Conclusion and seeing a medical physician for

Business, Management

ConclusionThe small sample size and other biasesincluding gender and socioeconomic circumstance are noted when commenting onthe results of this study, thus results can be taken as observations only. Verypositively it is noted that all patients were receiving appropriate ART andseeing a medical physician for monitoring at least once per year, in line withWHO recommendations. HOH seems to bedoing an excellent job in the care of HIV patients.

Of note was thesocio-emotional support for patients and the medication adherence of allpatients. Socioemotional support as previouslymentioned is one of the key components of helping a person living with HIV, with many patients commenting on the encouragement they receive from HOH, doctors and family, as well as further understanding that they can live a fulllife with HIV, to be the reasons they cope well and do not continue to sufferfrom symptoms of depression. Patients also noted feeling very well supportedwith taking their medications and attending hospital check-ups. The positiveoutcomes of this support are seen with the minimal hospitalisations of patientsand overall minimal symptoms experienced by patients (Table 4). The main areas identified forimprovement when considering the previously mentioned data and comparing to WHOstandards include TB exposure prophylaxis at House of Hope, education andempowerment of patients regarding HIV details, such as CD4 count and viral loadand third the lack of physical examination by medical professionals.

Tuberculosis is spread via airbornedroplets that are expelled whenever a person with active tuberculosis coughs, sneezes or spits, only a few of these germs need to be inhaled for anotherperson so become infected (WHO,

March 2017). Studies have shown tuberculosisbacterium to remain viable in the air for up to 12 hours (Schwartzman & Menzies, 2000). Tuberculosis therefore requiresstrict airborne precautions to prevent transmission to other people, mostimportantly those compromised immune systems, such as HIV patients. WHOrecommends two levels of control of TB in HIV care setting including work placeand administrative controls and environmental and respiratory controls (CDC, WHO& The Union, 2006), more information on these can be found by followingthis resource. Understandably, House of Hope does not have the infrastructure suchas ventilation rooms, but there are many small changes that are possible witheducation and understanding of the mechanism of tuberculosis spread. Someexamples include; rapid testing of any individuals showing symptoms oftuberculosis and initiation of the possible airborne precautions in the interimincluding education around cough hygiene, protecting health-care staff andvolunteers (particularly those from non-endemic countries) by instructing themto bring their own N95-level masks when needed (WHO, 2009) and total physicalisolation of TB and suspected TB patients from HIV patients, in well ventilatedareas (CDC, WHO & The Union, 2006). While HOH achieves many of theseobjectives as outlined by WHO for “ Resource-Limited Settings” (Granich, 1999) communication and education ofvolunteers and staff members is still further required.

CD4 and viral load monitoring is a keycomponent of understanding HIV status. Results of this study have shown that fourout of nine HOH patients did not know what CD4 count was and six out of nine HOHpatients did not know what viral load was. While this is very difficult tocomment on and make suggestions for, for cultural and individual reasons, thisstudy highlights that

there is room for improving education of patients withinthe House of Hope community with the aim to improve their sense of control overtheir condition and therefore wellbeing.

On the part of medical professionals, thelack of screening at the time of diagnosis, particularly for STIs, but alsoviral hepatitis is difficult to comment on as it may relate to the diagnosis ofmany patients being over 20 years ago, health literacy of the patients orcultural considerations. A lack ofregular physical examinations is also noted. A possible suggestion to bridgethis gap is education of these patients for what to look for themselves by HOHstaff or the Projects Abroad Public Health Team. Examples include such inspectionof their oral cavity and skin for signs of cancers (e.

g. Kaposi Sarcoma), skinrashes, noting their weight and any changes (Martagon-Villamil &Skiest, 2017), furtherinformation can be found in the references below. In conclusion, this study has shownvery positive outcomes for the HIV patients at HOH when comparing their ongoingmanagement to WHO guidelines. Areas identified for further possible improvementinclude; tuberculosis prevention and prophylaxis, education surrounding HIVmonitoring and finally self-physical examinations to watch for warning signs ofHIV-related illness.