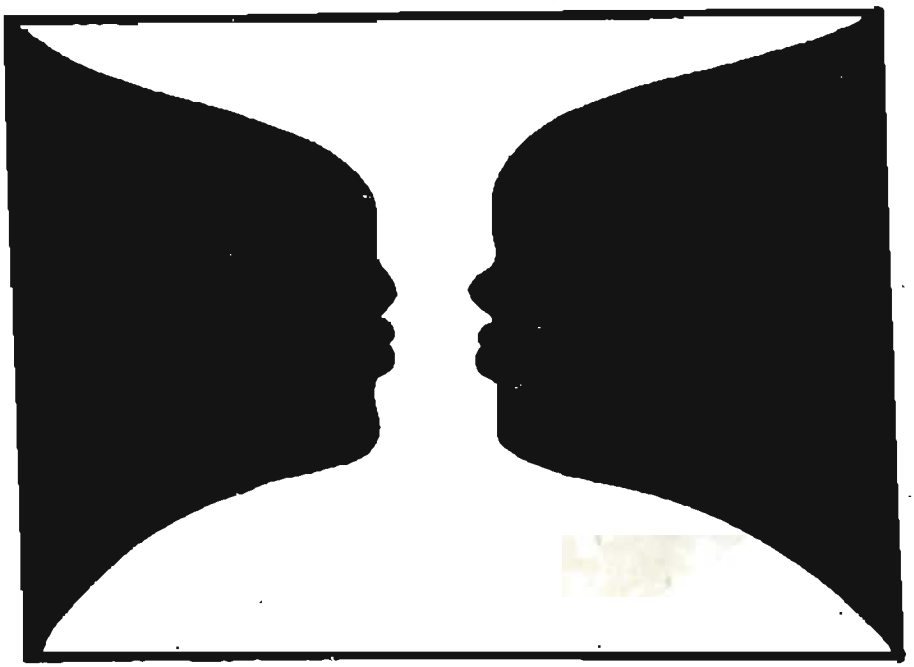
Volume 4 — No. 4 1986/87

JOINING HANDS FOR HEALTH

LOVE ♥ CAREFULLY



AIDS KILLS

CARING AND SHARING AT SCHOOL TIME

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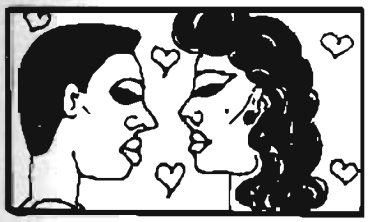
...AIDS...AIDS...AIDS...

WHAT IS AIDS?

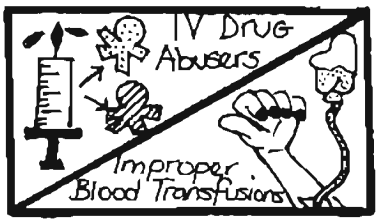
AIDS (HIV) is a serious illness that impairs the body's ability to fight infection. Without full resistance, a person with AIDS is unable to fight off diseases & infections which otherwise healthy people can.

HOW IS AIDS SPREAD?

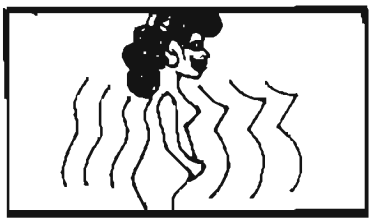
(1) Sexual Contact



(2) Contaminated Blood



(3) Via Pregnancy



WHAT ARE THE SYMPTOMS?

Profound Fatigue, Chronic Diarrhoea, Swollen Glands (neck & armpits), Rapid Unexplained Weight Loss, Dry Cough, Shortness of Breath, Skin Changes, Night Sweating.

HOW IS AIDS PREVENTED?

Practice Abstinence (no sex) or Monogamy (one partner); avoid sharing instruments which puncture skin (needles, razor blades), Reduce your sexual partners, Use a condom with spermicide.

Note: YOU CANNOT GET AIDS THRU CASUAL CONTACT

— For Example:

by Dionne Benjamin

EDITORIAL

This issue of Joining Hands For Health, Caring and Sharing at School Time, deals exclusively with the disease AIDS (Acquired Immune Deficiency Syndrome, now referred to as HIV); we have sought to share as much information about this disease as possible with our colleagues. Both the infection and the disease itself are incurable. Less than half of those infected so far have gone on to develop the disease. The disease is often fatal. For the most part, young men and women in the prime of their lives are affected. The costs to them, their families and the nation when computed are likely to be phenomenal.

It should be most reassuring though for the public to learn that AIDS is NOT a communicable disease and therefore that, by adopting certain behaviours, they can readily reduce and/or eliminate their risks of both getting the virus (becoming infected) and possibly later of developing the disease.

Unfortunately, AIDS reflects a side of our lives about which we are not only often reluctant to speak but also, one which is shrouded in mystery, double talk and morality, human sexuality.

AIDS also forces individuals to assume greater responsibility for their personal health — nutrition, personal cleanliness, adequate rest and physical activity, non-dependence on substances.

The presence and prevalence of AIDS In The Bahamas is indeed a cause for grave concern. The Minister of Health, the Hon. Dr. Norman Gay, in recognition of this fact and also that this disease has been recognised globally as the number one public health problem of the century by the World Health Organisation (WHO) has developed a major co-ordinated strategy and appointed a Standing Committee for the Prevention and Control of AIDS. Its terms of reference are:—

1. To further develop and ensure implementation of a programme for the Health Education for the community as a whole;
2. to continue monitoring blood banking procedures and ensure its safety;
3. to further develop and monitor treatment protocols for patients with AIDS;
4. to promote and disseminate protocols for Health Care and Allied Health Care Workers;
5. to develop policy on National Screening Programmes and to recommend regulatory and/or legislative measures;
6. to monitor research on AIDS epidemiology, clinical course and treatment in the Bahamas.

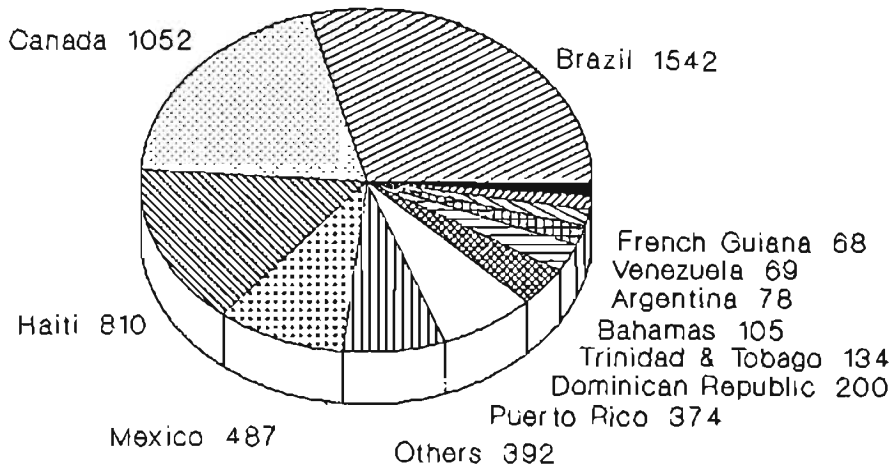
The Chairperson of this Committee is Dr. Vernell Allen, Chief Medical Officer.

We in the Ministry of Health and more especially the Health Education Division now have the uneviable task of reassuring the public that AIDS is hard to get and that they CAN take positive steps to reduce their risks. Because the HIV lives in body fluids mainly blood and semen, with basic precautionary measures they can live, work worship, relax, indeed have any number of social contacts with any AIDS patients or carrier without fear of contracting the disease. They should, however, all be alerted to the fact that greater responsibility than hereto fore exerted in sexual encounters will now have to be taken. In this regard, only they can make the decision.

AIDS IN THE AMERICAS

Cases Notified By 19 June 1987

Excluding the USA



AIDS

OWASA DUAH

During the past five to six years, AIDS — Acquired Immune Deficiency Syndrome — has been a medical mystery often surrounded by fear and confusion. Since it was identified in 1981, scientists worldwide have put forward many theories to explain this tragic illness. Much has been learned to further our understanding but many questions are yet to be answered.

This summary is intended to give you the facts about AIDS and correct some of the myths and misconceptions that have resulted from fear of this illness.

WHAT IS AIDS?

AIDS is a condition that, by attacking the immune system, affects the body's natural ability to fight disease. A normal immune system, like a well organised army, rallies its forces to combat invasion by foreign agents. AIDS weakens the body's defences; as a result, the body becomes vulnerable to unusual, serious illnesses.

WHAT CAUSES AIDS?

AIDS is caused by a virus referred to as HIV. There are now two types of virus, HIV I and HIV II. The former is found to be the culprit in the Americas, Europe, Central Africa, and Caribbean. HIV II is found to cause AIDS In West Africa.

WHO GETS AIDS?

AIDS PRIMARILY AFFECTS YOUNG PEOPLE:

a) Homosexual and bisexual men between the ages of 20 and 39 years

b) intravenous drug abusers — use of dirty and contaminated needles and syringes.

c) blood tranfusions e.g. Haemophiliacs

d) heterosexuals are also now affected by the illness.

REMEMBER!

AIDS has mainly occurred in very well-defined groups of people. If you or your sexual partner (s) do not belong to one of these groups, your chances of getting AIDS are virtually zero.

IS THERE A CURE?

Not yet — but scientists are getting closer to finding one. There are now drugs such as AZT in experimental and clinical trials.

PREVENTION IS THE KEY
TO THE CONTROL OF THIS ILLNESS.

All that doctors can do at the present time is treat the illnesses contracted because of the weakened immune system such as tuberculosis and fungal infections. Unfortunately, without help from the body's natural defences, illnesses may recur or new ones may develop.

HOW CAN AIDS BE PREVENTED?

The following precautions will help prevent the spread of AIDS

1) Decrease your number of different sexual partners.

2) Use condoms.

3) Maintain high standards of health and personal cleanliness.

4) Do not have sexual relations with persons known or suspected of having AIDS or who is a known carrier of AIDS.

5) Do not share needles and syringes if you use intravenous drugs.

6) Do not donate blood if you belong to a group affected by AIDS.

REMEMBER!! AIDS may be contagious long before symptoms appear.

WHAT IS BEING DONE NOW TO DEAL WITH AIDS IN THE BAHAMAS?

The government of The Bahamas, through the Ministry of Health, has set up a Standing Committee to look into the problems of AIDS in the country. Various subcommittees have been set up and are now in the process of submitting their reports to the main Committee.

◆

AIDS IS HARD TO GET

KENNETH OFOSU-BARKO

AIDS is now a disease of choice and not of chance!!!

YOU WON'T GET AIDS IF YOU DO NOT WANT TO!

Acquired Immune Deficiency Syndrome (AIDS) has been acknowledged as the major public health problem facing mankind in this century. However, it may not be an exaggeration to say that the other disease "FRAIDS" — the fear of AIDS — has caused more havoc than AIDS itself. AIDS is caused by the Human Immunodeficiency virus (HIV), formally known as HTLV-III/LAV.

The World Health Organization (WHO) has offered the following definition for AIDS in adults and children, in the absence of confirmatory test for HIV antibody.

Adults:

Aids in an adult is defined by the existence of at least two of the major signs associated with at least one minor sign, in the absence of known causes of immunosuppression such as cancer or severe malnutrition or other recognized causes.

1. **Major Signs**

   a) weight loss greater than or equal to ten percent of body weight;

   b) chronic diarrhoea longer than one month;

   c) prolonged fever longer than one month (intermittent or constant).

2. **Minor Signs**

   a) persistent cough for more than one month;

   b) generalized pruritic dermatitis; (itchy rashes)

   c) recurrent herpes zoster; (shingles)

   d) oro-pharyngeal candidiasis (thrush in mouth and throat)

   e) chronic progressive and disseminated herpes simplex infection (fever blisters)

   f) generalized lymphadenopathy (swollen glands)

The presence of generalized Kaposi's sarcoma and/or cryptoccoccal menigitis are sufficient by themselves for the diagnosis of AIDS.

Children

AIDS is suspected in an infant or child presenting with at least two of the following major signs associated with at least two of the following minor signs in the absence of known causes of immunosuppression such as cancer or other recognized causes.

1. **Major Signs**

   a) weight loss or abnormal slow growth.

   b) chronic diarrhoea of more than one month's duration.

   c) prolonged fever for more than one month.

2. **Minor Signs**

   a) generalised lymphadenopathy;

   b) oro-pharyngeal candidiasis;

   c) repeated common infections (otitis, ear; pharyng itis, throat);

   d) persistent cough;

   e) generalized dermatitis;

   f) confirmed maternal HIV infection'

If after reading the above signs and symptoms of AIDS you are beginning to suspect that you have AIDS, just relax, this is a normal phenomenon. Remember, the sign and symptoms of AIDS are non specific and may occur in other disease states!

When the Human Immunodeficiency Virus invades the body, the immune system produces antibodies against the HIV before the immune system is destroyed, if it is going to be. Generally when the body is invaded by organisms that cause infection, it produces antibodies against those organisms. On subsequent contract, these antibodies are used to fight this specific invader. These antibodies are said to be protective antibodies. The antibodies produced in AIDS do not have such protective function.

The presence of these antibodies is a confirmation that the individual has been infected by the virus. In the absence of the above signs and symptoms, he or she is said to be a healthy carrier of the virus. In the presence of the above signs and Symptoms he is said to have AIDS.

These antibodies to HIV do not commonly appear before six weeks after infection. The majority of people who are infected will develop antibody responses which can be demonstrated over the following six weeks. However, there will be some rare individuals who harbor the virus and will not develop the antibody response. When tested, these rare individuals will show a negative response but will in actual fact continue to transmit the virus. There is also a short "window" of time during which antibody test will not identify a newly infected person

even though he or she is capable or passing on the virus to his or her sexual partners. All currently available antibody tests would miss such a person during this short time interval. Improvements in testing methods may reduce the duration of the "window" phenomenon, but will not eliminate it.[2]

HIV Infected individuals can be divided into four broad groups:

1. well with no signs of infection. These are the asymptomatic carriers.
2. well with swellings (kernels) (lymphadenopathy in armpits, neck, groin.) These individuals are said to have persistent generalized lymphadenopathy (PGL)
3. Less well with fatigue and night sweats. They may have minor infections such as shingles or oral thrush. They are classified as having AIDS related complex (ARC).
4. Those who meet the established diagnosis of AIDS.[3]

At present there is no cure for the disease, but luckily for mankind, it can be prevented. Transmission of HIV has been established to be the same in all parts of the world where it has occurred. The three major routes of transmission are:

1. transmission by sexual intercourse (heterosexual or homosexual)
2. transmission by blood or blood products as, for example, through blood transfusion or the use of unsterilized syringes and needles.
3. transmission from mother to child, before, during or shortly after birth.

With the advent of screening for HIV infection in blood donors, the only people who may get AIDS by chance are those who might have been transfused with HIV infected blood prior to 1985. (in The Bahamas)

It is important that certain misconceptions about HIV transmission are dispelled. YOU DO NOT GET AIDS BY:

1. living in the same house with an AIDS patient.
2. using the same plates and cutlery with an AIDS patient.
3. travelling on the same bus, boat or airplane with an infected person.
4. shaking hands with an infected person.

However, you are advised to avoid sharing toothbrushes or razors with other people. These objects allow the possibility of blood contact.

As a matter of fact you have no means of distinguishing a healthy carrier of HIV from a healthy non-infected person! Persons with AIDS represent only the late stage of HIV infection and it is believed that they may not be as infectious as those individuals who are in the earlier stage of their infection.

Short of asking you to abstain from sex, the following measures should reduce the risk of HIV infection:

a) DO NOT have multiple partners. Limit your sexual partners to the minimum number tolerable, perferably to one.

b) Use condoms. If used correctly, they should reduce the risk of HIV infection. The protection is increased when used in combination with spermicidal agents such as Duragel which destroys the HIV.

c) Be gentle as usual and avoid trauma to the genital tract.

PRACTICE SAFE SEX ALWAYS.

It is still not known what percentage of infected individuals will go on to develop the disease. The present evidence indicates that only a minority have done so. There is every indication that the majority of HIV antibody positive individuals will never become unwell, let alone develop AIDS.[3] So even if you go looking for it, you may not get it. BUT JUST DON'T BE "RUDE".

Ref:
1. Carec Surveillance Reports Vol. 12 No. 6. June, 1986.
2. Report of the consultation on International Travel and HIV Infection. Geneva 2-3 March, 1987.
3. Farthing Charles: Advice for people who are HIV antibody positive. Postgraduate Doctor Vol. 3 No. 3 1987.

ACQUIRED IMMUNE DEFICIENCY SYNDROME PREVENTION — A ROLE FOR EVERYONE

PETER DIGGORY

1 HISTORY

The first report of the Human immunodeficiency virus (the virus which causes AIDS) was in 1959 from Kinshasa, Zaire. This early detection was followed by reports of 1.4% positivity in the sera (blood samples) of 144 children from Burkina Faso — this sera was collected for another purpose in the later sixties. Similarly, 50 out of 75 sera collected from Ugandan children in 1972-73 had positive sera.

However, these observations have not gone unchallenged. The ELISA (Enzyme linked immunabsorbent assays) and Western Blot confirmations were the first generation of such tests (for AIDS) and believed by some to have cross-reacted with malaria and other parasities.

However, there is no doubt that there was a marked increase in cases of AIDS during the late 1970s in Kinshasa and the early 1980s in Uganda and Tanzania where the syndrome became known as the slim disease due to the characteristic wasting.

In the USA, it was the observation, in 1981, of the occurrence of a rare form of cancer and pneumonia in young men, which served as an alert. On investigation, it was found that they were all homosexually active. It was also discovered that their immune system had been severely damaged and, as more cases were discovered, it was noted that infections that individuals with normal immune systems could fight off, without being aware of the infecting agent/protective mechanism battle, would be in these immune compromised individuals — life threatening.These observations of a series of illnesses in homosexual men led to the syndrome being called Acquired Deficiency Syndrome and the infections being called opportunistic infections. There was then a major effort launched in North America and Europe to discover the casual agent. This resulted in the almost simultaneous discovery of a virus, a retrovirus, in USA and France and given the names HTLV III and LAV I, respectively. Later by international standardization, the virus has been renamed Human Immunodeficiency virus and HIV for short.

Much research had been undertaken to determine the origin of the HIV and recent published evidence suggests the origin in the Simian Immunodeficiency Virus from monkeys.

As already mentioned, AIDS was seen as primarily a problem for homosexuals. Indeed, it was stated to be a divine judgement by those who bitterly opposed the gay community. However, it was soon realised in the USA that others were at risk, including intravenous drug abusers, recipients of blood products such as haemophilics and occasionally recipients of blood transfusions. The ratio of male to female cases was 14.1.

However, in Europe it was observed that whereas the indigenous population had similar predominance of homosexual and intravenous drug abuser cases, immigrant workers from Central and East Africa were also developing AIDS, but most gave histories of heterosexual activity. It was also observed that their predominant clinical presentation was of gastric symptoms and opportunistic infections.

This observation led to the intensification of epidemiological studies in Central and East Africa with most surprising results. Instead of the 14 to 1 ratio between male and female cases, the ratio was only 1.4 to 1.

It was found in the female cases that two out of three had never been married and nearly one third of the married AIDS cases had had one previous marriage or "Union Libre" — persistent cohabitation without formal marriage. Eighty percent gave a history of receiving injections from health care workers and/or traditional healers in the past three years. It must be pointed out that for economic reasons re-usable needles are the norm and sterilisation procedures, even when practised, are often suspect. Interestingly, no less than nine percent gave a history of receiving a blood transfusion during a three year period before the onset of illness.

The AIDS patients had a higher number of heterosexual partners than controls (mean 32). There was an apparent association between sexually transmitted disease and AIDS, especially the presence of genital ulcers.

It was found that with the urban drift from rural areas men frequently prostitutes. Sequential studies of the same group of prostitutes over a four year period have revealed rapid build-up of infectivity, between 27 to 83% in some studies. Similarly, observations have been made in prostitutes in the USA including Miami and the Belleglade area of Florida, but there prostitution may be secondary to intravenous drug abuse.

Heterosexual cases in Africa were questioned as to sexual practices, anal intercourse of bisexuality, but these were not significant factors.

This heterosexual transmission pattern will gain in importance throughout the world unless effective measures are implemented.

The lesson from the known distribution and epidemiological studies is that neither the infecting virus nor the resulting AIDS is exclusively associated with any single race, culture or sexual activity preference. All are at the risk without appropriate precautions and all should be concerned and support the necessary educational programmes and other prevention and control measures.

2. PRESENT WORLDWIDE STATUS

As of July 1987, 55,396 cases of AIDS have been reported to PAHO/WHO from 91 countries. Compare this with only 771 cases reported in 1982 from only 16 countries. The 55,396 consists of 38,808 cases from the USA, followed by Brazil (1,695), France (1,632), Uganda (1,138), Tanzania (1,130), West Germany (1,089), Canada (1,000), United Kingdom (870), Haiti (851), Italy (771).

However, it is estimated that the number of cases worldwide is more than 100,000. WHO further estimates that between 5 and 10 million persons are currently infected with HIV. It is a sobering thought that it is estimated that 10 to 30% of positive individuals will develop AIDS plus another 20 to 50% will develop AIDS related illnesses. The recent discovery that the HIV can damage the brain and cause dementia, as a long term effect, brings into possibility an epidemic of progressive neurological disorders. Notwithstanding the unparalleled intensity of high quality research as of now, there is nothing that will alter the ultimate course of the disease in those already infected, although much can be done to prevent further spread.

3. THE CARIBBEAN SITUATION

CAREC has been receiving AIDS reports from the English-speaking Caribbean and Suriname since 1983. By March 31, 1987, 370 cases had been reported but this is an underestimate as 7 countries have not sent in reports for the first quarter of 1987. Only Anguilla and Montserrat have not reported a case.

Unfortunately, it is only recently that countries have been providing information on age and sex of cases. Out of 130 cases for which such information is available, 27 occurred in females (4:1 ratio). Of the 18 adult female cases, 13 had had heterosexual contact with an infected individual, 1 had had a blood transfusion, 1 was an IV drug abuser and no risk factors could be identified in 3.

4. PREVENTION AND CONTROL ACTIVITIES

Every sexually active person must be able to understand the risk of casual sex and adjust their lifestlye accordingly, whether heterosexual, homosexual, or bi-

Every sexually active person must

sexual. Condom use is an added safety measure. Unfortunately, the disease prevention role of the condom is too often confused by some as a birth control campaign. There is no room for infighting in this serious situation; all should be on the side of promoting meaningful relations and the discouragement of casual sex.

The gay community who, depending on local cultural pressures may be underground, needs to be reached to discuss their special risks and the precautions to take. The bisexuals are a special risk since they facilitate heterosexual spread and may be hard to identify.

It is important that those who think they may have been exposed to the risk of infection can obtain a confidential test. This should be done in consultation with their physician, who will ensure that this is not a frivolous request. It is an expensive procedure, since being positive on the first ELISA test is not conclusive as there can be false positives. Additional special tests can be done at CAREC or other facilities which can confirm true positivity. There is much work in progress on improved testing and new procedures should be available within the next 12 months.

Both those who are apparently well but are positive for HIV and those who are AIDS cases need counselling on lifestyle modification and how to maintain the quality of life when facing a life-threatening situation. The families need much support and where the individual can still work or attend school, appropriate action has to be taken to keep the public aware that HIV cannot be transmitted in non-sexual relationships. Everything from handshaking to sharing the chalice at church should be cearly understood by the public to pose no risk.

The Bahamas Government took early steps to screen all blood before transfusion to ensure that it was free of the virus. Long before AIDS was known, care has been taken with needles and syringes and surgical instruments to ensure that either disposables were used or safe sterilisation procedures were followed. Such precautions were long known to be necessary to prevent the spread of the Hepatitis B virus (serum sickness) in blood contaminated equipment. Incidentally, HIV is much less contagious than the hepatitis virus and is easily destroyed by a 1 in 10 mixture of household bleach.

Pregnancy has a special risk both for the HIV positive mother and her baby. It has been observed that pregnancy seems to bring on AIDS and secondly that there is a 50% risk of AIDS developing in the baby. This percentage may rise with longer term studies of babies. There has been at least one report of transmission through breast milk. Therefore, for those women positive for HIV who continue to be sexually active, birth control methods, besides condom use, should be advised. For those who are pregnant, abortion should be seriously considered. Where sperm do-

nors are free of infection. Similar care has to be taken with the donation of body parts.

Besides the wealth of medical research articles, the AIDS pandemic has stimulated much literature for the public. Catchy titles are in vogue "Safe sex in the Age of AIDS" or AIDS — You can't reach it by holding hands.

National educational programmes are endeavouring to reach both the general public and those with risk behaviours through a variety of approaches. Australia has used the frightening approach with its Grim Reaper video, in which the Reaper bowls away men, women and children. I understand the bowling alley operators were not too impressed but the programme has been reported to have greatly increased public awareness. Switzerland has used a standard logo — STOP AIDS — where the 'O' in stop is the end of a condom. Switzerland has also promoted a musical video aimed at the adolescent and young adult audience. The theme music became one of the top ten hits. Ghana has an attention getting video on the deterioration of a young woman with AIDS — a living proof of wasting disease and her unawareness of the risk of her life style. The United Kingdom has undertaken a saturation type public education programme, which included the delivery of literature to every household and a coordinated array of advertisements in the media, both for the general public and for the high risk behaviours.

WHO is encouraging the sharing of ideas and experiences on the development and evaluation of community education programmes. I had the privilege to attend the meeting on the Exchange of Strategies. Information and Materials for AIDS Public Health Communication, which was held in Geneva on 6-9 July, 1987. CAREC is being strengthened to provide support to the member countries in this vital area of public education.

May I leave you with the thought that no amount of brilliant scientific studies will have the impact on AIDS of our individual efforts geared to the common goal of avoiding infection and unnecessary anxiety.

THE PUBLIC SPEAKS?

SHANDALANAE EDWARDS

In our search for objectivity in presenting a complex and subjective topic such as AIDS, we decided to invite public opinion. A short questionnaire, designed to determine knowledge and attitude towards the disease was used. The sample survey was carried out during the month of July.

The study population comprised people off the streets, workers in insurance companies, health care workers and school teachers. They fell into the age groups between fifteen and forty years of age. Analysis of the study would seem to indicate that: while they had some superficial knowledge of the disease eg. Acquired Immune Deficiency Syndrome, a break down of the immune system, a fatal contagious disease, gleaned mainly from the media, newspaper, radio and television, one person's source was gossip, this knowledge was limited and vague and showed very little if any understanding of the implications of the disease.

Their concerns were mainly because there was no cure for the AIDS virus and because they felt it could have a great effect on society. With regard to their knowledge about the signs and symptoms of AIDS, again this was very limited. The majority of answers to the question, "list some of the signs and symptoms of AIDS" was "weight loss". While the answer is correct, it is not by itself a conclusive sign and therefore not enough to show any understanding of the disease.

With regard to children's knowledge about the disease, many felt that children should learn about AIDS at a young age, five or a little older and that parents and "influential" friends should be the source of their knowledge. On the other hand, they stated that children with AIDS should not be allowed in schools because other children might contract the disease unknowingly, through cuts, spitting or biting.

On the whole the study population seemed tolerant towards AIDS patients; they would not treat them any differently or would show added understanding. Some would prefer to have no sexual nor physical contact at all with the person.

CONCLUSION:

If this tiny study population is any true reflection of the wider public's knowledge and attitude towards AIDS and, in light of the difficulty in determining the rate at which the disease is spreading in the population, it would seem that the public's knowledge needs to be substantially increased so that they may protect themselves against the deadly virus.

At this point in time, public education seems to be the most effective answer.

AIDS: ITS IMPACT ON MOTHERS AND CHILDREN

DAVID SASSOON

The global epidemic of AIDS is posing what one expert has called the greatest challenge to public health in 50 years. A report on the toll it is taking and the issues it is raising.

Excerpts from: Action For Children, Volume 11, 1987 No.1
A publication of the NGO Committee of UNICEF.

There is a bit of good news about AIDS. If this incurable disease, which is currently causing a global pandemic, appeared 20 years ago, we wouldn't have had the faintest idea what was going on. Thanks to advances in biotechnology, the AIDS virus has at least been identified. But as Jonathan Mann, head of WHO's Control Programme on AIDS, recently said, "That's the end of the good news."

Cases of AIDS, or Acquired Immune Deficiency Syndrome, have now been reported in 74 countries, and it has been estimated that several million people worldwide have been infected with the causative agent of the disease, the human immunodeficiency virus or HIV.

AIDS is a disease that attacks the body's immune system, rendering a person incapable of fighting off almost any infection — by another virus, a bacterium, fungus or a parasite. It has proven fatal in 85% of all cases within 2-3 years after it manifests, and hope for a vaccine is still years into the future, if at all possible.

What is particularly alarming is the impact the AIDS pandemic is currently having on mothers and children and how it might impact on their health and well-being, both directly and indirectly, in the future.

AIDS Striking Mothers and Children

When AIDS was first "discovered" in 1981, it was thought to be a disease transmitted primarily through homosexual activity. Africa, where the virus is striking women and men in equal numbers, has shown the threat of heterosexual transmission.

Now there is the third generation of AIDS victims: Children. Children are acquiring the disease from infected mothers, either in utero or during birth. Experts have found that two of every three women with AIDS will pass on the fatal disease to their babies.

Since 1980, close to 1,000 infants have been born with AIDS in the United States, and some experts predict that by 1991 the number will be 25,000. In Africa, where fare more women have contracted the disease, the rate of infection is astronomically higher. Zambia alone expects to be caring for 6,000 infants with AIDS this year.

What is also alarming experts is the threat AIDS poses to beneficial interventions which today are saving the lives of millions of children each year. Because AIDS can be transmitted through the use of unsterilized needles, extra care must be taken in hospitals, clinics and immunization drives; many are worried that unfounded fears could drive people away from any contact with hypodermic needles — one of modern medicine's most basic and important tools.

Immunization Deemed Safe and Necessary

Thus far, there has been no demonstrated transmission of the HIV virus as a result of immunization. It is thought that this is because properly sterilized injection equipment is widely used, and because relatively small numbers of vaccinations are received per child.

The Global Advisory Group of the Expanded Programme of Immunization, which includes officials from both UNICEF and the World Health Organization, proposed that "given the benefits of immunization, programmes should continue to try to achieve the highest level of coverage possible."

Vaccine injections represent, by some estimates, less than 1% of all injections administered in the developing world. The risk of acquiring vaccine-preventable disease is thousands of times greater than the risk of acquiring AIDS. The benefits of immunization far outweigh the miniscule risk of acquiring AIDS through vaccination, and vaccinations have already saved thousands of lives in Africa.

Nevertheless, in the world's developing nations, AIDS is still being transmitted through contaminated blood transfusions and exposures to unsterilized needles, as well as from infected mothers to newborns...

Education One Key To Halting Transmission

The basis of protection is education, and education needs communication — even about a subject like sex which is not a part of public discussion. Ever since the AIDS virus was "discovered" in 1981, standards of acceptable discourse have been evolving in the news media. What words can be printed? Uttered on television? Spoken on the radio?

Similarly, a debate has erupted in school boards throughout the United States. Should AIDS education become a part of regular sex education curricula? Parents, teachers and health officials are struggling to determine just to properly educate children about such a SENSITIVE TOPIC.

African Nations Start to Respond

In Africa, too, AIDS is becoming a topic of wide discussion. Initially silent about the virus, governments in countries particularly affected are becoming aggressive about combating the spread of AIDS, where incidence is second in absolute numbers only to the United States.

In Rwanda, the government, in collaboration with the Norwegian Red Cross, began an education programme using television and widely distributed pamphlets, and is not integrating information about AIDS in school curricula and targeting other efforts at women, the segment of the population most afraid of, but least informed about the disease...

While this new openness is welcome, it comes as a *response to an already well-entrenched problem...World* health experts hope to begin the fight against AIDS in other nations before the disease becomes so widespread.

Screening of Blood Supplies a Priority

In addition to public education, therefore, the World Health Organization, the lead agency in the campaign to combat AIDS, has launched a global campaign to clean up blood supplies...

It costs about US$6 to screen one pint of blood for the virus, adding roughly 25% to the cost of blood transfusions, and it requires special equipment and training of laboratory and medical personnel.

WHO's global programme calls for US$1.5 billion annually — several times its current annual operating budget — to accomplish this task. A quick response to WHO's efforts is an urgent priority for the medical establishments in all nations, whether AIDS is currently prevalent or not. Policymakers are being asked to mobilize their health delivery systems to respond.

Prostitution Poses High Risks

Another area of great concern to health experts is prostitution...Prostitution could become a dangerous avenue for the transmission of AIDS to the population at large. At the same time, it puts many mothers and children at risk. It is no secret that many prostitutes are themselves little more than children. This is the most horrifying possibility; prostitutes infected with AIDS, many of them mere children, giving birth to more children born with the fatal disease.

AIDS is challenging mankind in a way that disease has never done before. it is threatening the efficacy of some of modern medicine's most fundamental tools of healing; it is testing the ability of mankind to work cooperatively on a global scale; in short, this simple biological development is affecting the behaviour of individuals, communities, and nations.

YOUR TEST RESULTS ARE...
(PATIENTS' REACTIONS TO INFECTION WITH HIV)

ROSA MAE BAIN

Testing for the Human Immune-deficiency Virus (HIV) began at the Princess Margaret Hospital in New Providence in August, 1985. Testing began one month later, in September, at the Rand Memorial Hospital, Freeport. Since that time, some private laboratories in the country have also begun testing for the HIV. Between August 1985 and June, 1987, The Bahamas has recorded the following statistics relative to AIDS.

August — December, 1985	36 cases	15 sero positive (HIV)	5 blood donors 24 deaths
January — December, 1986	50 cases	71 sero positive (HIV)	12 blood donors 19 deaths
January — June, 1987	40 cases	52 sero positive (HIV)	14 blood donors 12 deaths

Once a person tests positive for the HIV, he/she is placed into one of the following groups:

1. **A CASE** (or AIDS, Acquired Immune Deficiency Syndrome with positive HIV) The person is ill he/she has an "Opportunistic infection". In The Bahamas, such persons usually present with any combination of the following —chronic diarrhoea, weight loss, prolonged fever and persistent cough, diagnosed as pneumonia or tuberculosis. A significant number also have other sexually

transmitted diseases such as herpes, syphilis or gonorrhea.

2. **AIDS RELATED COMPLEX (ARC),** positive HIV. These persons are usually not ill, but may present with one or more symptoms such as swollen glands (lymphadenopathy), fever, diarrhoea and cough which is intermittent but persistent for more than a month.

3. **ASYMPTOMATIC INFECTION** with positive HIV — seropositive group. These persons test positive for the virus but are all physically well. They are known as CARRIERS and can infect others. They may/may not become ill from the virus, but those persons whom they infect can quickly become ill and die as a result.

When a person tests positive for the HIV antibody, whether he has symptoms or not, the following procedure is followed:—

i) the physician for infection disease informs him/her of the positive test;

ii) further laboratory tests on all systems of the body are done to determine how well the systems are functioning so that if there is a problem, it can be treated early; for example low iron or some other infection.

Tests done are:— full blood count; a liver function test; a kidney function test; test for syphilis; stool and urine tests.

iii) a complete physical examination is then carried out.

NEW PATIENTS

iv) A return appointment for one week is given to assess the laboratory results. All other persons are monitored. They are either seen on a three monthly basis if asymptomatic (have no symptoms), or more frequently, depending on their illness and the treatment necessary.

Further, all new persons who test positive for HIV are referred to the Infection Disease Consultant and seen at a special Infectious Disease Clinic. The physician and Community Health Nurse working with these new referrals witness at first hand the emotional changes and stress these patients undergo when told they are carriers of or have the disease — AIDS.

Once informed, individuals become very anxious because most of them know very little if anything about the disease. Many are convinced that it is only a matter of time before they die.

Because of this, QUALITY TIME has to be spent educating them.

In dealing with sexuality, the biggest concern of these individuals is for strict confidentiality.

They are assured that this important request will be respected, and it is adhered to.

They are appropriately advised and urged that all sexual contacts must be notified so they can be tested for the HIV.

Counselling done at the Special Clinic and on home visits include:—

i) building up a rapport with clients.

ii) bolstering their self-image. This is important.

iii) discussing their condition and determining what they know already about it.

iv) giving standard advice to help persons who are not ill, but have a positive HIV to reduce their risk of becoming ill and developing the full blown disease (AIDS).

— they are advised about the importance of relevance to them of having adequate nutrition, adequate exercise and rest;

— they are advised not to become exhausted;

— they are advised about proper ventilation and sunlight;

— they are helped and encouraged to accept their condition, to avoid stress, to avoid becoming depressed and referred for professional counselling if necessary;

— they are further encouraged to avoid drugs and alcohol abuse;

— they are urged to practice safe sex only —for example to have one partner, or person with same HIV antibody status, to use condoms always and pay strict attention to good personal hygiene.

We explain that persons with HIV infection can live at home and maintain a normal life as the virus is NOT spread by casual, non-sexual, household contact.

We stress the urgency of not infecting others.

Although you may not be ill, we say, you have the HIV and can transmit it to others whose resistance may not be as good as yours. You can infect them and they may develop AIDS and die after a short time.

To avoid this you must NOT engage in any form of sex that can result in the exchange of body fluids, semen and blood, OR cause injury to body tissue as happens in, for example, anal sex.

You must ALWAYS use a condom. If you have cuts or lesions on your hands you must not engage in fondling or manual masturbation. You must NOT become pregnant. You must not use drugs or alcohol, share razors or toothbrushes.

In addition to the above, you should practice good personal hygiene, good health and housekeeping habits; use 1:10 solution of household bleach for cleaning up any spills of body fluids such as blood, semen, urine, faeces or vomit.

On being told that they test positive for the HIV persons attending the infectious disease clinic, not surprisingly, undergo tremendous emotional strain. Their reaction can be anything from shock, disbelief, denial, fright, depression, anger, concern for loved ones, revenge, suicide to total dependency on others.

Their immediate reactions, to list a few: Are you sure? Can you repeat the test? How did I get it? Why me? How long do I have and what about my family? Am I going to infect them too?

SID, a 24 year old intelligent young man, was referred to the Clinic for investigation of swollen glands and generalized fatigue. He was obviously well read and knew a lot about Acquired Immune Deficiency Syndrome. Because he fell into the "At Risk" group of bisexual male prostitute and drug abusers and had swollen glands with intermittent diarrhoea, he told the doctor he felt he has AIDS even before his test confirmed this. Sid was given the standard counselling and health education. His list of sexual contacts was, to say the least, shocking, approximately fifty; most known only by nick names with no known address. They usually met at the base houses where anything goes for another hit of drugs. His reaction to his condition was, "I' don't feel sick, I am not a risk to my immediate family; the disease is not spread by casual contact, I live alone anyway and I am sure the group I hang out with must all be already infected.

His reaction to avoid infecting others and changing his lifestlye and practices was "I know I can do a lot to help in the fight against AIDS but sorry, I am not ready just yet. Later on I will re-enter the drug programme, start going to church and visit at risk areas where the disease is spread and teach people how to avoid contracting and spreading the virus. In the meantime, I will continue to work, make good money, use my drugs and enjoy life. You see, I don't feel sick yet". He was classified as ARC (Aids Related Complex).

DICK, a 19 year old quiet, reserved young man, was homosexual. He developed a chest infection and presented with swollen glands (kernels) everywhere. He was ill and required weeks of treatment and care. On learning of his position HIV testing, his reactions were fright and concern for his immediate family. He agreed to conselling sessions with them. In that setting the disease was discussed in relation to its spread and prevention. Guidelines were given for household contacts. It was stressed that persons with the infection can safely live at home and maintain a normal life since the virus is not spread by casual contact. Family members were very supportive, although initially they were obviously upset and emotionally strained. They cried and prayed and promised to do all possible to help him keep his resistance up by ensuring he got adequate nutrition, rest and exercise, to help to reduce stress and remind him about keeping his clinic appointments regularly.

Today, two years later, Dick, has developed AIDS. He is adjusted, still working, receiving family support and is very active in his church. His main concern and that of his family was CONFIDENTIALITY by all those concerned in his care.

Since his diagnosis, he has avoided sex, changed his attitude toward sexual practices and knows that if he does engage in any form of sexual activity he MUST use a condom to prevent contact with semen, vaginal and/or salivary secretions and blood.

RON, an 18 year old, was very excited about his girlfriend having their second child. Feeling strong, healthy and almost like He-man, he went to donate blood in case it was needed during her delivery. When he got a call from the Blood Bank to visit them, his immediate reaction was, "Gosh, you mean they need more blood?" his chest swelled and he felt the proud father-to-do.

When given an appointment to see a hospital doctor because of a problem with his blood, he said, "I feel O.K., how come my blood is low?" He was politely but gently told that the doctor would discuss it with him and explain the problem.

Thinking there might be a small problem and he may need some iron tablets, Ron went to see the doctor, surprisingly, taking his mother along for company. Soon the Nurse called him in and mother sat smiling and waiting for her son's return. Then like a wild bull, Ron dashed from the room calling to his mother, "Come mammy, come here". Together two very frightened persons entered the examination room. The parental role then came to the fore, "Goodness child, what is the matter, what so bad you crying, sweating and shaking like that? Nothing could be that bad, only AIDS and I know you don't have that. Come doctor, what wrong with my child, he has cancer?"

Following the education, advice, counselling and support given the family that day, both the nurse and the doctor were weary. They were also two concerned, disturbed individuals, who wondered where it could all end.

Ron had completed his high school education at a private school at 16 years and started working. He had continued seeing his high school sweetheart and was saving money for the down payment on a low cost house. Unfortunately, his girlfriend had become pregnant, but both families supported the young couple, each continued to live at home. They were upset that they had started a family before marrying but the wedding was planned for as soon as they got the house.

Apparently Ron's biggest mistake was that he had accompanied friends from work on a few occasions to a prostitute house for kicks.

Neither mother nor son could believe he had AIDS.

In contrast to the mother, the girlfriend's reaction was one of extreme anger. She actually threatened to stab him. It took days of continuous counselling, emotional support and visiting before she actually accepted the situation. Her boyfriend, herself and the new baby were all positive for the HIV. Alas, the new infant developed the disease and dies.

Today the young family is married, closer than ever and obtaining active support from parents.

In this instance, one or two slips ended in chaos for youngsters who had their whole life mapped out from school days. How sad.

JANE, a 25 year old, had two children by her first boyfriend. After they broke up, she had one child by the second boyfriend. The baby boy died shortly after birth in 1983. She then got pregnant for her third boyfriend and has another baby boy. By the age of eight months, the child had been admitted to hospital with Failure To Thrive and several episodes of gastro-enteritis (diarrhoea). In 1985, the child was positive for AIDS and died shortly afterwards. By this time, she was not only already pregnant again, but almost to term (due to have her baby). Blood tests on her and the father were positive, the new baby was also positive for the HIV. The first two children's tests were negative along with their father.

The mother refused to have her tubes tied after her delivery, despite intensive counselling from the health team, Infectious Disease Doctor, Obstetrician, Nurse and a Spiritual Leader. The new baby has already been admitted to hospital four times with diarrhoea, skin rashes and Failure to Thrive.

Seven months later, Jane has left her boyfriend who took his infant daughter and she is now living with a new partner and is pregnant again! The new boyfriend's blood test is presently negative, but, for how long?

Jane's case history is presently under review. She has not only refused to have a tubal-ligation but she also refuses to use condoms.

SUSAN, is a 15 year old student. She is taken for treatment for her drug problem by her mother, a single parent who has three children involved in drug abuse. Because of the association between drug abuse and promiscuity which result in numerous sexually transmitted disease including AIDS, screening was done, it showed a positive HIV. Double trouble!!!

Susan who never missed a school day, admitted to using drugs from the age of 12, she became sexually active at 13 years. She can only give first names of her contacts and doesn't know their addresses.

Her condition has been explained to her and her mother. Advice and counselling have been given. The Psychiatrist and Social Workers are working with the family since she dropped out of the drug programme. The family's attitude is "so what, she brought it on herself".

SALLY, another 15 year old high school student, was brought to the clinic by her mother after she viewed the five part series on AIDS, on ZNS TV 13. She really came for advice because her daughter had lost weight and got swollen glands all over in the past few months. The test for AIDS was positive. The student was told of her problem. Her reaction was to continue smiling and nodding her head... shock no doubt. She admitted to becoming sexually active at Christmas 1986, but did not know where the boy was now.

Although the mother had initially brought her daughter to hospital, her reaction was one of extreme shock.

On being told the results, she jumped up, took off her glasses and said to the doctor, "repeat what you said." The distraught mother then lashed out at her daughter, but she very quickly composed herself.

The following day, she requested a letter from the clinic stating her daughter's test results and problem. She had already sent her off to relatives in the United States; she was at this time emotionally unable to cope with questions from friends or others about her daughter's condition. She wanted everything to remain anonymous and confidential.

Another young student engaging in a casual sexual relationship, the first time in her life, she became infected.

NANCY, a beautiful, caring parent spared her only 18 year old son nothing she could afford once she considered it good for him. He was attending school abroad, became ill, saw a doctor, was diagnosed as AIDS and returned home to his young 36 year old mother.

What a blow! Shocked and hurting, she set out to continue giving her son the loving care that only true mothers can provide. Her first task was to visit a doctor and learn all she could about the disease process. She then stopped working, stayed home and with the support of her doctor, nurse and spiritual leader, stood by her son until he succumbed to the dreaded disease.

Here was a promising young Bahamian, preparing himself to return home after equipping himself to contribute to the economic development of his country but, alas, a few casual affairs cost him his life and his family and friends a ton of distress.

The message, loudly, clearly an unequivocally must be: DO NOT ENGAGE IN CASUAL SEX. FORM A

LONG-LASTING STABLE RELATIONSHIP WITH ONE PERSON. SAVE SEX FOR AFTER MARRIAGE.

BEN, a 40 year old seasoned worker took ill on his job. He felt weak and blacked out. While in hospital, he had routine investigations for his black out. One test showed he was positive for the AIDS virus. Physically he was thin, had lymph nodes, skin changes, fever, weight loss and a chest infection. He was diagnosed as having AIDS. His reaction was one of shock and disbelief. It took a while for him to actually accept his condition.

As the disease progressed, Ben's condition deteriorated. He fully understands how he contracted the disease and how he may have spread it to many others.

Ben visited base houses and had many casual sexual partners. He provided the drugs and the money, they the sex.

His main objective in life now is to abstain from sex. He suggested that all persons with positive HIV do the same. He is also prepared to assist in educating the general public so that adolescents, young adults, adults like himself, mothers, mothers-to be, unborn and newborn infants may not become infected.

JACK, a 22 year old young businessman, being a good corporate citizen, went to donate blood. His test showed positive for the AIDS virus. His initial reaction was one of disbelief and shock. When screened, two of his three contacts also showed positive HIV.

Jack lives alone and sees no reason to involve his family in his health problems. He understands the disease, its methods of transmission and prevention. He keeps in contact with the clinic and attends his private physician.

Two and a half years after his blood was positive for the HIV Jack has lymph glands but is otherwise well and continues to run his business which is doing well.

He has changed his sexual practices and knows that he must practice safe sex. He too is working with young people and helping to channel them into areas where they will not contract the disease.

From the above nine cases studies, all names have been changed, it is hoped that others like young Sid, intelligent and a first class employer, will not get involved in drugs and casual sex, and automatically at risk for the AIDS virus.

Young Dick, a homosexual, was very much at risk for getting AIDS.

Young Ron a heterosexual, went with female prostitutes twice only. He had had only one girlfriend. His encounters with prostitutes resulted in two innocent persons being positive for the HIV.

Jane, a young woman with numerous sexual partners, infected her unborn/newly born children, they died very young.

Susan, an adolescent, had had only one sexual partner.

A young adult had casual affairs while abroad.

A mature adult with a family involved in drugs and multiple casual sexual contacts.

The main thrust of the counselling sessions are to:

1. Provide support for clients and their families.
2. Provide information about AIDS to clients and families and to advise them about preventive and protective measures they should adopt.

Emphasis is placed on adhering to SAFE SEX so as not to infect others. Patients are urged to:—

A) Avoid exchange of body fluids in any and every sexual encounter;

B) Avoid anal sex — it is traumatic, it causes bleeding and semen is readily absorbed into the circulation thus allowing easy access of the AIDS virus to the blood.

C) Use condoms — they are a barrier and as such give protection.

D) Avoid casual affairs/one night stands.

E) Avoid multiple partners

F) Avoid drugs.

Working with persons who have AIDS or are positive for the HIV (ARC or carriers) and their families requires an immense sensitivity to persons' needs, deep commitment to helping others, a firmness of will and a bottomless pit of emotional strength. At the end of the special clinic we are often exhausted. Some patients obviously require much more than others. The co-operation of colleagues in every department of the Ministry of Health is vital to helping patients and their families cope as successfully as possible with their disease. Needless to say, Confidentiality, divulging of information about the patient's condition to anyone, unknown to or without his/her consent, must be our hallmark if AIDS is to be controlled in our society. It also makes the task of working closely with these patients and their families slightly less onerous.

EDITOR'S NOTE:

The advice relative to safe sex is also most germane for ALL sexually active members of the public. Abstinence and/or monogamous relationships for each member of the couple are the recommended precautions. Maintaining high standards of personal health and cleanliness are also suggested.

UP-DATE

FELICITY AYMER

WELCOME

To The Health Education Division:—

* Mrs. Dale CLARKE, Typist, on transfer from the Supplies Section of the Princess Margaret Hospital effective 1st June, 1987.

  Mrs. Clarke brings with her a degree of quiet elegance and willingness to work which is just as well because so far, the volume of work has been heavy and is expected to increase.

  Mrs. Clarke is married to Mr. Theadore Clarke a Customs Broker/Sales Manager at Bahamas Drug Agency and the couple have a son Kedar Tavares aged two years.

* Mrs. Joan DEMERITTE, Chief Clerk, on transfer from the Public Health Department, effective 21st July, 1987.

  Mrs. D as she is fondly called, is like a family member returning home; but, as is to be expected after a long absence, the family's composition has changed. Mrs. Demeritte is quickly settling in and is attempting to imprint on the Division her unique stamp of calm efficiency and order. It is most reassuring to be working with a new member of staff but one whose capacity for hard work, efficiency and dedication are known and proven.

* Summer Students Dionne BENJAMIN and Shandalanae EDWARDS.

  Dionne is an Art Student at the College of The Bahamas. Her understanding of health and her willingness to interpret ideas are indeed refreshing. Our regrets are that her stay with us has been so short and that the possibilities of her returning to work with us, remote.

  The Division appreciates your graphic contributions most sincerely and wishes you all the very best in your studies and later in your professional life. Thank you for passing through Dionne and thank you Stanley (Burnside) for identifying her.

* Miss Edwards joined the Division having completed a first degree in health education at Morris Brown College, Atlanta, Georgia, in May of this year and it is hoped that she will continue in the Division as a Health Education Officer at the end of the summer period.

  Miss Edwards left The Bahamas with her family at the age of nine years. She has now finally returned home to work and contribute to her country. She is young, attractive, quietly confident, willing and able to work. The Division welcomes you, Shanda. We hope you will spend many years with us especially as you have already demonstrated a capacity for "soliciting support" for the Division! Welcome.

  Having welcomed four persons we have said goodbye to:

* Mrs. Keva NEWBOLD and Mrs. Patricia FERGUSON.

  Mrs. Newbold our young, exuberant typist of many years, discovered she had a flair for figures and has eventually been transferred to the Accounts Section.

  Best wishes in your new job Keva, we hope you continue to enjoy it and that you continue to progress up the accounting ladder.

* Mrs. Patricia Ferguson transferred to Ministry of Health Headquarters in mid-June and is happily busy. Very best wishes Mrs. Ferguson.

To the Princess Margaret Hospital:—

* Dr. Mario BLANCO, Pathology Department, 1st July, 1987

* Dr. Owasa DUAH, Registrar, Pathology Department, 11th June, 1987.

  Dr. Duah completed basic medical studies at the University of Ghana's Medical School and went on to post graduate training at the University of Western Ontario in Canada. His fields of specialisation are in Tropical Medicine, Clinical Immunology/Allergy and Laboratory Medicine. His research interests include Immunological Diseases including AIDS, Haematological (blood) Disease and Oncology (cancer). Dr. Duah is married and the father of five children.

* Dr. Jill GIBSON, dentist, and

* Dr. Ellen STRACHAN, also a dentist, to the dental department both on 1st July, 1987.

* Manessia SMITH to the ECG Department in July, 1987.

  The following nurses to the Princess Margaret Hospital:

* Staff Nurses Kayla COLEBY: Donnel DEVEAUX: Janet FORBES; Berthamae FRAZIER: Portio FERGUSON: Clarabell GARDINER: Maria HALL: Katie McPHEE; Sabrina MUNNINGS: Julian NAIRN; Agatha

STRACHAN: Karen THOMPSON, In November, 1986. Jane BYRAN in April, 1987.

Trained Clinical Nurses:

Kendra ADDERLEY; Sandramae BETHEL; Carmila EDGECOMBE; Roslyn FARRINGTON; Kim HARRIS; Canal HEPBURN; Vernita INGRAHAM; Naomi JOHN; Lescetus McGREGOR; Sophia MILLER; Patricia MITCHELL; Esther ROBERTS; Melda ROLLE; Valarie RICHARDS: Melony SANDS; Valarie SMITH; Dorothea TAYLOR, in mid January, 1987.

To all auxiliary nurses and members of the housekeeping staff joining the large family of the Princess Margaret Hospital during the past year.

To the Sandilands Rehabilitation Centre:—

* Mrs. Carolyn MINUS-ROBERTS, Pychologist

* Mrs. Margot ROLLE, Executive Officer.

All auxiliaries and support staff who joined the family at the Sandilands Rehabilitation Centre during the past year.

* Attendant Mr. Joseph PENN after a long illness; Welcome back.

CONGRATULATIONS:—

* Mr. Nathaniel BASTIAN on your promotion to Assistant Maximum Security Officer, Sandilands Rehabilitation Centre.

* Dr. Barrington NELSON on your appointment to Senior House Officer, Sandilands Rehabilitation Centre.

* Gloria ANDREWS, Gabrielle O'BRIEN and Brian SEYMOUR (Medical Records Department, Princess Margaret Hospital); Dencie BROWN, Doretta ROLLE and Sonia THOMPSON (Administration, Princess Margaret Hospital); Merril COOPER (Accounts Department); and Anita BURROWS (Eye Clinic) on your promotion to Senior Clerk.

CONGRATULATIONS:—

To the ninety four nurses who graduated on 15th August, 1987. Ceremonies were held at The Wyndham Ambassador Hotel, Cable Beach.

Graduants comprised forty-three Registered Nurses, thirty-seven Trained Clinical Nurses and fourteen Psychiatric Nurses.

CONTINUING EDUCATIONS:—

Dr. Donald COOPER, Public Analyst and Mr. Carlton SMITH, Acting Senior Health Inspector, Grand Bahama, attended an International Workshop on Impact Assessment for International Development, sponsored by the Inter American Development Bank and held in Barbados 31st May — 4th June, 1987.

* Mr. Edwin STRACHAN, Deputy Director, Department of Environmental Health Services, attended the National Environmental Health Association and Educational Conference 13-18 June, 1987, held in San Diego, California.

* Health Inspector Grade I, Melony McKENZIE and Senior Laboratory Technologist, Dwayne CURTIS attended a Seminar on Canned Foods: Thermal Processing and Container Evaluation 22-26 June, 1987 in Barbados.

The following Nurses from the Community Nursing Services attended a Drug Abuse Workshop held at The Bahamas School of Nursing 13-17 July and 20-24, July, 1987:—Brenda ARMBRISTER; Linda ABERE; Sandra COLEBY; Brenda COX; Kathleen JOHNSON; Dorothy MILLER (New Providence); Pattie DANIELS, Inagua; Bernadette MOSS, Exuma; Barbara RECKLEY, Abaco; Edna TINABOO, Harbour Island; 13-17 July, 1987.
Albertha BAIN; Thirza DEAN; Norma GORDON; Bowlene NIXON; Maggie TURNER (New Providence) 20-24 July, 1987.

TCNs Pearl MILLS and Luella MONROE (CNS) attended Refresher Work Improvement 2 course 18-22 May, 1987, at the Public Service Training Centre, Arawak Cay.

Also attending courses at the Public Service Training Centre were:

* NOs 2 Gloria GARDNER and Bernadette GODET (CNS) Effective Working in Government;

* NOs 2 Philabertha CARTER and Deborah FOX, SN Maggie TURNER, (CNS) Management Improvement 1 29th June — 3rd July, 1987.

* HAs Pearline BURROWS and Lilian CLARKE Refresher Work Improvement 1, 13-17 July, 1987.

CONGRATULATIONS:—

* Ms. Lynn GARDNER on having obtained a B.Sc. degree in Dietetics at the Texas Women's University in May of this year. Ms. Gardner returned to work at the Sandilands Rehabilitation Centre in June.

* Anthony DEVEAUX on successfully completing a course in Electrical Installation (with Honours); Wayne Gardiner, Air Conditioning and Refrigeration; Brian JOHNSON, Plumbing; Erwin JOHNSON, Masonry; Elijah McKENZIE, Carpentry; Paul RAMSEY, Electrical Installation; at the Industrial Training Centre. All are staff members at the Sandilands Rehabilitation Centre.

* Dr. Herbert ORLANDER, Princess Margaret Hospital, on obtaining a Masters in Public Health (MPH) at the

University of the West Indies, Mona, Jamaica. Dr. Orlander has already returned to work in the Comprehensive Clinic.

- SN. Tanya THOMPSON, Princess Margaret Hospital on successfully completing a diploma in midwifery.

- Dr. Robin ROBERTS on having successfully completed a four year period on specialised training in Urological Surgery at The University of Dalhousie's Medical School, Canada.

- Dr. Paul WARD, Senior House Officer, Princess Margaret Hospital, is presently pursuing a three year course in Obstetrics and Gynaecology at the University of the West Indies, (Jamaica) Department of Medicine.

- SN Rema BURROWS (PMH) is presently pursuing a one year course (started 1st May, 1987) in midwifery at the University of the West Indies Hospital.

- Principal Nursing Officer (PMH) Mrs. Theda GODET and Financial Controller (PMH) Mrs. Francina HORTON proceeded on an observation tour (one week) of the East General Hospital, Toronto, Canada.

- Nursing Officers Ruth FERGUSON and Rose AHWAH both of (SRC) will be travelling to London to pursue a one year course in Nursing Administration at the Royal College of Nursing.

- Nursing Officer Julian ARANHA will be travelling to Jamaica to pursue a one year course in Nursing Administration at the U. W. I.

- Psychologists at Sandilands Rehabilitation Centre:

  Harry FERERE who will be leaving to enter the doctoral programme in Clinical Psychology at Nova University, Fort Lauderdale, Florida.

- Fabian THURSTON who has been accepted for graduate studies in Clinical Psychology at New Mexico Highlands University.

- Kerry WORREL-HIGGS who will be starting studies in Guidance Counselling Education at the University of South Florida.

  Attendants at Sandilands Rehabilitation Centre Allen Smith and Zack FRANCIS have been given In-Service Awards to enable them to enter an Associate Degree Programme in Occupational Therapy in the United States.

- Lorinda HANNA, Health Aide in the Laboratory at Princess Margaret Hospital will be entering a Bachelor of Science degree programme in Medical Technology at Florida Memorial Hospital, Miami.

- Tomacina ROLLE, Clerk in the Accounts Department, Ministry of Health has gained admission to the B. Sc. programme in Business Administration Management at the University of the District of Columbia, Washington.

- Wendymae FERNANDER, Clerk (PMH), has gained admission to the BA programme in Psychology with a minor in Personnel Administration at St. Benedicts' Minnesota.

- Staff members at the local PAHO office said a fond but sad farewell to one of their most efficient colleagues, Miss Althamese HALL, who has gone on study leave. We in Health Education and Joining Hands For Health will also miss Miss Hall's cheerful and speedy efficiency. Very best wishes for your success in further studies. We look forward to your return.

- The Training Department, (SRC) in collaboration with the Public Service Training, Centre, sponsored an in-house seminar for its supervisors and heads of department. From all reports, the seminar was a resounding success and all participants received certificates on its completion.

- The on-going summer programme at the Child Guidance Centre has been successful. In addition to formal instruction, the children were taken on numerous field trips including a trip to Coral World.

CHANGE AND ???

Change is an inevitable part of life and the Public Health Department has had its fair share recently.

On 12th June, 1987, staff members of the Department met in the Health Education Division Conference Room to say goodbye to Dr. Farhat MAHMOOD, Acting Medical Officer of Health since the retirement of Dr. Cora Davis in August, 1985.

Dr. Mahmood joined the Department in September, 1978 and was particularly interested in Occupational Health matters and health education. He spearheaded the epidemiological survey in Grand Bahama which is still underway and expanded the workforce in the department of almost unrecognisable proportions. Under Dr. Mahmood's leadership, the complement of Medical Officers in the department grew from five to seven so that two physicians have been on duty at each of the main Child Health Clinics since February of this year. In addition, a physician is also present during all clinic sessions.

Dr. and Mrs. Mahmood and their two sons left The Bahamas for a well earned vacation in their native Pakistan via the United States. This Journal joins with the staff of the department in extending best wishes for health, happiness and success to the Mahmood family.

The Department took the opportunity to offer best wishes to Dr. Sandra HEADLEY, Medical Officer who has worked mainly in the Ann's Town Clinic and who has now left for further studies in Public Health in Florida. Joining Hands for Health extends its best wishes for your success in academia, Dr. Headley.

* After twenty-five years with the Ministry of Health and Principal Nursing Officer, Community Nursing Services for the past four, Evelin PRESCOD decided to take life at a more leisurely pace.

With hindsight we appreciate and thank you for those words of discipline and advice.

On a wet evening at the end of July, Colleagues gathered at Longley House, Headquarters of the Nurses' Association, to extend envious farewells and reminesce over the "old days" when Mrs. Prescod, known then as Miss Stewart, joined the nursing sorority as a general duty nurse and steadily moved up through the ranks. While Mrs. Prescod seems to have had an outstanding career in general nursing she seems to have further excelled in the Community Nursing Services. Her colleagues have agreed to allow her a short respite "to cool out under the cherry tree in her garden". They will then request and expect her to graciously agree to lending them one or two helping hands as

We shall miss you Mrs. P. we wish you all that is good and lovely in the years to come.

We rejoice and say thank you for the time spent among us.

the situation dictates. They will most certainly miss her objectivily and ability to see the other side of the coin.

Very best wishes for a long, healthy, exciting and productive retirement Mrs. Prescod. We shall keep in touch.

* Dr. Kenneth Ofosu-BARKO known as Dr. Barko, is presently carrying out the functions of the Medical Officer of Health.

* Mrs. Celeste LOCKHART, veteran nurse, past president of the Nurses' Association of The Bahamas and Senior Nursing Officer, Community Nursing Services, is currently sitting in the hot seat recently vacated by Mrs. Prescod.

* Mrs. Jacqueline MYCHLEWHYTE, for many years Chief Executive Officer at the Sandilands Rehabilitation Centre has been transferred to the Personnel Department at the Ministry (of Health's) Headquarters.

TRANSFERS:

* SNs Cleala HAMILTON and Ervine STUBBS from Sandilands Rehabilitation Centre to the Princess Margaret Hospital, 13th April, 1987.

* SNs Phillip GAY and Marcel COOPER from the Princess Margaret Hospital to Sandilands Rehabilitation Centre, 13th April, 1987.

* SNs Carolyn BENEBY and Juliette SAUNDERS from the Princess Margaret Hospital to Community Nursing Services, 11th May, 1987.

* TCN Francita McDONALD from Princess Margaret Hospital to the Rand Memorial Hospital 17th August, 1987.

* TCNs Sylvy BELIZIARE: Yvonia BETHEL; Laverne CHARLTON; Charlene GARDINER; Brendamae McKAY; Brendamae SMITH-ROLLE; Vanessa SMALL

from the Princess Margaret Hospital to Community Nursing Services, 11th May, 1987.

* TCN Brendamae ROLLE moved to Kemps Bay, Andros, 11th June, 1987 while

* TCN Sylvy BELIZAIRE moved to Marsh Harbour, Abaco, 15th June, 1987.

* TCN Althea WILLIAMS for Princess Margaret Hospital to Community Nursing Service, Rock Sound, South Eleuthera, in June, 1987.

* TCN Esther MILLER from Princess Margaret Hospital to Community Nursing Service, where she is currently on orientation.

* SN Leah WILLIAMS from Princess Margaret Hospital to Community Nursing Service.

* SN Valdamae ROLLE from Princess Margaret Hospital to Community Nursing Service, Kemps Bay, Andros.

* NO Edna IJEOMA from Princess Margaret Hospital to Community Nursing Service, 10th August, 1987.

* SNs Patrice KING and Lola KNOWLES from the Community Nursing Service to Princess Margaret Hospital.

* SN Lolita PRATT from Community Nursing Service (Marsh Harbour, Abaco, where she had worked for the past year) to the Princess Margaret Hospital.

The Community Nursing Service takes this opportunity to express its sincere thanks to those nurses who have returned to Princess Margaret Hospital especially SN PRATT.

* SN Maggie TURNER from CNS (School Health Service) to The Bahamas School of Nursing, 10th August, 1987.

* The following staff nurses at the Princess Margaret Hospital have resigned:—

* Karlene CAREY; Linda RUSSEL and Sylvia WHYLLY.

* Dr. Julius FUFHIK, having completed his tour of duty at the SRC (Geriatrics) has left and will further his medical education. Very best wishes to Dr. Fughik

* Social Worker Tracey GODET and Alvin KING (Maintenance Department) both of the PMH have resigned.

GET WELL SOON:

Dr. Glen BENEBY (PMH)

CONGRATULATIONS:

To Dr. Norman Gay on being re-elected to the House of Representatives and also on his reappointment as Minister of Health. Joining Hands For Health wishes you a most successful and not too stressful period at the helm Mr. Minister. If you are able to wave a magic wand Sir, we should sincerely ask that you wave it in favour of and imprint an indelible mark for health promotion.

FROM THE MINISTRY OF HEALTH:—

The Minister of Health, Hon. Dr. Norman Gay, accompanied by Chief Medical Officer, Dr. Vernal Allen and Under Secretary Mrs. Veta Brown, travelled to Washington DC (22-26 June, 1987) to attend the 99th meeting of the Executive Committee of the Pan American Health Organisation (PAHO). Dr. Gay chaired the meeting at which fifteen resolutions were approved together with the PAHO's proposed budget for the biennium 1988-89.

The total budget approved was in excess of $121 million. The Bahamas was allocated $867,000 for the period, up from $785,500 for 1986-87. It contribution during that two year period was $56,370.

Other resolutions taken at the meeting concerned Women, Health and Development, Emergency Preparedness and Disaster Relief Co-ordination, Co-ordination of Social Security and Public Health Institutions and AIDS Prevention and Control. In this respect, countries were being urged to develop, implement and sustain national programmes.

Mrs. Brown was the Rapporteur of the sub-committee on planning and programming.
Source: Bahamas Information Service Release.

The Pan American Health Organisation (PAHO) the regional office of the World Health Organisation, (WHO) will be holding its first teleconference on AIDS In Quito, Ecuador 14-15 September, 1987.

The Conference will be beamed live, via satellite to a number of countries including The Bahamas. Interested persons can participate via satellite and ask questions from remote reception sites. These will be simultaneous translations in English, Spanish, French and Portuguese.

The objective is:— to increase the awareness of health workers, decision makers, the media and the general public regarding AIDS.

Further details may be obtained from the Ministry of Health, co-ordinator of The Bahamas arrangements.

Recently, Mrs. Dorothy Philips, First Assistant Secretary, Ministry of Health, travelled to Washington to attend the sub-committee meeting of the PAHO on Women, Health and Development (17-19 July).

Faculty and students of the former Department of Nursing Education, now The Bahamas School of

Nursing, are gradually settling into their splendid new premises, hewn out of the rock at the end of Grosvenor Close, which were officially opened by the Hon. Clement Maynard, Deputy Prime Minister, on Monday 15th June, 1987.

Guests for the occasion included such luminaries in Bahamian nursing as Miss Hilda Bowen first Bahamian matron, later, Director of Nursing and Mrs. Monica Knowles, first nursing tutor at the Department of Nursing Education; the architect of the building Mrs. Dorothy King; the Manager of World Bank project (funding agency) Mr. L. B. Darville; the project Supervisor Mr. William Petty and members of the diplomatic corps; — HE. Mrs. Carol Boyd-Hallet, US Ambassador, Mr. Colin Mays, British High Commissioner and Mr. Sam Aymer, Programme Co-ordinator PAHO

Music for the ceremony was provided by nurses, choir director Florinda Clarke, soloist SN Maggie Turner. Mrs. Turner very ably and most pleasingly rendered a Clement Bethel composition, When The Road Seems Rough.

Deputy Prime Minister Maynard elicited audible groans of disbelief and horror when he revealed during his address that significant sums of the Ministry of Health's annual budgetary allocation go unused. The Minister of Health hastened to publicly assure him that over the past year or two the allocation had been very marginally exceeded!

The new building is spacious and well equipped with modern teaching aids including tight security for a potentially comprehensive and up to date library. Eventually, it is hoped that the building will be much more fully utilised than at present. The tour which followed the ribbon cutting procedure, done by Mrs. Maynard, revealed ample classroom space in pleasant surroundings. Hopefully they are also comfortable and conducive to learning, suitable for the steamy summer weather.

From The Princess Margaret Hospital:—

The Yellow Birds, that volunteer group of women who have provided sterling service to the hospital over the past twenty years, met to honour some of their own on the evening of 28th May, 1987.

This group of women was officially organized in November, 1966, following a disaster in October. They have donated over a quarter of a million volunteer hours since then, scholarships and many expensive items through their fund raising activities. From a few members working on the female and male surgical wards and eight teenage girls working with children, their numbers have swelled to forty active members. The current President is Mrs. Emily Erskine-Lindop and they work in the canteen, Blood Bank and wards.

One of their members has donated 10,000 hours and persons like Mrs. Pearl Cox, Phyllis Hamilton and Jennie Mackey have been Yellow Birds since the inception of the group.

Permanent Secretary in the Ministry of Health, Mr. Harcourt Turnquest, presented plaques.

The Yellow Birds are always soliciting volunteers and would welcome any help as their projects are constantly growing.

Mr. Raul FALCONI, Director, Organisation of American States (OAS), Nassau and Mr. Michael NEELY, Manager of Texaco Bahamas Ltd., jointly presented the Princess Margaret with three culdoscopes and a special opthalmascope camera on August 12th on behalf of the Pan American Development Foundation and the OAS.

The culdoscopes will be used in the cancer programme (for early detection of cancer of the cervix) while the camera will be used in the eye programme.

Dr. Linnelle Haddox, MSC at the hospital, received the gifts and thanked the donors for their generosity.

The Princess Margaret Hospital will once again be observing October as Hospital month. This year the display will focus on AIDS, the theme of Caring and Sharing at School time, 1987.

The month will officially start on Friday 2nd, October; 14th has been designated T-Shirt Day; 17th the hospital concert will take place; 19th will be observed as St. Lukes Day; and the annual sports day will take place on Saturday 24th.

Chairperson of the planning committee is Dr. Perry Gomez, Infectious Disease Consultant.

From The Department of Environmental Health Service!

The former Health Inspectorate Division of the Department of Environmental Health Service has been renamed the Environmental Sanitation and Consumer Protection Division to more accurately reflect the functions and responsibilities of the division under the Environmental Health Services Act 27th May, 1987. Further, it is consistent with the reorganisation which is taking place within the department under the new Act.

The Public Analyst Laboratory is to become The Environmental Monitoring and Risk Assessment division and will be under the direction of an Assistant Director — currently Dr. Don Cooper, Public Analyst. The position of Public Analyst will continue.

The Department now comprises three divisions:—

1 The Division of Environmental Sanitation and Consumer Protection.

2 The Division of Environmental Monitoring and Risk Assessment.

3 The Division of Solid Waste Management and Restoration — this division includes maintenance of vehicles and Roads and Parks.

* The Department of Environmental Health Service is planning a seminar on Environmental Pollution and Control for 5-7 October, 1987, to be held in Freeport, Grand Bahama. The seminar is to be sponsored jointly by the department (Ministry of Health, Industry and the Community). Presentations will be made by external persons who are all experts in the field of industrial health and hygiene.

The primary objective of the seminar is to provide the public with information on environmental pollution/control and reassure them that their interests are constantly being monitored and reviewed.

From Sandilands Rehabilitation Centre.

Congratulations to Mr. Owen CAMPBELL, a patient, who won a silver medal at the Special Olympics, held in Indiana recently.

This year their annual fair will be held on Saturday 31st October, noon — 9 p.m. All staff members of the Ministry of Health, relatives and friends are asked to support this most worthy cause.

Other news for New Providence:—

* At a recent monthly meeting of the Bahamas Diabetic Association held on Saturday 25th July 1987, two glucometers (blood testing equipment for diabetes) were presented to Dr. Ronnie Knowles, Consultant Physcian, Princess Margaret Hospital, for use at the Princess Margaret Hospital.

From Grand Bahama.

World Health Activities — spread over the month of April — included schools essay and poster competitions, a well baby contest and culminated with a staff picnic.

Deepest Sympathy to staff members at the Rand:

* Mr. Herbert BROWN on the death of his nephew, Anthony Edwards.

* Mrs. Cabrena ADDERLEY on the death of her brother Rodney Bowe.

* Ms. Jacinta McGREGOR on the death of her sister Stacy McGregor.

* Ms. Shirley WEECH Senior Housekeeper on the deaths of her brother and sister.

* Maintenance Manager Valentine WEECH on the death of his sister.

* No. 2 Barbara SWEETING.

VITAL STATISTICS

Births Congratulations:

* Social Worker Telicia (SRC) and Wilfred McKENZIE on the birth of their daughter Wilicia on 12th July, 1987.

* Grounds Supervisor Lawrence (SRC) and Linda ROKER on the birth of their daughter.

* TCN Yvonia BETHEL (CNS) on the birth of her baby 15th August, 1987.

* TCN Sheila HUMES (CNS, Ann's Town Clinic) on the birth of her baby in June. Nurse Humes has now returned to her duties at the Ann's Town Clinic.

* HA Dora SAUNDERS (CNS) on the birth of her baby in May.

MARRIAGES

Wedding Bells rang out for:—

* HA Loretta DEAN-MAYCOCK (SRC) In May
* Clerk Sonia McNEIL-GILCOTT (SRC) in July.
* Chief Clerk Orlene LIGHTBOURN-RODGERS (SRC) In August.
* Dr. Alfred ALINGU and Juliette ANGOLE, 18th July, 1987 in Grand Bahama.
* NA Patrice BUTLER (PMH) and Wilman COOPER 27th September, 1986.
* TCN Felecia ROLLE (PMH) and Ashwood TURNQUEST, 11th April, 1987.

DEATHS

Joining Hands for Health extends deepest sympathy to the following persons on the death of a loved one:—

* Dr. Farhat Mahmood Acting Medical Officer of Health, Public Health Department, on the death of his father in Pakistan, May 1987. Dr. Mahmood was unable to attend the funeral.

* Dr. Linnelle Haddox, Medical Staff Co-ordinator, PMH on the death of her mother, famous educator Mrs. Mable Walker on 8th July, 1987.

* TCN Barbara BURROWS (PMH) on the death of her husband.
NO. 2 Janice BROOKS (PMH) on the death of her father.

No. 3 Letitica CURRY (PMH) on the death of her mother.

SN Genevieve JACKSON (PMH) on the death of her brother.

TCN Margaret KINLOCK (PMH) on the death of her sister.

SN Marilyn KNOWLES (PMH) on the death of her brother.

SN Virginia MORTIMER (PMH) on the death of her mother.

SN Merlina MOSS (PMH) on the death of her grandfather.

TCN Clara SMITH (PMH) on the death of her grandmother.

TCN Jacqueline STIRRUP (PMH) on the death of her brother.

TCN Sharon TURNQUEST (PMH) on the death of her father.

EO Elizabeth KEJU and Lynn GARDINER, dietary technician, both of the SRC, on the death of their father.

Deepest sympathy to the families of Messrs. Howard THOMPSON and Lionel STURRUP both of the Maintenance Department (PMH)

ERRATA:

Ms. Ellen Deveaux was a maid at the (SRC) and not the Medical Records Office as indicated in Volume 4 No. 3

THE NURSE'S RESPONSIBILITY TO AIDS PATIENTS AND THEIR FAMILIES

ALICE GARDNER and JULIETH MINNIS

Nurses' responsibility to the patient suffering from AIDS on the Infectious Unit.

The nurse plays a pivotal role in the care of all patients in any hospital but this is more evident in patients suffering from AIDS. The nurse interacts with the patient twenty four hours a day. Despite personal fears, she/he must administer to the needs of these patients in a friendly and caring manner. In fact the nurse may be the only person to exhibit love and a caring attitude during the initial phase of the patients' illness as family members become frightened and abandon their relatives when they learn the diagnosis.

At this time also, patients go through a phase of denial. They may become very hostile and withdrawn. The nurse then enlists the support of the Psychiatric team as well as that of ministers. In addition, they try to involve all patients in daily devotions and recreational activities.

While in hospital, the nurse's main responsibility is to teach the patient healthy habits as well as how to prevent the spread of AIDS. The patient is strongly advised to use condoms in any future sexual encounters and to limit his/her sexual contacts.

In addition, the nurse must keep abreast of all the latest developments in AIDS and share this information with her colleagues. She must adhere strictly to the guidelines laid down by the Ministry of Health in relation to blood and body fluids, namely wearing of gloves, gowns and masks.

She must also instruct and insist that all other personnel on the ward, for example Laboratory technicians and Maids, adhere to the above precautions.

The nurse must ever be vigilant that supplies of gloves, masks, gowns, bleach and hibiscrub are **always** available.

Responsibility Towards The Family And Their Reactions.

The family is fearful and their knowledge about AIDS is limited. The nurse's primary responsibility here is to distill their fears by teaching them about how AIDS is spread — that it is through sexual intercourse, infected blood transfusion (no longer a risk in The Bahamas) and sharing contaminated needles. She emphasises that casual contact, like for example, sharing the same bathroom, holding hands and being in the same room cannot cause one to "catch AIDS".

Relatives are encouraged to visit and they are regularly brought up to date on the patient's condition. They are also encouraged to ask questions which we answer honestly and by so doing try to dispel any myths they may have about the disease. They are given information on how to care for their relatives at home. They are told that clothes, for example and eating utensils must be washed separately in detergent and bleach, that a solution of bleach one in ten should be used for household cleaning. Proper handwashing after attending to the AIDS patient is stressed.

The challenges for nursing are immense as the number of patients affected by AIDS is increasing daily. We must however never try to judge patients but continue to offer them the best care that we can and above all our sympathy and love.

AIDS — A LEGAL PERSPECTIVE

EMANUEL OSADEBAY

Sometime ago I wrote an article AIDS AND THE DUTY OF CARE which was published by the two leading dailies in The Bahamas. The article was centered on the duty of care, if any, owed by doctors to the general public where a doctor, in the course of his practice, discovered that one of his patients suffered from the disease AIDS.

The purpose of this article is to further assist doctors and health-care workers in the performance of their respective duties.

It is now known that the disease AIDS is a disease transmissible through sexual contact. Therefore it is classified as a "venereal disease" within the law. Recently I was privileged to read two articles — one in "The Observer" newspaper (published in England) of Sunday, 19th July, 1987 and the other in "The Atlanta Journal Weekend, The Atlanta Constitution" of Saturday, August 1st, 1987. In England, the British Medical Association voted in July for doctors to test for AIDS without patients' consent. The argument was that tests, including routine tests before operation, were essential a) to control the spread of the virus, b) to prolong HIV patients' lives and c) to protect hospital staff who may be at risk by unknowingly treating sufferers. In Atlanta, law enforcement officers including Prison Officers were seeking wider disclosure of information on the results of tests carried out. Their argument was that from time to time these officers risk their lives while arresting or dealing with persons who have been determined as carriers of the virus. Not infrequently they found themselves giving first-aid treatment to persons who have been injured in a fight or in an accident. Therefore they were entitled to information on known carriers of the virus in order that they might be better prepared to protect themselves.

Whichever side of the argument one prefers, it cannot be disputed that dissemination of information and education are some of the ways of containing this disease. Within the society there may be persons who are carriers of the virus without knowledge of that fact. They might have acquired the virus through relationships with carriers of the virus or through blood transfusion.

The Venereal Disease Act, Chapter 222 Laws of The Bahamas may serve as an effective instrument for combating this disease. It provides an effective weapon for tracing contacts. It places certain legal obligations on doctors who, through their work, have acquired knowledge and information about their patients.

Section 5 of the Act obligates, under penalty of fine or imprisonment, persons suffering from venereal disease (in the case AIDS) to place themselves under the care of a qualified Medical Practitioner for treatment. If the patient desires to or changes his medical practitioner, then the new medical practitioner must notify the previous practitioner of the change.

Section 6 of the Act obligates the medical practitioner to require the patient to obey the doctor's instructions. If the doctor discovers that the patient has failed to obey the instructions given him in every such case such medical officer or practitioner shall forthwith notify the Chief Medical Officer in writing of such failure of the patient to obey his instructions. The obligation placed on the doctor by this section is important because it has been revealed that certain known carriers have refused to obey their doctor's instructions. Persons who have been certified as carriers of the virus have been known to continue their sexual activities with innocent parties. Failure to obey the medical practitioner's instructions is an offence punishable by a fine or imprisonment.

Section 7 of the said Venereal Diseases Act endows the Chief Medical Officer with powers to trace and find "contacts". By "contacts" I mean persons who are known to have had relationships with known carriers of the virus. If a person is suspected of being a carrier of the virus, regardless of the means of acquisition the Chief Medical Officer may require such person to present her/himself within three days from the date of the service of the notice at the hospital to undergo medical examination for the purpose of ascertaining whether or not such person is so suffering from the venereal disease, and if so suffering, to receive medical treatment. The Chief Medical Officer may request a warrant from a Magistrate directing a peace officer to take such person to the hospital for the said examination. The certification of a person as being a carrier of the virus must be done in writing by the medical practitioner. A copy of the certificate must be given to the patient. It is important for the doctor, if possible, to obtain evidence of the service of such notice or certificate. This may assist the doctor in proving, should it become necessary, that the patient was informed of the findings or result of the medical examination.

Once a person has been certified as a carrier of the virus then the medical practitioner is obliged to serve the patient with a warning in the following form:—

THE VENEREAL DISEASES ACT

TO:—

.....

.....

.....

Whereas you have been found to be suffering from a venereal disease, to wit .....

You are hereby notified that the disease is highly infectious and that should you infect another or others with the said disease you may be liable on summary conviction to a fine of one hundred pounds (£100) or to imprisonment for any term exceeding twelve (12) months or to both such fine and such imprisonment.

You are hereby warned not to have sexual intercourse nor to contract a marriage with any person until you have been granted a certificate of cure in accordance with section 9 of the above Act:

Enclosed herewith is the following printed information relating to the venereal disease from which you are suffering and to duties of patients so suffering as aforesaid.

Dated at Nassau, Bahamas, this day of , A.D., 19 .

.....
Medical Practitioner or Medical Officer

Received from .....

the following printed information relating to the venereal disease known as .....

.....

Dated the .....day of .....19 .....

It is important to note that the law prescribes absolute confidentiality in these matters. All communications and information must be kept confidential.

In the event that a carrier of a venereal disease is cured the medical practitioner responsible, if requested by the patient, shall give to the person a certificate to that effect in the following form:—

THE VENEREAL DISEASES ACT

TO:—

.....

.....

.....

This is to certify that I have medically examined the above named .....

.....and am satisfied that:—

a) he is cured of the attack of.....
the venereal disease from which he has recently been suffering; or

b) he is free from venereal disease.

Dated at Nassau, Bahamas, this .....day of.....A.D., 19 .....

.....
Medical Practitioner or Medical Officer

It is an offence, punishable by a fine or imprisonment, for a carrier of any venereal disease including AIDS to knowingly infect others with the disease.

In order to maintain secrecy and confidentiality in these matters the Venereal Diseases Act prescribes the following:—

Section 13. Every person who acts or assists in the administration of this Act and every person present in any court when any proceedings taken under this Act or an appeal therefrom are being heard, shall preserve secrecy with regard to all matters and things which come to his knowledge while so acting or assisting or present and shall not communicate any such matters or thing to any person except in the performance of his duties under this Act or in pursuance of any legal or official duty.

Section 14. All proceedings under this Act or on appeal from any judgement or order given under this Act shall be held in camera.

Section 15. If any person found by a medical officer or a medical practitioner to be suffering from a venereal disease gives him information as to a contact, such information shall be deemed for the purposes of the law relating to defamation to have been communicated in pursuance of a statutory duty.

Section 16. No action shall lie against a medical officer or a medical practitioner or any person appointed by the Chief Medical Officer for the purposes of this Act for anything done by him or them in good faith in pursuance of the powers conferred by this Act.

Section 17. Any person who shall fail, neglect or refuse to comply with the provisions of this Act for which no specific penalty is provided shall be liable on summary conviction to a fine of fifty pounds or to imprisonment for twelve months.

Some have argued that contact-tracing in the disease AIDS is a waste of time. Some doctors have argued that because the incubation period is not known, it may take months from the date of the sexual relationship before the first signs and symptoms appear. They also argue that at present there is no known cure for the disease AIDS and therefore contact-tracing will be of no value because there is no medicine to give the patient. But doctors in favour of contact-tracing argue that we are dealing with AIDS as a contagious, transmissible virus. Contact-tracing will assist in identifying people who are HIV positive and help can be offered and these persons will be alerted to be sensible in the future.

There is no doubt that we are all worried about the spread of AIDS. Doctors are worried and the public is worried. Doctors have argued in favour of testing at the hospitals before surgery. It is well known that during operations doctors and nurses come in contact with the patient's blood. It has also been shown that during such operations doctors often pierce their gloves and some of the gloves sustain damages causing the doctor or nurse to come in contact with the patient's blood.

It is reassuring therefore to note that the Ministry of Health has established a Committee to deal with these matters.

THE PASTORAL CARE OF AIDS PATIENTS

EMMETTE WEIR

"And heal the sick that are therein, and say unto them, the Kingdom of God has come nigh unto you." (Luke 10:9)

The pastoral care of patients suffering from AIDS (Acquired Immune Deficiency Syndrome) is one of the most difficult and urgent facing the church today. It is most challenging and complex. There are several reasons for this phenomenon.

In the first place, there remains a tremendous amount of ignorance in regard to this disease. As Dr. Perry Gomez has so rightly pointed out, it is a new disease, having manifested itself in the late seventies. As a result, there is widespread fear and the very mention of AIDS evokes alarm and terror in the minds of many. Those who are suffering from AIDS are often therefore, shunned by relatives and friends. This increases their suffering as they are made to feel like "social outcasts." Many indeed are very lonely and live their last days in remorse and isolation. What then should the ministry of the church be when it comes to treatment of AIDS? The responsibility of the church in the care of AIDS patients should be seen at three levels: the educative, the area of pastoral care, and the ministry of the church for those whose conditions is regarded as terminal.

First, the church has an important educative ministry. This it has to share with medicine. Because of the immense fear and ignorance which presently surrounds the disease, people think that they can "get AIDS" in all sorts of ways. In many cases these are just rumours, and as such have no real foundation in truth. The church here has an important ministry of educating. It is called upon to share in the task of letting people know the facts about AIDS. Through its parish ministry, its bulletins, and even pulpit notices, the church may spread the message of how AIDS is contracted and accordingly, warn its members against doing what may lead to suffering from this deadly disease.

It is important to note that the spread of AIDS has been caused largely by the lax moral standards of our times, an age of widespread promiscuity and rapidly declining moral standards. The church has the responsibility of reiterating its ancient moral codes which advocate the very responsible exercise of sexual relationships associated with a strong sense of commitment (Exodus 20:14, Mark 10:2-10).

The fear of AIDS is very great. It is therefore highly significant that a major American denomination, in its report on AIDS, begins with a seminar on how to dispel the fear of AIDS. Surely this is an extremely important ministry for, where there is fear and ignorance no real progress can be made.

Specifically, the church has a ministry of pastoral care to exercise to the AIDS patients themselves; the dispelling of fear is a ministry as much to the family as to the patient himself or herself. The pastor who is called to minister to those suffering from AIDS must be sensitive to their needs. Perhaps he has to, first of all, assure the patient that he is genuinely interested in his welfare. In approaching the patient, the pastor must never betray an attitude of condescension nor give the impression that he is concerned about his personal health. In short, he must make the patient feel comfortable and assure him of his concern.

Since it has been established that AIDS is a disease which is contracted mainly by means of sexual relationships, there may be in many cases, a strong element of guilt. The pastor, then, may be called upon to deal with the patient's moral and spiritual position as well as his or her physical state as it will be important for the pastor to come to terms with the patient's moral and spiritual conditions.

What should be the approach of the pastor to a patient who is suffering say from guilt because he or she has contracted AIDS as a result of sexual promiscuity? What is the case of the married man who has been unfaithful to his wife or vice versa and as a result is suffering from AIDS?

There can be no doubt that in many cases those who suffer from AIDS also have the scars of moral and spiritual lapse. Here the biblical incident of the healing to the paralytic (Mark 2:1-14) is most instructive.

It is noteworthy that the friends of the paralytic, in their determination to bring their sick to Jesus, lets him down through the roof. It is quite obvious that the man is very sick physically. The Pharisees, the enemies of Jesus, survey the scene.

Jesus, however, does not immediately heal the man. Rather He declares to the paralytic, "Thy sins be forgiven thee." This pronunciation of forgiveness invokes the wrath of the Pharisees who regard it as presumptuous of Jesus to forgive the man since it was held by them that only God could forgive. It is highly significant that Jesus heals the man physically after He has dealt with this spiritual condition. There was FORGIVENESS OF SINS FIRST, followed by healing of the man's body. Or, to put it another way, Jesus dealt with the man's spiritual condition before attempting to tackle his physical condition.

A similar method may be often necessary in the pastoral care of AIDS patients. The pastor, ever sensitive to the needs of the patient, may enquire about the way in which he/she contracted the disease. If the person knows that it has been through a sexual relationship which may be regarded as immoral (whether involving homosexuality, prostitution or adultery), then he/she may have a strong sense of guilt. Put another way, along with the depth of emotional and physical pain, the person may also be suffering from the guilt caused by his/her immorality. This may be the situation especially in the case of someone with a strong religious background.

Having determined the way in which the patient has contracted the disease, the pastor, if he senses guilt, he many attempt to deal with the person's moral and spiritual state. If the person desires sincerely to be forgiven for his/her sin, then the pastor may lead the person in receiving the forgiveness which is at the heart of the christian revelation. The main purpose is to bear on the situation of the AIDS sufferer the abundant resources of the christian faith to bring about forgiveness and reconciliation to the sufferer.

The example of Christ Himself, again, is instructive. In biblical times leprosy was greatly dreaded as there was no cure for it (I Kings).

As persons suffering from AIDS today are ostracised so those suffering from leprosy in those times were isolated from the rest of humanity. But Jesus did not neglect the lepers. Rather He ministered to them and met them at their point of need (Mark 1:40-45).

The sensitive contemporary pastor must also be prepared to meet those suffering from AIDS just where they are. He or she must not betray an attitude of fear or scorn in regard to their condition. The patient can always sense an attitude and when this occurs, the effectiveness

of one's ministry is compromised. Nor must the pastor be moralistic or condemnatory in attitude. Rather it must be his desire to bring the healing resources of the Gospel to the believer.

Here then, the pastor has to exercise a ministry in which he deals with the problem of guilt. His must be a ministry of forgiveness and reconciliation. The words of John are relevant:

> "My little children, I write you that you may not sin; but if any man sin, we have an advocate with the Father. Jesus Christ the righteous and He is the propitiation for our sins."

Here the writer, points out that the christian ideal and objective is that we sin not, that we attain christian perfection. However, he is realistic, he understands that mortal man does sin because man is sinful, God has made provision for forgiveness in sending His Son to be the Saviour of us. He, the Son, is able to cleanse from all unrighteousness.

The patient, burdened by guilt, has to be assured that as he repents, there is forgiveness in the Blood of Jesus. Thus, ransomed, forgiven, restored and healed, the person would be in a much better position, spiritually consequently, physically, to cope with his or her situation than would have been the case without the element to confession. It has been truly said that "Confession is good for the soul." It is also good for the body.

Because AIDS is such a difficult disease, it is essential that the pastor works closely and in cooperation with the medical authorities. There are important rules regarding the care of AIDS patients which should be strictly observed by him. It would be prudent for him to enquire from the medical authorities before visiting the patients whether or not he is required to wear any protective clothing in order to prevent any infection (to him or to the patient). The pastor should ensure that he observes all rules and that he cooperates fully with those who are in charge of caring for AIDS patients.

It is also important to remember that all those working with AIDS patients, for example doctors, nurses and medical technicians are constantly under pressure, and that they may be concerned about the possibility of contracting the disease themselves. A warm greeting and a word of encouragement to all involved in the treatment of AIDS patients by the pastor, can prove most effective. The pastor has a ministry, then, not only to the AIDS patient and his family, but also (in the light of contemporary problems), to those involved in the treatment of those who are the victims of this modern scourage.

Finally, there is the matter of the pastoral care of those in a terminal condition. AIDS is often fatal. Destroying the body's immune system, it leaves the individual weak, unable to resist the ravages of many diseases which prey upon his or her debilitated state. It is indeed a very sobering and disturbing fact that many of the world's great leaders in "all walks of life" have in recent years, been victims of AIDS. In some cases, the person suffering from AIDS realises that his life is short. He knows that "his days are numbered."

The realization that one may soon die, or that he or she is suffering from a disease for which there is no cure must indeed be a shattering experience and one for which the pastor is especially equipped, the ministry to the dying. What is the responsibility of the pastor to a young man, still in the "flower of youth," very promising, with a brilliant college career behind him and (up until the time he discovered he had AIDS) a very promising future? It is certainly not easy to help such a person to come to terms with the fact that he has a limited time to live except he or she were to experience a real miracle.

Here the pastor goes a step beyond that of offering the abundant resources of forgiveness available to those who are willing to receive it. He has to inspire the patient and encourage the belief that there is "more to life than this transitory life." The pastor may have to help the patient to "face the fact" that life is short and that death is not far away. For in many cases, people do not readily accept the fact that their days are numbered. Here more than at any other time, the christian pastor has to speak to the patient of the christian hope of the Resurrection, of the life beyond "the sunset" and of the hope that will be theirs trusting in Christ.

Suffering from AIDS is a new malady. At this time, many approach it with fear and terror. Those who are suffering from it as well as their families are in need of pastoral care of the highest order. The minister has to exercise compassion and help the patient to face up to the fact. He has to work in concert with the medical authorities so that he may know the most suitable approach to take. A young promising patient has to be treated differently to an old person who may be resigned to the idea of death anyhow.

In his ministry, the pastor should follow the example of Jesus who identified with publicans and sinners. He or she cannot turn his back upon the AIDS sufferer. The ministry is universal in its scope as we know from the gospels, especially that of St. Mark. Moreover, since the gospel is for all and since it proclaims forgiveness, then because AIDS is often associated with sin, then the pastor is called upon to show the AIDS sufferer that he or she can be forgiven by Christ.

Most of all, the pastor called upon to minister to the terminally ill AIDS patient, must seek to lead him or her to a deep understanding of the christian faith. He, the pastor, needs to assure the patient that, trusting in Christ, although ravaged and suffering in this life, he or she can look forward to a new life in Christ, and eternal life which begins on earth in obedience to Christ and is consummated in a new life in union with the Christ who

has conquered death. Let the church in this age of AIDS then once again proclaim with boldness the morality which encourages the responsible exercise of sexual relationships. Let those who are called to minister to the sufferers from AIDS do all they can to bring them the resources of forgiveness which are to be found in Christ. Let the church assure those who are suffering from AIDS in a terminal condition, that in Christ there is the message of a new life beyond the bounds of this transitory life. For it is to us all without exception that the suffering of mankind from this new and devastating disease that we understand the profound words of St. Paul, "For I reckon that the sufferings of this present time are not worthy to be compared with the glory which shall be revealed to us. For the earnest expectation of the creation waiteth for the revealing of the sons of God. That the creation itself also shall be delivered from the bondage of corruption into the liberty of the glory of the children of God. "I am persuaded that neither death nor life, nor angels, nor principalities, nor things present, nor things to come, nor powers, nor any other creature shall be able to separate us from God, which is in Christ Jesus our Lord."

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) IN PREGNANCY

MADLENE SAWYER

At the present time, the virus that causes acquired immunodeficiency syndrome (HIV) is thought to pass through infected blood, genital secretions and breast milk. It is estimated that at least twenty five percent of exposed individuals with antibody will develop clinically significant disease over a five year period. Women with asymptomatic infection may continue to pass the infection to their unborn and newborn baby.

Most of the women infected with the virus are childbearing age and are in the following high risk groups:

Intravenous drug abusers
Sexual partners of high risk men
Prostitutes
Women who received blood containing the virus.

Of the children who have been found to have AIDS, eighty percent are believed to have been exposed to the virus while in the uterus or around the time of birth.

The risk of an infected woman passing the virus to her baby is approximately forty to seventy percent. However, the proportion of infected babies who will eventually develop the full blown disease is unclear, but the progression to severe disease seems to be substantially higher in babies than in adults.

Babies delivered by Caesarean section who had no further contact with their infected mothers have developed the infection, this suggests that the baby was infected even before birth. In addition, a baby has developed AIDS after being breast fed by a mother who acquired the virus after the child was born.

Women with the full blown disease present additional problems since their disease may become worse during pregnancy. There is a normal suppression of cellular immunity and other changes which are similar to those caused by the immunodeficiency virus. Therefore, the combination of these normal changes of pregnancy and those due to the virus may lead to progression of the disease in the pregnant woman.

Also of concern is the recently reported combination of abnormalities in the infants born with the virus. The affected children are small with smaller head size and abnormal facial structures. These findings, however, need further study.

At present there is no cure for this disease. Since pregnancy in women infected with the immunodeficiency virus is associated with risks to herself and her baby, women of high risk groups should be tested for the virus regardless of symptoms. Those women who test positive should be advised to avoid pregnancy and those who test negative should be tested again during pregnancy, since the antibody may not develop for up to four months after infection.

In addition, women with positive test results who are already pregnant must be followed carefully for worsening of their disease. These women should also be cautioned against breast feeding. Finally, high risk women who test negative should be educated in ways to reduce their risk, especially during pregnancy. Avoid using dirty needles. Insist on condom use during sexual intercourse, reduce sexual partners, maintain high standards of personal health and hygiene.

INCOME REPLACEMENT FOR AIDS PATIENTS

AUDREY DEVEAUX

The statistics on AIDS are frightening: Each statistic, for example, forty known cases by June, 1987, represents one person and many possible contacts. Unfortunately, from all that is known about viruses they are very, very friendly little organisms. They love to travel from one person to another communicating and the AIDS virus is no exception.

When it moves into a new home (the host's body), it takes along its own very special friends. Some of these friends include, but are not limited to, weight loss, pneumonia, various types of cancer, tuberculosis, fear and terror, anger, ostracism, loss of job, income, friends, family, lifestyle — and especially "bad feelings".

What can the "host" do about such an invasion? Elsewhere in "Joining Hands For Health," other articles focus on "how to prevent an invasion from taking place"; "how to minimise the effects of such invasion" — palliative or symptomatic treatments; "how to feel better in the midst of the invasion — spiritual counselling;" and also "how to ensure that you get an opportunity to serve as host methods of infection."

This article will briefly highlight how some of the effects of the AIDS, "friends" that is (temporary) "loss of income" (sickness), and in extreme cases "loss of job" (invalidity due to the progressively debilitating effects of the invaders), can be overcome.

TEMPORARY AND PERMANENT INCOME REPLACEMENT

John, a normally fun loving and hyperactive 25 year old travel agent, has been having severe headaches for the past three weeks. They have, in fact, been so bad that on four occasions he was forced to call in to work and cancel tours and speaking engagements. This has worried both John and his supervisor; for in the four years that John has been with the firm, he has never been late nor absent. To set both their minds at rest, John made an appointment to see his doctor.

Mary, a 48 year old thrice-divorced mother of two grown sons, was wondering if she should make an appointment to see her doctor before going on a cruise with her new boyfriend. She had been feeling weak and tired for sometime, and dispite drinking gallons of bad-tasting serasee, she just could not shake her nagging cough.

The situation was taken out of her hands when she quietly and inelegantly "passed out" while shopping for some new clothes in one of the most elegant downtown boutiques. An ambulance was summoned and she was transported to hospital, where she was admitted with an initial diagnosis of tuberculosis. Mary's job paid a maximum of two weeks sick leave, her insurance would cover the hospital bills, but, she would have nothing left. What was she to do?

Two months later, John was very worried. His headache had been too severe for him to make his doctor's appointment. Eventually he had seen another doctor nearer to his work on an emergency basis, who had given him some tablets for his headache, some more for his "nerves" to deal with the "stress of his job," and seven days sick leave.

Over the past two months he had missed a total of fifteen work days and his salary was being cut for the first time. Additionally, he was not getting any overtime, John's total income (salary and overtime) was needed to pay all the bills he had incurred as a result of his high style of living. What was he to do? His supervisor advised him to call National Insurance, either the Local Office or the Consumer Hotlines 322-1280/322-2009. John called the hotline number 322-2180.

Mary has been moved to the special AIDS ward, she is much better than many of the patients there, she will be able to go home soon and is looking forward to going back to work eventually. The doctor has advised her to apply for Sickness Benefit in the meantime. In the unlikely event that she is unable to return to work, he also informed her that she would be able to apply for Invalidity Benefit after she had used up her Sickness Benefit entitlement.

Mary wanted to know more. A nurse advised her to call the National Insurance Board, either one of the Local Offices or the Consumer Hotlines 322-1280/322-2009. Mary was worried about her eligibility for the benefit as she had been out of work for six months the previous year and had only worked on her new job for nine months. Mary called the hotline number 322-2009.

John was told in response to his question, "Do I qualify for Sickness Benefit?" that, as he had worked continuously for the past four years and was paying National Insurance at the maximum of the insurable wage ceiling ($250 per week/$1,083 per month), he would be entitled to Sickness Benefit. He was advised to go to the New Providence Local Office, take the medical certificate which he had been given a few weeks ago, and he would be assisted with completing a claims form by the staff of the Customer Relations Department.

John was further told that even though it would be submitted a little late, (claims for Sickness Benefit may be submitted up to six months following the illness), he would be awarded his benefit for that week, less three waiting days (he should receive a cheque for $100, if

Sunday was one of the "waiting days," within a week to ten days). Additionally, John was advised that as his headaches were persisting, he should visit his own doctor for a thorough examination, and, if he needed additional sick leave, he would then be paid for the full week (no further "waiting days" as the claims would be continuous). John was told that a doctor's medical certificate is required for processing of Sickness Benefit claims.

In response to his question "For how long and how much Sickness Benefit can I get?" John was informed that he could be awarded Sickness Benefit for up to twenty six weeks. He was further told that this benefit period can be extended for a maximum of forty weeks nine months, provided that the Board's Medical Officer certifies that he is likely, with additional medical treatment, to recover his health and return to work.

John was also informed that he would be paid Sickness Benefit at the rate of $150 per week. This is 60 percent of the weekly insurable wage on which his contributions are paid.

On questioning Mary, it was found that she had had a number of jobs over the years since the introduction of National Insurance (October 7th, 1974). On a few of these, no National Insurance salary deductions had been made. However, she had worked for Batelco for three years in the late 70's before relocating briefly to Florida with her third husband.

She was told that she satisfied the qualifying conditions for Sickness Benefit. These conditions are that:

— The claimant had worked as an employed or self-employed person and had paid at least 40 contributions since the Scheme began (she had done this during her tenure at Batelco);

— The claimant had paid or been credited with at least either:

  i) Thirteen (13) contributions and credits in the 26 contribution weeks immediately preceding the first day of the continuous period of incapacity for work; (Mary met this contribution on her most recent job), or

  ii) Twenty-six (26) contributions and credits in the 52 weeks immediately preceding the first day of the continuous period of incapacity for work; (Mary also met this condition, although she was already eligible for the award, by reason of having met the first two conditions), or

  iii) Twenty-six (26) contributions and credits in the contribution year, immediately preceding the first day of the continuous period of incapacity for work (Mary also met this condition).

In response to her question "how much benefit would I get?" Mary was told that as she had earned/paid contributions on an average weekly salary of $210 over the qualifying period, she would receive 60 percent of this each week as benefit, or $126 each week. She was greatly relieved. She was also very touched when the Board's employee offered to send the necessary forms needed to process her claim to the hospital to her, and told her that she would be called when her cheque was ready for collection.

As Mary's doctor had also raised the point of Invalidity Benefit with her, she also asked for more information when she called the Board's Consumer Hotlines. She was told that Invalidity Benefit is paid to insured persons who had a minimum of 150 contributions, who were seen by one of the Board's medical referees, and had been diagnosed as being permanently incapable of work.

She was further told that application for this benefit follows the expiration of the Sickness Benefit payment period, and once awarded, the benefit is paid for the remainder of the claimant's life, this is converted to Retirement Benefit when the claimant reaches age 65.

This benefit, like Sickness Benefit is also paid as a percentage of the insured person's average weekly insurable wage/income. The amount paid for the minimum qualifying period three years or 150 contributions) is 15 percent, (minimum payment is $100 per month, maximum is $650 per month).

Mary was reassured to know that at the end of her maximum Sickness Benefit period (26 weeks/40 weeks), she could make application for Invalidity Benefit. She was also informed that should she not have the minimum 150 paid contributions, she could for Invalidity Assistance.

Invalidity Assistance is awarded to eligible, needy claimants who do not meet the contribution conditions for the award of the benefit. All applicants for assistance awards, must satisfy a "test of resources," i.e., a determination of need, be a Bahamian citizen, or a resident who had worked for twelve months continuously over the past fifteen years.

For more information on any of the Board's nine benefits and four assistance awards, please visit one of the Local Offices situated throughout the Commonwealth, or call the Consumer Hotline 322-1280 or 322-2009.

EDITOR'S NOTE: Both John and Mary are fictitious persons. The two case histories are designed to a) remind b) inform readers of some of the many benefits which are available under the National Insurance Programme.

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The Impact Of Aids On Hospitalization

PAMRICA FERGUSON

From April 1985 up to the present time (August 1987), hospitalisation periods of AIDS patients re-admissions have totalled an unsuspected or shocking number of hospital days. The Table below depicts the overall total of their recurrent hospitalization periods, giving an idea as to what has transpired.

Total Periods of Admissions of AIDS Patients April 1985 — August 1987

Total of Hospital Periods	Males	Females	Total
1 day - 1 week	29 (8)	16	45
2 weeks - 3 weeks	41 (4)	18 (1)	59
4 weeks - 5 weeks	19 (3)	17	36
6 weeks - 8 weeks	15 (1)	5	20
9 weeks - 12 weeks	1	21 (1)	3
13 weeks - 16 weeks	2	1	3
17 weeks - 20 weeks	1	—	1
21 weeks - 14 weeks	1	1	2
25 weeks - 28 weeks	—	1	1
29 weeks - 32 weeks	—	—	—
TOTAL	109 (16) (93)	61 (2) (59)	170 (18) (152)

N.B.

The 18 cases in parenthesis were suspected cases. These patients had some of all of the clinical manifestations of AIDS. Ten of them were admitted, three to four months prior to the screening of blood in our Blood Bank. Most of these cases came to hospital and died within one day or one week of admission.

Also, prior to screening here, some of our cases were confirmed by tests performed in Miami. They were extremely ill patients.

Due to opportunistic infections associated with AIDS, some patients have had as many as five admissions from confirmation of diagnosis up to the time of their demise. However, a few were admitted and died within a period of one day or one week. Overall the average number of admissions for these patients have been three. One hospitalization period is usually two to three weeks but there was a patient who hospitalization spanned a period of three months.

Prior to the opening of the Infectious Ward, these patients were accommodated throughout the hospital — children on paediatrics, adults on medical and surgical areas and wherever their specific wards in the isolation room.

Now that the Infectious Ward exists, most of the AIDS patients are nursed on this ward and when discovered on the other wards they are transferred here. But in situations when all beds are occupied, a patient is nursed on the ward of his/her admission.

The Infectious Ward/and Accommodation For AIDS Patients

The male section has twenty-four beds, twelve beds (located at the back of the ward) are allocated for nursing AIDS patients, and the twelve beds at the front of the ward are utilised for nursing tuberculosis and chest cases. Since children require more care and attention, their cots are placed in the front section of the ward. There is also a single (private) room which is used for very ill cases.

The female section has twelve beds, eight are allocated for AIDS patients and four for tuberculosis and other chest cases. There is also a private room which is used for very ill or special cases.

The average number of AIDS patients varies from six to eight adults per month and there are usually two children.

In so far as there exists no vaccine or cure for AIDS, public education is the only way the AIDS epidemic can be controlled. This will also control the spiralling cost of caring for AIDS patients and reduce the number of recurrent admissions. Caring for patients with AIDS is difficult and frustrating work.

Dr. Harold Jaffe (Centre For Disease Control) believes that the AIDS epidemic maybe teaching us something about ourselves. Most of us are believing that no answer. Usually that was true. We are now safe from answer. Usually that was true. We are not safe from diseases like syphilis, poliomyelitis and smallpox, the scourges of the past. When we encountered the AIDS epidemic, it was reasonable to think that science was the answer. If we could not develop effectively treatment or vaccine in a year or two, then we should spend more money and we would get the answer. But so far it has not. However, there is another answer and that is taking responsibility for our own actions. The great majority of AIDS transmission occurs through consenting acts — sexual transmission and sharing needles. The gay man who enters into a monogamous relationship with an uninfected man will not become infected himself. The addict who can get off drugs or at least stop sharing needles will be safe from this disease.

AIDS forces us to return to earlier times. Although in an age of medical miracles we must some how return to the time when each of us has more responsibility for our health and the health of others. We cannot afford to wait for science to save us. We must learn to save ourselves.

Education and lifestyle are intertwined when we think of preventive measures. Here are some basic facts for avoiding AIDS:

Preventive measures relative to blood/body fluids:

— reduce your number of sexual partners.
— avoid oral ingestion of faecal matter, semen or urine.
— use condoms.
— curtail use of drugs (speed, cocaine, marijuana, poppers, tobacco and alcohol.
— do not share needles.
— do not share tooth brushes or razor blades.

General preventive measures:

— exercise regularly.
— eat a balanced diet.
— get plenty of rest.
— have regular check-ups.

Symptoms are:

Unexplained fatigue; weight loss; swollen glands; persistent cough; persistent diarrhoea; fever; chills; night sweats; pink purplish spots on skin.

In conclusion we must remember that AIDS does not discriminate! The AIDS virus does not care if you are straight or gay, male or female, old or young, doing drugs or not, black, white or otherwise. They key to controlling the spread of AIDS is through education and to follow the guidelines of prevention.

References

1. Dr. Jaffe, Harold, (CD) AIDS Lecturer for National Foundation for Infectious Diseases and Association for Practitioners in Infection Control, Las Vegas, Nevada, May 4, 1986.
2. Readers Digest — June 1987.
3. Information (Princess Margaret Hospital).

THE STATE OF AIDS IN THE CARIBBEAN AND NORTHERN AMERICA

MARK CROWLEY

Never before in the memory of present generations has a disease conjured up so much fear, anxiety and respect in so short a time as has the deadly Acquired Immunodeficiency Syndrome, more commonly known by the acronym — AIDS.

The AIDS pandemic global or international epidemic — spread silently from the early 1980s when the human immunodeficiency virus [1]) was first discovered. The international impact of the AIDS problem began to become evident during the mid 1980's as countries on all five continents began to report AIDS cases to the World Health Organizations (WHO). As of December 1982, 711 AIDS cases were reported to WHO. By June 1987, a total of 51,535 AIDS cases had been reported from 113 countries. While a portion of this increase is due to improved diagnosing and reporting, the trend is clear. The number of countries reporting cases of the disease has more than doubled, from 51 in January of 1986 to 113 in one year and a half. The extent and magnitude of the AIDS pandemic had been underestimated and ignored on a global basis.

Regionally, what does this mean? As of June 18, 1987, a total of 39,090 cases of AIDS had been reported to the Pan American Health Organization (PAHO), the Regional Office for the World Health Organization in the western hemisphere, from the Caribbean and Northern America. It should be emphasized that as of June 18, 1987 and at the time of this writing — August 1987 —the actual number of reported AIDS cases would be noticeably higher than stated in this article. Also, WHO views the number of countries reporting cases of AIDS as a more reliable indicator of the magnitude and extent of the disease since numerous countries suffer from under-recognition of AIDS and from under-reporting to the national health authorities. This implies that the number of reported AIDS cases represents only a fraction of the total cases to date — estimated to be over 100,000 worldwide. WHO also estimates that between five to ten million individuals are currently infected with the virus. In some areas of the world, it is estimated that between four and fifteen percent of healthy adults — THAT IS FOUR TO FIFTEEN OUT OF EVERY ONE HUNDRED ADULTS — are already infected and UP TO SIXTY TO EIGHTY OUT OF ONE HUNDRED PERSONS IN VARIOUS HIGH RISK GROUPS (homosexuals, bisexuals, intravenous drug users and prostitutes) are possibly infected with the virus.

Table 1 gives the distribution of these 39,090 reported AIDS cases and deaths along with the last reporting date, by country.

Looking at cases alone, we find the United States ranking first in number reported with 36,133, followed by Canada with 1,052 and Haiti with 810 reported cases. However, out of a total population in the U.S.A. of about 241,000,000 (241 million) in 1986, one would generally expect a relatively higher number of cases since there

are more persons at potential risk. We therefore need to calculate an indicator to approximate the magnitude of the AIDS situation by country. For example: If the cumulative number, or the total number to date, of reported AIDS cases to PAHO/WHO from the U.S.A. are divided by the total population of the country, we can arrive at an AIDS cumulative incidence indicator per 100,000 population which allows for international comparisons as it adjusts each country's reported cases by population size. This results in a U.S.A. AIDS cumulative rate of 15.0 per 100,000 population-meaning that TO DATE, a total of approximately 15 out of every 100,000 persons in the U.S.A. have been diagnosed with Acquired Immunodeficiency Syndrome.

These rates are not perfect: they include cases reported over sometimes different time intervals. The rates are using mid-year 1986 populations, through the reporting periods go beyond that date and, being cumulative, they do not reflect the risk of acquiring AIDS. Furthermore, as this indicator is based on reported cases in some areas, it may actually be higher.

The rates are, however, the only available tool at the present time which allow for international comparisons of the reported AIDS situation.

Table 2 shows the cumulative reported AIDS cases per 100,000 population for the countries in Table 1. On a per capital basis, the U.S.A. with the most reported cases, ranks sixth while French Guiana apparently ranks first. It should be emphasized that these indicators are subject to change as more countries improve their diagnostic and reporting systems and, being cumulative, they are unlikely to decrease in the near future.

TABLE 1

REPORTED CASES AND DEATHS FROM AIDS,
By country in the Caribbean and Northern America
(Notified as of June 18, 1987)

SUBREGION AND COUNTRY	CASES	DEATHS	LAST REPORT
CARIBBEAN			
ANTIGUA	2	2	31-Mar-87
BAHAMAS	105	49	31-Mar-87
BARBADOS	39	25	31-Mar-87
CAYMAN ISLANDS	2	2	31-Mar-86
CUBA	3	3	31-Mar-86
DOMINICA	3	3	31-Mar-87
DOMINICAN REPUBLIC	200	35	31-Dec-86
FRENCH GUIANA	68	52	31-Dec-86
GRENADA	4	3	31-Mar-87
GUADELOUPE	38	22	31-Dec-86
GUYANA	2	0	31-Mar-87
HAITI	810	124	31-Dec-86
JAMAICA	21	17	31-Mar-87
MARTINIQUE	23	15	31-Mar-87
PUERTO RICO	374[1]		8-Jun-87
ST. CHRISTOPHER-NEVIS	1	0	31-Dec-86
ST. LUCIA	3	2	31-Dec-86
ST. VINCENT & THE GRENADINES	3	2	31-Dec-86
SURINAME	3	3	31-Mar-87
TRINIDAD & TOBAGO	134	93	31-Dec-86
TURKS & CAICOS	2	2	31-Dec-86
U.S. VIRGIN ISLANDS	7[1]		8-Jun-87
NORTHERN AMERICA			
BERMUDA	58	39	31-Mar-87
CANADA	1052	521	1-Jun-87
U.S.A.	36133	21155	8-Jun-87

1) deaths includes under United States
SOURCE: PAN AMERICAN HEALTH ORGANIZATION/WORLD HEALTH ORGANIZATION

TABLE 2

CUMMULATIVE REPORTED AIDS CASES
PER 100,000 POPULATION,
By country in the Caribbean
and Northern America
(Notified as of June 18, 1987)

SUBREGION AND COUNTRY	CUMMULATIVE REPORTED CASES PER 100,000 POPULATION
CARIBBEAN	
ANTIGUA	2.5
BAHAMAS	44.5
BARBADOS	15.4
CAYMAN ISLANDS	10.0
CUBA	0.0
DOMINICA	3.9
DOMINICAN REPUBLIC	3.1
FRENCH GUIANA	81.0
GRENADA	3.5
GUADELOUPE	11.3
GUYANA	0.2
HAITI	12.0
JAMAICA	0.9
MARTINIQUE	7.0
PUERTO RICO	10.7
ST. CHRISTOPHER-NEVIS	2.1
ST. LUCIA	2.3
ST. VINCENT & THE GRENADINES	2.9
SURINAME	0.8
TRINIDAD & TOBAGO	11.1
TURKS & CAICOS	25.0
U.S. VIRGIN ISLANDS	6.5
NORTHERN AMERICA	
BERMUDA	71.6
CANADA	4.1
U.S.A.	15.0

THE CHRISTIAN RESPONSE TO THE AIDS CRISIS: A Reflection

ALFRED CULMER

In recent times we have been confronted with a new and fatal disease, AIDS (acquired immune deficiency syndrome). It is important that AIDS be seen as a human disease, and deserves the same care and compassion as any other disease. This is the context in which this short reflection is being presented.

The Christian community must overcome fear and prejudice towards AIDS victims and become a community of healing and reconciliation in which those who are suffering from AIDS can move from a sense of alienation to one of unity, from a sense of judgement to one of unconditional love.

When we minister to persons with AIDS, like Jesus, we do so with love and compassion. It is not a task to make judgements but to call ourselves and those to whom we minister to a deeper conversion and healing.

As a faith community we must reject any form of discrimination against AIDS victims as a violation of their basic human dignity and inconsistent with the Christian ethic. It calls for collaborative segments of society to address the acute health care, educational and psychological needs created by the AIDS crisis.

There are many persons in the community at large and in the Christian community in particular, who share the expressed opinion that AIDS is a divine punishment for what they describe as the "sin of homosexuality". Without questioning their sincerity, I disagree with this assessment.

First, medically speaking, AIDS is not a disease restricted to homosexuals. In fact, it appears that originally it might have been spread through heterosexual genital encounters. In many parts of the world, it has been shown that persons exposed to the AIDS virus or those who have contracted it have done so through intravenous drugs, tainted blood transfusions and heterosexual genital activity. Consequently, even though a large percentage of those persons concerned who have been exposed to the AIDS virus are homosexual, AIDS is a human disease, not a specifically homosexual one.

Second, God is loving and compassionate, not vengeful. Made in God's image, every human being is of inestimable worth, and the life of all persons, whatever their sexual orientation, is sacred and their dignity must be respected.

Third, the Gospel reveals that while Jesus did not hesitate to proclaim a radical ethic of life grounded in the promise of God's Kingdom, he never ceased to reach out to the lowly, to the outcasts of his time — even if they did not live up to the full demands of his teaching. Jesus offered forgiveness and healing to all who sought it. When some objected to this compassion, he responded, *"Let the one among you who is guiltless be the first to throw the stone"* (Jn. 8:7).

That is why we who are followers of Jesus see the AIDS crisis as both a challenge to respond in a Christlike way to persons who are in dire need and a responsibility to work with others in our society to respond to that need.

In the light of these facts, it is understandable, that this disease, which spreads so quickly and is invariably fatal, would occasion misunderstanding, fear, prejudice and discrimination. Quite frankly, people are afraid that they may contract it. This is not a new phenomenon. Recall, for example, how we used to isolate tubercular patients and discriminate subtly (and sometimes not so subtly) against cancer patients. So also, for different reasons, we spoke with moral righteousness and indignation about the "sin" of alcoholism. In time, however, scientific advances and growth in human awareness and understanding helped us to see things in new light and to develop better ways of relating to those suffering from these diseases.

Similarly, we are now called to relate in an enlightened and just way to those suffering from AIDS or from AIDS-related complex (ARC) as well as those who have been exposed to the AIDS virus. While it is understandable that no one wants to put himself or herself in a vulnerable position, we must make sure that our attitudes and actions are based on facts, not fiction.

At the present time there is no medical justification for discrimination against these people and, in fact, such discrimination is a violation of their basic human dignity and inconsistent with the Christian ethic. To the extent that they can, persons with AIDS should be encouraged to continue to lead productive lives, in their community and place of work. Similarly, government as well as health providers and human services should collaborate to provide adequate funding and care of AIDS patients. If it becomes necessary, all agencies in our community should be contacted to seek ideas and support of what can be done to further assist in the financial support of caring for the AIDS victims.

The church also has a specific role to play in ministering to those suffering from AIDS, their families and

their friends. The church should collaborate with others as it seeks to fulfill its own responsibilities.

The final point I wish to make in regard to **The Christian Response To The AIDS Crisis,** is that when we minister to persons with AIDS, like Jesus, we do so with love and compassion. It is not our task to make judgements but to call ourselves and those to whom we minister to a deeper conversion and healing. It would be a mistake to use our personal encounters with AIDS patients only as an occasion to speak about moral principles of behaviour.

Nonetheless, as persons concerned about the well-being of all our sisters and brothers, we should do all we can — as ministers to the broader community — to encourage people to live in a way that will enhance life, not threaten or destroy it. It seems appropriate, therefore, to remind ourselves of the call to use God's gift of sexuality morally and responsibly, as well as the obligation to seek help when problems with drugs or other substances develop. In addition to being the correct thing to do, it could do a great deal to prevent the spread of the AIDS virus in the future.

ACQUIRED IMMUNODEFICIENCY SYNDROME

SURAYYA KAZI

There has been no disease in recent memory that has occupied the attention and stimulated the concern of the medical community and lay public as has the Acquired Immunodeficiency Syndrome (AIDS). The first recognised cases of AIDS occurred in the Summer of 1981 in America. Reports began to appear of an unusual pneumonia (pneumonocystis carinii) in young men whom it was subsequently realised were both homosexual and immunocompromised. The virus now known to cause AIDS was discovered in 1983 and given various names. The internationally accepted term is now the human immunodeficiency virus (HIV). More recently a new varient has been isolated in patients with West African connection — HIV II.

VIRUS

Although it is clear that HIV is the cause of AIDS, its origin remains obscure. It seems to have infected humans for the first time 15 to 20 years ago, but earlier unrecognised infection may have occurred. The HIV is a human retrovirus which preferentially infects certain blood cells-T-lymphocytes subsets (Helper/Inducer cells). These cells have been termed "the leader of the immunological orchestra" because of the central role in the immune response. Thus destruction of these cells causes the severe immunodeficiency characteristic of this disease.

TRANSMISSION OF THE VIRUS

HIV has been isolated from semen, cervical secretion, lymphocytes, cell free plasma, cerebrospinal fluid, tears, saliva, and breast milk. This does not mean, however, that these fluids all transmit infection since the concentration of virus in them various considerably. Particularly infectious are semen, blood and possibly cervical secretions. The commonest mode of transmission of the virus throughout the world is by sexual intercourse. Whether this is anal or vaginal is unimportant. Other methods of transmission are through the receipt of infected blood or blood products and donated organs and semen. Transmission also occurs through the sharing or re-use of contaminated needles by injecting drug abusers or for therapeutic procedures and from mother to child. It is still uncertain whether the virus is transmitted through breast milk; only one case has been recorded of possible infection in this way.

There is no well documented evidence that the virus is spread by saliva. It is not spread by casual or social contact. Finally, there is no evidence that the virus is spread by mosquitoes, lice, bed bugs, in swimming pools, or by sharing cups, eating and cooking utensils, toilets, and air space with an infected individual. Hence, HIV infection and AIDS are not contagious.

PATTERN OF EPIDEMIC

In the United States the rates for cases of AIDS per million of the population show wide geographical variation. New York has a rate of 991, San Francisco 966, Miami 584, Los Angeles 363 compared with 140/million for the U.S.A. as a whole. In the U.S.A. and U.K. the first wave of the epidemic occurred in homosexual men. The next and current wave is among intravenous drug abus-

ers and after this it might affect the heterosexual population. Case reports and epidemiological surveys clearly show that the virus can be transmitted from men to women and from women to men.

The AIDS epidemic has not left out The Bahamas and the incidence of cases since 1985 seems to be increasing. In 1985, thirty-six cases were reported, in 1986, fifty and in the first half of 1987 — forty cases were reported. In general males were affected almost twice as commonly as females. Of the total reported cases in 1985 and 1986, 19 were children.

CLINICAL PICTURE

Infection with the HIV can produce a very varied clinical picture ranging from an acute illness with a recently positive test for HIV to full blown AIDS, many years later. Infection can be asymptomatic or symptomatic. Probably not all of those who have a recent positive test for HIV will progress to chronic infection. Those who do not, probably go into a latent phase of infection. Nevertheless, it is prudent to assume that the individual is still infectious despite the latency. A positive antibody test to HIV indicates only that a person has been exposed to the virus and not that he or she has gained any natural immunity.

Patients who have some of the constitutional symptoms and signs of AIDS without the opportunistic infections or tumors found in the end stage disease are described as having the AIDS related complex. (ARC).

Common presenting clinical features are:

— fever, weight loss (greater than 10%), enlargement of the lymph node, diarrhoea, fatigue, night sweats and laboratory abnormalities showing depression of blood cells.

The two main clinical manifestations of AIDS are tumors and a series of opportunistic infections. The clinical presentation in our Bahamian patients has been identified to that described above.

TEST FOR ANTIBODY AGAINST HIV

Since the tests for antibody against HIV became commercially available in 1985, they have been widely used in diagnostic and transfusion laboratories all over the world. The accuracy of the test is being improved all the time and the occurrence of false positive and false negative results is less and less frequent. The test usually becomes positive three weeks to three months after intercourse. At the present moment the test is performed in The Bahamas in the 'high risk' population and all prospective blood donors.

MANAGEMENT

Firstly, it is important that asymptomatic patients with only a positive test should be reassured that having a positive test is not the same thing as having AIDS and that at the present time it is known that a minority of those infected will in fact progress to the full blown syndrome.

One of the most important aspects of dealing with any antibody positive patient is confidentiality. Maintaining confidentiality might be complicated: for example, the patient's family or friends may not know his diagnosis or indeed his sexual orientation; people at work (or school) may seek medical information (especially if the patient is having time off work); or the patient may fear that information may inadvertently be given to third parties. Special precautions may be required, firstly, to reassure the patient that confidentiality is protected and, secondly, to limit any unwarranted dissemination of confidential information.

The routine medical management of these patients is usually straight-forward. Patients should be seen regularly — for example every two to three months. At each visit the patient's weight should be recorded and special attention given to mouth or skin problems. If necessary the patient should be referred to the appropriate specialist. Repeating a full blood count and measuring the erythrocyte sedimentation rate at each visit is often helpful. Patients should be advised to re-attend if they develop signs or symptoms suggestive of Kaposi's sarcoma or opportunistic infection — purplish lesions of the skin, shortness of breath, cough, dysphagia (difficulty in swallowing), diarrhoea, weight loss, fever, headaches, fitting or altered consciousness.

Patients should also be advised about reducing the risk of transmission. Psychological and emotional support of the patient, the family, and friends are a vital aspect of management. The physician may also be asked to advise about dental treatment, insurance, and work. Patients should be advised to tell their dentists about the infection, and it may sometimes be necessary to refer them to a dental unit with an interest in HIV and related problems. People with antibodies will often have considerable difficulty in obtaining life insurance. Some insurance companies are asking specific questions about the virus and refusing to insure those who are positive. Finally, patients should be told that being positive is no bar to employment. Because of widespread misconceptions about infectivity, however, information about the patient's condition should not be divulged to employers.

Patients with acquired immunodeficiency syndrome die of overwhelming infections as a consequence of the destruction of a subset of lymphocytes. Approaches to the treatment of AIDS have involved attempt to re-establish immune competence as well as to treat opportunistic infections. Among the various antiviral drugs that have been tested one drug, A.Z.T. has provided encouraging results and has now been approved by the F.D.A. in the U.S.A. for treatment of AIDS.

TWO PATIENTS' VIEWS

FELICITY AYMER

Both patients were young men, in the prime of life but they looked like old men! They were both courageous, willing and able to talk, they both did.

They both know they were suffering from AIDS and that it was fatal, but at that time, they felt well and were looking forward to going home. They both had difficulty in sharing the information about their illness with relatives and friends but one felt comfortable enough to share it with a special "lady friend" who visited him regularly in hospital and helped with providing personal comforts such as combing his sparse hair which he was unable to do for himself.

They had both accepted, each on his own, the inevitable, that AIDS is fatal and spent much of their time reading their bibles.

They both admitted to living hectic lives, substance abusing and sex. Neither accepted the use of condoms as a preventative measure. One suggested sexual intercourse between persons only after they had been tested for the HIV and were negative, and/or some means of reducing sexual urges.

For both, AIDS was a personal illness which each dealt with in his own way, drawing on his own inner resources of strength. It was, as one said "his business". He would tell no one. He didn't want to find out about anyone else either nor was he is search of information. He would accept whatever the doctor told him, whenever he was told it.

They had both been feeling unwell, weak, tired and had had diarrhoea continuously for over two weeks. They had both lost a lot of weight, but neither had visited a doctor until they lost consciousness and were taken to hospital.

Mr. A., aged about forty, had taken various kinds of bush medicine for his diarrhoea which had given him very, very temporary relief. He had had severe itching about a year previously and had been diagnosed as having diabetes. Later, however, when his diarrhoea developed and he was admitted to hospital, unconscious, he had learnt he had AIDS. Initially he refused to believe the diagnosis but, as his condition deteriorated, he lost weight, his sense of balance and ability to walk and his eyesight deteriorated, he gradually accepted the diagnosis.

Mr. A is an intelligent man. His lady friend has been tested and is sero-negative. Even though he is weak, talks and walks with great difficulty, he maintains a sense of humour. He is convinced that condoms are unnatural and is not willing to sacrifice health for unnaturalness. Reasonably well informed about his condition, Mr. A is looking forward to his independence on discharge. He will work as a craftsman, live alone, do his chores and enjoy his environment. A close, supportive relative who lives nearby will keep an eye on him. He cannot face sharing his illness with this relative.

Mr. B aged about thirty, a bisexual, knew he was sick but did nothing to get himself better until he was brought to the hospital in an unconscious state. He had been vomitting, had had diarrhoea for about ten days previously and was very weak. With rest and treatment, his general condition and his diarrhoea have improved but he feels nauseous all the time. He is resigned to the fact that he has AIDS, a condition for which there is at present no known cure and to which he will eventually succumb. Although he felt well at the time of the interview he admitted that one week he was up another down.

His first words of advice were that all his friends, mostly men, should "go for testing and have routine check-ups" but he would not personally offer that advice. AIDS was his business and he would tell no one that he had it. He was not concerned about anyone who may have it. His girl friend(s) and children have all been tested and are negative. His mother with whom he lives, along with his seven children, knows he is ill and collects his medication as and when necessary, but he will not, under any circumstances, share the nature of his illness with her.

Mr. B knew he was ill initially but did nothing to change his life style because he said there was nothing that anyone could do to help patients with AIDS or prevent its spread. Subsequently though he stopped drinking and severed all contacts with friends. Now he is also suggesting that everyone should "check with the doctor" before they become sexually active.

Mr. B is content to follow his doctor's instructions on discharge, he will get plenty of rest and take his medication on time.

Mr. A, starting young had abused drugs, you name it, he had used it, but he has not admitted to being an addict. He had frequented basehouses which are numerous in Nassau, he says, adding that they can be found in the most unlikely places.

Mr. B had abused alcohol. He had had an enjoyable period with his drinking buddies but had stopped seeing them and drinking when he learnt he had AIDS.

They were both as it were resigned "to their fate" but Mr. A was more positive, he would be willing to assist in an AIDS education programme because he recognised the importance of "looking after one's body".

THE STORY OF AIDS

DIONNE BENJAMIN

Once upon a time there lived a young woman named Lana. She was very popular with the men.

She had 'relations' with all kinds — old men, young men, homosexuals, bisexuals, and the like.

Her friends tried to warn her about her lifestyle but she wouldn't listen. Until one day it was too late.

The doctor said she had AIDS. Lana was shocked. There was no cure or treatment for her. She was going to die!

The days of casual sex with many men and drug abusing via needles had caught up with her. She should've listened to her friends. It was all a matter of time then.

As time passed, Lana grew thinner and weaker. Every week she would get sicker. Her life was pure torture then. Now she is dead. Now she is at peace.

EVALUATION

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Please complete, detach and return this short evaluation form to the Health Education Division, Ministry of Health, Nassau, Bahamas

Tick the most appropriate response.

1. How did you find the newsletter?

   a) very interesting b) interesting c) somewhat interesting d) uninteresting e) did not read

2. Was there any article of particular interest to you?

   Yes ☐ No ☐

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3. What changes, if any, would you like to see?

   .....

4. What topics would you like in future issues? .....

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Thank you for your co-operation!

HEALTH EDUCATION DIVISION
MINISTRY OF HEALTH

P.O. BOX N-3729
NASSAU, BAHAMAS.

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ABOUT THE CONTRIBUTORS

- AYMER, Felicity Is a Health Education Officer, Ministry of Health, Editor.
- BAIN, Rosa Mae Is a Community Health Nurse.
- BENJAMIN, Dionne is an Art Student, College of The Bahamas.
- CROWLEY, Mark is a Statical Advisor, PAHO/WHO based in The Bahamas.
- CULMER, Alfred Is a Roman Catholic Priest.
- DEVEAUX, Audrey is the Public Relations Director, National Insurance Board and a member of the Editorial Committee.
- DIGGORY, Peter is the Director, Caribbean Epidemiological Centre (CAREC) based in Trinidad.
- DUAH, Owasa is a Registrar in the department of Pathology, PMH.
- EDWARDS, Shandalanae is a summer student in the Health Education Division, Ministry of Health.
- FERGUSON, Pamrica is the Nurse with responsibility for Infection Control PMH.
- GARDNER, Alice is a Nursing Officer (Grade 2) PMH.
- KAZI, Surayya is a Registrar, department of medicine PMH.
- MINNIS, Julieth is a Senior Nursing Officer, PMH.
- OFOSU-BARKO, Kenneth is acting for the Medical Officer of Health, New Providence and a member of the editorial committee.
- OSADEBAY, Emanuel is a Barrister-at-law.
- SASSOON, David is the Managing Editor of Action For Children, a publication of the NGO Committee on UNICEF.
- SAWYER, Madlene is a practising Obstetrician and Gynaecologist in Grand Bahama.
- WEIR, Emmette is the Chairman and General Superintendent of the Methodist Church in The Bahamas and Turks & Caicos Island.

EDITORIAL COMMITTEE

PLAY HARD TO GET — AND MEAN IT

PREVENT AIDS

Cover designs by:
Dionne Benjamin

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PUBLIC HEALTH DEPARTMENT
MINISTRY OF HEALTH
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