

ORIGINAL

PROF-1113

HIV / AIDS; EXPERIENCE AT TWO TERTIARY CARE HOSPITALS OF PESHAWAR.

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ABSTRACT... hamza_kmc@yahoo.com **Objectives:** To determine the experience of physicians posted in two tertiary care hospitals of Peshawar regarding HIV/AIDS. **Design:** Descriptive observational study. **Settings:** Khyber Teaching Hospital (KHT) and Postgraduate Medical Institute Hayatabad Medical Complex Peshawar (PGMI, HMC). **Duration:** From 12th September to 21st December 2005. **Material and Methods:** A total of 50 clinical experts were selected, 35 from KHT and 15 from HMC. Medical specialists, Pathologists, gynecologists and dermatologists were included. A questionnaire was designed in accordance with the objectives of the study. Questionnaire contained information's about, 1) The experience of physicians posted in these centers regarding HIV/AIDS management and on. 2) Clinico-pathological aspects, risk behaviors, preventive and precautionary measures, diagnosis and treatment of the HIV/AIDS. **Results:** A total of 50 health staff including physicians, pathologists, gynecologists and dermatologists were selected. Only 2% of physicians were claiming themselves volunteers for management of HIV cases. Main referral center for treatment and diagnosis was National Institute of Health (NIH) for 72% of physicians. Of total, 74% of physicians had recorded only 0-5 cases during their carrier. No outreach counseling or advertising VCT recorded. Opportunistic infections recorded by physicians were: Tuberculosis (18%), Oral/esophageal candidiasis(14%), STIs(6%), Herpes simplex, CMV Infection & Pneumocystic carinii (4% each) and septicemia (2%). Malignancies recorded were: Kaposi's sarcoma (6%) and Non-Hodgkin's lymphoma (2%). **Conclusion:** The knowledge and attitude of the medical staff was satisfactory but majority of the physician had recorded negligible HIV/AIDS cases. There is need for more awareness through advertisement, workshops and seminars on HIV/AIDS.

Key words: HIV/AIDS, medical staff, Peshawar.

INTRODUCTION

Acquired immunodeficiency syndrome (AIDS) is a leading infectious cause of adult death in the world. Untreated disease caused by human immunodeficiency virus (HIV) has a case fatality, which approaches 100%¹.

The first case of AIDS in Pakistani citizen was reported in 1987 in Lahore. During late in 1980-90 it became evident that increasing number of Pakistani's mainly men, were becoming infected with HIV while living or traveling abroad AIDS cases have grown to 1699 in

September 2000 in Pakistan².

The estimated number of HIV/AIDS cases in Pakistani adults age 15 to 45 years, by year 2003 are 73,000. The number of female patients of the same age is 8900. Unfortunately most observers believe that the number of cases reported represents only the "Tip of the iceberg" and the actual case may be far greater than official report suggests³.

Globally less than 1% people who need anti-retro viral therapy receive it. An estimate five to six million people in low and middle-income countries will die in the next two years if they don't receive any anti-retro viral therapy⁴.

In a prevalence study sponsored by UNICEF Peshawar, conducted in Lady Reading Hospital Peshawar. It was concluded that there are only 276 cases of HIV/AIDS in NWFP. The most affected area is kurram agency with 43 cases followed by Kohat (29), North Waziristan (26), South Waziristan (18), Bannu (16) and Peshawar (9). If we consider the professional distribution of HIV positive patients it was as such: laborers (83), drivers (43), house wives (20), infants (7), businessmen (4) and one case in students. One hundred and twenty patient's profession was unidentified⁵.

Keeping in view continuously increasing burden and stigma of HIV/AIDS in frontier province of Pakistan, this study was designed as To determine the level of experience of physicians/physicians posted in two tertiary care hospitals of Peshawar regarding HIV/AIDS.

RESEARCH METHODOLOGY

A descriptive observational study was conducted in Khyber Teaching Hospital (KHT) and Postgraduate Medical Institute Hayatabad Medical Complex Peshawar (PGMI, HMC), From 12th September to 21st December 2005.

A total of 50 clinical experts were selected, 35 from KHT and 15 from HMC. Clinicians, Pathologists, gynecologists and dermatologists were included.

Inclusion criteria were all physicians who had recorded HIV cases. For pathologist criteria only hematologists and microbiologists were selected.

Exclusion criteria were all physicians or pathologists that had not ever been in contact with HIV/AIDS patients.

A questionnaire was designed in accordance with the objectives of the study. Questionnaire contained information's about,

1. The experience of physicians posted in these centers in treating HIV/AIDS cases,
2. The questionnaire also contained information's on, clinico-pathological aspects, risk behaviors, preventive and precautionary measures, diagnosis and treatment of the HIV/AIDS.

Questionnaires were distributed among these selected categories during their duty timings, and they were asked to fill the section of the questionnaire related to their specialties.

Finally the filled returned questionnaires were collected and provided information's were statistically analyzed.

RESULTS

1. Study population:

The study population compromised of two groups. Group-I consisted of 35 faculty members from KHT. Group-II consisted of 15 faculty members from PGMI, HMC. These groups were further subdivided into clinicians, pathologists, gynecologists, and dermatologists. (Table-I).

2. Experiences of the clinicians/physicians in management of HIV/AIDS cases.

These information's are summarized in (Table-II). Special attention was given to the HIV AIDS cases observed in whole carrier, in last three months, and clinical experience of these physicians in management of such like patients.

3. Opportunistic infections associated with HIV/AIDS observed by the physicians.

Opportunistic infections recorded by physicians were: Tuberculosis (18%), Oral/esophageal candidiasis(14%), STIs(6%) ,Herpes simplex, CMV Infection &

Pneumocystic cranii(4% each) and septicemia (2%). Malignancies recorded were: Kaposi,s sarcoma (6%) and Non-Hodgkin's lymphoma (2%).(Table No-III).

Table-I. Categorizing faculty members

Name of the speciality	KTH (Khyber teaching hospital): 35	PGMI, HMC (Hayatabad medical complex): 15
Clinicians	20	3
Pathologists	7 (including three from KMC (Khyber medical college) (pathology department)	3
Diabetologists/ gastroenterologists	0	2
Hepatologists/gastroenterologists	0	2
Gynecologists	3	0
Dermatologists	2	0
AWARD clinic KTH	1	0
VCT Centre HMC	0	2
Pulmonologist	2	1

DISCUSSIONS

Pakistan has an estimated adult HIV prevalence of 0.1%. It has about three million heroin users, many of who started injecting drugs in the 1990.the first outbreak of HIV infection among injecting drug users happened in 2003³.

In our selected hospitals only 2% of the physicians were claiming themselves volunteers for treating HIV/AIDS cases, which is very unfortunate number. But The situation is probably the same in all developing countries, if we take example of sub Saharan Africa, an estimated 4.3 million people need AIDS home based care. But only one third of people receive at least essential packages⁴.

Out of total 72% of the physicians had recorded only 1-6 patients. It may be because of the low burden of disease in this area. But due to very expensive treatment and not well-understood etiology to all clinicians, world health

organization therefore suggests '3 by 5 initiative' to respond to disease burden. '3 by 5 initiative' means treating 3 millions by 2005. As of June 2004, Canada Sweden and United Kingdom together with UNAIDS allocated budget and funds for '3 by 5 initiative' of WHO⁶.

The opportunistic infections recorded by physicians were: Tuberculosis (18%), Oral/esophageal candidiasis(14%), STIs(6%) ,Herpes simplex, CMV Infection & Pneumocystic cranii(4% each) and septicemia (2%). Malignancies recorded were: Kaposi,s sarcoma (6%) and Non-Hodgkin's lymphoma (2%). Tuberculosis is becoming a great challenge for physicians that often coexist with HIV/AIDS. In 1998, WHO recognized the need for tuberculosis and HIV programme to work together in sub-Saharan Africa that shares 70% of aids burden. So it begin Protest project for joint tuberculosis and HIV programming in Malawi, Zambia and south Africa⁷

Table-II. Practice of physician's regarding HIV/AIDS cases (n=50)	
1. Do you have clinical experience in treating HIV/AIDS patients?	2% Yes
2. Referral centers	
National Institute of Health (NIH),	72%
Aga Khan Hospital Karachi,	28%
3. Number of HIV patient's observed / recorded in whole carrier	
0-5 patients	72%
5-10 patients	12%
10-30 patients	10%
31-50 patients	2%
4. Number if HIV patient's observed/recorded in last three months	
1-3 patients	10%
4-6 patients	62%
7-10 patients	24%
10-15 patients	0%
5. Outreach counseling	0%
6. Advertising VCT	0%
6. Any UN assistance to these centers for decreasing burden and stigma of disease or reducing price of antiretroviral drugs,	0%

We observed no out reach counseling and advertisement from medical staff posted in these centers in reducing stigma of the disease. As it is clear that advertisement and media plays an important role in awareness and prevention. WHO has simplified the prevention of HIV/AIDS in terms of ABC of combination therapy.

1. A means abstinence, or not engaging in sexual intercourse.
2. B means being faithful to ones' partner or

reducing the number of sexual partners.

3. C means correct and consistent condom use which reduces the risk of HIV transmission for sexually active young people or for couples where one partner is HIV positive. Condom use is also vital where sex workers are involved⁸.

Table-III. Opportunistic infections associated with HIV/AIDS observed by the physicians (n=50)	
1. Types of opportunistic infections	Observed
Tuberculosis	18%
Oral/esophageal candidiasis	14%
Herplex simplex	4%
Pneumocystic cranii	4%
Spetecemia	2%
CMV Infection	4%
STIs	6%
Isosporidiosis / Cryptosporidiosis / Microsporidiosis / Toxoplasmosis / Bacterial Pneumonia / Herpes zoster	0%
2. Frequent malignancies observed	
Kaposi's sarcoma	6%
Non-Hodgkin's lymphoma	2%
Primary CNS lymphoma / Basal cell carcinoma / Anogenital neoplasia / Uterine cervical cancer / Hodgkin's lymphoma / Squamous cell carcinoma of conjunctiva	0%
6. Any UN assistance to these centers for decreasing burden and stigma of disease or reducing price of antiretroviral drugs,	0%

Mass media is increasingly important in most young people's lives.

IN South Africa, media approach a message of "love life" the national young peoples HIV prevention programme, have been helpful in use of comprehensive health

services. "Love life" has "Y-centers" or youth centers that provide HIV education and sexual health services in reactional environment⁹.

CONCLUSIONS

The threat and stigma of HIV/AIDS is continuously increasing in Pakistan. Simply prevention and care will not solve the crises. Unless the health community responds now for AIDS treatment, the fight against the most powerful enemy will not be won. Clearly, there is no room for complacency and the time to take action is now.

REFERENCES

1. The world health reports 2003: **Shaping the future**. Geneva, World Health Organization, 2003:43-55.
2. National HIV/AIDS strategic framework (2001-2006), Pakistan: UNAIDS/Ministry of Health, 2001.
3. UNAIDS Report; Global HIV/AIDS epidemic, 4th global report on HIV/AIDS. UNAIDS/UNICEF/WFP/UNFPA/UNODC/ILO/UNESCO/WHO/WORLD BANK, 2004:196-99.
4. Progress report on global response to HIV/AIDS epidemics, UNAIDS, 2003; **Coverage of selected services for HIV/AIDS prevention and care in low and middle-income countries in 2003**. UNAIDS/USAID/WHO/CDC and the policy project, 2004.
5. Fact Sheet: HIV/AIDS, NWFP. Prevalence of HIV/AIDS in N W F P 1 9 8 9 - 2 0 0 2 . UNICEF/PVDP/AWARD/SAHAR/SABAOON, 2003.1-4.
6. Farmer P, Leandre F, Mukherjee Js. **Community based treatment of advanced HIV disease: introducing DOT HAART**. Bull World Health Organization, 2001:79-80.
7. **WHO report on "lessons learnt" workshop on six protest pilot projects in Malawi, South Africa and Zambia**. World health organization. Geneva. Durban, 3-6 February 2003.
8. UNAIDS. **Progress report on global response to the HIV/AIDS epidemic**. Geneva, 2003.
9. Family health international 2003. MTV: Staying Alive 2002. **A global HIV mass media campaign**. Available at. <http://www.fti.org/en/youth/youthnet/publications/youth issues paper>.

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