needed.

Protective apparels:

- Gloves: clean gloves, sterile gloves, utility gloves.
- Mask: surgical, cloth, masks to protect from respiratory infections – N95, N99, N100.
- Goggles.
- Face shield.
- Gown.
- Cap.
- Apron.
- Shoes cover.

Ask participants to speak about aims and affects of each device. Note on flipchart. In most of the trainings, workers only mention the protective affects to the workers and rarely mentioned benefits to patients.

Summary: there are different protective apparels, mostly to prevent health workers to contact directly to pathogenic agents on the skin, in the blood, bodily fluids or in respiratory tracts of patients, and vice versa – patients are protected from pathogens present on the skin, in saliva or in respiratory tracts of health workers.

2. Current situation on using protective apparels in this health facility

Show pictures of the current practices on using protective apparels in their own facility (2-3 minutes).

Please be cautious while taking pictures to not showing worker's faces to avoid any trouble may arise.

While showing pictures, don't comment but let participants to realize the current situation.

Leave 2-3 minutes for reflection and comments.

3. How to use protective apparels?

Demonstrating putting on and off protective apparels.

Handout samples of protective apparels to participants to look at. Invite the volunteers to demonstrate wearing and removing each device. Correct the mistakes. This activity is only demonstrative, not to spend much time.

Discussion led by powerpoint slides.

Slide 1: Hands and gloves. Intact skin is the best protection. Study on ungloved 2,500 health worker's hands which had come in contact with blood of HIV patient: no infection occurred.

Broken skin offers the entrance for pathogens to enter the body.

Benefits of gloves:

- Protect the skin from irritable chemical products
- Inhibit the penetration of microorganisms
- Preserve the hand skin sensation

Slide 2: When gloving is needed?

Show this question on the screen and ask participants to list scenarios where clean gloves, sterile gloves and utility gloves need to be worn. Note the responses on flipchart. Discuss to clarify and come to conclusion about indications for each kind of gloves as the followings:

- Clean gloves: when contact with blood, bodily fluids; contact with
- contaminated instruments; broken skin on health worker's hands.
- Sterile gloves: surgical operations and procedures; wound care.
- Utility gloves: cleaning; collecting used linens, wastes.

Slide 3: When to remove or change gloves?

- Remove gloves immediately after each procedure or providing care for each patient.
- Change gloves after 1 hour if the procedure lasts very long because after 1 hour, gloves can be porous, punctured and become unsafe.
- Use separate pair of gloves for each patient, and wash hands right after caring for one patient and before caring for another.
- Change gloves between clean and contaminated activities on the same patient
- Change gloves when they are torn, pierced or punctured by needle

Slide 4: Disposal of gloves

- Gloves contaminated by blood and body fluids disposed like the contaminated medical wastes.
- Used gloves disposed as medical waste.
- Reuse of glove is not considered a safe practice.

Slide 5: Masks and size of pathogens

Introduce the figure on the side and explain:

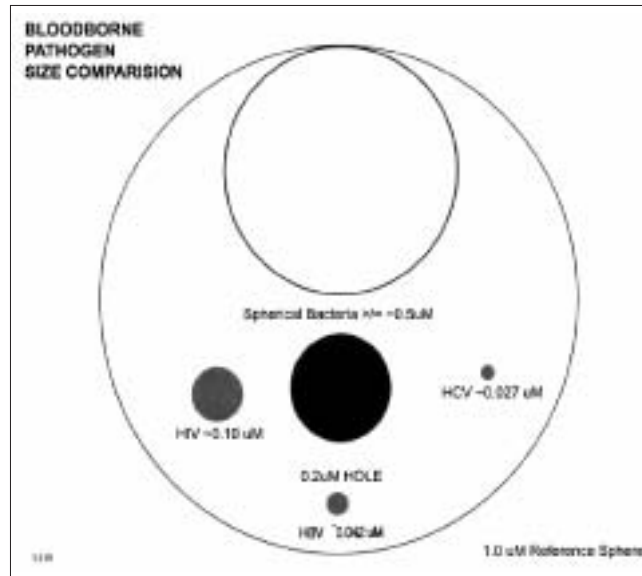
Average bacteria diameter: 0.5 micrometer; HIV: 0.1 micrometer, Hep B: 0.042 micrometer, Hep C: 0.027 micrometer

Average diameter of holes in surgical mask: 4 micrometer. Average diameter of holes in N95 mask: 0.3 micrometer. Therefore, surgical masks can not prevent bacteria and virus to enter respiratory tract.

N95 mask: prevent about 95% micro-organism transmitting through airways (thus named N95). N99 prevents around 99%; N100 prevents around 99.7% germs getting to and from the airways.

Slide 6: Actual benefits of masks

- Protect patients: prevent spilling of saliva from health worker's mouth to wounds or skins of patients, which need to be sterile.
- Protect health workers: prevent blood and bodily fluids from patients splashing to health workers during procedures. N-series masks can prevent infections transmitted through respiratory tract.



Slide 7: When mask is needed?

Show this question on the screen and ask participants to list scenarios where a surgical, cloth or N-series mask is needed. Note the responses on a flipchart. Discuss to clarify and come to an agreement as the followings:

Surgical masks:

- in a surgical theatre.
- in a sterile environment.

Cloth/paper mask:

- during procedures which splash of blood or bodily fluids may happen.
- changing/putting bandage.
- providing care for patients having infections that can transmit through respiratory tract.

Slide 8: Change and reuse of mask

- Masks should be provided and used as a disinfected/sterile medical device.
- Cloth masks, if reused, should be washed and disinfected everyday.
- Masks used in special isolated rooms should be disposed as infectious medical waste.
- Mask is not needed while performing common procedures such as intra-muscular injection, taking temperature, pulse or blood pressure, as well as common care services which involve no risk of splash or getting infections transmitted through respiratory tract.

Slide 9: Goggles

- Protect eye's membrane of health workers from splash of blood, bodily fluids or small articles from patients.
- Indications:
 - During procedures which splash is anticipated, such as: delivery assistance, abortion, intubation, aspiration, tooth extraction, etc.
 - While caring for patients with SARS or Avian flu...
- Should be available in operating and procedure rooms.
- After using, soak goggles in decontamination solution then clean with water and detergent.
- Health workers who have an eye infection should not share goggles.

Slide 10: Other protective apparels

- Cap: there is no evidence about wearing cap would reduce hospital infection. It is probably only needed in sterile environment.
- Gown: wear if there is possibility of contacting patient's blood, bodily fluids and wastes.
- Apron: wear where there is risk of splash.
- Face Shield: use when there is risk of splash to health worker's face.
- Shoe covers: required in a sterile environment, while care for very infectious patients such as those with SARS.

Refer participants to session of protective apparels in Safe and Friendly Health Worker Handbook.

4. Case studies

Divide into 4 groups, give each one case study. Give groups 5 minutes to discuss and 2 minutes to report back. Put each case study in one powerpoint slide and show it as the whole group discuss the case.

Case study 1. Please comment on UP practices of the health worker in the following 2 pictures.

Case study 2. Lan is a nurse working in a antenatal care clinic. Her tasks include taking pulse, temperature, weight and taking blood from finger-tip for hematocrite test. Lan don't usually wear gloves while doing these. She only put on gloves with women who look sick. Following UP principles, what has Lan done correctly, and what has she done incorrectly? Why?

Case study 3. Mr. Nam works in the Surgery Department. He is going to change the bandage for a patient having HIV who has had an appendectomy. You see that Nam is putting mask, cap, gloves and apron. He doesn't wear these apparels while changing bandage for other patients. Which protective apparels Nam should wear while changing bandage for patients in general and HIV patients in particular?

Case study 4. In the picture is the reception desk of a city hospital. Please comment on the protective apparels of the three staff.



Draw blood for testing



After having drawn blood



Example – discussion on case studies

March 2007

Case study 1. Correct: the health worker wear gloves while drawing blood.

Incorrect: the syringe and needle after drawing blood was left on the desk, could contaminate the desk and other stuff on the desks, and could possibly cause injury. After drawing blood, she did not take off the gloves and washed hands. The hands that had drawn blood touched papers, pen, desk... may spread pathogens to these surfaces. Taking blood and doing paper-work on the same desk.

Case study 2. Correct: there is no need to wear gloves while taking patient's temperature, blood pressure and weight. Incorrect: 1) does not wear gloves while prick finger-tip for blood, only do if the patient looks sick. 2) wears gloves while taking pulse, temperature, blood pressure of patients who look sick.

Case study 3. Wears too many protective apparels unnecessarily. Changing bandage of a patient had appendectomy poses no risk of splash, so only need to wear sterile gloves and surgical mask. The mask is to prevent saliva spilling from health worker to the wound, which can cause infection, and not to prevent HIV transmission for health worker. Use the same protective apparel for patients with and without HIV.

Case study 4. Hospital workers at reception desk don't need to wear mask because there is no requirement for sterilization, no risk for splash. Health workers usually worry that there are many patients in the reception, among them may be TB patients or patients with diseases transmitted through respiratory tract so wearing mask will make them feel more confident. However, it is important that regular masks can not prevent bacteria and virus, and can become a reservoir for germ to grow.



5. Summary

- ▶ Correct use of protective apparels is not based on patient's HIV status. All body parts of health workers that have risk of exposure to blood or bodily fluids of any patient should be covered by appropriate apparels.
- ▶ A health worker only need to protect parts of the body that may expose.
- ▶ Regular masks can not prevent micro-organisms that transmit through respiratory tract. When there is an actual risk, all health workers and patients should wear N-series masks (N95, N99...)
- ▶ Wearing one pair of gloves to provide care for many patients increase the risk of hospital infection to patient, because health workers eventually spread the germs from one patient to the others.
- ▶ Wearing gloves which have been used to provide care for patients to touch surfaces such as taking note on patient's chart, opening doors, picking up the phone increase the risk of infection for co-workers, oneself and other people in the same facility.



B4. Safe disposal of sharps

Note to trainer: This module address safety for infection disposal of sharps in health care settings.

To demonstrate sharp disposal, you should use both kinds of safe box (puncture proof container - PPC): the disposable, and the reusable because many health facilities can not afford the disposable.

Objectives: After this session, participants will:
 Know how to handle and dispose sharps safely.
 Agree upon methods to dispose used sharps.

Time: 30 minutes

Materials:

- 10 disposable syringes with needles;
- 4 reusable PPC;
- 4 disposable PPC.





Steps

1. Introduction

You can introduce this module by mentioning that 3 million health workers experience occupational exposure every year involving sharps, causing a considerable number of infections with Hep B, Hep C, HIV and other blood-borne micro-organisms. In Vietnam, between 33 to 60% health workers had ever injured by sharps. This is the most common occupational exposure among health workers. Nevertheless, most of those injuries could have been avoided if health workers know and follow instruction about how to handle sharps.

2. Group work

Divide into three groups and give each group a different task:

Group A: List what activities might lead to accidents related to the use of sharps

Group B: Make a list of safety practices to be used by health workers when handling sharps

Group D: Practice how to recap needle using “one hand” technique use puncture proof containers to isolate and dispose of used needles – and prepare to give a demonstration to the group

3. Report back

Groups A, B, and C present their reports on flipchart – then Group D gives a demonstration. Invite comments after each presentation.

Example: Discussion

Training July 2006 and March 2007.

What activities often lead to accidents related to sharps

Recapping of needles with 2 hands.

Handpassing sharps.

Sharps left around and someone cleaning up gets pierced.

Giving injection or performing procedure on patient who is unstable or a child.

Leave sharps among linen.

Not concentrated, chatting at the same time or paying attention to something else.

Unsafe disposal (dispose sharps in plastic bags, or in plastic box but do not cover with a safe lid and note outside).

Hand safety

Don't recap needles. If needle need to be recapped, use “one hand” technique.

Don't bend, break, or cut needles with your fingers

Don't remove the needle from the syringe before disposal. If needle need to be removed, use long forceps.

Don't hold specimen container while putting specimen in, stabilize it in a holder.

Never leave sharps among linen.

Never attempt to catch a falling sharp, let it drop

PPC near the patient, try to limit the distance from place where sharps are used and the PPC

Don't walk with a needle in your hand. If you carry needles, carry them in a tray

Don't hold a specimen container with one hand while a specimen is dropped or scraped into it from a slide, biopsy.

Hold the container in a tray or place it on the bench or trolley.

If the patient you use the needle on is a child, demented or unstable get the help of a colleague to stabilize the patient.

Keep hand behind needles do not bring your hand towards the needle.

Don't attempt to guide needles in or out of the injection site with your fingers.

Use syringe and needle which are good quality and safe.

Concentrate while working with sharps.

Do not indicate procedure involving sharps if it is not really necessary (eg. if oral medicine is good enough, don't prescribe injection).

Dispose of used needles in a puncture proof container immediately after use.

Practical steps to recap needle using "one hand" technique and dispose of syringes and needles in PPC

Note:

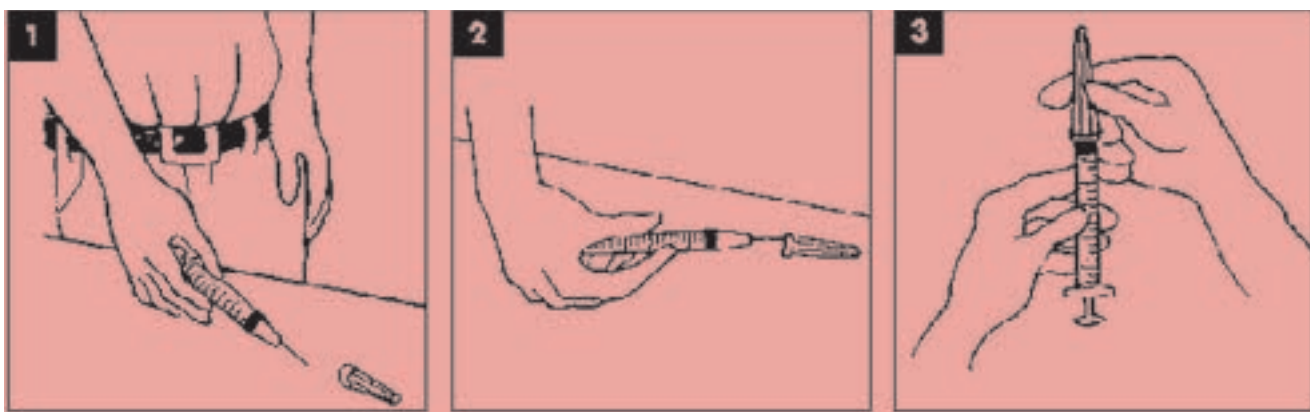
Dispose of one sharp at a time.

Store in a puncture proof container immediately after use at the site of the injection

Change the container when it is ? full and don't overfill.

"One-hand" technique to recap needle – if it must be.

If needles must be recapped, use the "one-hand" technique:



4. Summary

- Sharp injuries is the most common occupational accident among health workers.
- Different reasons may lead to sharp injuries but unsafe or careless practices while using or discard sharp account for most accidents.
- Some practices such as use of "safe box" (PPC) to dispose sharps right after use, or "one-hand" technique when needle must be recapped can prevent sharp injuries.

B5. Disinfection - sterilization of medical instrument

Note to facilitator: This module introduces briefly about processing of medical instruments, so that participants understand and can participate to safe processing of instruments. The instrument processing starts with health workers who use the instruments on the patients, and only complete with the workers who are responsible for store those instruments. However, many health workers who use the instruments are not clear about their role in this process so their participation has not been effective. Another fact is that some health workers think medical instruments used for HIV patients need to be processed separately, and more carefully. In this module, you should make it clear to participants that instruments used for different patients can be processed together, with the same procedure, following the instruction. Instrument processing should also follow Universal Precaution principle – consider blood and all bodily fluids are all potential source of blood-borne micro-organisms.

Details on instrument processing are available on Handbook – Safe and Friendly Health Worker in the presence of HIV. At the end of the module, you should point participants to part of the handbook where they can find detailed information and instruction.

Objectives: After this session, participants will:

- a) Be able to explain principles and common procedures of medical instrument processing;
- b) Know how to decontaminate used instruments;
- c) Understand that it is safe to process instruments used by HIV and non-HIV together, given the process is correct.

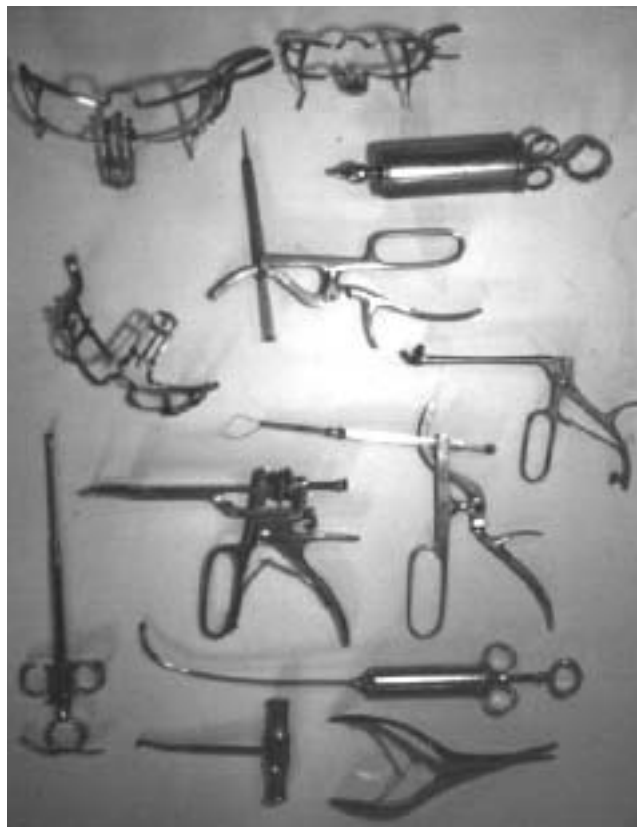
Time: 30 minutes

Material: Powerpoint slides.

Steps

1. Discussion

Ask – “How medical instruments are processed in your facility?”



“How do instruments used for HIV patients processed?”

Note the responses on flipchart.

2. Powerpoint slide presentation

Use slides to guide discussion. Before presenting each slide, you can raise the issue for participants to discuss to assess their level of understanding. After presenting each slide, you may want to pause to respond to questions, comments and to have participants’ reflection about current practices.

Slide 1: Why is correct instrument processing important?

- Prevent hospital infection for patients.
- Ensure safety for health workers who handle or use the instruments.
- Maintain instrument’s quality and life-span.

Slide 2: Four principles of instrument processing.

- 1) Clean is the first priority.
- 2) Sterile instrument for aseptic organ/body part.
- 3) Sterilization is the highest level of instrument processing.
- 4) Processed instruments should be kept in a dry and clean place.

Slide 3: Steps of instrument processing.

Decontaminate --> Clean --> Disinfect or sterilize --> Store --> Use

Slide 4: Decontamination soak

This step involves health workers who use the instruments.

Applied to all medical instruments in contact with blood, bodily fluids or put inside patient's organ/body part, and will be reused.

Goal of decontamination:

- Eliminate most of organic substances on instruments;
- Reduce the risk of transmission from instruments to the person who process them;
- Avoid blood and bodily fluids dried on instruments, make it difficult to clean.

Steps: Immediately after use in patient:

- Disassemble the instrument (if relevant);
- Soak all parts in the decontamination solution or water with detergent that contains decontamination chemical. Leave the instrument in the solution for at least 20 – 30 minutes.

Note: Some metallic instruments will be rusty if soaked for too long in decontamination solution. Such instruments should not be soaked for longer than 30 minutes.

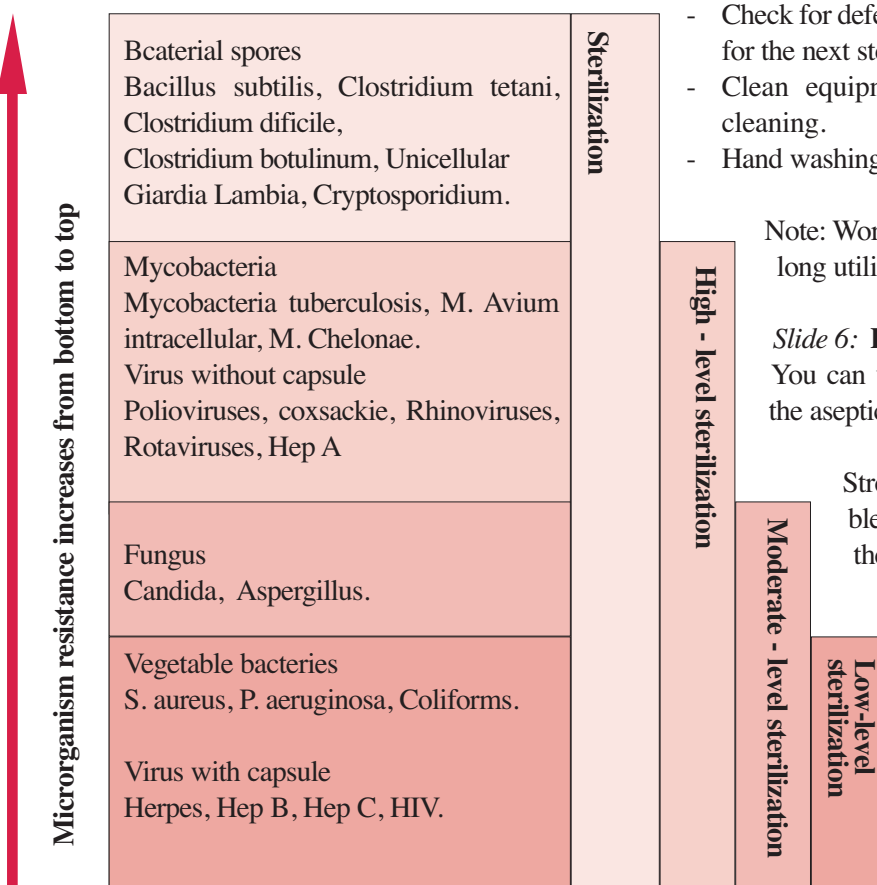
Slide 5: Clean

- Use brush to clean all the stains in luke-warm water with washing power.
- Rinse thoroughly.
- Dry by air or by clean towel.
- Check for defects before store or move the instruments for the next step of processing.
- Clean equipments used for decontamination and cleaning.
- Hand washing.

Note: Workers who clean instruments should wear long utility gloves.

Slide 6: Disinfection and sterilization – methods

You can use the following diagram to introduce the aseptic level of different methods.



Stress that HIV is among the most vulnerable, the most easy to be eliminated. Even the low-level disinfection (such as soak in solution of Chlorine 0.25% for 20 – 30 minutes) could be enough to eliminate HIV from instruments.

Slide 7: Disinfection or Sterilization?

Requirement on level of aseptic lies on the specific organ, body part that the instrument will be used.



- Tissues, blood, aseptic cavity and any aseptic body part or organ: all instruments must be sterilized.
- Semi-aseptic such as membrane of respiratory or digestive tracts: instruments must be sterilized or high-level disinfected. If endoscopy involves intervention, instruments must be sterilized.
- Mouth membrane, intact skin: instruments only need to be cleaned properly.

The choice of method should also take into the consideration material used to make the instrument. Eg. plastic instruments will not stand dry sterilization.

Slide 8: Storage of instruments after processing

- Store all sterilized instruments in intact package;
- Store sterilized instruments on shelves or in dry and clean cases;
- Daily check required to discover expiration:
 - Intact unpacked steam sterilized instruments in cotton wrap: 72 hours.

- Packed instruments in standard intact sterile bags: 1 month
- All instruments in damaged, wet packages must be reprocessed.
- Opened packages: only use within 24 hours.

3. Summary

- All medical instruments that have been used in patients or are no longer meet sterilization requirement must be processed.
- HIV is among the most vulnerable micro-organisms. Medical instruments used for HIV patients are processed together with the same kind of instruments used in non-HIV patients.
- Decontamination is the first important step of instrument processing.
- Required level of sterilization depends on the body part/organ where instruments will be used.



B6. Processing linen

Note to facilitator:
This module discusses procedures to process linens. The baseline study of the study Reducing HIV-related Stigma and Discrimination on Vietnamese



Hospitals found it was common in studied hospitals that linen used by patients with HIV were processed differently. Some hospital used a separate washing machine for linen used by HIV patients. Some hospital used bag in different color to collect such linen. In one hospital, staff burned those linen, or limited the amount of linen used by HIV patients. All the above practices are not based in any medical reason. Linen used by HIV patients pose the same level of risk as linen used by other patients, and should be processed together, and the same way as other linen.

Objectives: After this session, participants will:

- Be able to describe basic principles and procedures for linen processing;
- Know how to sort linen;
- Be assure that it is correct to process linen used by HIV patients together with linen used by other patients.

Time: 20 minutes

Preparation: Powerpoint slides.

Steps

1. Discussion

*Ask: "In your facility, how do you categorize used linen?"
"How do you process linen used by HIV patients?"*

if there is difference in processing linen used by HIV patients and those used by other patients, ask *"For which reasons do you do that?"*

Example: Training July 2006 and March 2007

Linen categorization

Categories: dry linen, linen that have stains of blood or bodily fluids, linen used by HIV patients.

Categories: dry linen, dirty linen (stained by blood, bodily fluid, vomitus, stool), soiled linen (used by patients with infectious diseases, HIV patients), linen for staff.

Categories: linen used in the operating theatre, linen stained with blood/bodily fluids, linen for staff.

Processing linen used by HIV patients

Linen used by "normal" patients are gathered into blue plastic bags. Linen used by HIV patients are gathered into yellow plastic bags.

Linen used by HIV patients are decontaminated before washing.

The hospital bought a washing machine to wash linen used by HIV patients.

Lend only old linen to HIV patients.

Linen used by HIV patients are burnt.

2. Powerpoint slides

Use slides to guide discussion. Before presenting each slide, you can raise the issue for participants to discuss to assess their level of understanding. After presenting each slide, you may want to pause to respond to questions, comments and to have participants' reflection about current practices.

Slide 1: Risk posed by linen

- May cause contamination of surfaces in the local environment (wards, places where linen gathered).
- Disseminate pathogen into the air (while gathering, counting or distributing linen, etc)
- Some sharps left among linen can cause accident.

Slide 2: Principle of linen processing

- Make sure it is clean.
- Make sure it is safe.

Slide 3: Sorting, gathering and transporting linen

- Categorization linen used by patients: 1) Regular linen; 2) Soiled linen (have stains of blood, bodily fluids, stool).
- Do not keep soiled linen in the ward for more than 24 hours.
- Gathering technique: fold areas with stains inside, do not shake, put in water proof bag.
- Gathering process: from clean to infectious, after gathering put immediately used linen in bags, do not leave them on the floor or the next patient's bed.
- Personal protective equipment: gloves, gown, mask.

Transportation: use trolley, avoid carrying by hands, there should a designated route for transportation of linen. Stress that it is not necessary to sort linen by HIV status. Linen should be sorted in 2 categories: regular and soiled linen.

Slide 4: Decontamination of soiled linen

- Soak in chlorine 0.5% solution for 30 minutes.
- Add more detergent and bleach to the washing machine. Use a program of linen with blood stain.
- Workers who are responsible for decontamination of the soiled linen should wear mask, gown, boots and utility gloves.

Slide 5: Store linen

- Each ward should have clean storage for clean linen.
- Linen should be arranged by type on shelves or cupboard, which must be clean and dry.
- Never leave soiled linen in the storage of clean linen.

Summary

- Linen processing is to reduce risks posed by linen. Objective of linen processing is to clean, and eliminates or kills germs.
- Linen used by patients should be sorted into "dry" and "soiled" categories.
- Soiled linen should be decontaminated before washing.
- Linen used by HIV patients should be collected, sorted and processed together with other patients, in 2 categories of "soiled" and "dry", not by HIV status of the patient.

B7. Hospital hygiene

Note to trainer: This module is to help health facility staff aware of the hygienic condition in their own facility, and encourage them to improve. This module also provides instruction on how to deal with blood and bodily fluids on surfaces, to avoid improper cleaning, or panicking – such as some in the cases involving blood of HIV patients.

In the project on reducing stigma and discrimination in Vietnamese hospital, at the baseline, participating hospitals are in a relatively poor hygienic condition but hospital workers and managers were not aware of that. The training rang the alarm. Only few weeks after the training, all hospital had improved significantly their hygienic conditions. This in turn, contributes to boost morale and pride of hospital workers.

Objectives: After this session, participants will:

- Understand principles of and methods applied for hospital hygiene.
- Know how to deal with blood or bodily fluids on surfaces.

Time: 20 minutes

Materials: Powerpoint slides on hospital hygiene, with photos showing contrasting environments – a dirty hospital and a clean hospital.



Steps

1. Picture - discussion

Slide 1: Pictures of a dirty hospital

Ask: “Who would like to work in this hospital?”



Slide 2: Pictures of a clean hospital

Ask: “Who would like to work in this hospital?”





And ask “*What are the differences between the two hospitals?*”

The answer is that the second hospital has a good hygiene and adhere to Universal Precautions, and not the other.

2. Powerpoint slides

Use slides to introduce, analyse some principles on hospital hygiene and guide the discussion.

Slide 3: Principles for cleaning

“Cleaning is to remove the dirt and contaminated material on the surface, rather than redistributing the dirt”.

Facilitate discussion to clarify this.

Slide 4: Methods for cleaning

- From the cleanest place to the most contaminated place,
- From up to down,
- From inside to outside,
- Tidy up the place, collect trash before sweeping floor,
- Only use broom in exterior areas, not inside wards or rooms. Ensure that cleaning it to remove dirt and not redistribute them,
- Use separate, clean mop/wipe for each area/kind of object,
- Do not clean while other people are working,
- Mops and wipes must be washed clean after cleaning (wash then hang sundry, or send to the laundry).

Slide 5: Regulation on hospital hygiene

- 1) Each department should have a room/closet for cleaning equipments.
- 2) There must be adequate equipments for cleaning.

- 3) Different mops are used for different areas of the department. After cleaning, mops must be washed and dry up.
- 4) Clean the cleaning equipments right after use.
- 5) Ensure that cleaning process do not disseminate micro-organism into the environment.
- 6) Do not wash cleaning equipments in a lavatory used for hand-washing.
- 7) Proper personal protective apparels must be worn.
- 8) Number of moppings and wippings are more important than volume of cleaning products used.

Slide 6: Cleaning blood and bodily fluids on surfaces

- Wear gloves and personal protective apparels;
- Use absorbent paper or disposable cloth to absorb fluids then gather all and put into bags for contaminated waste.
- Pour decontamination solution such as Javel 1%, Chlorine 1% on to contaminated surface and leave for 10 minutes.
- Clean using mop/wipe with detergent or decontamination solution.
- Change mop/wipe and clean with water,
- Clean cleaning equipment;
- Wash hands thoroughly right after removing gloves.

Emphasize: These are steps to clean surfaces with blood or bodily fluids of any patient, regardless their HIV status.

3. Summary

- Cleaning is to remove dirt and not redistribute them.
- Cleaning should be from the cleanest to the dirtiest places, from up to down, from inside to the outside.
- Surfaces with blood or bodily fluid of any patient should be cleaned properly with decontamination solution.

B8. Management of medical waste

Note to facilitator: This module addresses procedures to safely discard waste in health establishments. The project on reducing HIV-related stigma and discrimination in Vietnamese hospitals revealed some shortfalls in waste management, especially in sorting and handling medical waste. Mixing of harmful medical waste and trash, of sharps and other waste, which are quite common, pose risks to health workers, waste collectors and the community at large.

Objective: By the end of this session, participants will:

- a) Know how to sort different kinds of waste;
- b) Understand basic principles in discarding different kinds of waste.

Time: 30 minutes

Material: Powerpoint slides

Steps

Use slides to guide the discussion. Raise questions to stimulate discussion. After presentation, spend time for participants to discuss and ask questions. Try to have responses to questions from participants.



Slide 1: Why safely handling of medical waste important?

Waste from medical establishments include:

- regular waste, no contamination,
- waste contaminated with blood, biological sample, pathogenic tissues may cause harms to people who collect, process or community at large,
- chemical or radioactive waste can be environmentally hazardous.

Slide 2: Current situation in waste management in this facility

Show some pictures on waste management in the facility where participants come from. Below are some pictures show problems in collection, sorting, storage and processing waste in one hospital before training.

Slide 3: Five classes of waste in a health facility

- Contaminated waste
- Hazardous chemical waste
- Radioactive waste
- Pressurized tanks
- Regular waste.

Slide 4: Four groups of contaminated waste.

- a) Sharps (group A): are waste that can cause cut or perforation, can be infected. Examples of sharp waste





include: needle, surgical knife, pieces of glass pipes, ect. used in medical services.

- b) Non-sharp contaminated waste (group B): waste that contaminated with blood, bodily fluids and waste come from wards for infectious diseases.
- c) Highly contaminated waste (group C): waste generated from lab, such as: biological samples and their containers.
- d) Surgical waste (group D): include tissues, organs, body parts, placenta, fetus and bodies/body parts of laboratory animal.

Slide 5: Four groups of regular waste

- Household hospital waste (by patients and staff);
- Waste generated from professional activities not contaminated, such as bottles contain IV solution, ampules, etc.
- Waste generated from administrative activities such as papers.
- Waste from externality such as leaves...

Slide 6: Principles of waste classification

- The person who generates the waste should classify waste right at the origin.
- Waste should be contained in bag and container with proper code.

Slide 6: Color code for bag/container of medical waste

- Yellow: contaminated waste.

- Black: hazardous chemical and radioactive waste.
- Blue: regular waste and small pressurized tank.
- White: recycling.

Slide 7: Gathering and transportation of medical waste

- Waste container should be close to where waste generated.
- Contaminated sharp must be contained in "safe-box" (PPC).
- Medical waste should be transported separately to waste storage at least once daily and whenever needed.
- Health facility must define and clear route and time for waste transportation, avoid areas where services are provided and other clean areas.
- Bags contain waste must be tied closed, and carried in specialized trolley.

Introduce session that details waste management in Handbook for Safe and Friendly Health Workers in the presence of HIV.

Summary

- There are different kinds of waste generated from health facilities, including hazardous waste.
- To handle waste safely, it is important to classify it as it is generated, and contain it in proper container.

Chapter C

HIV Stigma and Discrimination

Introduction

This chapter gets participants to **NAME THE PROBLEM OF STIGMA**, to see that:

- Stigma exists and takes two major forms – isolating and blaming/shaming
- Stigma has two major causes – fear and lack of understanding on how HIV is transmitted; and moral judgment of others
- We are all involved in stigmatising, even if we are not aware that we do it.
- Stigma hurts – people living with HIV feel ashamed, isolated, and their self-esteem damaged
- Stigma is harmful to ourselves, our families, our health practice, and our communities
- We can make a difference by changing our own thinking and actions.

This chapter also gets health care workers to **name the problem in their own work context** – the specific ways in which they stigmatise HIV positive patients in the hospital. Participants learn that there are two broad categories of stigma within the hospital setting – the more open forms of stigma eg separating HIV positive patients or condemning them for their behaviour; and more subtle forms of stigma eg compulsory testing or breaking confidentiality, which hospital workers are less aware of. The aim is to get them to understand their own behaviour towards HIV positive patients in the hospital context and decide how they want to change things.

How do you introduce stigma in this chapter?

1. Start off with the **PICTURES** to introduce the idea of stigma – the pictures get participants to identify different forms of stigma. The pictures allow for distancing – stigma is described in an objective way – not yet personalised. At this stage we are only saying that stigma exists, but not saying that health workers are stigmatising.
2. Then introduce the **STIGMA DEFINITION** – to provide a language so that participants can talk about and analyse stigma.

3. Then a short powerpoint presentation on **OVERVIEW OF STIGMA IN HEALTH CARE SETTING**. This presentation address causes, forms of stigma in health facilities, including subtle forms, which may not be recognized by some people as stigmatising, or need to be changed. This session tries to help participants aware of stigmatisation in some practices in their own facility, as well as in the attitude, language, behaviors of their own and their colleagues.
4. After the overview of stigma in health care settings, participants will work in small group to identify and list all **FORMS OF STIGMA** in their own facility. This is the key session of the whole chapter C. This reflects participant’s awareness on stigma and their level of openness through admitting and sharing with other participants and facilitators stigmatising attitudes and behaviors right at their ward/department. In order to achieve this, facilitator team should be able to create a relaxing and open atmosphere in the training, and gain trust of participants. Facilitator(s) should address stigma issue in a neutral way, avoid criticism.
5. To close this half day, **PLHIV** give their **TESTIMONIALS** – talking about their lives since they discovered they were HIV positive and how stigma fees. These stories help to personalise the issue and show how stigma hurts, and that patients recognize health worker’s stigmatising attitude and behaviors.

Modules

- C1. Naming HIV stigma through pictures**
- C2. What is the meaning of ‘Stigma’?**
- C3. Overview of stigma in health care setting**
- C4. Naming HIV stigma in the facility**
- C5. How it feels to be stigmatised (Testimonials)**

C1. Naming HIV Stigma through pictures



Objectives: By the end of this session, participants will be able to:

- Identify different forms of stigma which occur in different contexts
- Identify how stigma affects people living with HIV and their families

Time: 45 minutes

Materials: Stigma Pictures. There should be one picture per group of 3-4 participants.

Steps

1. Naming Stigma

Picture Discussion – 15 minutes.

Divide into groups of 3-4 participants. Ask each group to select one picture. Ask each group to discuss – “*What do*

you see in your picture? How does this picture show stigma? How do you think the person stigmatised feels?”

2. Reportback

Ask one person in each group to report, one group at a time. Put the picture on the wall or on flipchart holder so that everyone can see – and have the group reporter explain its contents. Record points on flipchart. Keep a record of key points for a summary at the end.

After each report, **ask** –

“*Do anybody want to describe this picture in a different way?*”. This is to leave participants work with their imagination basing on their experience and knowledge. There is no wrong description of each picture. Each one can be described in many different ways.

“*Is this situation real? Have we seen or heard about these things happening?*”



Example – picture description

Training, July 2006

Picture A1 – Community giving their backs to a woman seated on a bench.

Woman sitting all alone – feeling sad and rejected. The whole community gives her their backs. They think she has done something wrong. Even a small child has been taught to stigmatise.

Picture A7: Parents stop their daughter from holding her baby.

Parents stop daughter from holding her baby. Fear based stigma. They know she has HIV and are afraid that she will transmit HIV to the child through physical contact. The woman is very unhappy. The baby is afraid, crying, asking for mother.

Picture A11 – A man looks sad, chained to a bed.

This is a picture of a drug user, who is chained to bed by the family with the hope that he would give up on drug. This person has possibly been infected with HIV. The family has no respect to him as a human being, so that they chain him as an animal. He looks sad but appears to accept the situation. There are broken utensils around him, showing that he had been very angry.

Picture A12 – The father is eating all alone

Father is eating alone. He looks thin – like HIV patient. His wife looks sad. She fears HIV infection so she asked him to eat alone. He is upset but he has accepted the stigma (self-stigma).

Picture A13 – Family hiding HIV patient in the house.

Family are hiding a family member with HIV in the house. They don't want the visitor to know that they have someone sick with HIV. Fear they will be stigmatised by the community. Stigma by association.

Picture A22 - Father returns home with HIV test results. Wife and daughter waiting for him.

Father returns home with HIV test results, looking very sad. He doesn't know how to explain his situation to his wife. Self-stigma – he is worried about disclosing his status.

Picture A24 - Man leaving office, looking very dejected.

One man has been fired after his employer found out he is HIV positive. He looks helpless and worried – not sure what he is going to do. Case of discrimination - fired by his employer.

A25 – Hospital staff watching and talking about a sick patient

Group of doctors and nurses gossiping about an HIV positive patient. They are keeping their distance – fear of infection. The patient looks very sick and hopeless.

A26 – Doctor wearing mask and gloves and staying at a distance from sick patient

Fear based stigma. Excessive use of gloves and mask. Doctor is afraid HIV patient will infect him. Fear-based stigma.

G4 – A woman going to a health center.

A woman walking toward a health center. She seems to want to hide. It is possible that herself or her family member has HIV and she wants to talk with a doctor but doesn't want anybody to notice.

Summary

Present and discuss the following points:

- ▶ Sometimes we mistreat people who we suspect are living with HIV. We isolate or reject them eg refusing to sit beside them in the tea shop; or we gossip about them and call them names. When we isolate or make fun of other people, this is called “**STIGMA**”.
 - ▶ When we stigmatise people living with HIV, we *isolate them*, saying they are a danger/threat to us (because we think they might infect us with HIV), or we *judge* them, saying they have broken social norms and should be shamed or condemned.
 - ▶ Stigmatising beliefs or attitudes lead to **discrimination** - unfair treatment of people living with HIV eg a worker living with HIV is fired.
 - ▶ **Stigma is not good. Stigma hurts people.** When we stigmatise, it makes people feel bad – lonely, worried, sad, and rejected.
 - ▶ People living with HIV are often **stigmatized by their own families and the community.** They have to eat alone, or they are forced to leave home and live somewhere else. This makes them feel very bad – and it affects their morale and their health.
 - ▶ Many PLHIV feel inferior about themselves – they think that they should feel shamed to themselves, that they are the source of infection, deserved to be looked down, isolated.
- ▶ There are different forms of stigma:
 - **ISOLATION AND REJECTION** – based on ignorance and fear about HIV transmission. People living with HIV are forced to sit alone, eat alone, and live alone. Examples: A1, A7, A12, A25, A26
 - **SHAMING AND BLAMING** – gossip, name calling, judging, shaming. People living with HIV are shamed for “bad behaviour”. Examples: A1, A11, A26
 - **SELF-STIGMA** – People living with HIV stigmatise themselves in reaction to stigmatisation from community. They accept the blame and rejection of society and isolate themselves. A1, A12, A12
 - **STIGMA BY ASSOCIATION** – The family is blamed and shamed by the community because a family member has HIV. Examples: G4, A13
 - ▶ Some of the **EFFECTS** of stigma are:
 - Feelings - sadness, loneliness, rejection, hopelessness, self-doubt
 - Shame and loss of confidence. Feel they are no longer accepted by others
 - Discrimination – people living with HIV are kicked out of the family, their jobs, organisations, etc
 - Denial – stops people disclosing status and getting help



C2. What is the meaning of ‘Stigma’?

Objectives: By the end of this session, participants will be able to describe what stigma means and give examples

Time: 20 minutes

Steps

1. Participants’ ideas on Stigma?

(Brainstorm)

Ask – “What do you think is the meaning of ‘STIGMA’?”
Record the points on the flipchart.



Examples from training March 2007

- The word “ky thi” (Vietnamese word for stigma) is composed from 2 single words “ky” and “thi”. “Ky” means strange or different in a negative way. “Thi” means look or view. So “ky thi” means to look strange or different from others in a negative way.
- “Ky” means strange or different. “Thi” means to look down on or despise someone. So “ky thi” means to look down or despise someone because s/he is different.
- Blaming people for their bad behaviour
- Treating other people as inferior
- Keeping at a distance and avoiding contact with people
- Isolating or rejecting people out of fear that they will infect us with HIV
- Treating people as outcasts eg like lepers who should be forced to leave
- Condemning people for breaking social norms – social evil

2. Summary

Then explain and discuss the following:

- ▶ Stigma is a form of social control, separating those who are seen as different from the rest of ‘us’ who are ‘normal’. Often this ‘difference’ relates to some behaviour or physical attribute that is considered ‘wrong’ or ‘immoral’ by the dominant group. Stigmatised people lose face or status because of these ‘signs of shame’, which other people think show that they have done something bad or wrong.
- ▶ To stigmatise is to treat others as if they are inferior, have done something bad or wrong. The act of stigmatizing is an act of judgement; we judge people, saying they have broken social norms and should be shamed/condemned; or we isolate people, saying they are a danger/threat to us.
- ▶ Stigmatising beliefs lead to discrimination - unfair treatment of those who are believed to be inferior.
- ▶ HIV stigma has two major CAUSES -
- ▶ People don’t know how HIV is transmitted so they are afraid they might get infected through contact with people living with HIV – so they isolate them.
- ▶ People believe that HIV is transmitted mainly through

injecting drug use or sex with sex workers, so they assume that people living with HIV got HIV through these activities. So they judge or condemn people living with HIV for doing something immoral.

- ▶ Stigma is viewed at present as something right – they think that it is acceptable to shame and isolate people. People are not aware of how it affects people living with HIV and how it affects the HIV epidemic.



C3. Overview of HIV-related stigma in health care setting

Objectives: By the end of this session, participants will be able to:

- a) Understand root causes of stigma by health care workers.
- b) Be aware of stigmatization in some practices in health care settings, as well as in language and behaviours of health staff.

Time: 30 minutes

Preparation: Powerpoint slides.

Steps

1. Powerpoint presentation

Summarize the discussion in previous session (on meaning of “stigma”) to introduce this session – focusing on stigma in health care settings.

Slide 1. Definition of stigma

Explain to participants that there are different ways to define stigma and discrimination. This presentation shares definitions presented in Vietnam’s Law on Prevention and Control of HIV/AIDS.

“Stigmatization against a person infected with HIV/AIDS is an attitude of condescension or of disrespect towards another person due to the awareness or suspicion that the person is infected with HIV/AIDS or has close relationship with a HIV-infected or suspected HIV-infected person” (Vietnam’s Law on Prevention and Control of HIV/AIDS).

Slide 2. Definition of discrimination

“Discrimination of a person infected with HIV/AIDS is a behavior of alienation, refusal, isolation, mal-treatment, prejudice or restriction of rights towards another person because of the awareness or suspicion that the person is infected with HIV/AIDS or has close relationship with a HIV-infected or suspected HIV-infected person”. (Vietnam’s Law on Prevention and Control of HIV/AIDS).

Slide 3. Who are stigmatized and discriminated against?

- People who are different from the majority, in term of:
- Physical appearance
- Disease
- Behavior
- Members of certain social groups
- ...



Slide 4. Root causes of HIV-related stigma

- HIV causes diseases, may lead to change of physical appearance.
- HIV/AIDS is associated with death.
- HIV is usually associated with groups who have already been stigmatized socially (drug users, sex workers).

Slide 5. HIV-related stigma in health care settings

Causes:

- Perceive as having high risk of contracting HIV,
- Feel hopeless for not being able to cure patients from HIV, not having ARV, no being able to reduce physical and psychological suffering
- Social stigma: perception that PLHIV is associated with condemnable social groups,
- Being reluctant, having difficulty in interacting with PLHIV.

Slide 6. HIV-related stigma in health care settings

Manifestations:

Present some quotes taken from baseline study (if conducted) in the facility. For examples:

- “of course we have to test all patients, to know who are infected (with HIV) to have protective measures for our staff” (hospital manager).
- “when the nurse gave me a hot, it was very painful, I could not help but scream, she said “Why when you injected (drug) you didn’t feel the pain?” (patient).
- “If I stay in the hospital, I will have to stay in the AIDS Department” (patient).

Comment: stigma in health care setting can be with individual staff or with the whole institution using regulations, procedures.

Slide 7. “Open” stigma.

Institutional:

- Distinguish linen, instruments used by or for patients with HIV.
- Put HIV+ patients in separate room/department.
- Note HIV test result on the cover of patient’s file or on testing request (for other tests).
- Body of a dead patient with HIV has to be put in the double plastic bag, then the bags have to be sealed.

Individual:



- Treat HIV+ patient the last.
- Insult HIV+ patients.
- Avoid contact with patients.
- Deny services.
- Avoid providing some services (surgical procedures, injection...).
- Request patients or their family members to do some steps in the care procedures.
- Send patients to other providers or other facilities.
- Use excessively protective apparels.
- Request HIV+ patients to prepare body of a dead PLHIV.

Slide 8. “Subtle” stigma

Institutional:

- Process linen used by and instruments used for PLHIV separately.

Individual:

- Request HIV testing basing on perception of individual health worker toward individual patient ‘s level of risk.
- Perform HIV test without patient’s consent.
- Do not inform HIV+ test result to the patient.
- Inform HIV+ test result to family member, all staff of the department/hospital.
- Gossip.
- ...

Slide 9. HIV-related stigma in health care settings

Consequences:

- “We have to send older staff, who are married,

already have children to work in AIDS department because young and unmarried people don't want to work there" (Hospital director).

- "I rather die than stay in the hospital because if I stay in the hospital I will have to be in the AIDS department, everyone will know (that I have HIV)" (patient).
- "If I wear hospital clothes, it is no difference as if I would wear a board written HIV+ on my chest, from inside the hospital to the outside the hospital gate, everybody know (the clothes designated to HIV+ patients)" (Patient).
- "Some HIV patients do not cooperate. They even threaten to stick needle to us" (Nurse).
- "We only think testing is to protect our staff but didn't know it violate the law" (Doctor).

- Stigma against HIV+ patients exist in many health facilities.
- Stigma in health care setting can be institutional – basing on the institutional regulations or practices of majority of staff, or individual and manifested in different forms – from gossiping to avoiding contact or isolate patients with HIV.
- Health workers stigmatize, because of fear of transmission, of social prejudice about vulnerable groups, of difficulty in interacting with HIV patient, or of the helplessness because it is not possible to cure the patients.
- Stigma in health care settings deters PLHIV from seeking medical services, from disclosing their status, and pushes them to negative reactions. On the other hand, the separation of HIV+ patients in hospital also lead to challenges in staff management because the categorization of patients (into HIV+ and HIV-) creates the belief that it is dangerous to work with HIV+ patients.

2. Discussion and summary

Spend time for participants reflect and discuss the following points:

C4. Naming stigma in the facility



Objectives: By the end of this session, participants will be able to:

- a) Identify and name stigmatizing attitudes and discriminatory practices within their ward, their department, their hospital, and among themselves;

- b) Explain the causes of those attitudes and practices;

Time: 1 hour

Steps

1. Departmental group discussion:

Then divide into 4-5 groups according to their different professional tasks.

Ask each group to list attitudes, behaviours, practices that stigmatizing or discriminatory in their own ward/department.

Save time for groups discuss and debate about stigma manifestations in their own department. Sometimes stigma is hidden below the argument of "safety to health workers and other patients". Therefore, debate

and discussion are needed to define the line between stigma and technical procedures. You should go around to support discussion when needed.

See in the box examples of discussions.

2. Report back and plenary discussion

- Ask each group to report back. After report of each

group, the whole workshop will discuss on the following 3 points:

- Are those manifestations are seen only in few individuals or common in their respective department?
- Those manifestations are on seen in that particular department? Such manifestations exist in other department or not? In which way?
- Why those attitudes/behaviours/practices?

Example from March 2007 training

Surgical and Obstetric Departments:

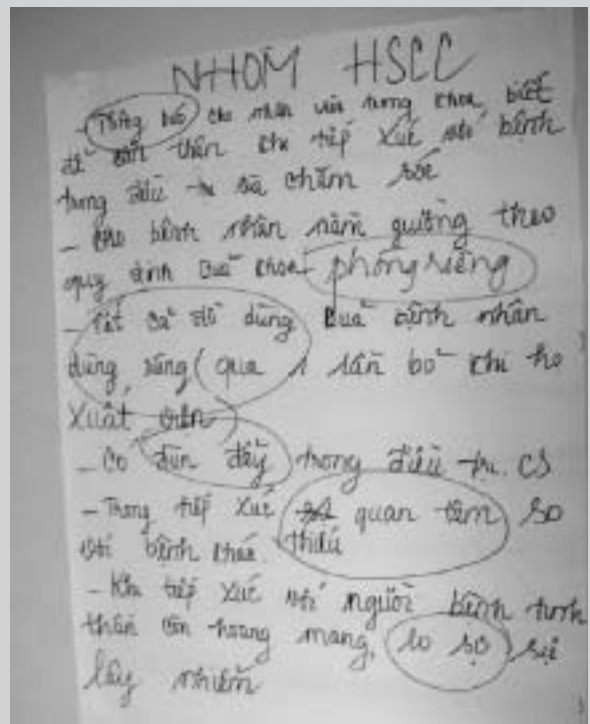
- We inform patient's HIV status to all staff of the department.
- We counsel their family so that they know how to prevent transmission (inform HIV test result without patient's consent).
- We are afraid, not confident while providing care to HIV patients.
- We (physicians, nurses, auxiliary nurses) do not contact HIV patients as often as we contact other patients.
- We do not give mattress to a HIV+ mother, we give her a simple mat and we burn it after.
- We visit HIV patient less often, to other patients we visit 2-3 times a day, check on them frequently. To HIV patients, we visit only once a day and check on them only now and then.

Outpatient and Paraclinical Departments:

- We wash our hands very carefully after we have examined patients who are suspected to have HIV.
- We wear goggles while performing procedures involving blood such as pulling teeth for patients who look like they may have HIV.
- When we suspect that the patient has HIV, we wear gloves and disinfect the stethoscope after examining the patient.
- Blood samples of patients suspected of having HIV are collected separately and tested separately.

Internal Medicine and Pediatrics:

- We give each HIV positive patient one whole bed while other patients often have to share two in a bed (give "priority").
- We take the vital signs for HIV positive patients only after we have completed all the other patients.
- We clean the instruments used for HIV positive patients separately.



- In our mind, we feel sympathy and pity, we want to pay attention.

Intensive Care Department:

- We inform all staff about the status of those patients who are HIV positive so that staff are careful while providing care.
- We locate all HIV patients according to the Department's instruction (in a room reserved for infectious patients).
- HIV patients are given their own stuff (only use for them, discard when they leave the hospital).
- We pass the buck when patients need care.
- We do not give the same attention to HIV positive patients as other patients.
- When coming into contact with HIV positive patients, some of us are afraid that we will be infected.

Example – Causes of stigma

Training July 2006 and March 2007

Fear of transmission.

Did not have any training on universal precaution, thus don't know how to ensure the safety.

Perception that patients get HIV due to bad behaviours, thus do not deserve respect.

Have never talked with a HIV patient, do not understand their feelings, thus don't feel sympathy or empathy.

HIV patients and their family members usually feel inferior, do not dare to complain or claim their rights.

See HIV patients as the "second class" patients – some of them are addicted, poor, abandoned.

There is no policy in the hospital. Staff just follows one another.

3. Summary

- ▶ Stigma exists in many health facilities, including the one holding this particular training.
- ▶ Stigma manifests in different forms, from isolation to avoidance.
- ▶ There are different causes of stigma in health facilities, including lack of knowledge, lack of skills, lack of policy and guidance, looking down at patients with HIV.

C5. How It Feels to be Stigmatised (Testimonials)

Objectives: By the end of this session, participants will be able to:

- a) Name some of the forms of stigma experienced by people living with HIV
- b) Describe the feelings of being stigmatised - how stigma hurts people living with HIV and affects their psychological health and their will to live

Time: 45 minutes

Preparation: Brief PLHIV beforehand on how to give their testimonials. Make the following points:

- Talk about your own experience in health care setting.
- Tell the story in a factual way without blaming or criticising the hospital staff. This will ensure that the hospital staff don't become defensive. This will make it easier for them to name the problem of stigma and accept some responsibility for solving it.
- PLHIV co-trainers should not give testimonial.
- Depends on the number of participants, you can invite 1-3 PLHIV to share in smaller groups, so that many participants have the opportunity interact with PLHIV.

Steps

1. Testimonials

If there are more than 20 participants, divide into two or three groups, each with a PLHIV. Ask each PLHIV to tell his/her story. Encourage participants ask questions to clarify the story. Before the PLHIV



start to tell their story, remind participants identify forms of stigma reflected in the story.

Focus on the experience of the people living with HIV, but also encourage hospital workers to respond to these stories with their own examples of stigma in the hospital or community. *“Have you seen or heard of things like this?”*

2. Report back

If there is enough time bring the groups back together and ask one of the participants in each group to give a brief summary of the story.

Then ask – “What were the main forms of stigma identified in the stories?”

And – “How would you feel if you were in his/her position?”

Example of Testimonial – Stigma in health facilities

Training, July 2006

I got married when I was 18 and got pregnant right after. When the labour started, I was brought into the city's hospital. There, doctor prescribed blood tests. While I was already on the delivery bed I heard someone entered the room and announced "This patient is infected with HIV". All of sudden, staff almost abandoned me on the delivery bed. I almost delivered the baby on my own, medical staff only caught my baby when he was already out. I was shocked and anxious because I had never thought of HIV. Attitudes of health workers frightened me. I was afraid that my baby and myself would be abandoned, and that our lives would be in danger for not being cared for.

Hospital staff tried not to touch me. After the baby delivered, nobody helped me to move to the stretch. I had to move myself to the stretch, also to the bed after. I was put in an empty room, alone. After delivering the baby, other women got examined and helped to change their delivery clothes, but I was asked to do it on my own. Almost all patients and their family members knew that I have HIV. Many people found an excuse to pass through the door to look at me as if I am a monster. I could do nothing than hold my baby and cried. I feel shameful and badly hurt. I even didn't want to continue to live.

Training August 2006

One day I had a problem with my stomach so I went to the CDC outpatient clinic for HIV positive patients. The doctor there sent me for an ultrasound scan in the provincial hospital. When I arrived at the hospital with the paper from the CDC clinic, the doctor who did the ultrasound gave me a very reluctant look (because he knew that I have HIV, everyone know that patients from the CDC clinic are all HIV positive). Then he made me wait for a long time, and I was only served last. He probably hoped that I would not wait, but would run away. When it came to my turn, he put on gloves. And not only that, he put a glove over the ultrasound probe. I was totally hurt by this behaviour. Even me, a person without any technical background understands that it is totally unnecessary, especially when my skin is perfectly normal. For the exam, he just put the probe on me for a few second then said "you have no problem". I realized how much he stigmatized and discriminated me. He didn't treat me as with a human being. And the exam had no significance. If I had had something, he would not have found it. I will never go back to that doctor again.

Training March 2007

Last year I got a unplanned pregnant. After meeting with the counsellor, I decided that I would not carry the pregnancy. But because my pregnancy is also 5 months, I was referred to a hospital in Sai Gon for abortion. Before going to Sai Gon, I was very sad and nervous. Many nights I could not sleep. I went to Sai Gon the previous afternoon so that I would be able to come to the hospital early in the morning, hoping that I would be among the first to get services. To my surprise, although I was the first to register, I was the last to be served. During the whole time of the procedure, although I was very sad and in pain, nobody talked to me, even once. When the procedure completed, nobody helped me to get up and put my clothes on. I had to get up on my own, put up my stuff. After that, the doctor asked me to clean the procedure table. I had to roll the plastic sheet where I lied and put in the bin. I has already known that PLHIV are stigmatized but I could never imagine doctors could be so stony-hearted.

Training March 2007

About 5 months ago, I got a CMV. Because it is an eye problem, I went to Eye Hospital to get treatment. There, after knowing that I am a PLHIV, they immediately sent me to Tropical Diseases Hospital, saying that PLHIV should be treated there. When I got to Tropical Diseases Hospital, they sent me to the Eye Hospital because only doctors specialized in eye problems could give me proper treatment. I had to go back and forth several times like that until I could not control my temper and threaten to sue Eye Hospital that they provided me treatment. I don't know if I live in a countryside province, or I don't know anything about law, my eyes could still see anything today or not.

3. Summarize

- ▶ This exercise helps us understand how it feels to be stigmatised. The feelings of being stigmatised are very painful. People get badly hurt.
- ▶ Some HIV positive patients say that hospital workers are afraid of them – that they will infect them with HIV. As a result health workers minimise contact with HIV positive patients –, so they can keep their distance. This makes these patients feel bad – as if they have a contagious disease.
- ▶ Some HIV positive patients think that the hospital workers are judging them – blaming them for getting HIV from “bad behaviour”.
- ▶ These two things – the isolation and shaming – make people living with HIV feel like outcasts – as if they are no longer human - and this has a serious effect on their health.
- ▶ Stigma destroys the self-esteem of people living with HIV – they begin to doubt themselves. They feel very alone, confused and demoralised at a time when they really need the support and company of other people.
- ▶ While respecting the fact that hospital staff do have fears about their own safety in the hospital, hospital staff need to take the views and feelings of their HIV positive patients into account – if they are to focus on the well being of their patients.



Chapter D

Development “Safe and Friendly Health Facility Code of Practice”

Introduction

In this chapter hospital staff will develop practical guidelines to apply their new knowledge, skills, ideas on HIV, stigma and universal precautions – for a “Safe and Friendly Health Facility”.

A Safe and Friendly Health Facility is where all patients and staff could avoid exposure to pathogenic agents, also where rights of patients and of staff are respected, and the relationship patient - staff is humane and mutually respectful.

“Safe and Friendly Health Facility Code of Practice” provides concrete guidance on some common practices in health settings that hospital staff will begin to use on the job. Applying the new code of practice on a daily basis will help to reinforce and deepen what was learned during the training course. Staff will begin to internalize the new, non-discriminatory ways of working, which will become standard practice. In this way the staff themselves will create a stigma free, “safe and friendly” facility.

The new code of practice will be written by the hospital staff themselves, rather than developed and imposed by management. This will help facilitate a sense of ownership by everyone – and staff will be more likely to implement the new procedures.

This Chapter – Development “Safe and Friendly Health Facility Code of Practice” helps to:

- Bring together all the knowledge and skills learned about HIV, stigma and universal precautions.

- Build up our commitment to change things – to stop stigma and discrimination and implement Universal Precautions.
- Agree on goals and how to achieve them.

Steps in drafting the Code of Practice

The process of developing the new code of practice involves a series of steps – and the modules coincide with these steps. The first two steps (and modules) are carried out in groups of 20 – 40 people – can be the grouping as for the training earlier. Staff are grouped according to their professions (doctors and nurses, auxiliary nurses/ward staff, administration and support staff). At the completion of module 2, each group will have their own draft of the Code of Practice.

The third step (and module) will bring all the groups together – the staff of the whole hospital - to share their draft guidelines and agree on the new code of practice.

The fourth step (and module) is carried out by the Steering Committee, who will synthesize all the draft guidelines into one comprehensive Code of Practice for a Safe and Friendly Health Facility.

Modules

- D1. Introduction of Law on Prevention and Control of HIV/AIDS**
- D2. Group Work to Develop Code of Practice**
- D3. Full Meeting to Agree on Code of Practice**
- D4. Final Draft and Implementation**

1. Key messages



Note to facilitator: Try to convey the following messages to participants, encourage them to actively take part in development and implementation of the Code of Practice.

- **We are all responsible for building a safe and friendly hospital.** We can all play a role in educating others and promoting the new practices.
- **Be a role model.** Apply what you have learned in your own lives. Think about the words you use about people living with HIV and try to change how you think and act.
- **Encourage people living with HIV to talk, listen to their ideas and concerns, and treat them as friends.**
- **Challenge stigmatizing words and actions when you see them.** Get people to think about how their words and actions can hurt.
- **Share what you have learned.** Tell your family and friends what you have learned and get others talking about HIV and how it affects our lives.
- **Talk openly about AIDS.** Show you are not afraid to talk about AIDS. This will help people see that this is not a shameful thing that has to be hidden. Talking openly about AIDS will also empower people living with HIV and help relieve some of their self-stigma.
- **Encourage people to talk openly about their fears and concerns about AIDS** and correct myths about AIDS and people living with HIV.
- **Help normalize HIV/AIDS.** Get people to regard people living with HIV as ‘people with a long term manageable illness’, and not ‘people with bad behaviour’.
- **Act against stigma as a hospital community.** Work together to put in place the new policies to create a “safe and friendly hospital”.
- **Think big! Start small! Act now!** Have a big vision – but start with something small. And don’t wait - act now!

D1. Introduction of the Law on Prevention and Control of HIV/AIDS

Objectives: By the end of this session participants will be able to describe the legal provisions on HIV-related stigma in health care settings

Time: 45 minutes

Materials:

- Copies of the Law on Prevention and Control of HIV/AIDS, or copies of “Handbook for Safe and Friendly Health Worker in the presence of HIV” in which the Law is an appendix.
- Small pieces of papers, each has one question written. Each participant should have one piece.

Steps

1. Starter (15 minutes)

Hand out one piece of paper with question to each participant at random. Ask each participant to read out his/her question and answer it. The trainer read out loud each question, and ask people who have picked that question to answer. Can also randomly invite people to read out loud their question and their response. Should not spend too much time here. The objective of this activity is to stimulate participants to think about concrete issues related to HIV, from legal perspective. Then introduce the presentation on AIDS Law.

- Can a health facility refuse to treat a patient because s/he is HIV positive?
- Is a health care worker allowed to work if s/he has HIV?
- Does the hospital director have the right to know the HIV test result of a patient?
- Are pregnant women provided PMTCT treatment to reduce the risk of mother to child HIV transmission free of charge?
- Is it legal if an HIV test is conducted without a patient’s knowledge?
- Under what circumstances can a person ask for an HIV test for a family member?

- The health facility that conducts the HIV test should provide the patient with pre and post-test counselling. True or false?

2. Law on Prevention and Control of HIV/AIDS (Powerpoint slides)

Introduce provisions of the law on some specific issues relating to stigma in health care settings.

Slide 1. Stigma and Discrimination

Stigmatization against a person infected with HIV/AIDS is an attitude of condescension or of disrespect towards another person due to the awareness or suspicion that the person is infected with HIV/AIDS or has close relationship with a HIV-infected or suspected HIV-infected person.

Discrimination of a person infected with HIV/AIDS is a behavior of alienation, refusal, isolation, mal-treatment, prejudice or restriction of rights towards another person because of the awareness or suspicion that the person is infected with HIV/AIDS or has close relationship with a HIV-infected or suspected HIV-infected person.

Slide 2. Rights of PLHIV

- a) Integrated life within the community and society;
- b) Treatment and health care;
- c) Education, vocational training, employment;
- d) Protection of privacy and confidentiality with respect to HIV/AIDS;
- e) Refusal of examination or treatment in the last phase of the disease;
- g) Other legal rights as provided by this Law and other related legal provisions.

Slide 3. Obligations of PLHIV

- a) Implementation of measures to prevent the transmission of HIV to other people;
- b) Informing his/her HIV-positive test result to his/her spouse or fiancé;
- c) Adherence to ARV treatment regulations;

- d) Implementation of other obligations provided by this law and other related legal provisions.

Slide 4-5: Behaviors strictly prohibited

1. Purposefully transmitting or trying to transmit HIV to another person.
2. Threatening to transmit HIV to another person.
3. Stigmatizing and/or discriminating against people infected with HIV/AIDS.
4. Parents or guardians abandoning underage children infected by HIV.
5. Publicizing the name, age, address, images of a person infected with HIV/AIDS or disclosing information about someone's HIV infection to others without consent of that person, except in cases mentioned in Article 30 of this Law.
6. Falsely reporting HIV/AIDS infection about a person uninfected with HIV/AIDS.
7. Compulsory HIV testing other than cases provided in Article 28 of this Law.
8. Transfusion of HIV-contaminated blood or blood products, transplantation of tissues or body parts contaminated with HIV to another person.
9. Refusing to provide examination or treatment to a person on the grounds that this person is or suspiciously infected with HIV/AIDS.
10. Refusing the burial or cremation of a dead person for reasons related to HIV/AIDS.
11. Taking advantages of HIV/AIDS control activities for profit or illegal behaviors.

Slide 6. Pre and post test counseling

1. Counseling should be provided to all cases of HIV testing before and after testing.
2. Only trained and authorized people shall be allowed to conduct pre- and post-test counseling.
3. HIV testing facilities shall be responsible for organizing pre- and post-test counseling.

Slide 7. Voluntary testing

1. HIV testing shall only be conducted on the voluntary basis of the person to be tested.
2. The person who voluntarily seeks HIV testing must be 16 and older with full civil behavioral capacity.
3. HIV testing of persons under 16 years old or incompetent persons may only be conducted when there is written voluntary informed consent of

his/her father, mother or the legalized guardian.

Slide 8. Compulsory HIV testing

1. Compulsory HIV testing shall be conducted in the case that there is an official request for justice and legal purposes, or a decision of a criminal investigation department, the People's Prosecution Institute or People's Court at all levels.
2. The Minister of Health is responsible for the issuance of regulations on compulsory HIV testing, in necessary cases, for the purpose of diagnosis and treatment.
3. The Government shall stipulate the list of occupation and professions requiring HIV testing before recruitment.
4. Costs for undergoing HIV testing for cases listed in item 1 of this Article will be covered by the State.

Slide 9-10: Informing of HIV positive testing result

1. "Positive" test results shall only be released to following persons:
 - a) Tested person;
 - b) His/her spouse; his/her parent(s) or legalized guardian(s) if the tested person is underage or lacks typical behavioral competence.
 - c) Authorized persons who are responsible for informing "HIV positive" test results and providing counseling to tested persons;
 - d) Those who are responsible for providing care and treatment for HIV infected people in health facilities, including: the head of medical department or ward where the HIV infected people are being treated; authorized staff and health care personnel in health establishments who directly involve in treatment and care for HIV infected people;
 - e) Directors, medical officers and staff who are directly involved in treatment and care for HIV infected people kept in prisons, educational facilities, and centers for treatment -education-social labor;
 - f) Authorized persons from organizations stated in item 1 Article 28 of this Law.
2. Persons stated in item 1 of this Article shall be responsible for the confidentiality of "HIV positive" test results, except the tested person stipulated at point a, item 1 of this Article.

Slide 11: Responsibilities in providing treatment to PLHIV

1. Medical facilities are responsible for examining and treating people infected with HIV; in the case that treatment is in the form of drugs to resist HIV, then the medical facility must meet the standards set by the Ministry of Health.
2. Medical practitioners and health care workers shall be responsible for providing care, treatment and health education for HIV/AIDS infected people so that they are able to take care of themselves and prevent HIV transmission to others.
3. People infected with HIV/AIDS who have opportunistic infections or other HIV/AIDS related illnesses shall receive treatment at the medical department specialized in the type of that conditions or at a separate department, and shall be treated equally as other patients.

D2. Group Work to Develop Code of Practice

Objectives: By the end of the session participants will have developed a draft Code of Practice for Safe and Friendly Health Facility applying their new knowledge, skills and ideas on HIV/AIDS, stigma and universal precautions

Timing: 2 hours

Materials: Outline of the Draft Code of Practice – copies for all participants

Steps

1. Current situation (group work)

Divide into 5 groups. In 15 minutes, each group will list all existing policy and practices in one of the five areas as the following:

- a) Admission, care and treatment for PLHIV
- b) Counseling and testing
- c) Confidentiality
- d) Universal Precautions
- e) Training and dissemination of policy on HIV/AIDS

Give each group 5 minutes to report back, and 5 minutes for comments, clarification, debate and additional inputs. After each group's report, facilitate the discussion to point out specifically policy items or practices that have not been implemented seriously, those have been missing or



inappropriate, basing on knowledge and skills gained during the training and with the reference of the AIDS law. Ask each group to note comments and inputs from the whole big group.

Summary: In almost all discussions, there are rooms for improvement in all 5 discussed areas. Point out that those pitfalls contribute to the health worker's feeling of being unsafe, and PLHIV being stigmatized and discriminated against. To improve, some policies and/or practices need to be changed. For that, we need concrete policy and guidance to be applied in the whole facility. Safe and Friendly Health Facility Code of Practice is one way to bring about these policies and guidance.

Example – Discussion on existing policies and practices in the hospital

Training – April 2007

Group A: Admission, care and treatment for patients with HIV

- Patient visits the hospital --> take vital signs --> invite doctor to examine --> admit to the hospital if appropriate
- Request patients to undergo routine tests and tests that required for diagnosis --> decide on treatment
- From the beginning --> put (HIV) patients in the infectious (diseases) ward: bed and cabinet are the same with other patients'.
- Doctors and nurses wear gloves and mask while providing care and treatment.
- Visit patient in the morning and in the afternoon, instruct patient and family about diet and daily hygiene.
- Treatment: medicines from the (national AIDS) program + as required by patient's illness.
- Medicine: sometimes patients have to buy.
- When patient leaves the hospital: discard bed linen + clothes + decontaminate their bed.
- Give patient the discharge paper and instruct them to go to OPC (out patient clinic for PLHIV).

Group C: Confidentiality of HIV test result

- When the test result comes out, if positive then inform Hospital Director and Department Head. Send the second blood sample to Preventive Medicine Center (for confirmation).
- Director Board and Planning Department receive the confirmation and inform HIV Counseling Room.
- HIV Counseling Room provides counseling to the patient.
- In fact, every staff of the department knows the result. During morning staff meeting, doctor informs so that we know to be careful. In the hospital, students who come to practice also know because they can look at the patient's file. Once the patient is invited to the Counseling Room then we know that s/he is positive because the negative patients won't be invited to come there.

2. Code of Practice development (Group work)

Participants stay in the same group as in Step 1. Ask groups to spend about 20 minutes to draft regulatory guidance for practices in their own facility in each of the 5 areas as above. Suggest groups to use AIDS law and Code of Practice developed by another facility as references.

Before groups prepares for reporting back, explain that pieces that groups are preparing, after being discussed in the big group will be merged into their own draft Code of

Practice. Each group will then assign one person to form a team of 5 people to refine the draft. A representative will present their draft in the meeting of all staff in the facility. The Steering Committee will then incorporate all drafts and inputs during that meeting to come up with the Code of Practice for the facility.

Spend 10 minutes for presentation and discussion of each group's work. Come to common agreement on each point of the draft.



Example – Group work on draft Code of Practice Training – March 2007

Group 1: Admission, care and treatment for PLHIV

- Equal in admission and care for patients with HIV.
- No separate room, no discrimination.
- Provision of pre and post test counseling.
- the confidentiality of positive HIV test result.
- there is opportunistic infections then refer the patient to the appropriate specialty.

Group 2: HIV testing and counseling

- All HIV testing are voluntary, or prescribed by doctor in line with Ministry of Health's instruction.
- All HIV tests have to be done with pre and post test counseling, provided by a trained health professional.
- Those who have been tested positive in a lower level will not be re-tested.
- Those who tested negative should be counseled to be re-tested again in 3-6 months
- Positive test result should be kept confidential, only inform the patient after counseling.

Group 3: Protecting confidentiality of HIV test result

- A positive HIV test should be informed to the patient, department head, treating doctor, counselor, and health personnel who directly provide care to the patient.
- Staff are prohibited to inform HIV test result of a patient to other people.
- During care and treatment: stigma and discrimination are prohibited.
- No need for a separate room for HIV patients.
- Assign health staff with experience and good morale to care and treat HIV patients.

D3. Full Meeting to Agree on Code of Practice

Facilitator's Note: This session brings all staff of the facility together. Representatives from each training group will share their draft for everyone to discuss, to come to an agreement about contents of the Code and Practice on Safe and Friendly Health Facility.

Objectives: By the end of the session participants will have reviewed the products of the different groups and agreed on a common Code of Practice to be applied in the whole facility.

Time: 2 hours

Steps

1. Group presentation:

Each group has 5 minutes to present its draft and 5-10 minutes for question, clarification and comment.

2. Discussion:

Summarize similarities and differences in different drafts. Prioritize time for discussion on differences and come up with common sense.

3. Wrap-up:

Repeat points that have reached agreement.

Explain that the Steering Committee will incorporate all drafts into one common Code of Practice then send copies to all departments as well as have them in poster size put up on walls in places where staff and patients can read.

D4. Finalization Code of Practice

Objective: To finalize the Code of Practice, disseminate to all staff and inform patients so that patients can help monitoring.

1. **Finalization of the Code of Practice:** The Steering Committee members meet in an appropriate time within 1 week after the meeting mentioned in D3 to finalize the Code of Practice.
2. **Dissemination:** Print the Code of Practice in poster size and put them up in waiting or resting areas, in

department's corridors, etc. Send laminated copies to departments and request them to have it available in the department's staff room. The Steering Committee requests each department spends at least 30 minutes in a staff meeting to inform all staff members about the final version of the Code of Practice.

Example of a Code of Practice for Safe and Friendly Hospital is presented below.

Code of Practice – Safe and Friendly hospital Hospital.....

1. Admission, care and treatment for patients with HIV

- a. The hospital ensures the equality in admission, care and treatment for patients with HIV.
- b. Quality of services for patients with HIV or suspected of having HIV is the same as services for other patients.
- c. Do not put HIV patients in a separate room.
- d. The hospital provides HIV patients with address and refer them to groups/organizations that provide medical and social support in their own communities.
- e. The hospital has a grievance cell, which registers and addresses patient complaints. Location, telephone number and working hours of this cell is posted in all waiting areas and common places for patients. There is always staff ready according to the announcement.

2. HIV testing and counseling

- a. All HIV testing are voluntary (requested by the patient or suggested by a physician and the patient consents).
- b. Mandatory testing for diagnosis purpose must be done according to Ministry of Health's instruction.
- c. In cases the patient has had a positive test result, certified by an authorized facility, no more HIV test will be prescribed.
- d. All HIV tests have to be done with pre-test counseling, provided by a trained health professional.
- e. All HIV positive test results have to be informed to the patient through post-test counseling, provided by a trained health professional.

3. Confidentiality of HIV test result

- a. A patient's HIV positive test result must be informed directly to the treating physician by an authorized staff of the Laboratory Department. This treating physician has the responsibility to inform directly to the counselor who provides counseling to the patient, and to other staff who directly provide care to the patient.
- b. The counselor is responsible for informing the HIV test result to the patient through post-test counseling and encouraging the patient bring his/her spouse for counseling on that positive test result.
- c. Hospital staff is not allowed to inform HIV test result of a patient to anybody else.



d. There is no sign on ward, file, linen and instruments used by and for HIV patient that somebody can identify their HIV status.

4. Infection Control

a. Hospital staff must always practice Universal Precautions to all patients, regardless of their HIV status, to ensure safety for health workers and patients, as the following:

i. Health workers must wash their hands with clean water and soap, or with alcohol-based solution in the following cases:

1. Before putting gloves.
2. Before touching a patient.
3. Before preparing instruments, medications.
4. Before preparing or distributing food.
5. After contacting patient's blood or fluid .
6. After examining, giving care to one patient.
7. After completing procedures in an infected zone and moving to a clean zone on the same patient .
9. After touching objects around patients.
10. After removing gloves.

ii. Health workers must wear clean gloves in the following cases:

1. when contact with blood, bodily fluids;
2. when contact with contaminated instruments;
3. if there broken skin on health worker's hands

iii. Health workers must wear sterile glove in the following cases:

1. surgical operations and procedures;
2. wound care

iv. Needles and sharps must be discarded in puncture proof containers. Medical waste must be contained in yellow bags, hospital household waste must be contained in blue bags. All medical waste must be proceeded according to Ministry of Health's instruction.

b. After exposing to blood or bodily fluids of a patient, staff must inform immediately the Planning Department and comply post-exposure prophylactic procedures, as guided by the Ministry of Health.

c. The hospital encourages all staff who have direct contact with patients or their bodily fluids to have hepatitis B vaccination.

d. The hospital commits to provide sufficient means to apply Universal Precautions.

5. Training on HIV

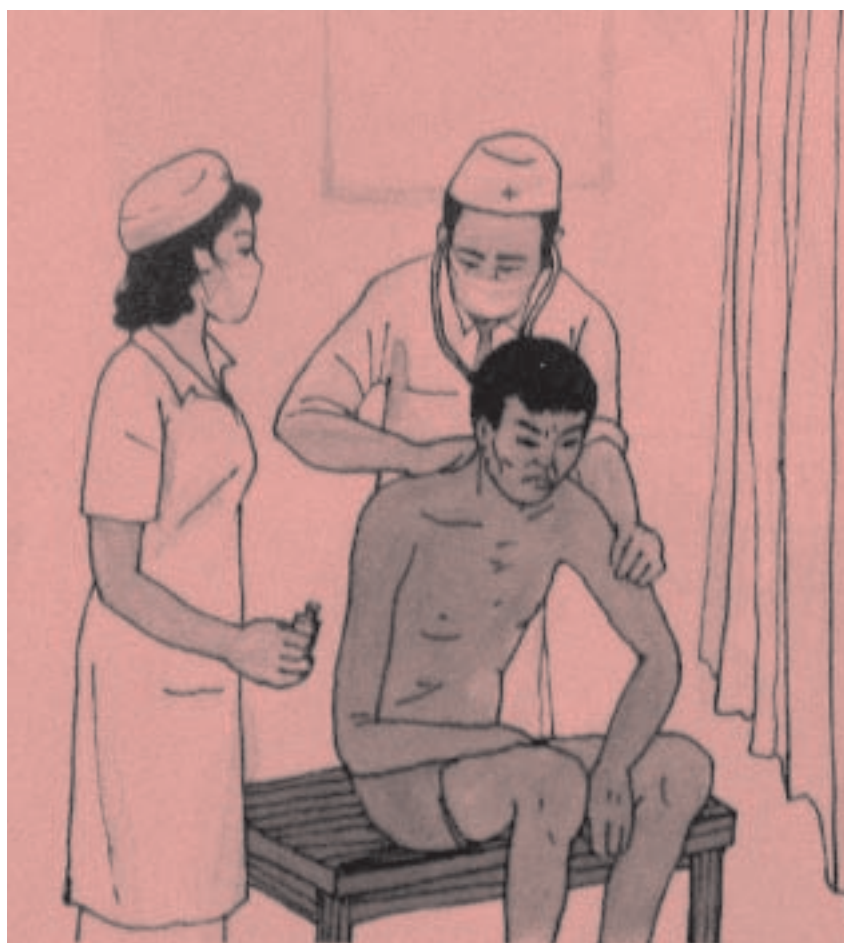
a. All hospital staff need to be trained on basic knowledge on HIV and Universal Precautions.

b. Quarterly, hospital provides updates on information and knowledge on HIV/AIDS during regular hospital's professional meetings for all staff.

6. Dissemination of policy and guidance relating to HIV

- a. All legal and professional policy and guidance must be disseminated to all concerned staff during staff meetings, and with copies of the documents sent to each department.
- b. Policies and guidance of patient's concerns must be posted in waiting areas and have copies sent to all wards.

7. The hospital's Committee on Comprehensive Care is responsible for organizing and monitoring the implementation of this Code of Practice.



Institute for Social Development Studies (ISDS)

Suite 19.1, VIMECO Building,
Pham Hung road, Hanoi
Tel: (04) 7820058. Fax: (04) 7820059;
Email: isdsvn@isds.org.vn
www.isds.org.vn