SUPPORTING HIV+ MEDICAL STUDENTS

The AIDS pandemic is forcing medical schools to choose between diverting scarce resources, taking on fewer students or raising funds in order to finance antiretroviral treatment (ART) for HIV-positive students.

This is according to Professor Max Price, Dean of the Faculty of Health Sciences at Witwatersrand University, who says the lack of any government subsidy for ART has forced him into choosing to 'go out and raise these funds'.

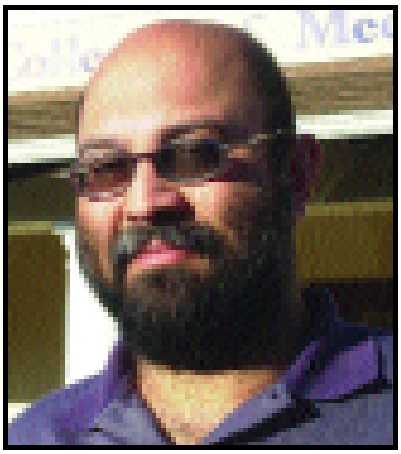
Interviewed at the inaugural meeting of the South African Association of Health Educationalists, Price said failing to provide HIV-positive medical students with ART would 'make a nonsense of their education'.

Price said medical students were virtually guaranteed employment and access to ART, 'so if you're going to invest R1 million in their education, why then skimp on drugs?'

The meeting, held in May at the Colleges of Medicine in Rondebosch, was the first time all the country's medical schools have sat down together to discuss HIV education, its impact and curriculum reform.

Price said medical students were virtually guaranteed employment and access to ART, 'so if you're going to invest R1 million in their education, why then skimp on drugs?'

HIV-positive medical students on continuous ART posed 'almost no risk' to patients because their viral loads were suppressed. However, aspirant doctors were informed of the HPCSA rules of disclosure and offered a specially designed risk-reducing curriculum if voluntarily found to be positive.



Amod Dhai, Chief Director of Health, Mpumalanga.

'It just makes sense to pay for the ART,' Price said. He told a breakaway workshop group discussing HIV / AIDS that a paragraph in the Wits admission papers told medical students that it was in their interests to know their HIV status and that the university backed this up with appropriate career counselling. Those who chose counselling and testing and tested positive were told by counsellors that becoming a doctor would expose them to infective diseases 'and that ART would be a good idea,' he added.

The entire Wits Student Representative Council had taken part in a very public voluntary counselling and testing (VCT) session in an attempt to reduce the stigma and emphasise this as a pragmatic approach.

Price said providing VCT without access to drugs would be counter-productive.

While confidentiality was paramount it also proved beneficial in protecting the university from potential patient litigation although, ' one day we'll know and then we'll have to deal with it.

The counsellors tell HIV-positive students that they're at risk and that they're expected to modify their careers appropriately - with our assistance'.

The price the HIV-positive student paid for this modification was to risk being identified through taking a risk-reduction curriculum which avoided practising and teaching risky surgical procedures.

HIV-positive students were discouraged from taking up dentistry while other risky areas included maxillofacial, orthopaedic and cardiothoracic surgery and gynaecology.

Dr Wendy Orr, Transformation and Equity chief at Wits, whose office until recently housed the HIV / AIDS Education and Support Programme, said financial constraints had led to Wits spending R1.5 million on student HIV / AIDS education and prevention services rather than 'pursuing the idea of a seroprevalence survey'.

Orr said this money was going into training academic staff to incorporate HIV / AIDS into curricula and providing free VCT (plus free medical follow up and CD4 cell counts for those who tested positive).

Price said providing VCT without access to drugs would be counter-productive.

'We would ideally like to provide ARVs as part of this package but we just can't afford it right now - we're also hoping that public sector provision will become a reality in the not-too-distant future.'

Amod Dhai, chief director of health in Mpumalanga, urged the educationalist workshop to call for a summit of health, education and labour to discuss HIV / AIDS policies in the workplace, with a particular focus on needlestick injuries.

He said the lack of insurance coverage for health care students working in State facilities was a 'major concern'. For the first five years, students were not covered by provincial or national governments for needlestick injuries because they were not defined as 'employed'.

A mechanism was needed to cover this because if a student seroconverted, they would be left financially helpless.

'This is where the government versus non-government argument comes in - they're not State employees, but they're serving in State facilities!' he said.

Some universities, like the University of Pretoria and Wits had taken the initiative and started partnering with their alumni to start funds to cover student counselling and treatment.

Orr said that the Wits Health Science Faculty provided cover for medical students against occupational exposure 'from day one - we don't rely on the province or State'.

A survey conducted at University of Durban/Westville several years ago revealed a prevalence rate of 17% among their student population.

Chris Bateman

MECHANICS OVERHAUL ETHICS POLICY

'Like trying to adjust the wheels of a car while it's in motion,' was how Boyce Mkhize, Registrar of the Health Professions Council of South Africa (HPCSA) described last month's policy workshop on undesirable business practices in the health industry.

If the profit motive without moral guidance was blind, then moral inspiration without financial backing was bankrupt.

Adjustments suggested by key stakeholders to a draft policy vehicle, which had little visible guidance from a patient-based constituency, would be finalised by October, Mkhize said.

Chairpersons or representatives of the various professional boards and associations, SAMA, the national and provincial departments of health, pharmaceutical companies, optometry businesses and private hospital executives were among the estimated 100 delegates.

Interviewed by the *SAMJ* at the Saint George's hotel outside Pretoria during a break in proceedings, Mkhize conceded that there was a lack of 'patient' participation at the workshop.

'The problem is how you get them. We have two community representatives on our council appointed by the ministers (of Gauteng and Limpopo Health Departments) here, plus Thandi Manganwe, deputy director of Human Resources at the national health department and the optometry board,' he added.

Gauteng Health Department's Sisa Mjikelane, a former Nehawu activist now serving on the HPCSA(one of nine such provincial appointees on the council) said the HPCSAwas 'beginning to transform and open up so it can take up interests and ideas from other bodies'.

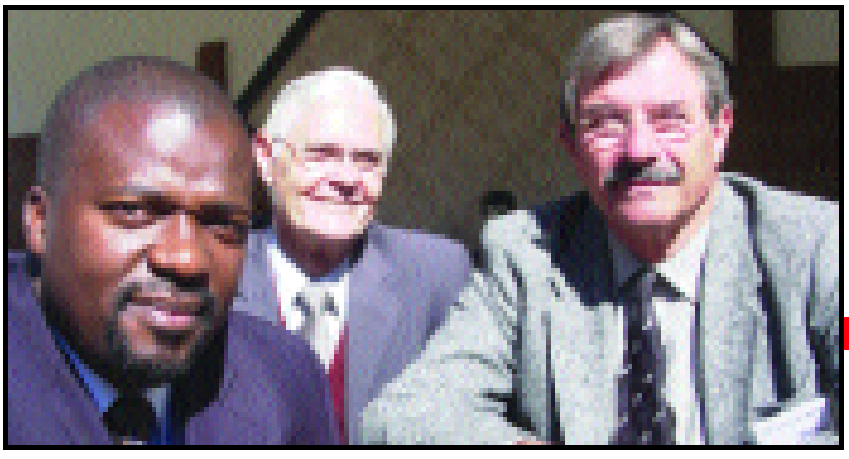
However community representivity and patient input were 'taking longer' because of the 'complexity' of the constituency and 'us working out how to articulate their views'.

His exact role and function on the council as a community representative was 'somewhat trial and error', but there was 'an appreciation that, at some stage, it has to get clearly defined and visible'.

Mkhize said 'patient' input had mainly informed policy when HPCSA regulations were originally put out for public comment in the government gazette.

Introducing the workshop, he said his executive committee had put together a task team including the Medical and Dental Professions Board (MPBP) chairman, Professor Len Becker, and former chief investigator into shady health business practices, Professor Jan van der Merwe.

Their job had been to probe the industry and draw up a preliminary draft policy. 'We want to ensure the HPCSA remains true to its mission of



Throwing light on shady business practices - Advocate Boyce Mkhize, Registrar of the HPCSA, Professor Len Becker, chairman of the MDPB and former task team chief, Professor Jan van der Merwe. *Picture: Chris Bateman*